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

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

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

Day One
October 31, 2023

Welcome & Introduction

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

Shaheen Halim, CMS, Designated Federal Officer

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

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

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

Morning Sessions

Session 1: GAPB Overview

Asbel Montes, Committee Chairperson
Rogelyn McLean, HHS

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

Session 2: Key Findings Discussion

Asbel Montes, Committee Chairperson

Next the Committee heard from Asbel Montes, who provided an update on the Committee's Key Findings. Mr. Montes provided a brief overview of the Medicare Ambulance Fee Schedule and the evolution of the ambulance payment system. The current Medicare ambulance fee schedule is based on a base payment that covers labor and administrative components, based on the physician fee schedule. The formulary was negotiated through rulemaking, with 70% of adjustments related to labor and 30% to non-labor-related portions. The RVU system is similar to the position fee structure, with a conversion factor for ambulances. Mr. Montes noted the ambulance industry faces challenges in determining cost, and experts have discussed various cost models and reporting methods at the state level. In 2018, Congress extended the Bipartisan Budget Act, which required a five-year extender for ground ambulance cost data collection. The MedPAC report was stalled due to COVID-19, but the Consolidated Appropriations Act extended it for two years. The report was due to Congress after reviewing the initial data set. The report was to provide recommendations on the Medicare ambulance fee

schedule and its impact on communities, whether urban or rural. The first public committee heard presentations on Medicare program data related to this issue. Mr. Montes then discussed with the Committee the four key findings. Mr. Montes stated the first key finding the Committee is recommending that Congress continue to work with stakeholders relative to the data that comes out of here in this MedPAC report as they modernize the Medicare ground ambulance benefit. Mr. Montes stated the second key finding the Committee is recommending that Congress establish a standing advisory committee. This committee would evaluate coverage and reimbursement of ground ambulance services under the Social Security Act. Mr. Montes then asked Gary Wingrove to provide an overview of Community Paramedicine. Next Peter Lawrence discussed Advance Life Support and First Response. Mr. Montes then discussed the remaining key findings and Gary Wingrove discussed ground ambulance service providers in rural, super-rural and underserved areas.

Following these presentations, the Committee adjourned for lunch.

Afternoon Sessions

Session 1: Public Comment

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

Scott Moore, Moore EMS Consulting

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

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

Randall Strozyk, American Ambulance Association

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

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

Katie Van Deynze, Health Access California

“Good afternoon, Committee members. I'm Katie Van Deynze with Health Access California, our statewide health care consumer advocacy coalition. We sponsored our new California law, signed earlier this month, which bans surprise medical bills for ground ambulance services and caps what the uninsured can be charged for ambulance services. We are here to share about California's new law, what we learned and offered and as an approach for your consideration, as well as recommendations to replace the federal prudent layperson standard for emergency care with California's law that offers greater consumer protection. Under California's new law, AB 716, if a consumer is transported in an out-of-network ambulance, consumers will be prohibited from receiving a bill beyond their in-network cost-sharing amount. In this situation, the insurer health plan will be required to pay the ambulance provider, both public and private, the remainder of the locally set ambulance rates. We chose to require payment at the locally set rate because this rate is set through an existing public process approved by elected officials responsible to their constituents, and these rates are set by cities or counties. These processes will also allow interested stakeholders to engage in that public process, including consumer advocates and health plans. Importantly, under California law local governments cannot charge more than the cost of ambulance services.

If adopted nationally, there should be similar guardrails for other states and local governments to prevent increases in rates to backfill other budget needs on the backs of consumers' health care. To monitor the local ambulance rates, our new law requires an annual state report on trending local rates by county and requires that report to be submitted to the regulators for rate review and our new Office of Healthcare Affordability. This law applies to both emergency and nonemergency ambulance transport, including inner facility transfers. We offer California's new law as an approach for your consideration and are here as a resource. We were also asked to provide recommendations on the standard for health insurance payment claims for hospital

emergency care, and we recommend replacing the prudent layperson standard with the reasonable lease standard in California law with adjustments appropriate for behavioral health crises and protections for post-stabilization care. You can find more details about all of these recommendations in our memo that we submitted to the Committee. Thank you for your time and consideration and all your work, thank you."

Doson Nguyen, National Rural Health Association

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

Wayne Jurecki, Bell Ambulance

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

Jack Hoadley, Georgetown University

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

Jamie Pafford, Pafford Medical Services

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

Some examples of the provisions that do not work for our consumers for ground ambulance services are the consumer protections related to the disclosures and the access to services, as well as the methodology for setting the initial payment amounts and rates. And I appreciate you all taking all of that into consideration as you move forward. But it's so important that you make specific recommendations with specific policy modifications to ensure that we're addressing the problem of surprise billing and that it does not jeopardize our access to care and, in some cases possibly, even eliminate the ability of ambulance providers, especially in rural service areas, to respond to the needs of our local communities. So, we realize that there's a cost factor. We

realize people don't want rates to go up. But at the same moment, they want to make sure an ambulance is there when their family members need it; and that's what we strive to do as our industry as well. Thank you for your hard work."

Adam Fox, Colorado Consumer Health Initiative

"Good afternoon, members of the Committee. My name is Adam Fox. I'm the Deputy Director at the Colorado Consumer Health Initiative. I think we would echo some of the comments that you've already heard, and we've already provided written commentary to the Advisory Committee and want to thank you for your time and work on this issue. I think we just want to reiterate that our end goal is to prohibit and ban the practice of balance billing consumers in emergency and nonemergency ground ambulance scenarios. We see through our consumer assistance program that where we help folks navigate medical billing and insurance claim issues in particular a significant increase in the number of balance bills resulting from interfacility ground ambulance transfers. As you know, Colorado has at least partially addressed surprise out-of-network bills for ground ambulances in emergency scenarios. However, we still continue to see some of those as well. And it's important to ensure that consumers do not continue to receive balance bills in these cases because they are incredibly difficult to resolve. We also want to emphasize the need to limit the out-of-pocket costs for consumers, preferably to a set amount that is reasonable, though we acknowledge that operating with the in-network cost sharing structure may be an option but would encourage the Committee to consider a set cost amount for the in-network cost sharing, whichever is lower for the consumer.

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

Kim Godden, Superior Air-Ground Ambulance

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

leaving the industry working in hospitals or leaving health care altogether or going to Amazon or other non-filled jobs because those jobs can pay more. Primarily that's because when reimbursement is fixed, we as an industry can't provide those competitive wages.

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

Angela Johnson, Oklahoma Ambulance Association

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

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

Tony Garr, Tennessee Health Care Campaign

"First of all, I'd like to make sure that public comments can be given following this meeting today and make sure that we have who to send that public comment to. The other comment that I'd

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

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

Kathy Lester, Lester Health Law

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

So to that end, I would just say that as you look at the No Surprises Act, Congress understood that some of the one-size-fits-all approaches around brick-and-mortar providers do not make sense in a ground ambulance situation and encourage you all as you think about the recommendations to make sure that we take into account the unique needs of communities and their different geographic locations; their availability of other health care providers in the area or lack of; and what it means to provide mobile integrated health care even at the emergency and interfacility level. So, to that, I just encourage you as you look at the recommendations to perhaps think about the framework of the NSA but to make sure it is tailored so that we don't endanger consumer access, patient access, to ground ambulance services. Thank you again for all your time and effort and look forward to the rest of the conversations this afternoon. Thank you."

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

Session 2: Definitions

Asbel Montes, GAPB Chairperson

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

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

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

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

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

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

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

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

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

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

Loren Adler is a Health Economist at the Brookings Institution in Washington D.C. Mr. Adler represents the non-stakeholder and non-government for this Committee. Pete Lawrence is Deputy Fire Chief, of Oceanside Fire Department. Mr. Lawrence represents state and local EMS officials. Mr. Lawrence has been in the fire service industry for 43 years and ambulance reimbursement issues at the state and federal level for 35 years.

