GAPB Public Meeting 2 – Afternoon Session

-Welcome back.

We will now begin our afternoon sessions.

For session one, we have Patricia Kelmar and Loren Adler who will provide us with an update from the Subcommittee on Public and Consumer Disclosures and Coverage.

-Thank you.

Great.

I think we're going to jump in.

I think Patricia and I was going to start off and kick this presentation off and then hand it over to Patricia around midway.

I think we wanted to talk to everyone here today about -- so, as you heard, it was sort of broke up into two subcommittees.

One of them was focused on public consumer disclosures and coverages.

Patricia Kelmar and I got the opportunity to help sort of organize things and try to bring together folks through conversations over various topics, which I think were very fruitful.

And today, I think we're mostly going to be touching on sort of, you know, what were the sort of concrete questions that we were attempting to sort of deliberate upon in our subcommittee.

And then also, you know, who did we hear from?

I think we've sort of mentioned we tried to bring in a bunch of subject matter experts to help inform our opinions on these matters and, you know, and sort of talk about what we learned and some of the takeaways that we've had from these discussions.

So jumping in, if we can change to the next slide.

Very broadly, just to kind of give an overview of the sort of goals of this subcommittee, right, we were kind of focused broadly on two big questions.

One very big question is sort of how can consumers best be protected from costly ground ambulance bills, right?

Sort of the, you know, what are the consumer protections here that can be important?

You know, what coverages might be needed?

And then the second question is around this issue of disclosures, which inevitably is very complex in the ground ambulance and any sort of emergency setting here.

But, right, is there a role for disclosures to help patients better understand the cost of ground ambulance transports and services more broadly?

And if so, what might those actually look like?

And stepping into a little bit more detail on some of the questions that we tried to tackle on the next slide here, some of these were touched on earlier by Asbel at the outside of things or Shaheen at the outside of things.

But we were kind of focused on, you know, the top -- at least coming into this, we wanted to discuss the following questions here.

The very sort of big one here, right, of should balance bills for ground ambulance services be prohibited?

And then I think, you know, a big question that comes up in all of these conversations, if so, should the ground ambulance services just be incorporated into the sort of No Surprises Act protections that we already have, or would different protections be more appropriate here?

And then sort of following on, right, should any protections apply to non-emergency transports or is this sort of only the EMS side of the world?

And if so, should those differ from the protections for emergency transports?

And then also, you know, should any protections apply to sort of assessment, first responder, or other non-covered fees often issued by the locality rather than even the ambulance entity themselves?

Moving on, a few more questions on the next slide here.

I just wanted to touch on the sort of on the disclosure side here, right, you know, can we really craft meaningful public and/or consumer disclosures for ground ambulance services?

And then a question that came up, you know, in our kind of early deliberations and in this subcommittee was, you know, should there be cost sharing limitations for emergency ground ambulance services in Medicare Advantage program where it's, you know, private plans administering the sort of public Medicare benefit?

And then lastly, you know, the sort of big picture question of should there be some sort of federal universal emergency medical services benefit?

And then as I mentioned at the outset, we heard a lot from a lot of folks in this subcommittee, if we could sort of push the slide forward.

And we heard from really kind of cross-section of different folks in this area.

So we heard from some folks from CMMI to talk about that ET3 model that came up a little bit earlier, right?

This is sort of a lot of talk has been, right, Medicare is right now only a transport benefit.

This, at least in theory, was sort of CMS's or CMMI's sort of move to try to go beyond that a little bit and get to sort of, you know, transports to alternative destinations and some sort of, you know, dealing with some of the treatment in place sort of issues.

So we heard from that side from CMS's side there.

We heard from a couple EMS billing companies, which is very helpful to kind of hear through what, you know, what are the services that are getting billed?

What are the difficulties?

You know, where do the difficulties lie?

What tends to get covered and what doesn't?

And sort of along a similar note, we also heard from some insurance claims data organizations.

So there's a handful of organizations out there who basically collect insurance claims.

So from the insurance companies, you know, so they sort of compile claims from different insurance companies and they can kind of, you know, you can see anything that gets billed to insurance there.

And, right, we can see when it's just the sort of base, just the transport sort of codes or, you know, in commercial insurance, we do see that sometimes there is billing and there is coverage for certain non-transport services or, you know, supplies and that sort of thing on top of what Medicare might have paid for.

And then also, lastly, we heard from a number of state officials in states that either have enacted/thought about state-level surprise billing laws for ground ambulance services or states that have sort of dealt with sort of the regulation of rates and coverages potentially at the state level usually.

So Connecticut being the kind of core example.

They're among these.

With that, I'll pass it over to Patricia to kind of give a little bit more detail on what we heard from these various folks.

-Thanks.

Yeah.

So we'll go to the next slide, please.

So these next two slides, we're going to recap some of the things that we did here from the subject matter experts that we brought in.

And as we discussed earlier today, right, emergency services encompass so much more than just that simple ride to the closest hospital.

We heard about the work being done by emergency responders for patients at home or in the community that don't end up with the patient being transported to a hospital.

And we got into it this morning, but the key thing to know is that these services called treatment in place, because they don't actually involve in the transportation, are not reimbursed under Medicare.

We heard some commercial plans offer some reimbursement for treatment in place, but we learned that at least some portion of ambulance responses are not reimbursed when the patient either doesn't need to go to the emergency room or refuses to get in the ambulance.

So obviously, besides the need to ensure our ambulance services are covering their costs, including this kind of response and treatment in place, we question that whether the lack of reimbursement for non-transport care raises the question about whether or not this incentivizes ambulances to transport patients to emergency rooms, even if there isn't a real pressing need for additional care, just to ensure that the ambulance provider can bill for their response time and effort.

So that kind of perverse incentive might exist there.

And, you know, we want to always be trying to drive towards the least expensive levels of care.

So if we can treat folks in place that would be better.

Obviously, once they get to an emergency room, then they're going to have all the emergency costs that are associated with that.

And so we don't want to have perverse incentives there.

In addition to emergency transportation from the home or community to the emergency room, there are many patients, as we talked about this morning, who are already in a hospital setting, who need ambulances to go to another hospital for the specialty care that they need.

And these are generally called inter-facility transports, going from one facility to another.

These transports are done more often, it seems, by private ambulances, not necessarily like the fire and community-based ambulance services, and are often not in network.

And so this is another source of surprise, billing those out-of-network costs that patients are experiencing.

But additionally, we came to understand that these inter-facility transports sometimes aren't covered by the health plan, especially if somewhere along the line, the transportation is deemed as non-emergency transport.

So patient billing problems arise, not just in emergency transportation, like from the community or from the home, but also for these hospital-to-hospital ambulance transports.

And then the last bullet there, although balance billing is prohibited for Medicare, we did learn that because of the cost-sharing and Medicare Advantage being set at a fixed dollar amount, it results in a much higher cost-sharing for people in MA plans.

So that doesn't necessarily make sense.

If you're on Medicare, you should be feeling like you're paying the same for your ambulance transports.

So those were the first three things we wanted to mention.

Anything you want to add there, Loren?

-Yeah, sure.

And just to kind of quickly add on, in terms of -- sorry, I think on the first point here, we were talking about coverage for non-transport services here, right?

Some of that is not necessarily just surprise bills in the traditional sense where we were talking about the definition earlier, where it is, right, and the balance bill that is the difference between the charge and the allowed amount, right?

This is often, or at least sometimes, is a case where the insurer might not cover it at all.

So you might just get a denied claim or something along those lines, and the patient similarly is left liable for what can be a hefty bill for services that obviously were rendered by the ambulance organization.

So that is, you know, I think one of the important parts that maybe doesn't fit in our technical definition of a surprise bill, but I think fits in the broad context of what people would think of here.

And then just, I think on the Medicare Advantage point, I think this one was something that was new to me, at least.

I hadn't really thought of as much, but it does seem that the data that we saw, that certainly showed that it does seem to be notably higher cost sharing sometimes for transports in the Medicare Advantage program than for the exact same transport for someone covered by traditional Medicare, even though broadly you're supposed to sort of -- Medicare Advantage plans are required to sort of have overall kind of similar cost sharing across all their services, or at least comparable coverage.

But this seems to be one of those potential gaps.

-Thanks.

Yes, we'll go to the next slide, please.

So just to go over a little bit about what we learned from the states, and as Loren mentioned, we heard from places where both, they have state ambulance surprise billing protections and states where they didn't, and some are doing different things regarding ambulances.

So we heard a lot of different things trying to learn from others.

The consensus of all the state regulators were that patients needed to be taken out of the middle of these network disputes and emergency situations because they have no ability to choose the in-network provider.

The ambulance is being sent to respond.

Regulators agreed that patients should be able to rely on their plan coverage and their cost share without worrying about whether or not the responding ambulance was in-network.

We discussed with all of them what kinds of disclosures might be helpful.

There seemed to be consensus around the fact that disclosures in an emergency situation wouldn't be helpful.

You're just going to go ahead and hop in that ambulance.

But some states did require some level of consumer disclosures in a variety of situations, in the billing situation, or we did hear, and if anybody knows more details about it, that there was at least one state that required a good faith estimate in the inter-facility situation.

So we'd love more public comment on the consumer disclosures and what is working and what we might want to look at.

Then we also heard from subject matter experts in the states that have established ambulance surprise billing protections, emphasizing the importance of creating a payment system for out-of-network ambulances that didn't drive up premiums.

So just being cognizant of whatever this mechanism is to pay those out-of-network bills is not the reason that prices were going to go up and that premiums therefore would go up as well.

We heard from states that use local or state rate-setting processes.

How rate-setting is done varied tremendously by the region, but the rates are essentially like charge master or list prices.

And even though rates are set by local or state entities, the insurers are not necessarily required or are not required to pay the established rate.

And so despite the fact of rate-setting, patients are still receiving surprise out-of-network bills if the transportation that is sent to bring them is an out-of-network provider.

So it was interesting to kind of hear all the different ways that rate-setting is done by the different regions.

And then, you know, just to recap a little bit for folks who aren't following, we now have 13 states that have ambulance surprise billing laws.

We had a good briefing on what most of those laws are doing, the commonalities between them.

And so most states are, you know, protecting patients and taking them out of the middle.

They're using some percentage of Medicare rates as a payment standard, citing that this was the simplest way to come up with a payment structure and create a clear payment without the need for arbitration, which helps keep the overall administrative costs of the program down.

So I think that's a recap of what we heard.

Is there anything else, Loren, you wanted to mention?

-Yeah, I was just going to add, I think, one sort of upshot of all of that to some degree that we heard, but also emphasized by a couple of the state folks here was, right, there's sort of two structures that we've seen in states and localities trying to get at the ground ambulance cost and billing side of things, right?

I think there is either the state rate-setting approach, and we heard about some of these, where it is, you know, obviously very intricate and trying to come up with very detailed, you know, taking into account the costs of all the services, you know, figuring out exactly which types of services you can bill for and how much.

But, you know, as Patricia was saying, right, that is regulating how much they can bill, right?

That is sort of the bill charge regulation and does nothing to say what the insurance company has to pay or that the insurance company has to pay that.

So, right, that situation still very often can leave in place a risk of a balance bill for the patient.

And I think we heard in some cases the state or locality might even require the ambulance company to bill for that full, the sort of regulated charge here.

So it's almost like requiring that there be a balance bill if the insurer isn't paying, isn't sort of allowing the full charge here.

And then the other approach here of the state surprise billing laws, a point that was emphasized some by the sort of overview groups that have looked at this as well, is, right, these only apply to basically less than half of folks who are in commercially insured plans.

So there's sort of this breakdown in health insurance world where there are, you know, about 40% of folks are in what are called fully insured plans, which means it is, you know, the employer pays a premium basically to the insurance company, sort of what you traditionally think of as health insurance.

And then it's really the insurance company on the hook if it ends up costing more money or the insurance company who makes money if it ends up costing less money.

And then about 60% of folks are in really what are called self-funded or self-insured employer plans.

So that is really when it is actually, you know, they still use an insurance company to kind of handle the benefit and handle the payments, but it's really the employer who's on the hook for the sort of end spending there.

And due to the federal ERISA statute, basically states are unable to, or it seems that this seems to be the legal delineation here, is that states are unable to regulate what those self-funded employer plans pay for medical services, including ground ambulance services, such that all of these sort of state surprise billing laws that we heard about don't apply to typically more than half of the commercially insured population in the state, all sort of getting out where a lot of folks were talking about how they're still, even though we have these sort of various apparatuses around the country, there still is very arguably a need for sort of federal regulation here that can sort of cover all angles here.

-Yeah.

And so next slide, please.

So we just had some very broad takeaways from all these subject matter experts, and we're still talking and thinking, and that's why your public comments are really important to us.

But our takeaways are that patients need protections from out-of-network balance bills.

And, you know, as Loren said, even though we do see states taking action, it isn't protecting everybody in those states, so a national solution is likely going to be needed to make sure that everyone has the same kinds of protections.

