GAPB Public Meeting 3 – Day 1 (Afternoon Session)

Welcome back. We will now begin our afternoon sessions with public comments. To participate, select the raised hand feature located in the toolbar at the bottom of your screen. The host will then see that you have your hand raised and invite you to speak. Participants will have three minutes to provide public comments. We ask that when providing the comments, you provide your name and organization. We will be selecting participants in the order the hands are being raised. So, we will begin with Scott Moore. Hello, my apologies, this took me a minute to get myself off mute. Thank you for taking my call. 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 in 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. Thank you, Scott. Next up we have Randall Strock -- Strozyk -- it's Strozyk. Okay. Thank you. If you can, state your organization and affiliation.

Sure, 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 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 a commitment to this. We look forward to seeing the process continue today and into tomorrow. Thank you. Next up we have Katie Van Deynze.

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. Thank you. Next up we have Dr. Nguyen.

Hello, everybody. 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. Thank you. Next up we have Wayne Jurecki.

Thank you. 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. Thank you. Next up we have Jack Hoadley.

Thank you. 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. Thank you. Next up we have Jamie Pafford.

Yes, sorry, yes, 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. Thank you. Next up we have Adam Fox.

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. Thank you. Next up we have Kim Godden.

There you go. You can hear me, correct? Yes. Thank you. 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. Thank you. Next up we have Angela Johnson.

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. Thank you.

I'm not seeing anyone else with their hands raised. Do we have any additional public comments? Okay, we have John Jurgati? John, you should be able to speak now. Are you maybe double-muted, John? Okay, it looks like John has lowered his hand. So, is there anyone else with public comments? Okay, we have Tony Garth. Tony, do you have your microphone muted? Sorry, can you hear me now? Yes.

Okay, a couple things. 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. Thank you. To Tony's question, we will be sending out a survey link at the conclusion of the two-day meeting where you can provide additional public comment. Okay, do we have anyone else? Okay, Kathy Lester? Okay, I think I'm unmuted now; is that correct? Thank you so much. 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. Do we have anyone else that would like to give public comment? Okay, I'm not seeing any hands raised. Asbel, would you like to go to break or...? So, we've got 15 minutes for public comment, so I'd like to extend the opportunity to the Committee members. I know we'll be discussing a lot when we get to, as soon as we come back from break, starting into the recommendations. But to give the opportunity to the Committee members in this last 15 minutes if you have a two- or three-minute public comment that you would also like to make. If you do, if you will raise your hand and we will call on you to give that public comment. Not seeing any, let's go to a quick 10-minute break here, Terra. Then we will come back and start right into the voting. Okay, so we will resume at 1:00 p.m. Welcome back. Next up, we will discuss definition recommendations. With that, I will turn it over to Asbel.

All right, welcome, folks. Before we get started here, I just want to try and go back over just a few ground rules as we get into this. First off, I think it will be helpful to the public for us to do an introduction again of all of our Committee members. So, we'll call on each one of them as well for them to introduce themselves and who they represent on the Committee or their representation on the Committee. Then we will get to a few of the ground rules, and then we will start with the recommendations. So, I will start with myself. I'm Asbel Montes, and I am Chair of the Ground Ambulance and Patient Billing Advisory Committee and a designee by the Secretaries as well. I'll pass it to - I'm just going to go down the list. So, I see first Regina. I'll let you introduce yourself.

Good afternoon, everyone, thank you for joining us today. I represent various segments of the Ground Ambulance Committee.

Then I'll go to Rhonda.

Hi, I'm Rhonda Holden. I also represent various segments of the ground ambulance business -- most importantly in Washington State, the Association of Washington Public Hospital Districts, the Washington State Hospital Association. I do work with the hospital-based ambulance service and have served nine years on our EMS and Trauma Council for Washington State.

Thanks, Rhonda. Pete Lawrence.

Hi, good morning. Pete Lawrence, the... Uh-oh. All right, I'm going to go to you, Adam Beck, next and we'll come back. I'm Adam Beck. I am the representative of the health insurance provider industry.

Thank you. Ted?

Hello, Ted Van Horne. I am representing various segments of the ground ambulance industry as a paramedic for 20 years in multiple states across the U.S.

Patricia?

Hi, Patricia Kelmar, I'm the representative for consumers. I am a nonprofit advocate. I work for U.S. PIRG, the Public Interest Research Group. We worked on the No Surprises Act. I also served on the Federal Advisory Committee on Air Ambulances a few years ago.

Thanks. Ritu?

Good morning, still for some of us. I'm Ritu Sahni. I represent physicians who take care of emergency/trauma/cardiac/stroke. I am an emergency physician and an EMS physician who serves as a Medical Director for two suburban counties in the Portland, Oregon area. I'm also a past president of the National Association of EMS Physicians.

Suzanne?

Good afternoon and good morning to some. My name is Suzanne Prentiss. I am an elected official at the State level, and I am representing those who regulate insurance at the State level. Thank you. I'll call on Gary. Hi, I'm Gary Wingrove, President of the Paramedics Foundation and uncompensated when serving on this Committee. I represent patient advocacy groups as a member of the Advisory Committee.

Carol?

Good day. My name is Carol Weiser. I am a Benefits Tax Counsel in the Office of Tax Policy at Treasury. We work 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.

Thank you. Rog?

Good afternoon, still good morning for some. I am Rogelyn McLean. I work in the Center for Consumer Information and Insurance Oversight within CMS at HHS, and I am the Secretary's Designee for this Committee. I work with Carol and our colleagues at the Department of Labor implementing the No Surprises Act. I also served on the Air Ambulance Patient Billing Committee a couple years ago with Patricia and Asbel.

Thank you. Gam?

Good afternoon, everyone. I am Gamunu Wijetunge. I am Director of the Office of Mercy Medical Services at National Highway Traffic Safety Administration representing the U.S. Department of Transportation. Then, Dr. Ayobami? Thank you so much. I...employee, and I work with the state of New Jersey as Program Manager and Alternate Grant Award Administrator. Thank you so much for making it possible for me to participate in this august Committee.