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

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

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

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

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

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

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

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

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

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

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

Van Horne, Edward - Yes
Weiser, Carol - Yes
Wijetunge, Gamunu - Yes
Wingrove, Gary – Yes

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

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

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

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

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Ritu Sahni noted that the sentence around medical oversight was added to this definition because several Committee

members agreed that the Ground Ambulance Data Collection System process will not fully account for the cost of medical oversight in the system such as treatment in place or non-transport and paying for that and guaranteeing those payments. Mr. Sanhi stated, “the importance of medical oversight is only magnified in terms of better patient outcomes and better patient safety.” Ritu Sahni then discussed with the Committee “medical oversight” or what is often called “medical direction.

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

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

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

Discussion:
Asbel Montes then opened the discussion on the Recommendation. Patricia Kelmar noted that over the last couple of months, but particularly from a patient perspective, having a very clear definition of this emergency interfacility transport is important. Ms. Kelmar stated, “What we've been finding and hearing from patients throughout the country is oftentimes they either get themselves to an emergency room or are brought to an emergency room that doesn't have the actual services that they need to treat their condition. The Committee wanted to recognize and acknowledge that especially in the era of greater consolidation and some communities moving within one health system like all their cardiac services to one hospital in the metro area or all their maternity work in another hospital. So, understand that sometimes you end up in your closest hospital that doesn't have the care that you need. A lot of patients were finding themselves needing that second ambulance, or maybe it's their first one if they brought

themselves to the emergency room but needing an ambulance from one hospital to another. If you're in a hospital that doesn't have the care that you need, it's still an emergency; and you might as well be in your church parking lot or at home without the care that you need. So, this is an attempt to clearly define the emergency nature of a situation where you're already actually in a hospital but you're still not getting the care that you absolutely need."

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

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

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

Ms. Kelmar also thanked the representative from California for providing input to the Committee and noted that California has a great standard that takes into consideration a lot of different educational levels, cultural differences, and some of the nuances of what a prudent person standard is in many states. So, this opens it up and gives a little bit more benefit of the doubt to

the consumer to make the right decision and not be denied coverage. Ms. Kelmar also noted that she supports this expansion based on the information provided by NEMSIS during the public meeting that was held in August. Ms. Kelmar stated, “What we saw there was only about 2% of 911 calls that were dispatched ended up being no-treatment/no-transport. So, folks generally call 911 when they need treatment. They seem to, for the most part, be making smart and good decisions about when they need emergency care. So, I don't think we have to narrow the definition to try to make people be smarter or be more hesitant to call care. We don't see that that's a problem right now. So, I think this is a great definition, and I appreciate the Committee working to get it.”

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

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

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

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

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

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

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

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

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

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

Vote:
Adler, Loren - Yes
Baird, Shawn - Yes
Beck, Adam - No
Godette- Crawford, Regina - Yes
Holden, Rhonda - Yes
Kelmar, Patricia - Yes
Khawar, Ali - Absent
Lawrence, Peter - Yes
McLean, Rogelyn - Yes
Montes, Asbel - Yes

Ogunsola, Ayobami - Yes
Prentiss, Suzanne - Yes
Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes
Next PRI provided the opportunity for those that voted no to provide comments.

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

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

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

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

Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

Session 3: Disclosure/Coverages

Asbel Montes, GAPB Chairperson

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

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

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

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

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

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

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

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

> Rhonda Holden: “Yes, for the same reasons that Pete mentioned, I just feel like it's critical that we have coverage for when we treat and don't transport because that's an incredible expense. When people call 911, we must respond. We don't have a choice. So, the comment made about medical necessity, being required for payment, just doesn't apply when someone calls 911.”
>
> Peter Lawrence: “I'm going to make it easy, what Rhonda said and what I've said previously. We need to cover non-transport services, or the patient gets impacted.”
>
> Gary Wingrove: “I don't believe I feel really strongly that the cases of treatment and release and other things are important and shouldn't be ignored. That's why I'm 'No' on #3A, but I'll be 'Yes' on #3B.”
>
> Rhonda Holden: “I just had one more comment about that, about the care that can be provided in the field, and we don't transport a patient. We could have someone who's actively coding and dies and ends up being transported by a coroner rather than by an ambulance service, and we have put an intense amount of care into trying to save someone's life. That's another reason that I feel so strongly that we need to vote 'Yes' on #3B and make that required coverage.”

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

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

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

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

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

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

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

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

Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sahni, Ritu - Yes
Van Horne, Edward - Yes
Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - Yes

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

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

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

Discussion
Asbel Montes then opened the discussion on the Recommendation. Patricia Kelmar discussed the importance of mirroring the No Surprises Act in medical billing, ensuring out-of-network payments count towards deductibles and maximums. Ms. Kelmar stated that consumers should be directed to the same place they are already informed about medical billing. She noted that patients often cannot provide information about their insurance, so relying on other sources such as technology solutions is often necessary. Ms. Kelmar noted however, a finite number could be administratively burdensome and delay the process.

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

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

Weiser, Carol - Abstain
Wijetunge, Gamunu - Yes
Wingrove, Gary - No

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

> Patricia Kelmar - “I'm voting 'No' on this not that I don't believe that there should be some type of cap; but I think Option B is better. I've talked to patients who have bills in $8,000/$7,000/$10,000 ranges. Ten percent of that would be really hard to meet and would be a real deterrent for people to call an ambulance. The other thing I would say is I would really like folks to have a very clear idea in their head of how much this ambulance ride is going to cost them before they call 911. I think having 10% of a rate that may, depending on how the recommendations go later, could be variable by the community that you happen to have an accident in is just really not a great way to set a rate or have people understand what their coverage is. So I'm going to be voting for Option B.”
>
> Dr. Ayobami Ogunsola: “Yes, my reason for voting 'No' is that 10% at a flat rate is -- I'm somewhat not comfortable with a flat rate. That is my major concern about that. So I don't want to subject patients to a flat billing or a flat cost-sharing rate of 10%. I just don't like the idea of paying a flat rate, and that is it. Thank you.”
>
> Gary Wingrove: “Yeah, I mostly agree with Patricia. I think there are some areas where there's some recommendations in my head where there's one standout option, and the others aren't very good. I just think it's going to confuse people by saying, 'Here, pick one of these three choices,' when there's a standout option; and option B is that standout option. Otherwise, we're just saying we couldn't come to consensus on what it actually was.”

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

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

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

Discussion
Asbel Montes then opened the discussion on the Recommendation.

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

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

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

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

> Adam Beck – “Just one of the other options is my preference here. No other comments.”

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

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

The patient cost-sharing requirement for ground ambulance emergency medical services may be no higher than the amount that would apply if such services were provided by a participating ground ambulance provider or supplier.

Discussion
Asbel Montes then opened the discussion on the Recommendation.

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

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

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

> Loren Adler: “Sure, I mean I think for the same reasons that Patricia and some others have stated, while I think this is better than nothing, I'm voting 'No' here because I want to sort of show my support for having more of a fixed metric, with the acknowledgement that I do understand that it is difficult to go away from something like this if it's simply left up to the sort of local governments to set rates like in recent state laws.”
>
> Shawn Baird: “Yes, some of my thoughts have already been captured on looking for greater certainty and what that amount would be for a consumer. But something that hasn't really been emphasized is the lack of data around actual in-network rates now because there are so few in-network providers in the ambulance world with insurers that I see this as being problematic in the sense that there's no real dataset to work off of that's meaningful when no negotiations took place in a broad scheme like other health providers to be in-network.”
>
> Regina Crawford: “I concur with the comments that I've made previously. You don't know what that bill's going to look like, and I think it just could be really astronomical. My concern is also there's no data to prove this. We don't have anything to compare it with.”
>
> Rhonda Holden – “Everything said above, but also going back to comments that we've heard over and over again, and even heard today from Angela in Oklahoma, that the

insurance companies aren't always negotiating. It's sort of a take-it-or-leave-it. So, I would be fearful that this could be a really low payment amount that they might be receiving, or, I'm sorry, a really high payment amount that our consumers would be having to pay.

Patricia Kelmar: “Nothing additional to add.”

Peter Lawrence: “Nothing additional to add.”