The network status of the responding ambulance shouldn't impact how much the patient pays in cost sharing.

We should acknowledge the value of care offered in communities that doesn't result in transportation, so we can be incenting the right types of treatment at the right time and reimbursing ambulances for the time and service of providing even non-transport care, especially as that seems to be growing.

Disclosure is not helpful in an emergency situation, but there could be a helpful role for disclosure for transportation for perhaps scheduled transports, especially if the patient has some level of choice and could benefit from the cost savings based on that choice.

Also, as we talked earlier this morning, you know, the disclosures of a better bill, a clearly understood ambulance bill, would be really helpful in this situation.

And it's not on this slide, but the other takeaway is following up on what Loren was talking about with people with MA plans are paying more generally for ambulance transportation than those in regular Medicare.

So those were our big takeaways.

Loren, anything to add there?

-I just wanted to clarify for folks watching on here that you'll notice sort of a gap in, just to re-clarify that our committee was focused on the sort of consumer protection and coverage and sort of disclosure side of things.

Our purview, we were sort of not really focused on the sort of payment pieces.

We still, you know, when you're talking to states, you still hear a little bit of that.

But you'll notice that some of what's going to be here and some of what's going to be in our next slide are sort of questions we're looking for feedback on are not -- we're not saying that isn't very important.

It is very important.

That's just the next thing you're going to hear about after ours.

So I think also for the discussion, it might be helpful to sort of narrow in on that.

We'll sort of talk about that in the next section of things, the sort of actual, like, what should a payment standard be?

Should we use arbitration?

Those sort of, I think, very big questions that are obviously going to be very important.

But I just want to clarify that if you're kind of like wondering where some of that is, that's the reason.

-Right.

Good point.

That was not our subcommittee's charge, although we're very interested in it, obviously.

Next slide, please.

So these are some of the questions that we are particularly looking for feedback from the public.

And I think most of them, if not all, are captured in the general set of questions that Shaheen put out at the beginning that are listed on the JAPB CMS website as part of this agenda and that I understand will be posted again in a different format.

But anyway, you know, generally, we are still looking for good ideas, examples that you can point us to, particularly in the disclosure area.

But we do want to hear from everyone.

And thanks for coming on this call.

It's really important.

The comments are due, as has been mentioned a few times, preferably before September 5th, just because we do have to, like, think about these things and read them and have time to be able to absorb them in order to write our final recommendations.

So that's it for our presentation.

As Loren mentioned, the payment side of things will be in a different part of the agenda later today.

So I think I'll let Asbel or Shaheen moderate the rest of this.

-Thank you, Loren and Patricia.

I appreciate the update or whatever.

And I see that there are several questions coming in from the committee as well.

I am going to ask Terra and Matt from PRI, if you will, open the chat for public comment as well, so we can have this Q&A.

We do have up until about, let's see, 2:45 Eastern time, 1:45 because I'm on Central.

So if you can get your comments in, we'll actually, if there's some questions that we can try to answer or at least acknowledge your comment as we continue to work through this.

So I'll first go to Gary.

-Hi, thanks.

Could you go a couple of slides back, the one before takeaways?

Yeah, that one on the bottom, when you guys got information about the% of Medicare's rates that would be covered, I'm wondering if that percentage was expansive enough to cover the cost of a full-time rural ambulance service, where it might be like four or five times the Medicare rate, or was it more limited to something like 150 to 200% where it would not cover the cost of rural, super-rural and frontier ambulance services at all?

-Loren, would you like to kind of comment on how we got to that point as well from the subject matter experts?

-Yeah, sure.

So there's a handful of states who have sort of used a percentage of Medicare.

All of the states so far have used the same percentage of Medicare across all transports.

Some of them exclude certain transports altogether from the law, but they do use sort of a standard thing.

So Colorado, for instance, is using 325% of Medicare.

But we do remember, right, that the rural Medicare rate is substantially higher than the urban rate.

So to some degree, that's, right, there is some -- 325% of the rural rate is more money than 325% of the urban Medicare rate in dollar terms.

So there is a differential that's built into these sort of structures.

Whether that is enough, I think, is an open question.

And then I think there's states like Maine who had, I think, it's 180% of Medicare in Maine, or it's 200% if it is an in-network transport, or 180% if it's out of network, a slight differential there in Maine.

But some of this is, right, coming from different places.

Maine historically had sort of lower charge master, or sort of bill charges for their ambulances than maybe Colorado did.

-And I think to further clarify just about where this came from, from the state's perspective, Gary, is just the different states that are doing, that we asked for subject matter experts to come to the committee to discuss what they might be doing at the state level around these protections.

And some of them have actually put some type of Medicare rate benchmark in there for out-of-network.

-Yeah.

And a lot of it, they were talking about just the simplicity by and large of just, look, it's a rate structure that exists.

It may be imperfect, but if you can pick a multiple of it, right, it is dialable in that sense.

Although it did not seem like any of the states had touched on the sort of requiring a specific payment for non-transport services.

Although I could be wrong because we haven't heard from literally everyone and that sort of thing, but that would actually be something for public comment that I personally would be very interested in is if folks know of sort of any state payment requirements on the insurer side that they get at the non-transport services.

-Okay.

We see public comment coming in.

I'll go to committee member Ritu.

-Yeah.

Hi.

There are two thoughts.

One of the things that we did discuss a few times, and I think would be very interesting from a public comment perspective, is the idea of just not allowing there to be in-network versus out-of-network in the emergency setting.

And so I think getting feedback on that, it does seem odd to me that since you don't get to pick who comes to your house when you call 911, that having networks makes very little sense.

And then on the disclosure side, one of the things that a couple of us have felt is pretty important is to make sure that the field provider, the paramedic or EMT, is not sandwiched in the middle having to obtain disclosures at various times, that that is not a function of being a person who takes care of patients.

-Thanks for that, Ritu.

And I know that some of what you just brought up is in the request for public comment around this as we continue to deliberate moving forward.

Very great points to note for public comment.

Sean.

-Yeah.

And this is probably more of a question or clarification.

I think earlier in the slide deck when we were talking about state and local rate setting processes, a comment I believe was made about that wasn't necessarily tied to an insurer being required to pay that rate or whatever.

But I believe from some of the more recent states that have passed legislation, I'm thinking that Texas, Arkansas, Louisiana, things that we heard about, there really was a -- if there was a vetted state and local rate setting process, that would be in fact that payment and then balance billing would be waived or not done.

So comments on that or clarification?

-Yeah, I think that's probably important to note there, Sean.

And I'm seeing that coming in some of the public comments as well.

And as you can tell, we're getting more and more, I think from the individuals that actually we heard from, from the insurance commissioners, that was not the requisite, though we are very aware that the state of Texas, I know the state of Louisiana, the state of Arkansas, I believe we had individuals from Georgetown actually provide some clarification on some things on what they determined that to be as well.

So that is very important work that the committee is actually looking at, how that impacts, because this is a little nuanced, and then some of the other states that we heard from, that it appears like, for example, in the state of Texas, for the public that may not be in part of some of these deliberations.

If you submit, I think this starts effective January the 1st, but if you submit to the Texas Department of Insurance that you have a local governing rate, then that's kind of your established beginning of what they would call your billed charge or the allowable rate.

And if not, there is a percentage of Medicare.

I mean, I think something similar is happening in a few of the other states as they continue to work with it.

But that's an important point to note, Sean.

Thanks for asking that question.

Loren or Patricia, anything to add to that?

-Just to sort of clarify where I was.

I think more broadly when I raised that earlier, I was trying to differentiate that you can connect the two between rate setting, like local rate setting processes and surprise billing laws.

The way I was framing in my head is that there are plenty of rate setting processes where there is no connected payment, you know, payment connection there.

And that is very common in the country, that there is local rate setting, but there's no sort of payment standard.

And yes, like there is some rate regulation there, but that's not solving the full consumer protection problem.

And then separately, surprise balance billing laws at the state level also, because they don't address the self-insured, don't sort of address the full consumer protection problem.

But I think the broader question of how to set the payment standard is probably better punted for the next, or I guess its two sessions from now.

-You're exactly correct.

And that's the dynamic as we move into the next session to get the update.

And that's kind of what the committee will continue to work through into the second half of this charge up until November as well.

-Right.

And just to clarify.

-Oh, yeah.

Go ahead, Patricia.

-Yeah.

We were hearing from subject matter experts where the, you know, the law was already in place, right?

So these three that are mentioned are brand new, right?

Haven't gotten into effect yet.

So you know, for sure we should be looking at them and seeing how they're working, but there really wasn't anybody to talk to about like how it's working because it's not yet.

-Because it's just implementing, and that's a very good point that Patricia is, because this is new implementation.

So there's really not any background yet to kind of figure out how it's actually working.

Good point.

Pete.

-Terra, could you go forward one slide, please?

One more, please.

All right.

First off, great presentation, Loren and Patricia.

Appreciate the work and the partnership you guys have been participating in our network adequacy subcommittee, and appreciate it.

So on this, the second bullet point, should insurance coverage be required for certain non-transport services?

And absolutely.

It's something we've been talking about, you know, that first response component.

And again, as Bill and I had a good conversation a couple of weeks ago about one of the issues being is that in many cases, these non-transport services, they're being provided by paramedics, but they're being provided by paramedics that are working for agencies, the first response component that do not have an NPI.

And so for example, I'll use LA County, one of the biggest EMS providers in the nation, the paramedic providers, they provide the paramedic service and all of their response area, 180-some-odd fire stations, lots and lots of calls.

They're prohibited from billing for covered services because they have no NPI.

The NPI should not be, in my opinion, tied to -- this is a conversation we need to have -- the NPI should be tied to the provision of service, not the provision of transport.

So we need to look at how we can set up that the individuals can be billing for non-transport services that are not transport agencies.

Because in many cases, like LA County, unless the patient is transported, then they have a partnership with the private ambulance company who bills at the ALS level, but these non-transport -- same with Orange County Fire Authority that is below them, another 80-some-odd-station department.

We have to come up with a mechanism to be able to get the NPI to the provider of service, not tie it to the transport.

Secondly, we just get down to this issue of the cost sharing and Medicare Advantage.

If we are going to limit it, I just would hope that we would be able to model what the premium savings and everything was so that we can offset.

We always hear about how when we change some of these other rules to require a more appropriate reimbursement for ground ambulance transport and reimbursement for these non-transport services, the rates are going to go up, premiums are going to go up.

So if we're going to do anything that is going to reduce rates, recognize that's impacting those of us that are ground ambulance providers, but at the same time, we need to take into account the savings from the insurance companies to be able to move it potentially over to save the people not in the Medicare Advantage side of things from additional costs.

So thanks again.

-Thanks for that, Pete.

Regina.

-Yes, thank you.

I wanted to throw this question out for the committee just for consideration.

Have we had any thoughts in how insurers can help with consumer protections, and are we willing to perhaps negotiate those rates or assist with that and such as EOBs and plan coverages or et cetera?

Have we given any thought to that?

Is that within our realm?

-Yeah.

I mean, I would say I think about that a lot because the first thing that the patient gets is that EOB, and I think that's a great opportunity to do some education and to help clarify what people actually do owe or if they have a problem or a question, where to go for help.

So I do think we should be developing and would love people's comments on what are the different touch points for the patient in this whole healthcare journey that they experience when they're encountering an ambulance, whether it's from the community or already in the hospital.

And then who and when are the appropriate ways to give the consumer the disclosures that they need and that will actually be helpful.

So there are lots of touch points.

It doesn't mean that those are all the ones, but patients can only have capacity for some things, some information at some points.

And if there's really no choice, for example, the only one ambulance in the area is out-of-network and they're not protected from balance billing, then being told that is not super helpful.

So yeah, but I appreciate that and I think, yeah, the ideas, examples, send us the pictures of the kinds of disclosures that you're doing, all of those things would be super helpful.

-Thank you, Patricia.

-Rhonda.

-Thank you.

Kind of along those lines, I think Colorado had a really nice website where they provided a lot of education to the consumer about what their state law had enacted.

So I think that that would be beneficial for us to recommend.

Also, I think we have to be very, very careful about who is providing that disclosure.

It says here facility or the ground ambulance company, you know, and I would put that back on the insurance provider, making sure that they're a covered entity or the covered individual has a good understanding of their policy and what type of coverage it has for both a scheduled or inter-facility transport or an emergency transport.

As Ritu said, people who are in the business of caring for these patients, we don't know what their individual policy may be covering.

And it's just as important to get that patient to a higher level of care or wherever they need to be, whether it's from the field or from another facility.

And I just don't think we should be putting that on the facility or the EMS provider.

-Very, very good comments.

To a point, Patricia, when you guys were talking through that, wasn't there discussion around if emergency disclosures -- I think there was general consensus that emergency disclosures were probably something that wasn't even doable within the EMS space, but there was some discussion about maybe possibly like a scheduled or something.