Thank you. Loren?

Hi, my name is Loren Adler. I'm a Health Economist at the Brookings Institution in Washington D.C. I research a sort of host of health policies, so I'm on the researcher side of the coin. Brookings is a large nonprofit/non-partisan institution and foundation. I'm here as one of the designees as needed by the Committee. I think the only sort of non-stakeholder slot on the non-government side on the participation.

Then, Pete, are you back with us?

I am. I'm going to stop video here, but I'll be talking, see if I can do it. Pete Lawrence, Deputy Fire Chief, Oceanside Fire Department. I'm representing state and local EMS officials. I've been in the fire service 43 years. I've been doing ambulance reimbursement issues at the state and federal level for 35 or so. I sat on the Negotiated Rulemaking Process back in the late '90s, when we tried to get, I think you said 1.0 as the way the system should work.

Thank you. I believe. I don't see Ali here from the Secretary of Labor's Office, unless I've missed?

As a general rule based upon our bylaws for the charter and because we have moved into the voting portion of this, there is no proxy allowed at this point in time It does appear we do have quorum for voting. So, here's a little bit about the construct of where we will start. Very similar to what I talked about this morning, this will become kind of routine after a while because we have so many recommendations and options to go through. But just so you know how we're going to follow this, just so the Committee will know as well as the public. I will read the recommendation, and then we will open the floor to discussion. For the Committee members, of course you can use your Chat. That will be open to public record after this. But you can raise your hand for discussion, which is what I would suggest; and then I will call on you to discuss the recommendation. Once the discussion has finalized, we will close that out. Then Terra will take the vote. She will go in alphabetical order; not like I just did to introduce you all. She'll go in alphabetical order; and you will then vote 'Yes,' 'No,' or 'Abstain.' Then after the end of the voting period, if you voted 'No,' Terra will give you the opportunity to raise your hand; and you'll be given up to three minutes to discuss the reason why you voted 'No.' Then that will finalize that, and then we'll move on to the next recommendation.

We will follow the recommendations in the order of consumer disclosures, as well as consumer protections and disclosures and then into the prevention of balance billing recommendations. At the very beginning though, we will start with the definition and the general construct around the NSA framework. We'll start the recommendation list as well. Now that the recommendations have been finalized -- I know we have received several inquiries -- it does before it's publicly listed on the website will have to go through 508 compliances, and then it will actually be posted at that point in time. So, PRI is undergoing that work to make that happen. So, I am going to - I'll pause here and see if there's any questions from the Committee on the ground rules of how we're going to conduct the voting now.

All right, because we'll need a quorum, if you need a break, we have allotted breaks throughout this, we will end today around 3:50 p.m. I will close that out around 3:50 p.m. Eastern Time, so we can adjourn at four o'clock because it is Halloween. We have a lot of Committee members who have small children as well, maybe even want to get up and do some trick or treating or what have you. Then we'll get together starting tomorrow as well. So, we won't try to make it too formal. I mean, we are human; but we will kind of work through this process of allowing. We will try to shut it down around 3:50 p.m. and kind of do a brief closure on what to expect tomorrow, and we'll adjourn the meeting no later than four o'clock Easter Time as well. So, you that have children or when it gets trick or treating, we definitely have allotted for that as well. Any questions before I start, and we begin the first recommendation? All right, Terra, let's move to the next slide.

We will start with the recommendations. The first recommendation is this. 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. That is the first recommendation for the group, so I'll pause here. If you have a question or if you want to discuss this as a Committee member, please raise your hand. Give you a minute or so. Not seeing any hands, we will move to the first round of voting.

Terra, if you will take the roll call.

Okay, Lauren Adler?

I apologize, Asbel.

Sorry, go ahead, Rog.

I'd like to just with one revision. The word 'that' in the first line of the second sentence I think is extra, so I'd like to vote on a version that does not include that word. Is that the second, where 'The Committee recommends that...' The second 'that.' So 'The Committee recommends that the following provisions could be maintained without significant....' So, if we could just note for the minutes that we'll be voting on that sentence sans the second 'that' in the second sentence. So, it will read, 'The Committee recommends the following provisions that could be maintained....' Is that what you're saying? You could leave in that 'that.' It would say, 'The Committee recommends that the following provisions could be maintained....' Removing the 'I got you now.' Go slow this morning.

[Laughter]

Any further discussion on that recommendation? Okay, so we will vote with that modified recommendation of eliminating the second 'that' out of the second sentence there. All right, Terra, if you'll take the vote.

Okay, Loren Adler.

Thank you for that, Rog. I vote 'Yes.'

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden.

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

I don't think Ali's on.

Rogelyn McLean?

I'm going to abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Peter Lawrence? Is Pete on? He's disappeared again. Let's come back to him. Okay, Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Abstain.

Gary Wingrove?

Yes.

Okay, and we'll go back to see if Pete Lawrence is on.

I vote, 'Yes.'

Okay, I think that's everyone.

Okay, hearing no votes at this point, no further discussion; and we will move on to the second recommendation. This one is around definitions. So, there will be, I think, seven that we will vote on. The Recommendation #2 is that the Committee recommends that Congress adopt the following definitions to align with the recommendations and findings found in the final report. We'll start with Recommendation #2A. Are we going to have a discussion? Oh, sure, we can start with the recommendation first. So, let's go back to this recommendation. We want to have discussion on #2 before we ever get to the definitions. So, I'll open it for discussion. If you have something, you want to say for this piece of it if you'll raise your hand.

Go ahead, Gary.

I don't know why I didn't catch this sometime in the past, but I wonder if it should say, 'The Committee recommends that Congress or the Secretaries' or '...and the Secretaries...' adopt the definitions because I think it would be possible for the Secretaries to do it faster than Congress could do it; and I think that's a good thing. I would say that I agree with that, that there's some things within these recommendations that would be within the power of the Secretaries. So that would be a good change. Secretaries -- modifying this recommendation to also insert in the Secretaries' further discussion?