Asbel Montes: “The only thing I would like to note is that there were several presenters, as well as subject matter experts, that have presented in the May meetings and subsequent subcommittee meetings around the percentage of ground ambulance providers who were out of the network, which would be really hard coming up with some type of participating ground ambulance emergency medical... I think it's important to know that there is data that's come out in all claims payer databases, as well as other data that's been out there and reported by the Health Care Cost Institute as well as FAIR Health that's painted a picture around the out-of-network ambulance services that would hit here. This, to me, becomes really problematic in that environment of coming up with an appropriate cost share. So, I believe recommendation or Option A or B is probably the best consumer protection is giving them that number, knowing what they could possibly or potentially be liable for.”

Dr. Ayobami Ogunsola: “Yes...is that Option C seems to me to be... So, for that factor, that's why I would vote 'No.' Because I have... Thank you.”

Suzanne Prentiss: “Thank you. Most of what I want to say has been covered; but for the record, I'm just going to hit a couple key points. If we're talking about consumer protections, which this section is and this option is, then A and B -- and preferably B although I voted for both of them, are geared for all consumers, not a set of consumers that are covered under participating providers. I also think it's worth noting it has been talked about throughout all the months that we've met -- and it came up today I think in public comment, that not all people don't, emergency medical services isn't like all health care providers that are covered under the No Surprises Act. The episodic nature and the emergent nature of the business puts us in a different place. So I think that that's worth noting as well as what drove me to vote 'No' for C and support A and B, preferably, B.”

Ritu Sanhi: “Nothing to add.”

Edward Van Horne: “Yes, thank you. Everything that's been said. Also to reiterate the point that when someone calls 911, they're calling because of a critical event that they're having. With how many ground ambulance providers are in a service area, you may not have ones that are in this type of supplier network. So, you can't put the patient to be concerned about do they call for help or not. It needs to be consistent. That's all I have.”

Gam Wijetunge: “Nothing to add, thank you.”

Gary Wingrove: “Nothing to add.”

Session 4: Wrap-Up

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

Next Asbel Montes discussed with the next steps and provided the opportunity for final comments. Rhonda Holden suggested that the Committee vote on recommendations #3A and #3B and #8A and #8B again to provide a consensus for the report. All Committee members agreed with this suggestion. Asbel Montes noted the Committee will reconvene tomorrow with discussion and voting on Recommendation #9.

Shaheen Halim thanked all the presenters and members of the public for feedback during today's meeting. The meeting was adjourned for the day by Ms. Shaheen Halim around 4:30 PM. The meeting will reconvene at 9:30 AM ET on Wednesday, November 1, 2023.

Day Two
November 1, 2023

Welcome & Introduction/Recap of Day 1

The second day of the GAPB Advisory Committee (Committee) meeting began at 9:30 AM on November 1, 2023. Terra Sanderson, moderator with Provider Resources gave welcoming remarks and provided meeting logistics. Ms. Sanderson stated the meeting would be live cast and a recording would be available on the CMS GAPB website following the meeting.

Next, Asbel Montes provided the Committee with a recap of Day 1. Mr. Montes noted there will be no public comment in the oral component for Day 2, but additional public comment will be provided in a written form. Mr. Montes then reviewed with the Committee the voting process for recommendations. Mr. Montes then noted that no proxy is allowed for the Committee members during the voting process. After discussion each recommendation is final, and PRI will take the vote by calling each Committee member alphabetically. Committee members will vote, yes, no or abstain. Committee members that vote no will be given three minutes to discuss the reason for the vote. Mr. Montes then began the review of the recommendations.

Morning Sessions

Session 1: Cost/Payment

Asbel Montes, Committee Chairperson

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

Discussion
Asbel Montes then opened the discussion on the Recommendation. Asbel Montes discussed with the team feedback received during the subcommittee meetings from ground ambulance providers on access to patient insurance information, Mr. Montes noted a presenter from the Office of Civil Rights discussed with the Committee HIPAA regulations and what is permissible to providers. Mr. Montes stated the Committee is seeking a amendment from the Secretary of Health and Human Services to make it a requirement that they provide this information to a ground ambulance provider or supplier in order to continue to protect the patient so they do not receive a bill.

Patricia Kelmar noted that this recommendation will help to ensure that in emergencies, patients insurance information is shared between the hospital and ambulance company for efficient billing. Ms. Kelmar stated it is crucial to clarify that hospitals should provide this information to ambulances, even if they are still in the hospital within the first few days after their 911 call.

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

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

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

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

Discussion
Asbel Montes then opened the discussion on the Recommendation. Asbel Montes noted that this recommendation discusses some of the minimum elements that would need to be in a patient's bill. Mr. Montes noted that the Committee learned during discussions with billing offices and public comments that often not everything is included in a statement that a patient might be getting a bill relative to certain things. The recommendation is that a standardized bill be provided to consumers with the minimum elements in the bill. Mr. Montes noted that several states already have this process in place.

Patricia Kelmar discussed the recommendation and noted that patient billing is often confusing to consumers. This recommendation is to help ensure the consumers are aware of how to pay bills, including insurance determination, balance billing protections, surprise billing protections, and how to assert rights if a balance bill is received.

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

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

A state or local regulated rate for ground ambulance emergency and non-emergency ambulance medical services that are established outside of a state balance or surprise billing statute will meet the guardrail requirement under Recommendation 12B or Recommendation 14, if it:

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

AND

II. There is full transparency with the rate subject to public disclosure and reported to a state governing entity for accessible public viewing.

III. The tri-departments must maintain a publicly-available database of state- and locally-set rates that are binding for any minimum required payment, broken out by service and locality. States and localities must report the information required for such a database to the federal government.

Discussion

Asbel Montes then opened the discussion on the Recommendation. The Committee members addressed their support and reasons for oppositions for the Recommendation.

Vote

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

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

> Loren Adler: “Thank you. I think I've spoken to my vote already with the acknowledgement that I do think the provisions in this are still useful as guardrails to the local process, but just in addition to option B. And then, you know, I do think to Shawn's point, I'll just sort of add something. I do think $1,000 balance bills are meaningful. I don't think that's nothing. You know, and that's a quarter of balance bills are roughly over $1,000. That is meaningful in terms of patient costs.”
>
> Adam Beck: “Yeah, I would associate myself largely with Loren's comments from earlier. I think my primary concern with option A is the lack of any upper limit guardrail and really giving full power to the same entity that is providing the service and making the charge to also be able to dictate a rate. I'll get when we get to option B, which I think of these two is preferable, given that there's some restraint on, you know, on excessive charges or really just inflationary rates. But I would both would have concerns if this is being viewed as a recommendation to apply state or locally mandated rates to a ERISA group health plans, which I think would be a bridge too far and something that would not be

good public policy to recommend to Congress. The other thing I think with this sort of process is that it would be wise to allow for -- and I think this is referenced elsewhere in some of our mandate recommendations that payer provider negotiations and contracts can continue to exist. And so I think really allowing for a private market solution that may end up being more favorable towards the consumer and end up creating in network agreements that are beneficial to both parties, that those should be allowed to continue. And I'm concerned that these recommendations don't account for that solution, which really would, I think, be preferable to defaulting to any sort of whether it's federal, state, or local government rate setting. So that's some of my rationale for voting no on this."

Patricia Kelmar: "Just briefly, thank you, Loren, for a really well articulated argument of the concerns of the implication if we end up going with an out of network payment that requires the employers and plans to pay the locally set rate. The lack of cap in this option is what's most concerning to me. And I just want to underscore the extreme importance of getting roll up reporting to the states and then to the feds. I think that that will be the best way if this is the process that the Congress ends up choosing to monitor and keep track of rates. I've seen rates -- I appreciate that California has in place a cap, and that might be something that people want to consider as one of additional guardrails that the local ambulance rates can't do more than cover the costs. So that would be an important thing to consider maybe in future policy proposals. But just knowing in California, even right now, rates can vary by a thousand dollars from one neighborhood to the next, depending on the county which is governing your ambulance rates. So it's extreme differences and it could have a big impact on patient cost share and premiums eventually as well. So that's why I voted no. And I'll be voting yes on the next option."

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

I. Local set rates cannot be higher than the Payment Reimbursement Options referenced in Recommendation 12A.

AND

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

Discussion
The Committee members addressed their support and reasons for oppositions to the Recommendation.