Can you give a bit more information on that?

-Well, I think, you know, yeah, we're thinking about what would be helpful, particularly if we can't get protections and coverage for these inter-facility situations where the patient really has no choice.

They need to go get that other care.

But, you know, I think disclosure only is helpful when there's an actual choice that can be made and that, you know, is benefiting the patient to be able to make a choice that might cost them less.

Just telling them that, guess what, you need to go to this other facility, and you don't have coverage to carry you there.

I mean, yeah, they probably should be told that, but how is that helpful?

-So I guess, just kind of looking at it from a facility perspective, what we would be telling the patient is, you may not be covered for this ambulance transport, but you're also not going to be covered to stay in the facility any longer, like you've been discharged, for instance, or you need this or you need that.

So I don't know how beneficial that would be to the consumer, sort of that either-or.

-Yeah, and so this is like the challenge we're facing, right, because the committee's goal or mandate is to look at the billing and the surprise billing and the out-of-network billing, but what we're encountering in some of these inter-facilities is no coverage at all, or, you know, a debate about whether it's covered.

So you know, it's like somewhat beyond it, but also it's the bill that the patient is still getting, and it is a surprise, but maybe not technically defined as a surprise bill.

I don't know if Loren wants to add in there.

-No, I mean, that's right.

I mean, I think in the ideal world, the patient has some interfacing between the facility and payer to know whether it's going to be covered or not, but, you know, I think it's important to be upfront that it's hard to view -- I mean, for all the reasons Patricia says, that this is not like the solution here, right?

This is maybe one small piece of the puzzle, but it is challenging.

And especially once you get out, scheduled transport seems to be the only spot where this even seems possible.

I agree too, and others have brought up like the idea of doing this in the field on an emergency pickup.

It just seems absurd.

So you know, sort of focusing in on where and when this might even occur.

-Agreed.

-I think generally speaking, what you're hearing, as the committee has explored since May, has been emergency services, just trying to understand the disclosures.

There's other components of EMS that are happening.

Does it fall within the purview of the no surprise bill or the balance bill?

That'll be the basis.

Some things may come in as findings and may not necessarily recommendations as well, and that's something that the committee continues to deliberate on as you're hearing through this process.

Pete?

-Just was going to say that this is where we have these determinations of what's non-emergent or emergent.

I've got a significantly busy hospital in my city, and in San Diego County, when a facility needs to transport a patient, because it's not a trauma center or to a burn unit, they're required to call a private provider first.

That private provider has a certain amount of time to be able to staff and provide that service.

It's not necessarily considered an emergent when they're calling that private provider.

Yet, if the private provider is not available, the county protocols say that they can dial 911, and one of my ambulances goes and picks them up and sometimes gets a nurse to jump on board.

We take that patient to the hospital, and guess what?

It's automatically counted as emergency simply because they dialed 911.

This is where it's not efficient, and it's penalizing the private provider over semantics simply because the private provider isn't dialing.

They're not accessing them by dialing 911 in my jurisdiction in a lot of San Diego County.

It's still an emergent transport that that patient needs to be transported out of that facility to another facility to receive the appropriate level of care.

It becomes really problematic when the insurance company is able to say the private provider is not an emergent transport because, guess what?

They had an hour in order to get there, an hour and a half, but the 911 provider is an emergent.

It's the same transport.

-Thanks, Pete, for that comment.

We're still getting public comments coming in.

If the committee has something that they would like, there is going to be some stuff and discussion that we will have in the second half of this where our other subcommittee was talking about cost and payment and networks and things like that.

I know there's some stuff here about variable coverages, that insurance care.

We're getting some public comment on that regarding they might be covered, but the coverage is variable.

I'm making an assumption.

We're talking that there might be a limitation to the coverage.

So Loren and Patricia, I know that was kind of discussed, and there's certain things that we're asking for public comment on specific examples that individuals have of maybe where they've accessed emergency services, and there's been either partial coverage, no coverage at all, as we continue to deliberate that to make sure that our recommendations or findings are succinct.

But anything, I know this may have came up or whatever, but anything to talk about from that public comment or further clarification?

-I'll just say from the public comment perspective, I think we would love input on how specifically to define, right?

There are inter-facility transports, for instance, are sometimes covered, sometimes not.

There are a number of criteria that go into that.

If you're thinking from the writing a surprise billing law sort of thing here, how are you crafting that?

How are you defining that you have to have coverage for all inter-facility transports?

There's probably some limit, and how do you define that sort of limit?

So I think we would love sort of comment on how you just sort of define what coverages need to exist, particularly once you're outside of the sort of very standard kind of like a base rate and a mileage rate for an emergency 911 call transport.

-Okay, and I think that Gary Wingrove just made a comment, and as a committee member, Gary, I'm going to ask if you will, if you have the ability to come on and discuss that.

I think you make a really good point that needs to be discussed.

I don't recall that yet coming up in committee.

I do think that's probably something that we can interact.

We do have time to have some discussion around that as a committee relative to that if you are on.

Gary?

-I'm on.

My comment is we're spending a lot of time talking about ambulance service transparency and disclosure, but we haven't yet talked about transparency and disclosure of the insurer.

For example, did they submit a take-it-or-leave-it contract, or did they negotiate in good faith to try to get a contract.

And if they submitted a contract, how was the rate calculated?

There are probably other issues related to the insurer disclosure and transparency, but I just haven't seen us address the insurers yet, and I think they need to be addressed.

-Gary, can I just ask, how does that help the consumer?

I'm not understanding how that disclosure would help the consumer when they're facing an ambulance transport.

-Yeah, so they get the ambulance bill, and they've got some balance to be paid.

I think it's helpful to a consumer to have access to how the insurer contracted with the ambulance service.

I would like to have that if I'm a patient.

-I can fully see why academics and other policy people would, but I just don't see how that would help an individual consumer.

-Yeah, I think it gives them an understanding of why they're getting a bill at all, especially in the rural communities where that bill may be significant because of the cost.

If they're doing a 200% of Medicare, that's not going to cut it, and I think the insurer should tell the consumer that they negotiated it in faith or not, or there may be other topics.

I can maybe join your committee sometime and talk about this more, but I think we need to hit the topic of insurer transparency and disclosure because it's not just the ambulance charge that's a factor, but it's the ambulance service that the patient gets mad at.

Being able to give that patient a link to a website that talks about how the insurer does their contracts and how their rates are what they are, that helps the ambulance company, who's stuck again in the middle between the insurer and the patient.

Having a resource for the ambulance service to say, hey, this is your insurance policy.

Here's your insurance company website about how they do their rates.

-Go ahead, Loren.

-I was just going to add one point that I think colored some of how we were thinking about this in the disclosure category here.

There did seem to be broad agreement on there needing to be some protections from balance billing altogether, and while it wasn't our subcommittee's purview, there would be some sort of payment required from the insurer to the out-of-network ambulance.

So in that sense, that payment exists, so we don't really come across this problem, Gary, that you're kind of referencing.

The insurer who's just paying Medicare or something like that nowadays, that would be sort of against the law to begin with, so there's less of that, whereas -- and this came up in the disclosure rates to begin with because those are difficult under the current status quo.

Again, how much value is that providing?

But are there some disclosures?

And that's why we kind of focused on the EOB kind of focus here, you know, an EOB is under the No Surprises Act, for instance.

You're supposed to be telling the patient that this is a covered service under the No Surprises Act.

You should not be surprise billed.

Those sort of disclosures kind of after there is some law in place I think will be very useful.

-Well, and I think it's important to note, to Gary's point, that the charge of the committee is also to improve the disclosure of charges and fees for better-informed consumers of insurance options for such services, as well as protect consumers.

So protecting consumers, of course, is definitely important.

I think there's been general consensus on that from the committee, but are there some ways that we can inform the consumer of insurance options?

And that is broad.

Raj, I don't mean to put you on the point, and I'll get right to you, Regina, because I think this is a discussion that we have noted that that needs to be a discussion moving into, but I know there's some stuff around transparency already with insurance carriers providing rates that are kind of certain things that they've already negotiated with certain providers or what have you, as well as that.

That's something that's already under the purview of CMS that's currently doing something relative there, correct?

-Yes, you are referring to our transparency and coverage rule that essentially requires health insurance issuers and group health plans to make public their negotiated rates with all of their in-network providers.

And they are also required to make public certain information about out-of-network allowances and those payments and who those payments went to those providers.

So yes, a lot of that information is going to be able to inform consumers and regulators about how insurance companies are handling ground ambulance benefits.

At the same time, none of those data points are a slam dunk.

I smiled when someone mentioned a good faith negotiation requirement.

You know, good faith negotiation is really in the eye of the beholder.

And how do you define that?

How do you hold people to that?

So one of the questions I have in my head is what's an alternate standard to a good faith negotiation and standard?

So yes, Asbel, our transparency and coverage rule is there.

And much like, I refer to it as our older sister committee, the Air Ambulance Patient Billing Committee, we did discuss certain disclosures that would be valuable for consumers in terms of information that would be relevant to whether a consumer chooses one plan or another.

So great, great discussion.

And I think it's definitely fodder for our consideration.

Thanks.

-And Grace, to your comments, one of the issues we have is insurers will send an ambulance company a contract with rates in it and say sign it or don't.

And if you don't, you're out-of-network.

So that good faith negotiation you just talked about sometimes does not occur at all.

-And that point is duly noted and has been duly noted as we continue the deliberation of the second committee, which Raj and Lee have kind of been working through on several work groups to that process.

And that is going to continue to be worked through the process as well.

Anything else from the committee around the work that Loren and Patricia's committee has done around disclosures, consumer protections, insurance options, things like that?

There has been a lot of work, they condensed it all down into this great presentation, asking for some additional questions and feedback.

And I know Loren and Patricia have spent a lot of time working with the committee as well as the committee's input in putting this stuff together.

And kind of getting into more of where we can start putting together some recommendations that we'll all begin to deliberate on and vote by at the end of the committee as well in November.

And so this is work that's really been done.

And then we'll get into the crux of the stuff that Raj and Lee have been.

But I want to give any more time for public comment.

We do see a lot of public comment coming in.

We are going to take a lot of the comment that you're giving here under advisement as we continue to keep deliberating.

So please continue to provide the comment here.

And if it's more than three or four sentences, if you'll kind of submit it through the written comment to GAPB advisory website email address, and we'll put that back on here too, by September the 5th.

We'll also continue to look at the detail around that as to what they're saying as well.

Any other comments?

We do have some time here.

So I'm going to let the committee, if they've got anything else they would like to discuss or ask questions on as we continue to move through, as I'm scanning pretty quickly through some of the comments here to see if there's anything that we can address at this call.

-Oh, shoot.

Asbel?

-Yes.

I thought I was being kicked off again.

I'm sorry.

-Oh, no.

There you go, Raj.

I see you.

-While you are scanning, I actually have a question for Rhonda about something she put in our chat.

And Rhonda, you were mentioning this concept that ground ambulance services don't really work with an out-of-network, in-network type scheme.

And you mentioned that small agencies don't have the bandwidth to negotiate rates.

And again, there's reticence on the part of insurance companies to negotiate.

What I wanted to pick your brain about is, if it's not an in-network, out-of-network sort of scheme, what does the alternative look like?

-I would say that they're all considered to be in-network.

And so whatever we come forward as a recommendation for rates or establishment of rates, we would all be considered in-network for those services that we provide.

So in our county, our ambulance service, we don't have a contract with anyone.

And again, because we're small, we wouldn't have the bandwidth to negotiate with all the different insurance companies.

And like we've said many times, it just doesn't make sense because wherever you are located, for instance, we're in eastern Washington, central Washington.

Kaiser is very popular on the western side of the state, but they don't have any in our county.

We don't have a contract with Kaiser.

So if you are in my area and you need an ambulance, you're not going to be in-network with Kaiser.

-Right.

So if everyone is in-network, how do you envision that those in-network rates are set?

And I'm just assuming it's going to be in some way other than negotiation.

Is that how you would view this committee coming in?

-Right.

I think we've said a couple of bullet points in other presentations, either it's your state or local rate, or we would be recommending a percentage of Medicare at 350% or 325%, something similar that the other states have done.

-Okay.

I appreciate that.

Thank you for clarifying.

-Yeah.

-Looks like we've covered most of the time.

I see, Loren, your hand is raised as well.

-Yeah.

I was just going to chime in because one of the comments from Tim Dentz here reminded me of something that we didn't quite cover in our -- that we did talk about here.

So he sort of makes this comment about, you know, should coverage be required to be first dollar for ground ambulance services?

That is actually something I think that was sort of one of our touch point questions at the beginning, not necessarily first dollar per se, but also, right, the No Surprises Act framework here is just cost-sharing should be limited to what it would be for an in-network service, which is somewhat vague and really varies on the plan.

And, you know, if you're in your deductible, that could still be paying full rate for the service.