Not hearing any, okay, so we will make a recommendation first to amend this recommendation for the record that: The Committee recommends that Congress and the Secretaries adopt the following definitions to align with the recommendations and findings found in the final report. I think it would be or

the Secretaries. Congress or the Secretaries, so that it does not have be both. Yeah, when you use 'or,' it means and/or, so I think that's good. I see, Regina, you've raised your hand.

Yeah, I was just going to recommend the Secretaries or their appointee 'or' instead of 'and.' Thank you. So, I'm hearing, '...adopt the following definitions to align with the recommendations and findings found in the final report,' okay? Because that's not a substantive recommendation change, I'd like to ask Shaheen first. Do we need to do a vote on that?

I do not believe we do but just want to confirm. Shaheen, are you on, or maybe Rog?

Yes, Shaheen may have stepped away, but I do believe that this is appropriate for us to amend it; and we can vote on it here.

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

Terra, the role on that change really quick; and then we'll move into the definitions.

Okay, Loren Adler.

Is Loren on?

Sorry, yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Yes.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Yes.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

Okay. Okay, so the next recommendation is going to be actually the definition that we'll get to. So, Recommendation #2A is Rhonda, I see your hand raised.

I can wait for the discussion.

Okay, so Recommendation #2A is the definition of Community Paramedicine. 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. That is the recommendation for the adoption of this definition, and I'll open it to discussion.

Rhonda's hand is raised.

I just had a concern that maybe we need to put 'also known as mobile integrated health care' because community paramedicine is very often called 'mobile integrated health care' across the United States. I think Gary even referred to it as such in his discussion with us this morning. Yeah, I could just add in that when it's an ambulance service doing it, it's generally called 'community paramedicine' when one is a health system or nursing home or someone else. 'Mobile integrated health care,' I think that's a good

change. It's a modification or edit, so 'community paramedicine' could also be 'or mobile health care.' Any others

'Mobile integrated health care' is the way it's usually described. Mobile integrated health care? Yes.

Any further discussion on this definition?

So, for the record, we'll make some modifications to this definition. It doesn't take away from the technical side of that; it's more of a technical change. So, we'll add 'or mobile integrated health care.'

Okay, with that modification, you will be voting on that to adopt this definition when we refer to it within the recommendations and final report. So, Terra, if you will take the vote.

Okay, Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Yes.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Yes.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

All right, so then we'll move to #2B. Our second definition you'll be voting on is the definition of cost. 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. That is the definition before you, and so we will open it for discussion. I see that Ritu's hand is raised.

Yes, I just wanted to reiterate the - or I guess since this is our first public talk, but we added in the sentence around medical oversight because many of us believe that the Ground Ambulance Data Collection System process will not fully account for the cost of medical oversight in the system. As we talked about other provisions, such as treatment in place or non-transport and paying for that and guaranteeing those payments, the importance of medical oversight is only magnified in terms of better patient outcomes and better patient safety.

Ritu, may I ask that you give us a bit of a layman's look at what 'medical oversight' means, the actual activities that might break down into?

Certainly, 'medical oversight' or what is often called 'medical direction' is basically the kind of medical overlay of the organization. The best way to look at it is that I, right now, am providing health care because my agencies are out providing care to the citizens in my community. As the medical direction or medical oversight of the entire community, there's multiple ways that I do that -- both sort of prospectively by creating protocols, by creating and being involved in system education. In real time, by providing online medical control or online medical oversight being readily available for my crews to speak to me if there is a unique situation, and then retrospectively by providing quality improvement and quality review. But the fundamental point is that one of the things that's been my guiding principle throughout this entire process is, as Pete has often said, this is not just about a ride. This is a health care enterprise. From the second a patient calls 911, health care is being provided in some way or manner. It is the medical oversight of the system that really is the key component that works to ensure

that the care provided is appropriate, guided by medical principle, guided by medical guidelines where applicable, and focused on patient outcomes.

Thank you, that's very helpful. Any other discussion? Carol, I see your hand is raised.

Just as a technical point, in order for the statement regarding medical oversight costs to be abundantly clear, I suggest that the sentence be reworded as, 'In addition, the term includes medical oversight costs.' So that's it's clear that it's not already captured.

Perfect, and I think that will be noted for the record. So, when we do the final report, since it's not taking away substantively for it, I'm not sure we technically have to amend it in this piece. But we'll modify it to make sure that it's abundantly clear what this means as we work through the final report. That's a very good point to make, Carol. Any other further discussion on what this definition means?

It may wordsmith a little bit more in the final document. So, you might see some technical corrections as Carol is noting, but it won't take away from the substantive piece of what we're voting on. Okay, not seeing any further hands for discussion, Terra, I'll turn it over to you to take the vote.

Okay, Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Yes.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Yes.

Gam Wijetunga?

Yes.

Is Gam on?

Sorry, yes.

Gary Wingrove?

Yes.

Okay. All right, so we will move to the next definition. This definition and this recommendation is how we're defining 'emergency interfacility transport' within the final recommendations and bindings in the final document. 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. Any discussion on that definition? Patricia?

Yeah, thanks. So just to give a little context to anybody who is joining in the public and hasn't had the benefit of the conversations that we've had over the last couple of months, but particularly from a patient perspective, having a very clear definition of this emergency interfacility transport is really important. 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. So, we just wanted to recognize and acknowledge that especially in the era of greater consolidation and some communities moving within one health system like all their cardia services to one hospital in the metro area or all of their maternity work in another hospital. So, understanding that sometimes you end up in your closest hospital that doesn't actually 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. So that's the just the context and why we felt it was important to get a definition out there.

Thank you, Patricia. Gary, I see your hand is raised.

Yeah, for the benefit of the couple hundred people listening in, thank you all for being here today. I just want to also add that we had a lot of conversation about this. It might actually be going to a higher acuity facility. When we were discussing this definition, I had my own issue of being at a Level 1 trauma center and not having a PET scan available. So, I ended up going to a Level 3 trauma center, but it would still fit within the confines of this definition. So, if you're wondering about that, we've removed the higher level of care to be clear that it's necessary health care.