Vote
Adler, Loren - Yes
Baird, Shawn - No
Beck, Adam - Yes

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

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

> Shawn Baird: “Thank you. I certainly won't repeat all of the robust discussion that we just had, but I do think that my no vote really comes back to the principle that protecting transparency and allowing our consumers and patients the opportunity for the most direct access in the quality of care and rate setting happens at the local level, and that is where they can engage. And if there's a default federal rate that's set by Congress, that really basically strips some of that opportunity because that becomes the de facto rate, and there's far less direct access to participate in Congress than there is at City Hall. And the other comment I would make is that I believe Ritu really summed up what we're trying to do here, which is make sure our patients get the best care possible, and that is why I voted no.”
>
> Regina Crawford: “I'm not going to rehash what's already been discussed, but it all starts and begins at the local level. So I support. I do think Shawn and Ritu summed it up quite well. Enough said.”
>
> Rhonda Holden: “Just as said by Shawn and others before me.”
>
> Peter Lawrence: “Everything said prior, just reiterating local system, local control, local rates.”
>
> Asbel Montes: “The only thing that I'm going to add there is I only agree with this recommendation in the absence of a local rate setting methodology. So, if there is not a local rate setting methodology, then it would be appropriate for something like this to happen. But once the locals set that or the states do something similar, then to me this becomes, and they follow the guardrails appropriately, then this should not be an impediment to that happening.”
>
> Suzanne Prentiss: “Thank you. I've made my objections and my affirmations clear throughout the process. I want to thank Shawn for his comments just now on B, and also Ritu for always bringing us back to the patients that we serve and the medical, clinical

part of this process that we need to preserve and help sustain as we're thinking about the work we do here. Thank you."

Ritu Sanhi: "Thank you. I think I explained my vote. The one thing I do want to add, though, is I think this theme is going to percolate through the rest of the day. That being said, as I reflect on this, we've reached like 98% consensus. And when you really look at what comes out between these two options and what we discussed before, it's almost on the margins. And so, I just don't want to lose -- it may have sounded a little contentious, or at least there was great discussion from a lot of people that I really respect. But I think at the end of the day, you're really talking about just some small differences of opinion in some small areas. That overwhelming consensus of this group was very positive and pretty similar."

Edward Van Horne: "Yeah, Ritu, you said it well again. This is all our focus about the patient and getting the patient out of the middle. I think the multiple recommendations we're working on I think has that general consensus. We recognize the nuance there is that EMS is local. Every time you call 911, regardless of where you are, an ambulance has to respond regardless of your ability to pay. And the local systems, the local rates, the local transparency builds that model so that it makes it work as appropriately as is needed to save those lives regardless. And that's what makes it so different than a hospital or a physician or a different type of healthcare that you can choose and who and where to go. You don't get that with 911. So I would say thank you."

Gary Wingrove: "Yeah, I would just add that there is no greater consumer protection than having an ambulance to respond. Just like we know there's variation in cost in California counties, I'd be interested to know if the wages vary greatly in every state. But we also know there are ambulance services closing and we don't have a minimum guardrail. And I'm less concerned about a public process that a community or a county might have than I am about the known ambulance closures that have happened and we haven't addressed those."

<u>Recommendation 12A:</u>
Prohibit balance billing and guarantee reasonable payment for ground ambulance emergency medical services.

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

A. Payment Reimbursement Options

1. For fully-insured plans and other plans regulated by state law, the rate is the amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)

2. If there is no state balance billing law or the group or individual health insurance coverage is not regulated by state law, then the amount is
   a. If Medicare covers the service, a Congressional set percentage of Medicare.
   b. If Medicare does not cover the service, either
      i. i. A fixed amount set by the Congress or
      ii. A percentage of a benchmark determined by the Congress.

B. Timing of Payment

1. Within 30 days of receipt of a bill as currently defined in the NSA.
2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance provider or supplier
4. If it is determined that a plan or issuer has Not Adopted by Committee to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage). In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

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

Discussion

Asbel Montes then opened the discussion on the Recommendation. The Committee members addressed their support and reasons for oppositions to the Recommendation.

Vote

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

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

Shawn Baird: “Thank you. My no vote was based on option A, not preserving the full tier of state balance billing down to state and local regulated rate down to negotiations with insurers and then finally as a last resort, a federal rate.

Adam Beck: “Yeah, my no vote, as I indicated earlier, I think would be cured if it weren't for a recommendation, I believe it's A2b that requires coverage and payment for non-Medicare covered services. So but for that item, I think this would be a reasonable recommendation.”

Regina Crawford: “Yes, my vote no is because I did not think -- option one did not allow the steps for the locals to negotiate those rates and I think that is imperative. Although we started negotiating rates, at this point, we still have a long way to go, especially with ground ambulance. So, I could not support that. I think option B is a better option. Thank you.”

Rhonda Holden: “The same, it's taking away the ability of the locals to negotiate rates and then also the mutually agreed upon reimbursement rates between an ambulance service and an insurance provider.”

Peter Lawrence: “12B provides much more appropriate rate setting processes from the state to the local, to the negotiations, to then the federal, and that's the reason why I voted no on 12A.”

Asbel Montes: “I'm a no vote, specifically for some of the reasons that everyone is giving here as well. This option didn't go far enough to make sure we preserved the local rights relative to the cost in different areas around those appropriate guardrails that we spent a lot of time discussing. And for that reason, I'm a no.”

Suzanne Prentiss: “Thank you. So, I'm a no vote for reasons that I have stated on our last recommendation and bringing them through here. I am working in all corners to protect state and local, well, the sovereignty at the state level and what's already recognized. So, although I appreciate all the comments that have been made, both for and against, I think that option B is the -- I'm going to be voting for B because it's preferable and consistent with what I have voted on already. Thank you.”

Ritu Sanhi: “Nothing to add. I agree with statements already made.”

Edward Van Horne: “Yeah, thank you. I voted no, specifically as stated to preserve the ability to have the tiered response of tiered coverage from states to locals, to negotiations, and then a federal fallback if needed, which is 12B.”

Gary Wingrove: “Nothing to add.”

Recommendation 12B:

I. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries.

The group health plan, or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for ground ambulance emergency medical services provided to a participant, beneficiary, or enrollee.

A. Minimum Required Payment
    1. The amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
    2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
    3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the emergency ground ambulance services provider or supplier
    4. If none of the above exist, then the amount is:
        a. If Medicare covers the service, a Congressional set percentage of Medicare;
        b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.
B. Timing of Payment
    1. Within 30 days of receipt of a bill as currently defined in the NSA.
    2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
    3. Group health plan or health insurance issuer makes prompt payment directly to emergency ground ambulance services provider or supplier
    4. If it is determined that a plan or issuer has failed to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage). In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.
C. Maximum patient cost-sharing as indicated in Recommendation 8.
D. Minimum Guardrails for State and Local Regulated Rates for ground ambulance emergency medical services as indicated in Recommendation 11.

Discussion

Asbel Montes then opened the discussion on the Recommendation. The Committee members addressed their support and reasons for oppositions to the Recommendation.

Vote

Adler, Loren - No
Baird, Shawn - Yes
Beck, Adam - No

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

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

> Loren Adler: “I think I've said everything during the discussion portion.”
>
> Adam Beck: “Largely same principle as before, the coverage mandate for non-Medicare covered services, but then also this one does go a step further by mandating ERISA plans be governed by a state or local process, so that was also a deal breaker in this recommendation.”
>
> Patricia Kelmar: “Yeah, so I preferred option A, which is why I voted for that. And, you know, obviously in this option B, the important elements that I obviously, well, not obviously, that I do support are the timing payments, the guardrails, and the maximum cost share. So, I don't have any problems with that. It's just the payment mechanism. I just feel like it's going to be really confusing from the consumer perspective to understand which rate is applying, whether or not they're being overcharged, whether they're insurer or from the employer perspective who are paying these rates, you know, what's going on. So I think it's just much more confusing than option A and has the potential to have some issues with the local rate setting that I mentioned in the earlier conversation. That's why I voted no.”
>
> Dr. Ayobami Ogunsola: “Yes. My preference for option A is the fact that it provides a layer of checks, which I like, which I also think may be appropriate. And then option, my no-go to option B is because the methodology seems a little bit -- it should have been a little bit of complication here. So that is why I try to balance both. And my preference for option A is, I suggest, is more superior. And that's why I voted no for B. Thank you.”