I do think one option, which we haven't -- there's no agreement on sort of solution yet, but one option we've sort of discussed is, you know, should cost-sharing be limited to a fixed dollar amount, you know, $50, $100, you know, whatever, pick your number here, and that it is, it's not just in-network cost-sharing, it's that cost-sharing can't be higher than a hundred bucks.

You could even say that applies before the deductible, right?

We have sort of examples of this in, you know, preventive services under the ACA, for instance, have to have $0 coverage, pre-deductible even.

So I do think that is one of the issues under discussion, or even going first dollar coverage.

There is actually a lot of interaction with how the rates get set here, just in sort of the -- but I'll table that for now.

But just wanted to bring up that that is actually another issue we were deliberating on, I think we'll deliberate on more in the coming months.

-As you can tell -- -Loren?

-Go ahead.

-Go ahead, Asbel.

I think you're getting ready to ask the same thing I was.

-No, I'm actually just making a statement to what Loren's saying.

As you can tell, the committee's been deliberating a lot, and we're just giving you an update, and so there's still a lot of preliminary stuff that's happening that hasn't been purely vetted yet, but Loren just alluded that this is some of the conversation that's being had for consumer protections as well.

And so this feedback that you guys are giving are very important.

So Raj, your question?

-My question was, for the benefit of everybody listening on the call, Loren, can you actually describe the first dollar concept?

-Sure.

So I would interpret first dollar coverage as -- it can be defined in different ways.

I think that's a good question, but basically, first dollar coverage, to me, would mean that there is zero cost sharing for the patient.

So basically, it is the insurer has an allowed amount, and the insurer is paying 100% of that to the out-of-network provider, and the patient is paying zero dollars here.

Sometimes it gets referred to just as the deductible doesn't apply.

Basically, if you pay 20 bucks for a primary care visit, you pay that regardless of whether you're in a deductible or not.

I'm making up examples here, but it could be whether it just applies before the deductible or not.

But certainly, there are plenty of localities that say you get billed zero dollars for an emergency ground ambulance service.

That is certainly something we heard as well, including a few sort of near the D.C.

area.

So I do think that is something that a lot of people, you know, have that view here.

-Thank you.

-Adam, I see your hands raised as well.

I'm assuming you can probably give us further clarification on that in your opinion.

-Well, I wanted to just kind of touch on the solution when we were talking about basically whether or not any ambulance services would ever be out-of-network.

And then we kind of introduced the idea of recommending federal rate setting.

And my comment there would just be that I think we want to be mindful too, some of this harkens back to like even the consumer disclosure discussion and trying to figure out where we can make recommendations where there's already an existing vehicle or an existing apparatus to, whether it's change consumer disclosures, or in this case, change the reimbursement structure for out-of-network services.

And so I would look to the No Surprises Act.

And it sounds like what, you know, we may be talking about in terms of not having any out-of-network services or just paying them all, quote, the in-network rate, is that could look like a benchmark where we recommend instead of for ground ambulance claims, instead of directing those claims to an open negotiation and then IDR process, that we would be able to recommend some sort of benchmark.

And that could be looking at existing contracted rates, the idea of a percentage of Medicare was thrown out.

So just kind of trying to make that distinction that I think federal rate setting, we wouldn't have an apparatus, you know -- I don't see that as being feasible, given that there just aren't mandated rates at the federal level for any other item or service.

But we do have the No Surprises Act and could recommend a benchmark approach that would basically get at making sure that in-network rates can dictate payments for out-of-network services and that the patient is not held in any way liable.

They're taken out of middle and they would only pay the cost sharing, if any, as if it were provided in-network.

So just kind of wanted to make that comment on that distinction.

-Thank you.

That's very well.

Thank you for that, Adam.

Ted, I see your hand raised.

-And I think to add on to that, you know, we're also seeing and hearing in committee, a lot of locations, counties, and states that have gone through processes themselves on establishing, you know, rates and charges and how they manage and oversee ambulance operations within those communities to make sure that it's the right level of service that's needed.

It's met for the geographic and what those communities needs are.

So you do have a rate setting system also on the local and state level.

It's obviously seen across the U.S.

-And I think that's an important point to note, because I believe Loren and Patricia addressed that in one of their bullet points about local and state.

We did have individuals.

Namely, I'm thinking the state of Massachusetts, New Hampshire, I believe, as well as the state of Arizona has some type of rate regulated where they regulate the rates.

Though to, I believe, Loren and Patricia point to, we did determine that that really doesn't mean it's some type of payment threshold by the insurance carrier, though it's some type of rate that looks at the cost piece of it.

And so that's something that's going to consider to be looked at as we move into the second half of the deliberative process that Raj and Lee have been taking point on as well in that as well.

So I see public comment is still coming in.

And thank you for that public comment as well.

So anything from the committee that they would like to discuss related to disclosures and what we're working through at this point?

If not, I'm going to -- we're ahead of schedule by a few minutes.

So I'm going to turn this over to Terra to give us a few minutes of a break.

And then we will move into our next session, which is going to cover where Raj and Lee have talked about cost payment and network adequacy.

And a lot of this conversation that's already started is definitely going to probably bleed over.

And it gives us a little more time.

And once you kind of hear that summary and oversight of what we've been doing there as well, and that probably will be helpful to the public and the committee.

And it will give us some more time to do public comment.

Terra?

-Okay.

Thank you.

We will now take a short break and resume at 2:55 p.m.

with a presentation from the Office for Civil Rights.

Welcome back.

Next up, we have Timothy Noonan, who is the Deputy Director for Health Information Privacy, Data, and Cybersecurity at the Office for Civil Rights for the 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, Tim served in OCR headquarters as the Acting Associate Deputy Director for Operations, and the Acting Director for Centralized Case Management Operations.

Tim 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.

Tim is a graduate of Michigan State University and Wayne State University Law School.

And with that, I'll turn it over to Tim.

-Hi there.

I want to thank you for the invitation to speak today.

I thought I would start with a short overview of what are the HIPAA rules, who must comply with HIPAA, what is protected health information, and then focus on what I think are the areas of interest for this discussion when ambulance providers are covered by HIPAA and what protected health information hospitals can share with ambulance providers.

And then if folks have questions, happy to participate in that as well.

So starting with what are the HIPAA rules?

So the HIPAA statute required the adoption of federal privacy protections for individually identifiable health information.

And this is something that is accomplished primarily through three rules that I'm going to speak about generally today.

The HIPAA privacy rule, which provides federal protections to protect the privacy of protected health information, and gives individuals rights with respect to that information.

Some examples, it provides individuals with a right to access their protected health information.

So anybody can get access to their own medical records.

A right to a notice of privacy practices, how a HIPAA-covered entity is using and disclosing their protected health information.

A right to an accounting of disclosures to let an individual know who has seen their records, who the covered entity has made disclosures of their health information to.

A right to request restrictions.

An individual can request that their information not be shared with certain people or entities.

And a right to an amendment.

If an individual discovered an error in their medical record, they have a right to request that it be amended.

HIPAA, the privacy rule basically starts with this idea that a HIPAA- regulated entity may not make any disclosures of protected health information unless it is required or permitted.

And there's only two required disclosures under HIPAA.

It's to individuals requesting access to their health information, as I mentioned a little bit, and then to OCR.

When we're conducting HIPAA investigations, they're required to disclose protected health information if that's necessary for part of our investigation.

And so what that means is all other permissions, the ability to disclose health information under the HIPAA privacy rule are just permissions.

And so that means a HIPAA-regulated entity is not required to make these disclosures.

They're permitted to.

They have the option.

They have the discretion.

And so for example, and I'll list off some here, and then I'm going to focus at the end on the ones that I think are going to be most applicable for EMS and ambulance.

Treatment, payment, and healthcare operations when we're required by another law.

So if another law requires a disclosure, HIPAA says then you're permitted to make that disclosure.

Disclosures for public health activities.

And so this can be to public health authorities for the purpose of controlling disease, injury, or disability.

And we saw some of that during COVID.

Victims of abuse, neglect, and domestic violence, there's a permission to make disclosures to that.

Health oversight activities.

And so that can be for offices of inspector generals or state insurance commissions where information is necessary to determine eligibility or compliance with certain civil right laws or where health information is relevant.

Judicial and administrative proceedings, law enforcement.

And so my point is there's a bunch of available permissions.

Anytime a HIPAA-regulated entity is contemplating making a use or disclosure of protected health information, they should understand what requirement or permission they're going to be making a use and disclosure on.

You don't want to engage in that activity after the fact because you may discover you had an impermissible disclosure.

The HIPAA privacy also requires regulated entities to implement policies and procedures to safeguard protected health information.

The implementation of these safeguards.

And then, next I want to focus, you know, very briefly, the HIPAA security rule, which more and more we're seeing this become relevant as the breaches that are reported to OCR, the majority of them now involve hacking.

And that's impermissible disclosure access to individuals' electronic protected health information.

And so the HIPAA security rule establishes national standards to protect this electronic protected health information.

And it requires various implementation of measures to help regulated entities know where their health information is stored, what protections they have on it, and then different mechanisms to, in fact, protect the data.

So a risk analysis is usually the starting point where we talk about the security rule.

And that requires a regulated entity to understand the threats and vulnerabilities to the health information it possesses, where their health information is stored, and what security measures they've put in place to protect it.

Risk management is the implementation of various measures to bring any threats and vulnerabilities down to a reasonable and appropriate level.

And then there's different requirements, such as access controls, limiting who can access the information, what workforce members in a regulated entity may have in terms of access can depend upon what role they fulfill.

A security guard, for instance, may have very different access than a doctor on staff with privileges.

Audit controls to track who is accessing information.

Security incident response and reporting, when there is an incident, that there's procedures in place to investigate and determine whether anything occurred.

Security awareness training to train everyone that's going to have access to health information.

Then, finally, the breach notification rule.

When there is an impermissible disclosure of protected health information, when there's the discovery of a breach of unsecured protected health information, the HIPAA breach notification rule requires HIPAA-covered entities to notify affected individuals, so anyone whose health information may have been accessed or impermissibly disclosed, the department, HHS, OCR, and then, in some cases, the media.

And they're required to do this generally within 60 days of discovery.

And what OCR does is there's a couple of categories.

If the breach affected more than 500 individuals, then once we have verified the breach, it'll go up on a website on HHS.

So the public knows what large breaches, impermissible disclosures have occurred.

For breaches that are under 500, we don't post those on our website, but we do conduct investigations on some smaller breaches that affect less than 500 individuals.

So next, who must comply with these HIPAA rules, the HIPAA privacy, security, and breach notification?

The HIPAA rules apply to covered entities and certain provisions, the security rule and primarily the impermissible disclosure provisions apply to business associates.

HIPAA rules define covered entity as healthcare providers who transmit health information electronically in connection with the transaction for which there's a HIPAA standard.

So what does that mean?

CMS has promulgated standards, but for our purposes, the most common scenarios of where there's going to be a transmission of health information that makes a healthcare provider covered by HIPAA is when they do electronic billing, claim status, coordination of benefits, things of that nature.

Who are examples of providers?

This will be most healthcare providers, doctors, clinics, psychologists, dentists, nursing homes, EMS.

And then health plans are also considered a HIPAA-covered entity, so this can be health insurance companies, HMOs, employer-sponsored health plans.

And then the last category that isn't talked about too often is healthcare clearinghouses, and this is maybe a public or a private entity, including a billing service.

And what they do is they process non-standard data or transactions received from another entity into standard transactions or data elements or vice versa.

And so they're handling all of the coding in order to fit within the different transactions that CMS has adopted standards for.

Business associates, there are primarily two main prongs in defining who's a business associate.

One is a person who, on behalf of a covered entity, creates, receives, maintains, or transmits protected health information for a covered function.

And so what is this?

Some examples of this can be a claims processing or administration, data analysts, utilization review, quality assurance, billing, or another category of business associate is providing certain services to or for a covered entity where the provision of the services includes the disclosure of protected health information.

And so here you can see legal, actuarial, accounting, data aggregation.

Those are examples of some of the types of services that would qualify as business associate.

Perhaps some further examples of business associate, a third-party administrator that assists a health plan with claims processing, a CPA firm whose accounting services to a healthcare provider involves access to protected health information, or an attorney that provides legal services to a health plan.

Those can all be examples of business associates.

So what is protected health information?

What is HIPAA protecting?

It's most individually identifiable health information held or transmitted by a covered entity or its business associate.

And this can be in any form, whether it's electronic, paper, or oral.

The spoken communications about protected health information are also protected by the Privacy Rule.

And so this protected health information, which includes demographic information, relates to an individual's past, present, or future physical or mental health or condition, the provision of healthcare to the individual, or the past, present, or future payment for the provision of healthcare.

So for example, a medical record, a laboratory report, or a hospital bill, that would be protected health information where each document contains a patient's name or other identifying information associated with the health data content.

By contrast, a health plan report that only notes the average age of health plan members was, say, 45 years old, that would not be protected health information.