Any further discussion on this particular definition from the group? If you'll raise your hand. Okay so, Terra, if you will take the vote.

Okay, Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes, and, Terra, Gary has his hand raised.

Asbel, do you want to stop and go back?

Yeah, that was a mistake. I raised it from the discussion part.

Okay, so Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Yes.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes. Edward Van Horne?

Yes.

Carol Weiser?

Yes.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

Thanks, so we'll move to Recommendation #2D. This is a definition surrounding what a ground ambulance emergency medical service is according to the Prudent Person Standard. The definition that is being recommended is: 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. So that is the language of the ground ambulance emergency medical service Prudent Person Standard to adopt. So, we'll open it for discussion. If you have technical changes you'd like, we'll listen to them. If it changes the substance, we'll have to modify and come to a recommendation on that. But if it's technical in nature, let's discuss it; and then that can be a part of the final report. Pete, start with you; I see your hand is raised.

Yes, thank you very much and just again context on this. 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 of the criteria, and I appreciate the individual from Access California that provided good input and Patricia as well for keeping on this to get the patient to the point that they don't have to question, 'Is this truly an emergency?' So, I appreciate that the language to mirror what we've been very successful, I feel, in California is getting in to support the patients in the report. End of report.

Thanks, Pete. Patricia, your hand is raised.

Yeah, thanks, and thanks to California for setting a really 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. The other thing I would just point out and that makes me comfortable recommending this bit of an expansion as to what's a reasonable standard is looking at the information provided by NEMSIS during the public meeting that was held, I believe, in August. What we saw there was only about 2% of 911 calls that were dispatched ended up being a no-treatment/no-transport. So, folks generally are calling 911 when they actually need treatment. They seem to, for the most part, be making really 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.

Thanks, Patricia. Carol, I see your hand is raised.

Just again some technical points as to whether there has to actually be a specific prudent layperson who has a belief, or whether instead we are trying to say that a prudent layperson would reasonably believe. So that if in some thought pattern there was not a specific individual who one would consider a prudent layperson, you would not need to be worried about whether -- how this would apply. So that would be, that's a technical correction. We may not need to really resolve it now. Then just for consistency, the standard is 'reasonable belief' in the first one-sentence paragraph. But then as we go down into the second paragraph, the sentence starting with 'The determination' uses 'reasonably expected' rather than 'reasonably believed,' and it might be better for those to be consistent. Again, we don't necessarily need to adopt those now; but they should be considered, I think, for the final report.

I would agree with you on that, Carol. Noted for the record as we develop and write that. Shawn?

First of all, I would agree with those last comments on the edits. I think that's in the proper spirit of what we were trying to do. I did just want to comment. I think that this definition, along with the one that we just 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. So, I think the work that's one on those two definitions is going to be incredibly meaningful. I was very happy to hear from the person from California, consumers, in public comment that they referenced and acknowledged the work in California as being successful. So, I think that puts us on a good ground forward. I believe and to Shawn's point too is, remember, this definition and 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 really important to note when you see 'ground ambulance emergency medical service,' it ties in with that interfacility definition that was voted on as well.

Any further discussion on these terms? All right if, Terra, you will take the vote.

Okay, Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Yes.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Yes.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

Okay, so let's move to the next definition. Three more definitions, to those that are listening in; and then we'll get into more of the meat of the substance. Recommendation #2E, this is our fifth definition, ground ambulance provider or supplier. 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. So, I will stop here and leave it open for discussion. Not seeing any, we will move to vote. Terra?

Thanks. Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Yes.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Yes.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

Okay, so I believe this might be our sixth definition next, which is #2F, the definition of 'prompt payment.' What does that mean -- that is one of our charges. So this is how it is being defined when you see it used in a different report or in a different recommendation. Prompt payment is defined as means that a group health plan and health insurance issuer required payment under Recommendation #12 and/or 14 -- that you will see later on -- 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. It should be noted that there is another term in here that will be defined in #2G, which is 'bill triggering the duty to make a minimum-required payment.'

So again, I'll say this for the group. This will begin to make sense to the public that's listening when they start seeing the recommendations that prompt payment 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. I'll stop there and open the floor for discussion. Ted?

Asbel, we had talked because of some of the existing state balance billing laws that there was, we needed to have some comment on that, maybe something that would say unless there's a state prompt payment law that applies. Do you want feedback on that?

There was not a modification made to this definition. It could be made within the actual recommendation and noted when you make your vote. But as far as this definition goes, this is the definition. So, if there needs to be a modification to this definition or respectively within the recommendation where it addresses prompt payment.

Any further discussion on this vote? Carol?

I'm wondering whether there are some words missing, or is this 'required payment': is that a defined term? Or are we saying a group health plan or health insurance issuer required to make payment or provide a notice of denial? I'm a little unsure how this is to be read.

Rog, I know you're on here. We led this piece of it. Do you have context around that because I cannot remember to be honest with you.

Okay, I'm sorry, repeat the question one more time.

Rog, it appears to me that there may be some words missing here or that somehow or other I'm not putting all the pieces together. 'Prompt payment' means that a group health plan and health insurance issuer required payment under Recommendation #12. I think it means' So is that a defined term, or are we saying required to make payment under Recommendation #12?

Yeah, I think it should be read put a hyphen between that issuer and required, the issuer-required payment under Recommendation #12 and #14.

Oh, okay. Remind me, Asbel, Recommendation #12 would be....

Yeah, when we move to Recommendation #12, it is going to be around the preventing of the surprising billing around that national set rate and then that minimum-required payment.

Okay. And then #14 is on the non-emergent, so it's directing the preventing of the surprise bill when we get down to it if there's a prompt payment required in there. And because it is not currently defined within the No Surprises Act, the Committee wanted to make sure it was defined.

Right. So this is what they came up with. Okay, yeah, and we can make that more clear, Carol.