Following these presentations, the Committee adjourned for lunch.

Afternoon Sessions

Session 1: Recommendations Review

Asbel Montes, Committee Chairperson

Next Asbel Montes began the afternoon sessions with continuing the review of Recommendations. Mr. Montes noted Recommendations 13 and 14 are predominately based on the non-emergency components. The Committee discussed each Recommendation and followed the discussion with a committee vote.

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

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

The patient cost-sharing requirement is 10% of the rate established under Recommendation 14, subject to out-of-pocket limits with a fixed dollar maximum.

Discussion
Asbel Montes then opened the discussion on the Recommendation. Mr. Montes stated that Recommendation 13 is similiar Recommendation 8. Mr. Montes noted that when the Committee put the recommendations on how the prevention of surprise billing works, there's a reason why option A and option B for both, the non-emergency provision, and the emergency provision, is being voted on. While the committee agrees there needs to be some maximum cost of sharing that option of that amount for the participant or enrollee, there are different solutions to how to get to that.

Peter Lawrence suggested that based on the voting for Recommendation 8 that the Committee disregard Recommendation 13A and only vote on Recommendations 13B and 13C. Loren Adler noted that while there should be different protections between emergency and non-emergency, he agrees the vote should just be on 13B and 13C.

The Committee members then discussed examples of non-emergency ground ambulance medical services. The Committee agreed not to vote on Recommendation 13A.

Vote
No Vote

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

Any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to non-emergency ground ambulance medical services must be counted toward any in-network deductible and out-of-pocket maximum in the same manner if the services were provided by an in-network non-emergency ground ambulance services provider or supplier.
The patient cost-sharing requirement may be the lessor of $100 (adjusted by the CPI-U annually) or 10% of the rate established under Recommendation 14, regardless of whether the health plan includes a deductible.

Discussion
Asbel Montes then opened the discussion on the Recommendation. Asbel Montes noted that 13B is very similar in the same to Recommendation 8B that was governing the provision within the preventing surprise billing and creating a reasonable for ground emergency medical services. Recommendation 13B is more relative to the non-emergency recommendation and is the same recommendation of the patient cost-sharing requirement.

Loren Adler discussed the importance of cost-sharing in non-emergency ground ambulance services, which are often vital and critical. Mr. Adler argued that out-of-network cost-sharing should not be higher than if the service had been in-network. They suggest that CMS should consider this in Part C plans, where cost-sharing shifts are successful. However, there is concern that without this, consumers may receive an inordinate bill for a 10-mile transfer, potentially costing them up to $500 or more out-of-pocket. They also suggest that there may not be an alternative service outside the medical necessity provision.

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

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

> Loren Adler: “Sure. I think I've explained why not. If we wanted to do something broader and lower cost-sharing across the whole healthcare system, all for that. I just think sort of picking and choosing individual services opens up a game where every -- there's a lot of important medical services, and it opens up a sort of game that's going to be difficult

to -- well, maybe that's a good game if everything just has lower cost-sharing in my eyes, but that's sort of where I'm coming from here."

Adam Beck: "Similar reasoning that this would create lower cost-sharing for out-of-network services than it would for in-network care."

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

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

The patient cost-sharing requirement for non-emergency ground ambulance medical services may be no higher than the amount that would apply if such services were provided by a participating non-emergency ground ambulance services provider or supplier.

Discussion
Asbel Montes then opened the discussion on the Recommendation. Adam Beck discussed he will vote "yes" on this option based on the assumption or the belief that this is reaching covered non-emergency ground ambulance medical services, which means that, A, they are a covered benefit as part of the patient's health insurance plan, which would also, B, allow them to be subject to any of the utilization management rules that would apply to any other covered service.. Mr. Beck also noted that this Recommendation works within Recommendation 14.

Loren Adler discussed one potential risk when lower cost-sharing is required for one type of non-emergency service is that the insurers may just deny more types of that service or try to deal with things that way rather than, having 10 percent or whatever cost-sharing.

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

Wijetunge, Gamunu -Absent
Wingrove, Gary - No

Next PRI provided the opportunity for those that voted no to speak to their vote.

Shawn Baird: “Thank you. I think that the non-emergency -- I'm trying to sum up my comments briefly, and it gets really hard on this particular topic. I think the protection for the patient offered in Option B is appropriate, and I think as we revisit Item 8 on the emergency, we'll see that there was a consistent interest in keeping those protections strong and consistent. I heard a lot of the discussion around having various cost-sharing different between services on insurance, and my own insurance has different cost-sharing requirements for different service lines in it, and it's with a major insurer. So, I think that is actually fairly often done. The straight-across percentage, I struggle with it when we've had such an ineffective marketplace to determine what in-network and out-of-network really should be or is in an ambulance when so few ambulance providers are in-network. There just isn't enough to know what the cost- sharing requirement would be under Option C.”

Rhonda Holden: “I agree. I think Option B was just the superior option, and then Option C, I'm concerned that there just aren't enough in-network providers, and especially how that would impact in rural areas.”

Patricia Kelmar: “Yeah, just Option B seemed better, so that's why I voted.”

Peter Lawrence: “Option B seemed better.”

Asbel Montes: “At this time, I will just keep my comments to when we get to the recommendations on the prevention of balance billing, because it will all play into why this option is relevant.”

Dr. Ayobami Ogunsola: “Yes, it seems to me that Option B offers more protection than we can get in Option C. That's why I voted B as yes and no for C. Thank you.”

Suzanne Prentiss: “Quite simply, B is the better option, and I do think we need to be concerned about adequacy with, you know, having the number of participating providers available, especially, as Rhonda pointed out, for our more rural areas. This could become an issue. Thank you.”

Ritu Sanhi: “Nothing to add.”

Edward Van Horne: “Agree, Option B is better, and Option C does struggle with the solution on building out appropriate networks in rural and suburban areas and getting participating providers.”

Gary Wingrove: “Nothing to add.”

Session 2: Recommendation Review

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

I. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries.

The group health plan, or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

A. Minimum Required Payment
    1. The amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
    2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
    3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the non-emergency ground ambulance provider or supplier
    4. If none of the above exist, then the amount is:
        a. If Medicare covers the service, a Congressional set percentage of Medicare;
        b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.
B. Timing of Payment
    1. Within 30 days of receipt of a bill as currently defined in the NSA.
    2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
    3. Group health plan or health insurance issuer makes prompt payment directly to non-emergency ground ambulance provider or supplier
    4. If it is determined that a plan or issuer has failed to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage). In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.
C. Maximum patient cost-sharing as indicated in Recommendation 13.
D. Minimum Guardrails for State and Local Regulated Rates for non-emergency ground ambulance medical services as indicated in Recommendation 11.

Discussion
Asbel Montes then opened the discussion on the Recommendation. The Committee members provided feedback on the recommendation and suggested adding an additional recommendation to vote on. The Committee added Recommendation 14C and voted on this later in the afternoon.

Recommendation 14B:

I. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries.

The group health plan, or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

A. Minimum Required Payment
    1. The amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
    2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
    3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the non-emergency ground ambulance provider or supplier
    4. If none of the above exist, then the amount is:
        a. If Medicare covers the service, a Congressional set percentage of Medicare;
        b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.
B. Timing of Payment
    1. Within 30 days of receipt of a bill as currently defined in the NSA.
    2. Patient share can be billed after group health plan or health insurance issuer pays or denies the claim
    3. Group health plan or health insurance issuer makes prompt payment directly to non-emergency ground ambulance provider or supplier
    4. If it is determined that a plan or issuer has failed to make payments in accordance with the prompt and direct payment requirements, the Secretaries of the appropriate Department shall impose a per annum simple interest rate of some defined percentage. (Note that many states use 18% or more for this percentage). In addition, the Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.
C. Maximum patient cost-sharing as indicated in Recommendation 13.
D. Minimum Guardrails for State and Local Regulated Rates for non-emergency ground ambulance medical services as indicated in Recommendation 11.
E. Notice and Consent for Certain Non-Emergency Ground Ambulance Medical Services
    The non-emergency ground ambulance services provider or supplier may not bill or hold liable the patient for more than the cost-sharing amounts consistent in Recommendation 13 unless it has provided notice with the information required by the current NSA within 72 hours prior to the date of the service and the patient has signed a written consent consistent with the information requirements in the current NSA.