So although it may have been developed by aggregating information from individual plan member records, the actual report does not identify any individual plan members.

And there's really no reasonable basis to believe that it could be used to identify an individual.

And so the key with protected health information is the relationship the information has to the individual.

So identifying information alone, you know, for instance, if somebody found a sheet of paper on the expressway that had a list of phone numbers, that by itself, just a list of phone numbers, if nothing else, on the sheet of paper, that would not be protected health information.

It doesn't connect anything to an individual for anything that we've talked about, the provision of healthcare services, past, present, or future, or payment, for example.

However, if medical records that were on their way to a recycling center flew out of the bed of a truck, and so there was a bunch of patient health records, perhaps x-rays, other types of films with the patient's names and dates of treatment, that would be protected health information.

So next, I want to turn to when are ambulance providers covered by HIPAA?

Because this will also have an effect on what permissions a hospital can utilize in order to make disclosures of HIPAA to an ambulance provider.

So an ambulance provider is subject to HIPAA rules if it meets the definition of a covered HIPAA-covered entity.

So the ambulance provider is a covered healthcare provider if it conducts a standard electronic transaction, like billing a health plan electronically, for the healthcare services provided.

There is also the possibility an ambulance provider could be subject to the HIPAA rules, even if services are not billed to a health plan, where the ambulance provider is a HIPAA-covered component of a larger organization that is a covered entity.

And so you might see that, for example, where an ambulance provider is organized as part of a state or local health department that bills health plans electronically.

So what information can hospitals share with ambulance providers to ensure patients who have insurance do not get a bill?

I believe that was one of the questions that was posited to me.

So again, we start with our starting point, which is a HIPAA-covered entity may not use or disclose protected health information, except as the privacy rule permits or requires.

And so there's really going to be two main sections that are going to have any applicability.

So one, if a patient signs a HIPAA authorization, for example, a hospital may then disclose that patient's protected health information to whoever is designated in the authorization.

So if a patient were to sign it for the ambulance provider, that would give a permission, not a requirement, a permission for the hospital to make a disclosure of the information designated in the authorization to the designated party, in this case, an ambulance provider.

More likely, there are some permissions.

Yeah, it's under treatment, payment, or healthcare operations that are going to be more likely applicable for these type of scenarios.

And so a covered entity can also disclose protected health information for the treatment activities of any healthcare provider.

And so this treatment permission allows an ambulance provider to disclose patient protected health information, you know, to a hospital emergency department in anticipation of transporting a patient to the hospital.

Also, the hospital could disclose protected health information it may have about an individual to the ambulance provider for the ambulance provider to care for the individual while they're being transported.

So it's bilateral.

When covered entities are sharing information related to treatment purposes, they're allowed to do that with other healthcare providers.

Another permission, again, not a requirement, a permission is for the payment activities of another covered entity.

And so here, for example, a hospital emergency department could give a patient's payment information to an ambulance service provider that transported the patient to the hospital in order for the ambulance provider to be able to bill for the treatment that was provided.

Another permission is the healthcare operations of another covered entity involving either quality or competency insurance activities or fraud and abuse detection and compliance activities.

If both covered entities have relationship with the individual and the protected health information pertains to that relationship.

So what does that mean?

An ambulance provider that is a covered entity and has delivered a patient to an emergency room could request and be provided protected health information about the patient when needed for quality improvement activities of the ambulance provider.

For example, was the patient sufficiently stabilized when released to the emergency room?

This is considered a disclosure for the healthcare operations of the ambulance provider and is permitted under the HIPAA Privacy Rule.

So again, these are all available permissions that a health system, a hospital, could utilize in order to disclose protected health information to an ambulance provider.

One last thing I do want to be sure to cover regarding these permissions is the Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of and request for protected health information to, and this is the key language, the minimum necessary to accomplish the intended purpose.

So overbroad requests for all of your health information regarding a patient, a HIPAA-regulated entity would have to consider what is the purpose of the disclosure and then limit the disclosure to the minimum necessary.

There are some exceptions, and so some of which we talked about today.

The minimum necessary does not apply when disclosures to or requests for treatment purposes or disclosures to the individual who is the subject of the information or disclosures made pursuant to an individual's authorization.

Most of the other permissions within the HIPAA Privacy Rule do require the HIPAA-regulated entity to consider application of the minimum necessary before making disclosure, but as I say, for the ones I've discussed, there are some exceptions.

And the last piece, I think, there was a question about where complaints can be filed by consumers and providers.

So the HHS Office for Civil Rights, we are the entity that administer and enforces the HIPAA rules.

We have enforcement authority.

We conduct hundreds of investigations a year.

If anyone believes that a covered entity has violated HIPAA, their health information privacy rights or the rights of another, you can file a complaint with OCR.

You can go online.

We have a complaint portal.

Complaints are accepted electronically as well as in written form.

And then we do have provisions if someone has a disability and needs assistance in filing a complaint and isn't able to file it electronically or in writing, we make accommodations so that they may also report their complaint to OCR and we can take a look at it for potential investigation.

So I think I'll stop there and see if there's any questions or anything folks would like me to explain in greater detail.

-Tim, thank you very much for joining us.

And if you have any questions about this, and we appreciate you coming and discussing HIPAA.

And I know we were having our pre-meeting, there was a discussion because this did come up in our coverage and disclosures of why patients receive bills from ambulance agencies.

And oftentimes the nature of the work, they do not obtain the information until after the fact.

And so sometimes a bill will go out to the patient, and how do you get that information?

And some ambulance agencies have indicated that it's not disclosed to them from whatever entity they may have dropped them off at or what have you.

And so we appreciate you coming in here, but you also mentioned something.

I know that it doesn't come under your purview about information blocking.

Can you give a little a bit, whatever you know about that?

And then this is something that I think we might be able to have a discussion about maybe in a finding or recommendation.

-Sure.

So the HHS Office of the National Coordinator is responsible for the administration of the information blocking rules.

I think the easiest way to explain it -- and I certainly don't hold myself out as an expert or authority.

So please take that for what it's worth.

Information blocking is often considered perhaps the opposite side of the same coin of HIPAA.

So HIPAA, particularly the privacy rule, says you may make these disclosures generally, right?

So we talked about two required disclosures, but the bulk of what happens in the privacy rule is the various permissions.

So a covered entity may make these disclosures.

What information blocking does is it flips the script a little bit and says you're required to make these disclosures unless.

And then there's a series, I think there's about eight main categories of exceptions that can be applicable.

And so I know ONC has been working with the Office of the Inspector General on proposed rulemaking and information blocking enforcement for the very near future.

And so if you go to ONC's website, they have a whole bunch of information.

You can access the various rulemaking activities that have been published in the Federal Register.

And then they have dedicated resources that provide a lot of substantive content on information blocking.

And then, as I say, the various categories of exceptions that apply.

And so I would anticipate in the future in an information blocking investigation, ONC would be looking at where a disclosure of health information did not occur, is the regulated entity able to identify an articulable exception that doesn't require them to make the disclosure?

So it should facilitate the transmission of health information in a little different way than what HIPAA does, right?

HIPAA is a series of permissions and gives the regulated entity discretion.

The information blocking is a little more aggressive and says you must make these disclosures unless.

And that, you know, as a follow-up, there's some really great folks at ONC that I know we've given presentations with in the past about the compare and contrast of HIPAA and information blocking.

And so I'm sure they'd love to speak to your committee as well.

-And we may just take you up on that.

Appreciate your presentation and information.

Does anybody from the committee have any questions for Tim?

Give me a second here.

All right.

Moving on, appreciate all your work.

We did get some comments from the committee saying thank you.

Awesome job, Tim.

We really appreciate that.

Terra, I think we're going to bypass our break and kind of continue on into the next session with Raj and Lee.

So Raj, not to put you on the spot, but we'll kind of just move through and then break at the next break since we just came off break about 25 minutes ago, if you and Lee are ready.

But we might be taking a break just in the event that Raj may not be ready.

Okay.

-No, I am here.

-There we go.

-I am here.

[Indistinct talking] -Why don't we take a really quick 10-minute break and then we will reconvene here for the next session in 10 minutes.

Yeah.

Are we good with that, Raj?

Are you good with that?

Are you ready?

You want to take a break or are you ready to go?

-Whatever you want to do.

I'm ready to go either way.

-Let's go.

Let's go.

-Okay.

So if we could tee up the next slides.

Perfect.

So we are here to talk about the Subcommittee on Network Adequacy and Cost and Payment Structures.

This subcommittee is led by myself and my colleague, Lee Resnick.

Lee is one of our most valuable assets.

He is a trained and licensed actuary, even though he does not work for CMS as an actuary.

He's going to kill me if I don't make that clarification.

But we are here mostly to guide the subcommittee's work on behalf of the committee writ large.

Let's go to the next slide.

And so again, to start with our relevant statutory mandate here, again, we're going to be focused on providing those recommendations on potential federal, state, and local regulatory options, enforcement options for preventing ground ambulance balance billing.

So we are doing our work within the confines of this specific statutory charge.

Next slide.

And I just wanted to give a shout out to our core members on the subcommittee.

I cannot tell you what a great team this is and a great team it has been.

As federal regulators, there's no way that Lee and I are going to ever have the amount of subject matter expertise or knowledge in this area.

And all of these people have been integral to this committee's work.

And we appreciate all the effort because it has not been a small level of effort as we've been literally meeting every other week since the month of May.

Next slide.

So our little subcommittee actually broke up into four major areas of focus.

The first being the terms and definitions, which we've already discussed.

Then we had a team looking at those state, federal, and local authorities.

We had another lean but mean team looking at a potential methodology for compensating out-of-network ground ambulance suppliers.

And fourth, we had a team looking at the differences in costs between ground ambulance suppliers.

We'll kind of talk about those as we go through.

Next slide.

And this one we could skip since we've already been through this ad nauseam.

Go to the next one.

So our group on state, federal, and local authorities.

Our goal here was to, again, address those existing state and federal enforcement authorities that can potentially be leveraged to protect consumers from balance bills and generally prevent balance bills.

Part of this charge was also identifying these existing laws that do affect ground ambulance suppliers' ability to balance bill or otherwise cover their costs for the service.

As we've been discussing all day, this is very important because regardless of how ground ambulance suppliers are compensated by different payers, if a ground ambulance supplier is not able to cover its cost, that's when we have an access issue in our communities and an access issue for our consumers.

Next slide.

So this next major area, and I'm just kind of going through them because they're all going to kind of come together when we start talking about our questions for comment.

Our folks who worked on the methodology for compensating out-of-network providers, this really focused on potential recommendations on the optimal way to compensate out-of-network ground ambulance suppliers if balance billing for emergency ground ambulance services is to be prohibited.

I think we've heard today that I don't think anybody disagrees with the idea that consumers should be taken out of the middle.

But again, we do have important access issues here.

This is one of those things where you can actually say this is life and death.

So again, it's not enough to just say, you know, we think balance bills should be prohibited.

What's the rest of the story?

Next slide.

So our next, the fourth and final topic area that we focused on was the differences in cost between ground ambulance suppliers.

I think we're all familiar with, and there's been a lot of discussion today and at our meeting before, about the differences in cost between suppliers, whether they operate under a local utility model, whether they may be run as part of a hospital system's activities, all these differences that go into how different models of ground ambulance suppliers support themselves.

This is, you know, we heard from NEMSIS today.

There's been so many years of work going into this cost work, and it's continuing with this subcommittee.

So we're really well positioned at this time to do this work and provide those recommendations to Congress about how we can potentially address this within the terms of balance billing.

So next slide.

So having gone through our four areas of focus, I just wanted to touch on very quickly who we've heard from.

Patricia and Loren have already reviewed all the different entities that we heard from with regard to the Consumer Disclosure Subcommittee.

One of the great things about this committee is that everybody's been jumping in.

So by and large, you know, subcommittee members have been joining the calls of the other subcommittees so that we can just begin ingesting the information.

But to speak to some specifics, of course, we worked with NEMSIS and heard from them, and they were so gracious to join us today and share that information that we developed with this public body.

The Center for Medicare Services came in and talked to us about the ground ambulance data collection system.

We had folks who, not from the State of Connecticut, but people who deal with the State of Connecticut's process for setting ground ambulance rates from the commercial side, from the supplier side.

And we learned about Connecticut and how its systems work.

We also actually heard from the State of Maine regarding their consumer protections in this space and also their process for setting ground ambulance rates.

And again, also heard from the presenters to the Public Consumer Disclosures Subcommittee.

Ingesting all of this information, as Asbel has explained, has really been an exercise in, you know, research, compiling, kind of herding information and getting in.

And we are really just beginning to get into the meat of this subject matter, which is why this discussion, you know, is going to be so important.

Next slide.

Just to kind of touch on what we've learned so far and what we're hearing.

We've heard a lot about this today that many commercial payers have adopted the payment scheme that Medicare uses, which is a simple base rate plus mileage.