Yeah, and maybe the 'that' needs to come out. We're just going to need to look at this a little more carefully to make sure this really makes sense.

Okay. I think that the tenor of this, and we'll let the lawyers -- kind of get their help with the technical piece to make sure it really makes sense to get to the intent of what this definition was supposed to be, and that is basically to require payment under whatever prevention of balance billing we will do in these subsequent recommendations that they need to issue a notice of payment within 30 days or a denial based upon the next definition we'll talk about, which is the bill triggering the duty to make a minimum-required payment.

So, based upon that -- and we will clean up this, it's going to be more technical in nature but that's the premise of it, any further discussion before we go to vote? All right, Terra, if you'll take the vote.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

No.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Yes.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

Adam, would you like to speak to your vote?

Just that 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.

Okay, thank you for that, Adam. We will move to the next vote, the final definition. This definition is a little bit more concise. There was a lot that came around as a general context around clean claim, and there was a lot of discussion that was discussed in committee around clean claim definition or what was the objective to get to with this definition. So, the suggestion was to call it the 'Bill Triggering the Duty to Make a Minimum Required Payment or Issue a Notice of Denial of Payment,' which will subsequently be addressed in other recommendations when you get to the prevention of a surprise bill. So the definition as recommended is: 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. As I'm reading through that, I believe there's probably some technical changes and omissions that need to come out based upon discussions. Pete, I see your hand's raised.

Yes, all of the conversations that we had had during the Subcommittee meetings, we had removed the 'at a minimum.' So, on the second line down, '...a claim that includes the following elements.' We got rid of 'at a minimum.'

You are correct; that should be stricken. Otherwise, I'm good.

That should be modified.

Gary?

Yeah, just a question I think for Rog. Did we confirm that the hospital bills have all of this stuff?

We have not confirmed that yet, but we have confirmed the plan to go through and do this same list for the facilities' form. Thank you.

Mm-hm. So, the discussion of what Gary was talking about, there are some providers that are attached to a UB, which is the hospital side of it, the institutional form. So, this definition is basically showing what the claim needs to include in order for it to trigger the duty to make a minimum required payment or issue the notice of denial of payment when we get into our recommendations on the prevention of the surprise bills. Any further discussion?

So, the modification to this for the record, technical, should have removed 'at a minimum.'

Carol?

Not actually on this, but did we skip #2G?

Oh. That's a good point. I believe that that might be a typo. This recommendation is #2G, not #2H. So again for the public, thanks for catching that, Carol.

All right, so we will now take a vote, Terra.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Yes.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Yes.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

Okay, so we are through with definitions. Now these definitions will become relevant to many of the recommendations that you're going to start to see in front of you. So, we will move to #3. Now of the recommendation in #3 that we will talk about, there are two options that we will be discussing within this recommendation. So for the Committee, I will read the Recommendation #3; but we will move to A first and then open for discussion regarding Recommendation #3A. The way that we have put this in here through the presentation is to discuss what Recommendation #3 does. In that, there were two options to get to that same objective by the Committee. So, we will then work through that. We are now going to start going through the consumer protections and disclosures before we move into the prevention of surprise billing. The first came around the consumer protections around mandatory coverages, about the best way to say this, a requiring coverage.

Congress should require coverage of ground ambulance emergency medical services. So, the first option to get at that recommendation is Recommendation #3A. We'll move to Recommendation #3A, and I will walk you through what this recommendation is and then the relevant discussion that we'll have around it. 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. So that is Recommendation #3A.

In general, it is for any service where emergency medical services is requested where a transport occurs, including emergency interfacility transport within those four components. I'll stop there and open it up for discussion on Recommendation #3A. Gary Wingrove? I'm curious if we need to vote on the prior slide or not because in #2, we voted on the things in column C of our spreadsheet before we moved to column D. I'm wondering if we need to do the same thing here.

Yeah, Asbel, let's go back to the previous slide. I had a question about that too. It was my understanding that the evolution of this recommendation was to make sure that ground ambulance emergency medical services were recognized as an essential health benefit under the Public Health Service Act and the ACA. Do I have that right? There's going to be other recommendation specific to the essential health benefit under the ACA. This is actually requiring the coverage under Arista, which said essential health benefits does not cover that component. So, this would be requiring coverage under that statutory of those four relevant acts that we are looking at. Okay, that's helpful, thank you. So, to your point, Gary, through this process versus the definition, this is Congress should require the coverage of ground ambulance emergency medical services. If we did have two options to get at this, you would be right; but it's all within this. So, if you take it in context with it. So, Congress should require coverage of ground ambulance emergency medical services. Then Option A is this. So do you want to discuss anything related to this recommendation under: 'Congress should require coverage of ground ambulance emergency medical services' -- next slide, Terra.

Then it's going to say this is the recommendation for that particular provision. Then when we get to #3B, it's the same recommendation; but it's a different way of getting at it. So, we'll open for discussion. Patricia?

Thank you. Because we can't explain our 'Yeses,' I'm going to take a moment to explain it here how I'm going to be voting. This again is getting at this issue of people getting surprise bills, this is actually getting at the fact that if you don't even have coverage for these interfacility transports, then you get the whole bill. So, this is trying to start to define that really folks need and expect that their insurance coverage is going to protect them in these situations. So #3A is relating to emergency ground ambulance transportation, and then #3B is going to be one that also is similar to this but includes the no transport in the situation where the patient ends up not going. So, I agree with both but with caveats.

I think that this is really important, and people do need coverage for this because they are expecting it. Obviously, as a public health, the right public health thing is to make sure that people get ambulance services when they need them. I also agree that the system of only paying for transportation is antiquated, and we do need to start paying for some of those no-transport treatments that happen in the community. Medicine has evolved a lot; and we shouldn't unnecessarily have to drive people to an emergency room, where they're then subject to so much more medical treatment and medical bills that they may not necessarily need simply because the ambulance wants to get reimbursed for that call to the field. So it's putting me in a bind. I don't want to vote 'No' on either of these.