Discussion

Asbel Montes then opened the discussion on the Recommendation. The Committee members provided feedback on the recommendation and suggested adding a additional recommendation

to vote on. The Committee added Recommendation 14C and voted on this later in the afternoon.

Recommendation 15:
Emergency and non-emergency ground ambulance providers or suppliers and group health plans or health insurance issuers may access the Independent Dispute Resolution (IDR) process only when the Out-of-Network Rate (see Recommendations 12 and 14) is:

I. A set percentage of Medicare if Medicare covers the service or if Medicare does not cover the service, either
   a. A fixed amount set by the Congress or
   b. A percentage of a benchmark determined by the Congress and the process will be modified to be tailored to ground ambulance emergency medical services and non-emergency ground ambulance medical services.

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

A. Both parties would have the ability to request an IDR process, but only when the Out-of-Network Rate (see Recommendations 12 and 14) is a set percentage of Medicare or if Medicare covers the service or if Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.
B. The IDR entity should be required to consider the following ground ambulance emergency medical services and non-emergency ground ambulance medical services specific factors when determining the payment amount:
   1. The ground ambulance specific Out-of-Network Rate;
   2. The level of services being provided;
   3. The acuity of the individual receiving the services or the complexity of furnishing the services to the individual;
   4. The ambulance vehicle type, including the clinical capability of the level of the vehicle;
   5. Population density of the location where the patient was met;
   6. The time on task, including but not limited to wait-times and hospital wall-times;
   7. Distance from the destination, including but not limited to lack of access to providers within a reasonable distance (such as being in a medically underserved area); and
   8. State/local protocols and requirements.
C. The prohibition on the IDR entity considering other rates would be amended to remove Medicare rates from the list of prohibited factors.
D. The mileage and base rate elements of a single claim should be required to be batched (addressed) together. The process should also allow for batching of multiple claims that involve the same ground ambulance provider or supplier, insurer, level of service, and geographic area.
E. The cost of the IDR process should recognize the unique nature of ground ambulance service claims and their substantially smaller size when compared to claims of other providers. For the administration fee to be limited $50 updated annually (e.g., such as by the CPI-U). For the IDR entity charge, the amount could be to be a percentage of the value of the claim(s) in dispute.

F. The other IDR-related provisions of the NSA would apply without modification. The Secretaries should also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.
G. The other IDR-related provisions of the NSA would apply without modification.

Discussion
Asbel Montes then opened the discussion on the Recommendation. All Committee members provided feedback regarding this recommendation.

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

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

> Loren Adler: “I think I've said my piece on this.”
>
> Adam Beck: “Yeah, I mean, the independent dispute resolution process was a mistake to write into the No Surprises Act, and it has proven in the years since to be an abject failure, both in terms of any policy outcomes as well as just the administrative functioning of an IDR process that has been egregiously overutilized primarily by the same private equity-backed emergency staffing firms that would likely end up being the actors that are most likely to pursue IDR under this approach. So, I think setting up any IDR system is ill-advised. To recommend it when you have, in contrast to the No Surprises Act, you have an approach that we appear to be recommending where there is essentially a federal benchmark, a mandatory or required minimum payment that should eliminate the need for any subsequent independent dispute resolution. The reason, ostensibly, that Congress set up an IDR process followed by, you know, preceded by an open negotiation process under the No Surprises Act is because there is no mandatory initial payment, and there was a concern that initial payments would end up being insufficient or too low, and this gave an opportunity then for parties, primarily the providers and facilities and the air ambulance providers, to be able to seek what they believe to be a more reasonable out-of-network rate through IDR. Our earlier recommendations on

required minimum payment flat out say that this is the out-of-network rate. So it is, to me, illogical to say out of, you know, one side of your mouth that this is the appropriate out-of-network rate, but we are going to, despite declaring that the appropriate out-of-network rate, allow for certain actors to be able to seek really a windfall on top of the already, you know, additional payments that they are getting as a result of the mandatory payments through this IDR process. I think there are flaws in the considerations that are laid out, and there's an open question about what exactly this penalty is that would be assessed for noncompliance. I think there are weaknesses in how this IDR process is set up, but the fact that it's even a part of the recommendation when it's so clearly failed with the No Surprises Act is, for me, a clear enough reason to vote no.

Patricia Kelmar: “Thank you. As I mentioned, I am concerned that there will be a huge amount of costs, administrative burden added to the system overall if we open up an IDR process. I'm confident that Congress will be sensitive to the needs of making sure that access continues in all the communities. We’ve seen states that have relied on a percentage of Medicare to be quite generous in that rate when states have passed surprise billing. I would expect Congress would act in a similar manner. Obviously, as consumer groups, we would be making sure that the minimum amounts are not the Medicare rate would be one that would support 24-hour, seven days a week, good ambulance emergency care. So, I just see this as an added cost, and that's why I voted no.”

Peter Lawrence: “As I've said before, we've got all these other rate structures and all these other processes in place to establish appropriate rates, and I think we've made great strides to get there. I understand everybody's concern expressed that we need one more backstop. I think the IDR process, if we came forward to Congress with the IDR, I think it gives Congress the ability to basically shoot low and then force everybody to go into the IDR process. And I don't think that that's the way we need to go. We need to have Congress set the rate. Am I being altruistic? Possibly so. But the bottom line is that the IDR process, in my opinion, creates a crutch and allows Congress to say, you guys don't like what we've done, go use IDR. So that's why I voted no on it. I want Congress to take our recommendations, deal with them appropriately, and then establish a rate with everybody providing input, understanding that the GPCI is going to adjust for differences in geographic area and the rural, super rural adjustments will provide additional adjustment. I don't think the IDR process was appropriate for giving Congress an out.”

Dr. Ayobami Ogunsola: “Yes, I voted no because I think it would be counterproductive and it's not cost effective. That's my judgment about it. Thank you.”

Ritu Sanhi: “I voted no. This was very difficult though. This was not straightforward by any stretch. There were a couple of factors that led to my no vote. Number one, no matter who you talk to, probably the least effective and least popular portion of the No Surprises Act has been the IDR process. I mean, I guess there is a philosophy that if nobody likes it, then it must be doing something right. But I think that's been part of what has driven me to vote no. The other piece is, I don't necessarily share Patricia nor Peter's faith that Congress will set the right rate. What I do see as an additional backstop

in this process is that a community or state could create its rate-setting process. Everything we've done until now has said that that would be the minimum payment. The combination of those two led to my no vote. “

Gary Wingrove: “Yeah. I am generally concerned about the cost with this one, and that's all the cost. It’s hiring the firm that's going to go through it for you. That’s not even spelled out. But anyway, I'm concerned about the cost, and I'm not sure that it adds value to any part of the equation.”

Session 3: Recommendations Review

Asbel Montes, Committee Chairperson

Next, Asbel Montes continued the Recommendations Review. The Committee began with Recommendation 14. Mr. Montes noted that per Committee discussion Recommendation 14 now has three options to vote on. Recommendation 14A includes the minimum required payment and a walk through of the parameters. Recommendation 14B has the same thresholds as 14A with the notice and consent provision added. Recommendation 14C is the equivalent of Recommendation 12A except modified for non-emergency ground ambulance services.

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

II. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries.

The group health plan, or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

B. Minimum Required Payment
    1. The amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
    2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
    3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the non-emergency ground ambulance provider or supplier
    4. If none of the above exist, then the amount is:
        a. If Medicare covers the service, a Congressional set percentage of Medicare;
        b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.
C. Timing of Payment
    1. Within 30 days of receipt of a bill as currently defined in the NSA.

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

D. Maximum patient cost-sharing as indicated in Recommendation 13.
E. Minimum Guardrails for State and Local Regulated Rates for non-emergency ground ambulance medical services as indicated in Recommendation 11.

Discussion
Asbel Montes then opened the discussion on the Recommendation. . The Committee members provided feedback on the recommendation.