Again, paying for those services as a purely transport-only benefit.

We've heard that this eliminates the ability of EMS supplier to receive reimbursement for all the necessary and expensive supplies, services, medications, oxygens, the waiting times that EMS suppliers must endure at times before they're actually on.

All of these things present impediments to suppliers being able to cover their costs and make sure that they can pay their employees and making sure that they're available to the public in that area.

We also learned that many states do not require payment of an allowed amount to be sent by the insurance company directly to a supplier.

This essentially means that if a payer sends any amount in satisfaction of that bill, it may go directly to the patient.

The patient may not understand why they're getting those dollars, but I think that the natural next step is you receive a check in the mail and you cash it.

And so this puts an EMS supplier in a very tenuous situation when any dollars that the insurance company would pay go directly to a consumer who likely didn't understand and may spend it.

And again, this puts the provider in a situation to have to pursue that patient when none of that would need to happen if they were just required to send it directly to the provider.

Next slide.

Here again, one of the things that we've discussed a lot today are data challenges.

We're learning and seeing that the lack of cost data relevant to ground ambulance services is going to be a challenge with addressing balance billing and coming up with recommendations for how this should work.

One of the things that we've discussed within the committee are a number of reasons why an IDR process, like the one that exists now with medical services, why that might not be appropriate for ground ambulance.

So the question is, even if it were appropriate, let's say we did our work and decided that a QPA model and IDR was appropriate.

The question is, is that data there?

Does it exist?

Where is it to support a QPA or similar model?

So we've learned that currently there's no comprehensive national data set for ground ambulance payment data or allowable amounts across the country.

As Asbel noted, we did touch on the fact that the CMS transparency and coverage rule does provide some visibility into these allowed amounts.

But again, because this information is not consolidated, there would need to be work to kind of reach out to all of the payers' public disclosures to try to synergize and collect that data.

We heard from NEMSIS today and that it doesn't currently collect robust cost data.

We know that CMS is currently collecting cost data and that there is a forthcoming MedPAC report that's due in 2025.

So all of these things that we're learning have kind of gotten us to the next step of where we need to be to analyze what our recommendations are and what they should be and may be.

And so before we go to questions on feedback, Lee, would you like to say anything about the cost and the data work that we've been doing in the other subcommittees on this front?

-I think it's been pretty much covered in the discussions we've been having.

We're still in the process of gathering what data are available.

And as this slide kind of indicates, the data that are available are not robust enough, actually, for us to compute the amounts needed for, say, a reimbursement rate or a way to calculate it.

And because the states and municipalities are all a little different, I think it's a little hard for us at this particular moment to have a fully fleshed out recommendation.

-All right.

Asbel, can you talk to us a little bit about what we might be looking forward to out of the MedPAC report as it relates to data?

-So the charge of Congress when they remanded the ground ambulance industry to a cost data collection method was to basically, number one, have MedPAC opine on whether these extenders the ground ambulance industry has been receiving for 20-plus years now for either an urban transport, so transport that takes place in an urban region or in a rural area, or as defined as a super rural area -- so think more frontier type work, not necessarily, but just for individuals that don't understand ground ambulance.

It would be very, very, very rural areas that you live in.

And so there's an extension or Medicare extra payment that they make.

And so Congress constantly has been extending that.

And so this past time, they remanded the industry to a data collection process to collect data and then asked for MedPAC to provide them with a recommendation on what they should do with this extender and how it should be, how the current reimbursement system could accommodate that in any other, maybe, reform area.

There's a very specific charge and it really is centered around that extender payment.

-Thank you.

That's very helpful.

So before I flip this slide and go to the myriad question that we are looking for public comment and feedback on, before we flip it, it, of course, is a long list.

We're going to do our best to organize this conversation so that we make sure that we can get the most comprehensive input we can.

So with no further ado, flip that slide and let's go through what we're looking for feedback on.

-So Raj, what I will do is just ask PRI, because we will have time for public comment as well, but probably for the first 25 minutes, maybe at 4 o'clock, they can turn on the chat for public comment, but allow the first 25 minutes for Q&A amongst the committee.

-All right.

So of course, we're looking at, how should a federal scheme for addressing balance bill for ground ambulance services work with those existing state and local authorities out there?

I think most of us are familiar with the way things work for medical services under the NSA, but thinking about the special way that ground ambulances work and the reason that we're here today as a committee to talk about ground ambulance instead of ground ambulance already being within the scope of the NSA, how these things are going to work together.

One of the things that at least us novices in ground ambulance on the committee get loud and clear is that ground ambulance is a highly localized service.

And there are some areas of the country that get into it more than others.

Like we say, some of them treat it like a public utility model.

One of the first things that I, as the federal government regulator, kept asking is, you know, in my personal capacity, what happened that ground ambulance is not a public utility?

And I was able to get a lot of education on that.

So that's one of the biggest questions that we're looking for for feedback.

Gary, I see your hand raised.

-Yeah.

So the opposite side of that question is what about the myriad of states where they don't address ground ambulance rates?

-Right.

-Or the local governments don't.

Or there are some states where the local government does and other areas of the state where the local government doesn't.

-Right.

Right.

So you know, adding into this, you know, how do we make these things work together?

And what do we do when these states or local authorities do not get into this?

Thanks for that, Gary.

-Yeah, that was the point.

-Of course, one of the things that we've been talking about today, is should there be a federal universal EMS benefit?

This is a question that's really in its very earliest of discussion, because I think we've all heard, again, all of the reasons why it may be difficult to regulate ground ambulance rate from a national perspective.

Should EMTs and paramedics be classified as providers?

Is that something under state and local authorities and perhaps relevant federal authorities that could happen in order to decrease the chances of balance bills, decrease the chances that there has to be a balance bill at all?

Again, should a public utility model be employed?

-Raj?

-Yeah?

-Can we jump back for just a second on the EMTs and paramedics be classified as providers?

-You know what we're going to do, Pete?

I'm just going to kind of introduce all those these things and we can take them one at a time.

-Perfect.

-Yeah.

So that public utility model, should the federal government be responsible for collecting the necessary data, the data gaps that we see that would potentially allow a body like us to suggest a way to address appropriate out-of-network payments for ground ambulance services?

Is there a role for the federal government there?

Should states be allowed to set their own ground ambulance rates?

This question is probably an ill-formed one on my part because we know that states do have the authority to regulate ground ambulance rates if they choose to do so.

Next slide.

So if balance billing for emergency ground and land services is prohibited, what methodology should we use to determine appropriate payments?

Is IDR appropriate for ground ambulances?

We've discussed, is there a possibility that we could go a benchmark route and how would that benchmark be defined?

Again, universal benefit and what data is available.

So PRI, if you would flip back to that last slide.

And I, you know, there are so many other questions and sub-issues here.

I don't want these questions to define our discussion.

But Pete, why don't we start with you, and regardless of what bullet point you have input on, let's discuss what you have.

-All right.

Well, thank you again for all the work that you and Lee are doing.

Obviously, there should be a federal universal EMS benefit.

It's something that is important, ambulance service as well as EMS, both.

Because again, the system is not just ambulance transport, but transport as well as the service provided, the evaluation.

It's the only portion of healthcare in the United States that is not reimbursed unless something happens, you know, if the individual, you know, has to be transported.

If doctor's offices had to have people admitted to the hospital, it'd be hell to pay, you know, in order to get that payment.

With regards to the EMTs and paramedics classified as providers, are you referring to the difference between suppliers and providers, or are we referring to basically practitioners?

-I think that's a discussion we need to have, Pete.

I think the gist of the question does relate to those folks as providers so that they can be compensated.

But again, you know, I struggle with the provider versus supplier moniker.

-Yeah, understood.

And again, part of the issue also is that, you know, one of the things that I brought up is that we need to have, in my opinion, paramedics who are licensed.

Paramedics should be considered practitioners, which then allows for some of the treatment in place reimbursement to be done through state plan amendments, et cetera.

And that's a conversation we need to continue to have so that treatment in place can be reimbursed.

But again, some of this also goes back to that federal universal EMS benefit.

And again, appreciate the work.

End of my questions.

-Pete, actually, can you talk to us a little bit about what this universal benefit looks like?

Again, make it so we're all using the same language here.

-Absolutely.

You know, basically, we need to identify the levels of EMS that are reimbursed, that are considered, that need to be a mandatory part of an insurance policy.

And those need to be that the ambulance transport, and I'm going to reference just two aspects of it, and that is the emergency and the inter-facility.

Those two aspects, because those are the only ones that are really applicable to me in the fire service.

I fully support it being a universal ambulance transport benefit, but at a minimum, we need to deal with those two aspects.

At the same time, we need to deal with treatment in place and assessment and that ALS first response component, because again, it's a system.

It's an emergency medical services system.

It is not an ambulance transport.

And we need to get away from the 1960s when Medicare was first, you know, put in place as an ambulance transport benefit.

And we need to recognize that EMS is a full-service system and it involves everything from the dispatch, like ET3 pointed out, you know, emergency triage, treatment and transportation.

It identified that the dispatch component, having that medical, that nurse practitioner or that nurse provider to be able to determine if we need to send that ambulance on some of these calls, that needs to be considered a reimbursable.

The ambulance response, the treatment provided at the scene, the first response paramedic, and the transport, all of those components are part of an EMS system.

And they should be, in my opinion, contained within an EMS benefit.

-Okay.

-And to just segue off, I know, Raj, you and I have talked a lot about this as well.

And I think it came up in the first plenary meeting about should EMS be an essential health benefit.

It may have come up, and I'm thinking that this is maybe somewhere where it's inferred.

A lot of payers may treat it in certain components, like it is a covered, if you call 911.

But should there be a recommendation made that it is formalized as an essential health benefit so there's no ambiguity in how that looks as well?

-Okay.

Anybody else have anything on the EHB front?

Okay.

What about on the concept of the universal health, you know, kind of a universal EMS benefit?

Any additional comment there?

Okay.

So let's get to this point of classification as provider.

Pete, you want to start us off there?

-So you know, the issue comes down to some of the difference between supplier and provider.

Ambulance services, you know, we're suppliers unless we're hospital-based.

But more importantly, also is the issue of a practitioner for the paramedics.

And that is, you know, we need to be able to have the ability to provide and, you know, bill for treatment in place.

And we don't need to be bringing in necessarily other healthcare providers in order to do it.

The paramedics are very well equipped to be able to do evaluation, assessment.

They run a tremendous amount of diagnostics.

I mean, our cardiac monitors these days are top of the line.

Having the ability to bill for those treatment in place services is important.

And as a provider, or sorry, as a practitioner, that would allow the paramedics, in many cases, to be able to bill for some of those services using some of the ER-based codes that Community Paramedicine was considering to be using.

At the same time, you know, you've heard me talk about it before, and that is the provider, the National Provider Identification, the NPI.

And that's not for the EMTs and the paramedics.

That's for the agencies that employ them.

And really, it's about the paramedic that, you know, the paramedic -- it shouldn't depend on whether or not the paramedic that's responding is part of the ambulance.

The paramedic that's responding is responding and should be able to get reimbursed for that ALS-first response, especially when there's no paramedic on the ambulance.

It's like paramedic intercept.

It's just what's being done daily in huge, huge jurisdictions across the United States where we've got fire service-based paramedics.

We've got private ambulance-based EMT ambulance.

It's a great partnership.

It allows us to have a very efficient system.

And we need to be able to ensure that all components of the EMS system, again, not just transport, but all components of the EMS system are able to be reimbursed, be that via an NPI, via being a practitioner.

-Can I ask a clarifying question, Pete?

I don't know if you've thought about this or whatever, because I'm not sure if I've even given it much thought.

But I know there are some systems across the United States as well that maybe they have a nurse or something like that that's also providing this pre-hospital.

Should we be contemplating that as well, or just only EMTs and paramedics?

Or should we be contemplating that nurses as well have the ability?

-Correct.

And I believe nurses have the ability in some cases to be used at the billing.

And I'm going to defer over to Ted, because I think GMR runs some of the best pre-dispatch, basically nurse advice groups for the systems that they're used for.

Again, the bottom line is ET3 was triage, treatment, and transport.

We need to make sure that triage, treatment, and transport are reimbursable covered expenditures across the entire EMS benefit.

Because sometimes it's more important for us to evaluate before we send the units out.

That should be reimbursed.

But if we're sending the units out, we need to be able to ensure that those are being covered.

EMS is part of the healthcare system.

And we have so many sections of the healthcare system that are not reimbursed.

When we save taking a patient to the hospital, the downstream costs that are saved by insurance providers and by the patients is significant.

And that is saved from everything from triage, treatment, and transport to the appropriate destination.

Because sometimes the appropriate destination isn't the emergency room.

As we've talked about on the subcommittee meetings, there's times that an individual needs to go to a sobering center or needs to go to a mental health facility.

That may not be a basic emergency facility and it may not be able to be reimbursed.