I think that the ability to be able to pay for some that end up not with transports is probably a good thing. Whether we're going to pay for all of them, I'd rather see some guardrails on the #3B. So that's just to give clarity; but I do think this is coverage that people really do need and they're expecting; and it's the right public health decision. Thanks. Patricia is going to be able to provide more context around her #3B comment at length that will go into the public record as well, I'm sure. Pete? I'm basically mirroring Patricia's comments that this is critical. We need to make sure that health insurance is covering EMS. Again, EMS is a system; it's not just a transport. That's why #3B. The only difference between #3A and #3B is the language that says the non-transport component. This is where we kind of get some conflict -- that where both of them are approved, then essentially #3B is approved. So that's the whole issue here, is this #3A does not include the non-transport. The patient gets the bill, and the patient is impacted financially when insurance companies do not pay for the non-transport services. When we go to a call, we assess the patient; we provide treatment; we may even give medications. The patient declines to go, or we decide that the patient can go to their own facility. There's no reimbursement, and the patient then gets stuck in the middle. That's the problem with #3A; #3B is the way to go. As you can tell, this is why we have a few options to the same scenario.

Adam?

Just building on what Patricia noted since we can't explain 'Yeses,' I'll be voting 'Yes' on this but do want to emphasize the 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.

Gary?

Yeah, I feel really strongly in support of Pete's comments but for all of the additions that are in #3B. Because I feel really strongly about #3B, I'm going to vote 'No' for #3A. Any other discussion before we take the vote? All right if you will take the role.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Regina, I don't think I heard you.

Yes.

Rhonda Holden?

No.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

No.

Rogelyn McLean?

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Yes.

Gary Wingrove?

No.

Okay, I'm just going to ask those that voted 'No'. I'll give you the opportunity to speak on your vote if you wish to. We'll start with 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 have to 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.

Okay, 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.

Did we get everybody? I think you have your hand raised, Rhonda.

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.

All right, so let's move to #3B. We've had a lot of discussion around that, as you can hear. Then we will take a break following this, a quick 10-minute break, and then we'll begin and resume voting.

So, Recommendation #3B is very, very similar to #3A except it does cover such services when an ambulance has responded but no transport has occurred. So it goes to the same elements, except it is a different option to get to #3, which is basically mandatory coverage of these type of services. So, I will stop, and we will open the floor for discussion. Ritu?

Thanks, Asbel. I voted 'Yes' on #3A because since we don't count votes before, I felt that if neither #3A nor #3B passed, that would be a disservice. I think #3B is by far the better choice. As I think the report should reflect, I think other comments that will probably, that have already said and will probably say the same thing, which is that I think most of us feel very strongly that #3B is better than #3A. But the structure is not that we could pick one or the other. So, it's important that we had one of the two; but #3B is, I think, far superior. The other point I want to make about this is back to my comments around medical oversight. This is a prime example of the incredible importance of medical oversight. When

patients are not transported, which of course does happen frequently, 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. So, I just wanted to make sure that it is reflected, the importance of medical oversight, in this particular instance.

Shawn?

Thank you. I'm going to echo Ritu's comments on #3B being really very important to get through. I know that we've heard from a lot of Committee members about the need for payment for those incidences where we respond; and there are many, many reasons why that happens, and the patient doesn't ultimately get transported. So, I was a 'Yes' vote on 'A,' and I'll be a 'Yes' vote on 'B' with 'B' being the more comprehensive option.

Thank you, Shawn. Suzanne?

Thank you, Asbel. As Shawn Baird and Ritu have stated, well, this is about inclusivity for me. Both of these, I'm just going to piggyback or stand on the shoulders of their statements and add on here. This is about being inclusive of both. I hear my EMS colleagues loud and clear; and if 'B' was my only choice, then 'B' would be my only choice. This is something that I regularly advocate for in the state that I work within. But since we can do both, and this being important, I'm going to be inclusive and vote for both. Thank you very much.

Thanks, Suzanne. Patricia?

Thanks, yes, very similar to the others and as I mentioned before, this is the better option. I do think we missed the boat a little bit to further define kind of the types of no-transport services that we might be seeking coverage for. I know that ambulances are starting to charge for all kinds of things that happen in the field, and certainly we want patients to feel like they're covered for the medically-appropriate care in the field that doesn't result in transport. However, also as a consumer advocate, I always have to be thinking about the bottom line and overall cost to our health care system. I think we heard a lot of comments about that delicate balance between ensuring that we're supporting our ambulance services and having 24-hour care and that they're being paid for the work that they do in the field, but I also have to be sensitive that we don't necessarily want to be encouraging a lot of extra billing that may or may not be warranted. So without a clear definition for what the types of services with no transport are that would be covered and that ambulances would be allowed to bill for, well, I guess they could bill for anything, but that they would be covered and we would be paying for under some kind of payment program that we'll define later. I'm just being sensitive to that. But B is better. We know that there's really valuable care happening in the community and being treated in the community without having to go to an emergency room is really an important option, and we should be paying our EMS people for that care that they're doing, including the ones that end in death, unfortunately.

Thanks, Patricia. Regina?

Yes, I just want to explain since we don't have an opportunity to explain why we vote 'Yes' as opposed to voting 'No.' I support #3A and #3B strongly. I advocate for EMS every day across the country, and this is -- option #3B would just encase #3A. Again, we want a backup option; so I agree with both of these recommendations, and I strongly support #3B. I advocate for it every day. I do think the pandemic put us on the front line where EMS is recognized for what they do other than just transporting to the hospital, so thank you.

Thanks, Regina. Adam?