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

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

> Loren Adler: “Sure, I mean, I think we've discussed this a little bit as well. For this one, I'd say this is a more weakly held no than the previous ones, given that there aren't that many non-emergency set rates to begin with and given that there are sort of market factors and some coverage decision processes that can still happen behind that, yeah, sort of after the fact stuff, so I don't think this is quite as determinative. As long as it is a pretty weakly held no, but basically the main reason is just the encroaching on ERISA issue here for my hesitation here.”

Shawn Baird: “Yeah, I would have been able to support this if it had what the next one we're voting on, option B, has as its sub-point E, which is the notice of consent provision allowing for patient choice.”

Adam Beck: “Yeah, just can't vote to support subjecting ERISA self-funded group health plans to the state regulation.”

Regina Crawford: “Sorry, I was muted. Same reason, I want to support the state authority to have some say in this, so option B is better for me.”

Patricia Kelmar: “Nothing to add that I didn't already state in the earlier discussion around these different options, I think on recommendation 12, perhaps, and I think option C is the best.”

Asbel Montes: “No comment at this time.”

Dr. Ayobami Ogunsola: “Yes, there's no protective no, that's why I voted no.”

Suzanne Prentiss: “I just think that there's a better option and reflecting on what some of my colleagues have said, so thank you.”

Ritu Sanhi: “What she said.”

Gary Wingrove: “What she and he said.”

Peter Lawrence: “I'm back. Okay. I just prefer option B. Everything else has been covered by everybody else.”

Recommendation 14B:

II. Ground Ambulance Out-of-Network Rate is a Minimum Required Payment Rate Methodology Established by the Congress and Secretaries.

The group health plan, or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

B. Minimum Required Payment
    1. The amount specified in a State balance billing law (or in a state with an All-Payor Model agreement, the amount defined in that Agreement)
    2. If there is no State balance billing law, then the state or local regulated rate when the process for determining that rate has sufficient guardrails
    3. If there is neither a State balance billing law nor a state or local regulated rate, the mutually agreed reimbursement rate amount between the group health plan or health insurance issuer for such plan or coverage and the non-emergency ground ambulance provider or supplier
    4. If none of the above exist, then the amount is:
        a. If Medicare covers the service, a Congressional set percentage of Medicare;

b. If Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

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

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

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

F. Notice and Consent for Certain Non-Emergency Ground Ambulance Medical Services

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

Discussion

Asbel Montes then opened the discussion on the Recommendation. . The Committee members provided feedback on the recommendation.

Vote

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

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

Loren Adler: “Nothing further on this point.”

Shawn Baird: “Just that I think there is far too much complexity for us to be able to reach a recommendation on non-emergent at this point.”

Adam Beck: “I'd say, in particular, concerns about the notice and consent provision here.”

Regina Crawford: “It’s all been covered. Nothing further.”

Rhonda Holden: “Yeah, just the notice and consent I couldn't support.”

Patricia Kelmar: “Nothing to add”.

Peter Lawrence: “Nothing to add.”

Asbel Montes: “So I just want to go on the record. I'm generally supportive and want to make sure that, regarding the recommendation number 14, very, very supportive of making sure that we prohibit surprise billing and create some reasonable environment in the non-emergency when individuals are requesting it. I'm generally supportive of the notice and consent if it's done in enough time frame to allow that patient to have a choice of who they want to select, as not all non-emergency happens within less than 72 hours, or what have you. And this is also an elective procedure as well. My biggest issue that I have is, we're making assumptions around the required payment amount. And that required payment amount is a tiered approach if Congress adopts it. But in the event that it does not, and the market factors will correct in certain areas and markets across the country. But there are many markets where it will not. And so, with the failure of recommendation number 15 and the independent dispute resolution process in a very, very minimum capacity to be able to use that, in the event Congress opts to just this federal provision, and I am sure that option C will be voted on by a few as well in the affirmative, that doesn't look to the states to help with ERISA side of it. We are making assumptions that there is going to be a percentage to a Medicare rate that will ensure that the markets do not fail in certain areas across the nation. And right now, unfortunately, there is not enough data that allows for the ground ambulance side of it outside of understanding costs to ensure there's market failure do not happen. So I really am probably more a no on most of these options relative to the absence of having some type of avenue while the patient is out of the middle that the provider and the insurer can agree on something if the market factor has not been an area that has been able to play out in those individual geographic areas. So I'm going to be on the record for that. Supportive of the prohibition, that definitely needs to happen, but how we're getting there is concerning.”

Dr. Ayobami Ogunsola: “Yes, my take on this is that it is more restrictive instead of being protective, and can also be described as being arm twisting, or at best to be thought of a bit of conflict to the patient. And that's why I voted no. Thank you.”

Suzanne Prentiss: “It's all been said.”

Ritu Sanhi: “I just wanna echo some of Asbel's comments and hearken back to what I said earlier too, which is that I think we have broad consensus in the group that the patient should be left out of the middle. My concern was where we're going now and this process has been fascinating because I was planning to vote yes on this option until I heard a lot of this discussion. So I appreciate the discussion. My concern is that we are going to be left with no recommendation around non-emergency. And I do think that one of the fundamental things that we as a group agreed upon or seem to have consensus upon is that the patient should be left out of the middle in non-emergency also. And so I don't know if there's pallet or openness to discussing a more general recommendation that says something to the extent of what the overarching statement was for this section, which we would recommend prohibiting balance billing and guarantee a reasonable payment. However, given the complexities of non-emergent ground transport, we could not reach a consensus as to how to move forward with that. Something to that effect. That would be my only addition. Thank you.”

Edward Van Horne: “Yeah, everything has been said. I think in general, still trying to get the patient out of the middle, recognizing non-emergency is very different than the emergency and emergency interfacility urgent work. And I think the committee did a phenomenal job working through the pieces we needed for that. The non-E on not only disclosures, but network adequacy and ability to reimbursement levels for the quality of care that's needed still needs some more work. And that's why I voted no on that specific piece.”

Gary Wingrove: “I also was planning to vote yes for this one, but in general, I absolutely support the notice provision. It's the consent that I'm having trouble with. And if it said something like in areas where a choice is an option, that may have made me do something different. But I think notice is important, but the consent isn't going to work for most of the country.”

<u>Recommendation 14C:</u>

I. Ground Ambulance Out-of-Network Reimbursement is a National Set Rate by the Congress and Secretaries.

The group health plan or a health insurance issuer offering group or individual health insurance coverage (group health plan or health insurance issuer) must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance medical services provided to a participant, beneficiary, or enrollee.

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

b. If Medicare does not cover the service, either
    i. A fixed amount set by the Congress or
    ii. A percentage of a benchmark determined by the Congress.

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

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

Discussion

Asbel Montes then opened the discussion on the Recommendation. The Committee members provided feedback on the recommendation.

Vote

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

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

> Shawn Baird: “My broad comment would be, again, that I think this whole non-emergent work is so complex and so different than the emergent. And I agree, on the one hand, you know, another committee member said, well, it seemed like we had sort of broad consensus to cover non-emergent, but as we dove into more and more discussion on the options, including option C, it has become apparent that that is a very significant, complicated matter to try to take on.”

Adam Beck: “Yeah, actually, kind of similar. I agree, you know, if it were just recommendation 14 without the options, that first screen, I could certainly vote yes. And I think of the three options, this is, from my standpoint, the preference, because it keeps ERISA preemption intact, but I think there are too many outstanding questions about how the other mechanisms would work, including, like, the cost-sharing, that it looks like we're referencing directly back to recommendation, I guess, 13. So just, I think too many unanswered questions in this to vote for the specifics.”

Regina Crawford: “I would totally agree with what Adam said, and Shawn. I just think this is too big to get our arms around, so I just think we have to continue to work toward finding something that will work.”

Rhonda Holden: “Yes, I think that we probably, if we try to tackle this in the future, if they come back and ask for a recommendation, we need to be well-versed in non-emergent transports and have some presentations from subject matter experts that can really help us look at the impact that it might have, all of those unintended consequences.