Why do I need to take those patients to an emergency room, impact the emergency room, cause tremendous increase in their costs, the patient and the insurance provider, when we can be more efficient if we get out of 1960s rules?

But on the triage aspect, I'm going to defer over to Ted because I think, again, they run one of the best programs out there.

-And two pieces, you know, I mean, with regard to ET3, I think one of the findings you keep hearing about also is that the actual patients that utilize it the most are actually not the Medicare recipients, right?

So you ended up with people that were not the Medicare recipients where you did have that ability because of other payers or age and opportunities to do alternate care was a different population group.

And I think this was something that was obviously lesson learned on that.

But as far as the nurse navigation and other work done, you know, a lot of it is underneath though a physician level service or the physician practices are then delegating some of this so that the nurses and the advice lines are working in within the system.

So at least from a GMR perspective, when we do any of that reimbursement pieces, it's actually almost on a per-call basis, on a per-click basis.

It's not as much for billing out third parties, because we're doing it with municipalities and so forth right now.

Now, obviously that may change, but how, you know, nurses work in that environment and even within the hospitals, I think you see some of that where, you know, you're not billing for the nurse care necessarily in an emergency room.

So as we kind of go through this path here between, you know, how to get the right reimbursement for alternate care destinations, home-based care for the EMTs and paramedics that are there as single providers, you know, that's definitely something we need to do.

I think, you know, from a balance billing and, you know, charge of this committee, you know, really trying to focus because it is around the 911 in an emergency.

This is one aspect of that and that we're trying to solve for because it does have a trickle-down effect for patients when, you know, providers could have been reimbursed for work that they were doing to potentially, you know, have the downstream savings and there's a lot of work still to do on that.

-Right.

Definitely.

-I guess the only clarification, because I just am trying to wrap my head around -- and I know you and I have talked, Pete, about this even often, just to make sure.

This is only in the event if there's an EMS service provided where maybe the responding entity doesn't have an NPI number.

Then if the EMT or paramedic or nurse or whoever the clinician is has an NPI number, then that would be billable by the service because I'm just thinking there are hundreds of thousands of these individuals out there.

-But we don't need to do it by individual if the agency is providing paramedic level service.

Right now, the Oceanside Fire Department, we provide paramedics on all of our engine companies, every single one, as well as on half of our ambulances because we send ALS or BLS based on what it is.

But I still am required to send a paramedic to every scene, every call, because of the county EMS rules.

Again, we have to follow what is established for our county.

We don't need to have the EMTs and paramedics getting NPIs.

We need to have an agency that is providing paramedic level service to be able to get an NPI regardless of whether they provide transport.

Right now, the only way that you get is an ALS paramedic level service.

You get an NPI because you're an ambulance provider.

It shouldn't be that way, because we have an EMS system, and that system involves lots of different ways of providing services.

And a lot of them are, again, partnerships that work very well between public and private providers.

But there's no ability for an agency to bill for services to the insurance companies without that NPI.

And so what it does is it creates a bill that goes directly to Asbel.

And Asbel gets a bill because the insurance company says, they don't have an NPI, so we're not going to pay for it.

There's part of the problem is, again, we're still relying on a lot of old school process that the provider of EMS, advanced life support EMS services, doesn't get an NPI allowing them to bill for the service because they're not providing transport.

Everything's tied to the transport.

We need to get out of being a transport benefit and into being an EMS benefit.

-And I think that would be important to note, Raj, as we're kind of going through there for public comment, is that he's advocating for, if you don't meet the definition of an ambulance service to bill under what they call type 41, that you have the ability to maybe go under some other type to be able to bill, or they change the definition on that if you have that paramedic or EMT to be able to get that NPI number, not necessarily advocating that EMTs and paramedics obtain an NPI number.

And I just want to be clear on that for the record.

Pete, that's why I keep asking you those questions, because public comment may come back different understanding that.

So I think that's probably the public comment we would need back from consumers, others that are there if they have any particular, as we continue to deliberate these questions.

-Yeah, it needs to be the agency providing the service, not the individuals themselves, because then we're going to end up with all the nurses wanting to be considered providers and the number of NPIs we're going to issue is astronomical.

It should be the provider of the service.

So that if we're providing this service, we should be able to do it with an NPI.

The same for my dispatch center.

My dispatch center, obviously, we have a physician, two physicians overseeing our medical control and our dispatch.

We've got nurses that we're trying to bring in to provide service across our 100,000 calls in our dispatch center.

We need to be able to provide that dispatch service and be able to potentially be reimbursed if we don't send anybody.

But on the response side of things, again, EMS benefit, not an ambulance benefit, and providers of paramedic-level service need to get an NPI.

-Okay.

Thank you.

So anyone else have any input on that point?

-Well, I just, you know, if we're going to be adding, you know, a whole new kind of set of service providers, we should be anticipating or if that might be a finding.

I'm not sure it fits within the definition of our committee's work.

But, you know, we need to be addressing this in- and out-of-network issue with that whole set of folks.

Because what I'm hearing is insurance companies aren't negotiating rates with, you know, the existing emergency service ambulances, that's just going to add, you know, so many more.

I'm not saying it's not a valid point that you're making, but we need to, like, think about how it fits in the context of this advisory committee and the issue of balance billing.

-I think it fits in the treat in place concept, right?

And I think that -- -Still, if it's treat in place and we haven't protected people from the ambulance.

-Agreed.

Oh, yeah, yeah.

Oh, 100% agree.

100%.

100%.

Yeah, yeah.

-Okay.

I think, you know, right now, and just to make sure that everyone in the meeting is following, because we are very serious about sticking to our charge and this is such a huge issue, we really try to make sure that we adhere closely to our charge.

But still, there are a lot of facts, a lot of circumstances that we feel as a committee that we need to bring out to make sure members of the public and those that we are reporting to, that they understand how things are working at a ground level.

So I do envision that a conversation like this would go into what we've been referring to as potential findings that the committee could make that, again, may touch issues that are not directly within our charge but are still relevant to our charge.

So here, one of the findings that we may make and that, you know, we'll continue to discuss is whether this lack of reimbursement for very important services are a large contributor to balance bills.

It could just look like a finding that says a major contributor to balance bills is X, Y, and Z.

This could be one of those.

So I think as we continue to discuss and continue to make sure that all of our work goes directly to our charge, we'll be looking at making some findings in this area.

But again, some things that we might be thinking about as findings now as we continue to work may become part and parcel of a bona fide recommendation.

Any other comments on that point?

All right.

At this point, what I'd like to do is ask what's going to be a very loaded question, but something that I believe that we really want to get input from the public on and something we've definitely been talking about as a committee is whether or not the current scheme for handling balance bills for medical services that is already in effect is appropriate or not appropriate for the ground ambulance space.

And that's a conversation that I'd like us to have now.

And if you could please be, you know, as clear as you can what part of, based on what you know about the current process, you know, what do you think might work, what won't work, and why.

So who would like to kick us off?

Anyone?

-I'll start.

-Thank you.

-And I think it's probably the obvious of what's been going on through the IDR process or the independent dispute resolution process, and how that would correlate to EMS and work and navigate through that process.

And so depending upon now with some of the federal opinions around all of these TMA lawsuits that have happened, whether it was because of the administrative fee to the batching that possibly could say that some EMS systems could do that.

But I go back to some of the data that NEMSIS provided or NHTSA provided earlier today regarding the number of -- what really stood out to me was the number of volunteer agencies that are sending in data.

There was upwards of over 2,000 that were sending in data.

While there was a lot of urban, we would be remiss if we kind of worked through this of looking at the size of the ambulance agencies that could actually contribute into the IDR process if we worked through some of the same methodologies.

And so that to me, I think, is probably something that is problematic for the ground ambulance industry, knowing that almost two-thirds of the ground ambulance industry based upon -- now this is based upon Medicare data, a little more than two-thirds of that do less than, what, 2,500 transports a year, probably 70% or 75% now.

And I'm going off the top of my head, but there's actual data that you can get that I think HMA may have it that can actually provide that for the committee as well.

But the IDR process, just because of those low volume numbers, would be interesting to me how they could actually do that process as well.

So I'll start there and stop and let other people that are raising their hands, but that's kind of where I would start.

-So Asbel, I would add to that, and I think this is in line with what you were saying, but I would just add that in addition to the low volume of transports or of other services that they may be providing, one thing that's been really clear are the limited resources that ground ambulance providers or suppliers have for

just their base operations, let alone -- I mean, there are direct costs and there are indirect costs, and there's time and personnel that are involved with these IDR disputes.

And I think that's why with the current No Surprises Act structure, you see that it's, you know, they're predominantly being initiated by staffing firms or billing firms that handle hundreds of thousands or not millions of claims or employ, you know, thousands of providers where they have the resources to do it.

And so I do worry about then kind of shoehorning ground ambulance into an existing IDR structure where we would know that, you know, the vast majority of ground ambulance providers would not have the resources or the time to dispute those.

So I don't want to create a system where we're kind of setting folks up for failure.

-Yeah, and I think to follow that too, just the sheer cost to implement that on an individual per-case basis.

-Can you hold your thought here?

I think just for the public, they don't know what IDR is.

So Raj, can you give a tutorial really quick?

And then, Ted, I'm going to let you interject back because some people don't know what we're talking about at this point.

-Yes, and that is totally my fault.

Forgive me.

So what we are referring to is under the current No Surprises Act that is in effect for medical claims and other, I should say, air ambulance services and other medical services.

Under that process, if an out-of-network provider sends a bill to an insurance company for an insured person, the NSA first says that the patient is going to be protected from the balance bill, that balance bill being whatever amount above what the insurance company is allowing.

And no one can send that consumer a balance bill and they can look for, from that consumer, nothing more than their general in-network cost-sharing responsibility.

So the consumer is held liable.

I'm sorry, the consumer is held harmless.

What happens next is the insurer, under the statute, it says that they must send an initial payment.

And the current NSA defines what that initial payment should be.

And once that payer sends the initial payment, the provider has a chance to come back and say, hey, you know what, that wasn't enough.

I would like to enter into independent dispute resolution so that we can leverage an unbiased third party to help us arrive at the appropriate out-of-network payment amount for that service.

Okay, thanks.

The payment amount for that service.

What happens next is the provider wants to go into IDR.

There is a requirement for good faith negotiations, and there are all kinds of timelines when all of this stuff has to happen.

There's a requirement that the provider and the payer engage in good faith negotiations.

If there is no resolution, then they can move into the IDR process.

That IDR process involves filing claims and paperwork with what we refer to as an independent dispute resolution entity.

Again, these are non-government actors who are third parties that are actually paid by the parties to the dispute.

I'm hoping that kind of gives you an eye into kind of the various steps, but it is a multi-level process.

Especially because it's new, it's very labor-intensive.

And so that is leading us to this conversation, not only why we currently feel one way or another about the appropriate way to get to an out-of-network rate, but there's also a lot of history regarding why ground ambulances are not already subsumed within the current NSA.

So thanks, Angie, for giving me that thumbs up.

If there are other questions, please put them in the chat, but otherwise, Ted, let's pick back up and keep going.

-Yeah, I think it was just going to -- a couple pieces, you already kind of hit on some of it, but obviously the cost right now, as you see in the chat, you know, it might be $350 to even go through that process.

So the actual cost to go through an IDR is sometimes what generally the bill and the payment needs to be.

So it's not such a large gap that you're trying to recover from, which makes it, you know, a challenge there.

And then from a disclosure standpoint and what we were trying to talk about in the definition section, you know, people call 911 and they may not even be the caller themselves, it's other people calling.

So you end up with that period of, how do you disclose that?

How do you go into that process?

If it's an emergency case and the emergency ground ambulance is very different than somebody going in for healthcare that may be more -- you know, we talked about schedule, but going in for care being done and have the ability to make some choices there.

But when you're dealing with emergency, it's very different.

So you have quite a number of factors that I think make it hard for the IDR and NSA process to kind of, how does that work for emergency ground ambulance?

And probably why earlier on, when this was even talked about years ago, why it was so difficult for them to even try to put that in the ground ambulance into the program.

-Loren?

-Yeah.

So first, I think I'll just echo what everyone just said on the IDR process.

I mean, especially just thinking back to the NEMSIS data we saw earlier, right?

That EMS is 65% or something, public sector entities.

It seems somewhat difficult to imagine your sort of local government, county government, fire department, really kind of going through and spending the resources and time and effort on this sort of IDR arbitration process.

I think the other pieces of the No Surprises Act as well have some difficulties when you apply to the ground ambulance setting in particular, right?

The sort of the QPA, which is kind of this sort of dollar amount that sort of, you know, it defines cost sharing and does a lot of other things under the No Surprises Act, right?

That's based on the median of in-network or contracted rates.

But as everything we've sort of discussed today and previously, you know, in-network negotiations, as you might term them in the ambulance setting, or it's not really what you think of as a standard negotiations.

It's only something like 20% of ground ambulance emergency transports are in-network to begin with.