I think my question might be mostly about the phrasing or if there's a word change that might be needed in the opening sentence. So, it says, 'A plan or issuer offering group or individual health insurance must

provide or cover any benefits with respect to emergency ground ambulance services,' the parenthetical, and then, '...then the plan or issuer must cover such services.' So, I'm just not following if that is, I think just grammatically like where, if it's supposed to say, 'If a plan or issuer offering group or individual health insurance covers any benefits....' The reason I'm asking this is I think my concern is over the use of the term 'any benefits' and wanting to vote 'Yes' on this because I do believe that medically necessary treatment in place should be reimbursed. My concern is if the term 'must' and 'any benefits' are in there that that's a recommendation to basically cover anything that is provided by personnel without any limitation. So, I think we'll go back to #3 if you can just bring the general recommendation of #3, and this is option #B. 'Congress should require coverage of ground ambulance emergency medical services.'

Then we get to #3B, Adam, which basically is a mandate, must. So, if you go back to #3B, the recommendation here is if they must provide or cover any benefits. So, if you're a 'No' vote, it could be an issue with this, that you're supportive of it but not with such just broad latitude is what I'm hearing from you, correct?

Well, the main issue I was raising' A recommendation -- because that would be a substantive change to the recommendation, so you'd need to make that change. Okay, it's just, it's not entirely clear what the sentence is supposed, I think my main issue was I think there was a verb missing. But if what this is reading is a mandate to cover without any limit any benefit that is provided or any treatment that's provided, I think that, if that's what you're saying, that this is a mandate to us provide any treatment without any limitation. 'Limitation' is the definition of emergency ground ambulance services that we already approved. Yeah, this is the intent of the recommendation. I'll call on Gary to address Adam's standpoint.

Adam, I was glad to hear what you said. The limitation is really in this definition that we approved on emergency ground ambulance services. No matter how you voted on #3A, I just want to encourage my fellow community members to vote 'Yes' on #3B because it's so important and we're stuck in a system -- Patricia listed the import in her view -- we're stuck in a system where we're required to increase the cost of health care by transporting patients to the hospital in order to get the ambulance covered; and that's just the wrong policy way to go.

Okay, I'll go to Pete.

Again, it's this issue of we're the only section of health care, EMS is the only section of health care where we provide a service, and it's not reimbursed. If we go to the doctor and the doctor evaluates us because our shoulder is hurting or we've got abdominal pain and the doctor says, 'We can't figure out what is causing the problem,' they still get paid. EMS doesn't get paid when we show up; we do the evaluation. We're assessing; we're using a $38,000 cardiac monitor. As was said, sometimes we're running a full code; and some of the insurance companies are not covering it because it is a non-transport. Now obviously, Medicare has finally said they're going to cover those patients we work who are deceased. But the bottom line is the vast majority that we go to that we don't transport, it's because we've decided they don't need to go to the emergency room.

To Patricia's comment and to what Gary appropriately identified, we can increase the cost to the insurance industry and to the patients by transporting all of these patients, but they're not necessary. #3B, the B is the best. The best outcome here is that no-transport is covered, patient then is not responsible for having to cover that service out-of-pocket 100%, and EMS is a system. If we can get all of our stuff reimbursed that we go to, the transport costs can come down. Again, we're not able to make a profit in California here. I can't speak to other states, but I can't make a profit. I can't recover more than the cost of providing service. If we're able to level it out between those that we respond to and don't transport and those that we respond to and end in transport, the total cost comes down because I'm no longer having to recover the cost of the no-transport as part of the cost of a transport.

Carol?

You're speaking again to the technical point. I agree with Adam that the language is quite ambiguous as to exactly what is meant. I understand that Recommendation #3 was these benefits must be covered. The way in which the two different phrases here at the beginning are worded is technically fairly ambiguous.

I don't know whether the 'then the' should instead be 'specifically, the plan must cover such services' or 'in particular,' something along those lines. But I think that there does need to be a scrub for these recommendations to make sure that they actually are conveying what is intended. What the intent is, so to Carol's point, we'll note that -- to make sure that this language is changed to make sure that it covers the intent from a legal phrasing to say something where, 'They must cover the emergency ground ambulance services, as well as an ambulance that has responded but no transport has occurred' to the theme of that Recommendation #3B. That is the intent here. So we will have, Carol, once you do the final report, word smith this to ensure we go to the technical side of it to make sure it gets to that extent. I'm going to be retired.

[Laughter]

Oh, Carol, I think we all want to be retired by the time this is over. Any further discussion on this?

From my particular standpoint on this as well as voting on this in the affirmative, I think that we have to remember there are two options. We can hear it through the dialog that is happening here amongst our Committee members of the reasons why there is a nuanced option so that there can be discussion around that.

So, voting either one, remember these are recommendations that will go in the final report with everyone's discussion points. Then remember, option #2 or part 2 of this is Congress is going to have to act. So, they are going to have to have options related to that particular recommendation, which is around covering emergency ground ambulance services, including emergency interfacility transports. So, we will now go to vote on option B, which is also the inclusion of an ambulance response where a transport has not occurred. Terra, I will let you take the vote.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

Okay, so we are going to take a quick break for 10 minutes; and then we'll get back and go through a few more of these before we adjourn for the day.

Rhonda, I see your hand is up if you want to make a comment.

Yes, I just hope that when we provide the narrative to Congress that we had the discussion we had about we all really are preferring #3B and recognize that that is the preferred option -- that a lot of people voted 'Yes' for #3A just because we knew we had to get some sort of coverage there. I don't want them to think that because so many people voted for #3A that that was indeed the preference of the Committee.

Perfect, that will definitely be noted in the comments in the final report. Because we are not allowing, Ted, I'll ask -- but because we're not allowing, unless you are a 'No' vote a lot of your comments have been recorded through the discussion point that will absolutely be in the final report and so will be noted in the final report regarding this option.

All right, Terra, we're going to take a 10-minute break. We will be back and convene here at 2:52 p.m. Eastern Time.

Welcome back. We will now resume with the recommendation discussions.

All right, so we will go for the next hour or so; and then we will suspend, do a wrap-up, and then move into tomorrow on finalizing some of this stuff. The next recommendation is more along the lines of consumer protections as well. You did hear some discussion around this in findings that was addressed more towards those programs governed under the Social Security Act. But there has been a lot of discussion today. There's been a recommendation around some ambulance transports, the responses earlier that we just took for the record. But this recommendation, #4, is around the establishment of a statutory federal advisory committee. It would be a standing committee that would advise the Secretaries of Health and Human Services. The Subcommittee deliberated on this. This was discussed on what this would look like specifically for what our purview is. So the recommendation is as follows. 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.