Peter Lawrence: “Couple items. Item one was the ability for local rates to be utilized was excluded, and that's critical in my opinion. The second is, you know, I agree with the earlier statements that we have a broad consensus within the group that we need to work on balance billing with non-emergent as well as emergent, but this group spent most of our time dealing with the emergency aspect, and we didn't spend a lot of time with the non-emergent aspect, and I think everybody just took the assumption that we would drag them together, which is not the case. We still, in my opinion, need to have some statements in the report that says that we need to be looking towards prohibiting balance billing on non-emergent transports, but there needs to be further discussion, and maybe it needs to be added into the recommendation we have earlier that identified that treatment in place and the cost of supplies and ALS first response needs to be established or discussed as part of a standing committee, and maybe we can add that into that that the Congress needs to look at it. Thanks.”

Asbel Montes: “So not to add much more to what everybody has said here as well, but I think when the committee came here through the charge and the introduction of Section 117 into the No Surprises Act, which established this advisory committee, was relative to the services that patients were receiving where they didn't have a choice. And whether they called 911 or the equivalent or from the consumer receiving a bill because they were transported from one hospital to another for the continuous and furtherance of that emergency condition as they viewed that emergency condition within the prudent layperson standard of services that were not available to transfer them somewhere for them to get that care. Now, I believe in a lot of our recommendations, we have addressed that. We've addressed it through the way the definitions are, and then we've gotten to this more complicated component around non-emergency. And I understand that we'd like to protect the insurer from everything, or the consumer, but I think that there needs to be a much more thought process through that that still allows for the markets to correct themselves. And in those areas where the markets may not be correcting themselves, is how do we make sure that access stays. And so, from that perspective, generally speaking, and I agree with Adam on this, recommendation

number 14 and prohibit surprise billing and create a reasonable rate for the consumer for non-emergency services makes sense to me. It makes sense to most people that look at this. We get into the complexities of these options, and then we begin to determine that there's a lot more complexity to the non-emergency space that's outside of the purview of actually what we even begin to come in here with those lenses. So, for that reason, I'm really strongly suggesting a key finding. I like what Shawn has indicated as well. So maybe we need to think through this and ask for some type of more work to be done around this piece as well in those areas where maybe the market conditions are not doing what they should be doing properly."

Suzanne Prentiss: "So, a lot of this has been covered. I think Asbel just summed it up nicely, and I don't feel that we can move forward. I think it's premature here in a very complex area that is such an important part of the work that the EMS profession is doing for the entire healthcare system. So, making this into a finding versus a recommendation so we can keep the spotlight on it and hopefully continue to work, I think is the best solution here, best possible outcome. Thank you."

Edward Van Horne: "I agree with that, that we clearly as a committee have found that we need to solve and work with the non-E complexity and get the patient out of the middle. I think there's broad agreement on that. It's how we do that with the nuances of rural, suburban areas that are in-network. This space does have that done quite a bit still, right, where you've got providers in-networks and have that built, but how do you have the notice and consent? There's a lot to it. So, I like that idea on findings.
I do think this committee does need to come forward with something because we have been talking about it, but we've been broadly working on the emergency solve and the emergency inter-facility, and that's been an important piece of the main charter. So thank you."

Gary Wingrove: "Nothing new to add."

Ritu Sanhi: "There's one other component I just want to add to this just to make it even more complex, but as a county regulator in my state, we have the authority to regulate all ambulance service, including non-emergent, and we have chosen not to regulate non-emergent pricing, et cetera. But in other situations, the payer mix and just the breakdown of your emergent business could be such that it's difficult to make money. It's difficult to basically cover your cost without some component of local non-emergent control also. And so I think that reinforces why there has to be at least the option for local oversight of non-emergent and rate setting."

Recommendations 3A and 3B Discussion

Mr. Montes discussed with the Committee, for the adoption of the members that voted yes on 3A that the recommendation is that 3B was the members preference The Committee agreed with this suggestion. Mr. Montes informed the Committee the original vote counts will still be part of the public record. However, for the report that is sent to Congress, Recommendation 3B would be the adopted recommendation based upon the vote count for 3B.

Recommendations 8A and 8B Discussion

Mr. Montes discussed with the Committee, for the adoption of the members that voted yes on 8A that the recommendation is that 8B was the members preference The Committee agreed with this suggestion. Mr. Montes informed the Committee the original vote counts will still be part of the public record. However, for the report that is sent to Congress, Recommendation 8B would be the adopted recommendation based upon the vote count for 8B.

Session 4: Wrap-Up/Next Steps

Shaheen Halim, CMS, Designated Federal Officer

Next Shaheen Halim discussed the next steps for the GAPB Advisory Committee. Ms. Halim noted the Committee has developed a comprehensive set of recommendations over the past six months, which will inform Congress and the Secretaries on what to do next. The Committee will develop the content for the report this winter, compiling notes and artifacts from meetings. The report is expected to be issued in early 2024 after being edited. The final report will be posted on the CMS.gov ***GAPB*** website., with presentations, transcripts, meeting summaries, and recordings available in phases. Ms. Halim thanked the Committee members and the public for their participation.

The third public meeting of the GAPB Advisory Committee was adjourned by Ms. Shaheen Halim around 4:00 PM.

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

Shaheen Halim -S

Digitally signed by Shaheen Halim -S
Date: 2023.12.01 14:55:29 -05'00'

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

Asbel Montes

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Asbel Montes
Committee Chairperson
Ground Ambulance and Patient Billing Advisory Committee

Ground Ambulance and Patient Billing Advisory Committee

9:30AM – 9:45AM	***Welcome & Introduction***
	Morning Sessions
9:45AM – 10:15AM	***Session 1: GAPB Overview***
	Break • 10:15 AM – 10:25 AM
10:25AM – 11:45AM	***Session 2: Key Findings Discussion***
	Mid-Day Break • 11:45PM – 12:30PM
12:30PM – 1:15PM	***Session 1: Public Comment***
	Break • 1:15PM – 1:25PM
1:25PM – 2:25PM	***Session 2: Definitions*** • Recommendation • Discussion • Voting
	Break • 2:25PM – 2:35PM
2:35PM – 3:50PM	***Session 3: Disclosures/Coverages*** • Recommendation • Discussion • Voting
	Break • 3:50PM – 4:00PM
4:00PM – 4:30PM	***Session 4: Wrap-Up***

Ground Ambulance and Patient Billing Advisory Committee

9:30AM – 9:45AM	***Welcome & Introduction/ Recap of Day 1***
9:45AM – 12:00PM	***Session 1: Cost/Payment*** • Recommendation • Discussion • Voting
	Mid-Day Break • 12:00PM – 1:00PM
1:00PM – 2:20PM	***Session 1: Recommendations Review*** • Discussion • Voting
	Break • 2:20PM – 2:40PM
2:40PM – 3:55PM	***Session 2: Recommendations Review*** • Discussion • Voting
	Break • 3:55PM – 4:05PM
4:05PM – 4:50PM	***Session 3: Recommendations Review*** • Discussion • Voting
	Break • 4:50PM – 5:00PM
5:00PM – 5:30PM	***Session 4: Wrap-Up/Next Steps***

Appendix B

Committee Members

- **Asbel Montes –**Committee Chairperson; Additional Representative determined necessary and appropriate by the Secretaries.
- **Ali Khawar –**Secretary of Labor's Designee
- **Carol Weiser –**Secretary of Treasury's Designee
- **Rogelyn McLean –**Secretary of Health and Human Services' Designee
- **Gamunu Wijetunge –** Department of Transportation – National Highway Traffic Safety Administration
- **Suzanne Prentiss –**State Insurance Regulators
- **Adam Beck –**Health Insurance Providers
- **Patricia Kelmar –**Consumer Advocacy Groups
- **Gary Wingrove –**Patient Advocacy Groups
- **Ayobami Ogunsola –**State and Local Governments
- **Ritu Sahni –**Physicians specializing in emergency, trauma, cardiac, or stroke.
- **Peter Lawrence –**State Emergency Medical Services Officials
- **Shawn Baird –**Emergency Medical Technicians, Paramedics, and Other Emergency Medical Services Personnel
- **Edward Van Horne –**Representative of Various Segments of the Ground Ambulance Industry
- **Regina Godette-Crawford –** Representative of Various Segments of the Ground Ambulance Industry
- **Rhonda Holden –** Representative of Various Segments of the Ground Ambulance Industry
- **Loren Adler–**Additional Representative determined necessary and appropriate by the Secretaries.