So like using that as some sort of actual guidepost seems pretty difficult when we're talking about the ground ambulance context.

It's also just, if you were to look at like the in-network rates or the rates that insurers are allowing today across the country, it varies so much just based on what the local regulation scheme is and everything like that.

And to sort of cement that in perpetuity, I think seems risky.

And I think it sort of lends to itself to a pretty unfair situation going forward.

-And remind me, Raj, to what Loren's saying about like 20% and the way the QPA is defined.

I can't remember in the NSA, is this audited by an external entity or does CMS have oversight of the QPA audit?

Is that something we need to defer to someone?

I don't remember that.

-It's CMS.

CMS oversees the QPA audits.

-So CMS oversees the QPA audits.

-And I should say more accurately the tri-departments.

-Okay.

Is there a minimum number that you're aware of or not that they have to audit?

If we go down this thing for the QPA or is this something -- if something designs like that, like Loren said, and I agree there's only 20, we'd have to really define what that current definition looks like because I don't think in its current definition it's going to even work for us.

We'd have to probably look at air ambulance or something like that.

But is there a minimum or do they audit all QPAs?

-There is a minimum.

I do not want to get this wrong.

The number that is coming to my mind is 25 for each agency, but I want to confirm that.

-Okay.

-And you do need a minimum of three for the current rules, which could be changed in a new thing for ground, you know, for ground ambulances, but you also need at least three contracts.

The insurer needs to have three contracts for the service in question for you to calculate a median for the QPA.

So that also, right, there's going to be plenty of areas where there aren't three contracts for -- you know, you're going to have to get pretty broad in regions here.

And, you know, for a local or regional payer or something like that, that's in like upstate New York only, they might not have three contracts, period.

-Right.

Okay.

-Can I jump in on?

-Yes, please.

-And I saw Elizabeth Staple provided some great information and she's very familiar with this IDR process, given her background, who she works for.

You know, it's important to identify just so everybody's got it, you know, that every single code is a new arbitration.

So for example, you know, as identified the base rate mileage, if we've got, you know, supplies for non-Medicare transports, if there's even oxygen or waiting time for non-Medicare transports, each one of those has to be arbitrated separately.

We're not arbitrating the claim, which is all together combined.

We're arbitrating each code separately.

So if I've got four separate items within, you know, an ambulance bill, each one has to be arbitrated separately.

So the same documents, oh, and there's a 90-day cooling off period between them.

So you have to wait 90 days between talking to them about the base rate, talking to them about the mileage, talking to them about oxygen, talking to them about waiting time.

The final component that is really problematic is, yeah, you know, the NSA provides for direct pay to the providers, which is something we need to ensure is done for everybody so that the providers, the suppliers of the ambulance service, the EMS services are being reimbursed directly.

But we need to ensure that there's no requirement, which is in, to the best of my knowledge, the IDR process that I can get a check from Pete's insurance company.

But Pete's insurance company might require Asbel, who's the patient, and Pete's insurance company to both sign it to deposit it.

It's not being required right now, but it's built into the system.

We've got to ensure those things don't show up.

Otherwise, the system gets weaponized and it takes too long, too much money and people just don't do it.

And so the providers, the suppliers of the ambulance service, the EMS providers end up suffering because they just can't get it done.

-Okay.

Thank you.

Anybody else want to comment on the appropriateness of the current process or why it would not be appropriate for ground ambulance?

For those of you that have been involved in this issue for years as Congress has been looking at this, is there any basis cited within those conversations that we haven't talked about today?

I think we've covered the basics, kind of why we're here.

Okay.

So when we talk about why or why not when it comes to IDR, that of course gets us to, well, if IDR isn't appropriate, what is appropriate?

Today we've heard the term benchmarking.

We've talked about state and local authorities setting their own rates.

What are, in our last, I think, seven minutes here, what are our general thoughts on that?

I know that we will not today or anytime soon arrive on a final recommendation of how this should be handled.

But as you're hearing our discussions today and before we kind of move to the full public comment section, does anybody have any thoughts you'd like to share on kind of how you see this going, where you see the most light at the end of the tunnel for where you might suggest we head as an optimal way to land at appropriate out-of-network rates?

Anybody want to share their thoughts here in the last few minutes?

-I do think, you know, Raj, as we were getting some of the testimony from different states and how they've been working at it, I think as a committee, you know, we keep trying to gather as much of that information as we can to start trying to identify, you know, how states, local municipalities, how contracts are being managed both for the public sector and private sector, third parties, you know, HUMs that are out there, hospital districts.

There's so much of that's from a business standpoint where they're looking at it as a, what's necessary for that community, the level of service that's needed, response times, quality of care, and those local and state areas are driving, obviously, the reimbursement model around that and then sets the rates.

So how does that work with states and local governments and with the insurers and creating that?

If you call 911, again, focused just on emergency, is that considered the in-network rate or the rate set by the local area so that you can then prevent a balance bill for the consumer because that's where it's being addressed?

-Okay.

Regina?

-Oh, yes.

I agree with what Ted was saying.

I think we've got patterns and we've got models out there that other states have done.

I think we take that collaborative effort and use that as a model, not recreate anything, but take individual pieces from each and work through that.

I think that's the only thing we can do at this point, because we are so new in this process and we're trying to have recommendations that work.

I think we need to look at what other states have done individually and how they can design their model.

-Okay.

Sean?

-Yeah.

I think, Regina, just to follow up on that a little bit, it really comes down in my mind to looking at -- we're looking to protect the patient.

We're looking to protect the patient in a number of ways.

One of them is from being balance billed and another is that they have access to care when they need it at a critical moment.

We need to preserve the services in such a way that they can provide that care.

When we look at essentially what comes down to a structure that establishes a benchmark or whatever terminology you want to use, it has to accomplish protection in that manner where it's really about making sure that patients get what they need.

-Okay.

Loren?

-So I think hearing more about this, I mean, I think Regina's right that we've heard from a number of states here.

I think there are a lot of flaws to relying on some sort of like allowed amounts that are happening today for all the reasons we've kind of addressed before.

It's hard for me to envision anything that's too different from, I mean, either literally picking dollar amounts for codes or some percentage of Medicare plus some sort of amount for a non-transport service, plus some sort of treatment in place service, possibly also I think to Pete's idea of paying for your paramedic or your EMT services that aren't doing the transports as well.

I think one thing also important to keep in mind is in addition to sort of the balance bills, access to care, right?

There is at least some regard we're trying to keep in mind here is broader cross-sharing protections, right?

I think one risk that I see here is particularly if you're going kind of the let the local rate setting, you know, define how much insurers have to pay here is you invite a pretty natural response from employers and insurers who just go, okay, all I have to do is hold cost sharing down to in-network levels.

I'm just going to define my in-network cost sharing as, you know, you owe 50% co-insurance, patient.

So I am a little nervous once you create that sort of dynamic effect to really increase the sort of overall price, particularly once you're kind of increasing it above what would be sort of, you know, efficient level here, you invite that sort of response.

So I think we need to keep that in mind and also obviously the premium effects here, but I do think it's an important thing because I do get a little bit nervous there.

And back to an earlier point that I think Tim had raised in a public comment, right?

One nice aspect here would be to say, you can't do that insurance company.

You can't just say now it's 50% co-insurance for these transports.

But I feel pretty strong, I think that sort of relies on you having some sort of -- there is some sort of fixed rate that doesn't kind of open up gaming opportunities here.

So I think that is where you kind of lend that.

Even a very generous percentage Medicare multiple lets you sort of come in and then also say, you know, cost sharing can be no higher than $100 or something along those lines too.

-Okay.

All right.

Thanks, Loren.

Patricia.

-Yeah.

Thanks, Loren.

I appreciate that impact on the cost sharing for folks who have either, you know, a giant copay or co-insurance, you know, the bottom line is whatever they're going to be paying, you know, we need to be watching that, not just protecting people from that balance bill, but the overall cost that the whole system is incurring from each ambulance ride.

So I just wanted to raise a flag.

You know, we've talked to different communities about how they set their rates where, you know, we're getting some information, but we're, you know, it seems like every community it's different.

I would just be really -- I'm just not convinced that letting every community set its own rates is going to get us to a level where we're assured that the prices reflect the costs.

I just can't imagine every little community being able to have the staffing or have the understanding of knowing how to set their local rates.

And I think, you know, if it ends up being that this is the type of, you know, benchmarking that we're going to use as including the local rates, then I think we, it would behoove us to come up with some kind of standards of what those rates have to consider.

And, you know, the states that have used the percent of Medicare, you know, that there's a system there for setting those rates.

Now, I know that there's a lot on this call that would argue that that system is lousy, but at least it's a, you know, obvious system that people can look at and evaluate an impact.

You know, as consumers, if we end up finding a lot of local rates being really high, going around trying to like impact our local board of county supervisors in hundreds of communities around the country would be difficult.

So long-winded way of saying I'm a little skeptical of the locally set rates, and if we were going to be moving in that direction, I would want to seek some kind of national standard for what those rates have to consider so that we can be assured of some level of cost containment.

-Okay, good points.

All right, Asbel, I know we were scheduled to end at 4:20 and do a 10-minute break.

Do we want to take a break or do we want to move straight into the public comment?

-Public comment has been open.

-Okay.

-And so it looks like public comment is kind of winding down and we still have that.

So I'll leave this to the committee.

We can end a little early and Shaheen and I can wrap up and talk about next steps, which will take about 10 minutes or so, 10 to 15 minutes, or we can take a break and then come back.

So I'll let that be the will of the committee.

Anybody that wants to not continue on, if you will raise your hand.

-I think as long as we can keep the public comment part open here, just in case, you know, some people had to log off, do something else and come back.

I just want to make sure that if they're thinking they would be able to comment during the 4:30 time slot.

-Sure, right, we'll leave the public comment on, but as a matter of fact, just for the public, as we've reiterated several times throughout this, public comment isn't over just when the meeting ends.

You can also submit written comment up through September the 5th as well.

So Shaheen, if you're available, I would say that we start to wrap up and then talk about next steps.

Terra, if we want to advance there.

-Sure, thank you.

-Perfect.

So first, I would like to thank all of our special guest presenters today, the NEMSIS Technical Assistance Team and the Health and Human Services Office of Civil Rights for providing additional information requested by the committee that will be considered in the coming months as the committee wraps up and finalizes its findings and recommendations.

And thank you, members of the public for, you know, providing robust discussion during the meeting in the chat box here.

And I've also received several public comments already through the GAPB mailbox, so keep sending those, you have until September the 5th.

I mean, you can send a public comment at any time, but as stated earlier, to ensure that the committee is able to consider those public comments timely in its deliberations as it moves toward, you know,

generating a report, we ask that you submit your public comment to the GAPB mailbox by September the 5th.

Next slide.

Okay, and I believe I have covered this material.

And I believe that at the end of the discussion, our contractor will be displaying the questions so that the public can submit comment in the chat.

But we do urge you to submit comments that are longer than three sentences to the GAPB Advisory Committee mailbox, as some of you have already done.

So you know, as mentioned, we have a tentative meeting scheduled for October 31st and November 1st.

Between now and that next public meeting, the committee will be considering your public comment and drafting recommendations.

So I will turn it over to Asbel Montes, our chairperson, to talk about what those next steps are between now and then.

Thank you.

-And thank you for the robust discussion today and the comments and to our co-leads -- next slide.

To our co-leads, Loren Adler and Patricia, who have done yeoman's work on the subcommittee on public and consumer disclosures, as well as Loren and Lee as well.

Starting immediately next week, we will be committee meeting again and we meet every Wednesday.

We will be consolidating now these existing two committees that we did at the first half of this into one subcommittee of the whole that will be led by Raj and myself.

As we continue to deliberate and start to put together the findings, as Raj so eloquently put it, there's going to be some things that technically may not fall under the purview of the No Surprises Act charge that might be a finding.

And then we will have many recommendations.

And the one thing for the public to note, that in our final meeting here, where we will actually start the voting process of the full committee on these recommendations, and then this is where there will be an up and down vote on this.

So anything that falls within our purview and that makes it through the recommendation process will actually be deliberated by the full committee.

And then there will be a vote taken as well to either advance the recommendation into the final report or not.

And this will be through weekly meetings and then we will formalize these findings or whatever at the November meeting as Shaheen suggested as well.

So I wanted to say thank you to the public.

Don't forget, up until September the 5th for this subcommittee to start really its deliberative process on these recommendations.

But as Shaheen indicated, at any time, you can actually submit a public comment to that GAPB email address as well.

All right.

So I want to say thank you to the entire committee.

And Terra, I'll turn it over to you for the final -- whatever other housekeeping role that you have.

-Thank you.

Materials for this meeting will be available for download on the cms.gov GAPB website.

The presentations will be available within seven 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 that can be found on the GAPB website should be submitted by September 5th for consideration by the advisory committee.

This concludes today's meeting.

Thank you and have a wonderful evening.