So, I'll stop there. That's the recommendation before you for a vote, and we'll see if there's any discussion on that recommendation. I see Gam has his hand raised. Go ahead, Gam.

Thanks, Asbel. I think in the Subcommittee we had discussion about granting either, or recommending that either Congress or the Secretary of Health and Human Services establish the advisory committee. Then my second comment would be maybe to, on the third line where it says, '...ground ambulance reimbursement policy,' just make that period so that you don't limit the scope of the committee too much and to make the language after that about evaluating expanding coverage, et cetera, is part of the topics that the committee may address. So, I guess my first question is whether we are making the recommendation both to the Secretary of Health and to Congress.

I will ask Rog to answer that. Rog, are you on?

I am here. I think there was a deliberation and that is because this is a committee that is responsible to the three Secretaries. Can you opine on that?

Okay, let me back up again and, Gam, get you to repeat your question. Yeah, so the first question is whether we as a Committee could recommend that the Secretary of Health and Human Services establish a federal advisory committee to advise CMS on ground ambulance reimbursement policy in addition to also recommending that Congress establish a statutory advisory committee. I think we have the flexibility, and I'm going to defer to Shaheen here; but I do believe we have that flexibility. My question would be to the extent that we... I guess it seems that there's some overlap between those suggestions to the extent that there's a statutory FACA committee, and then we give the Secretary of Health and Human Services the discretion. Is there a kind of a reason we're kind of setting up these dual authorities?

I think it's more of kind of a sequencing issue. My preference would be priority one is to recommend that the Secretary establish a discretionary federal advisory committee because again, and this is an assumption on my part, my assumption is that the Secretary has the authority to do that now. And that moving forward, the Administration may want to then make that discretionary advisory committee a part of the statute so that it's part of the permanent statute. Hm, I do believe we have the flexibility to shape the recommendations however we want. It's interesting though, Gam, what you said about kind of the order of operations. I guess I would have seen it the other way in that we would ask -- that the suggestion would be for Congress to require such a committee and then or either give the Secretary discretion to set up that committee. Because one of the things that the federal agencies do look at is the dollars that they would have to use for that activity. So not knowing what those appropriations look like, I think we could recommend that the Secretary of Health and Human Services establish -- to the extent that he has authority -- that he establishes such a committee. I think we could do that as well as suggesting to Congress that a statutory FACA committee be set up; but probably within the final report, we would explain why we're making those dual recommendations. But I do think it's possible.

Let's go through some discussion points on this to the second point. Did we get your points covered or your questions answered, Gam? I know that was the first one.

Yeah, the only other second comment would be to' Put a period behind 'the reimbursement policy'?

Yeah, so that you don't necessarily limit the scope of what the committee might' Pretty much look at anything and direct on reimbursement. I think that's a really good point there. Ritu?

The other thing that popped into my mind as I was rereading through these with regards to supplies, drugs, et cetera, and maybe this can be just captured in the discussion -- but the ongoing drug shortage and supply shortage issues. And while I know NEMSAC has talked about that, I do think that reimbursement policy does and can play a role in affecting those shortages.

Yeah, that's good dialog in here. I think that this is just on topics relevant to move on. But basically to get at the objective of establishing an advisory committee. We'll talk through, hear more discussion on what Gam's recommending through the process, but to note what Ritu is saying as well as far as the discussion. Gary?

Yeah, I think Gam's got it right on the sequence in that the Secretaries will do something fairly immediately and then Congress could make it permanent. I'm not sure how I feel about putting the period. It's simply stating what occurs now, and I wonder if we lose something with that. For example, if you're in northern Minnesota 150 miles from the closest trauma center and if you need an x-ray, there's a clinic in town that has an x-ray machine; but we can't transport to clinics and get reimbursed because they can only be an intermediate stop when you actually go to the hospital. So, you tag on a lot of patient costs and health care system costs because we can't simply take them to the clinics. So, I kind of feel like because it's existing policy, I wouldn't move the period; but I'm not completely wedded to that. Then I just also wanted to say sort of on but also off-topic, when we had the real costs plus reimbursement discussion, it went from recommendation to the recommendation about the finding. It

never made the switch over to the findings. So, I just wanted to make sure when KPMG does their thing, that this gets in the findings.

Yeah, it'll be in the findings. In the findings document to patients, that will be actually posted in the presentation, Gary.

Great, thank you, that's it for me. Shawn?

I'm a little concerned about making many changes to this particular recommendation. I think that the items that are specifically included in here are items that dropped out of Subcommittee discussions for very particular reasons as we worked through the various topics over the last five months. We realized that this particular FACA Committee wouldn't have either the bandwidth or the statutory authority or whatever to address a very specific need. So, I'm not going to be favorable to adding the period just after 'reimbursement policy' because that in and of itself all of a sudden makes it relevant to all kinds of things that we have other processes and recommendations around and ways to go that I'm not necessarily thinking establishing another committee with wide-open range is appropriate at this time. Okay, Carol?

Again, more of a technical point in that until Congress has, while I'm certainly for providing flexibility to the departments and HHS in terms of setting up a committee, until Congress has acted on some of the aspects of other recommendations, I don't know that an HHS committee, an HHS-sponsored or established committee would in fact be able to accomplish much. I don't question the authority of the Secretary of HHS to set up a committee to advise; but without the other recommendations, I question whether the committee would be able to accomplish anything.

Ted?

I think a little bit to the point of there is so much information that's constantly changing in EMS, and what has fallen out of the committees and the subcommittees over the last few months specifically when you talk about 'among the topics.' Another reason why not to initially have the period because it is about advanced life support, first response fire, first response treatment in place, making sure we're communicating those things consistently as the changes happen. To have an advisory group standing, I think, is a good thing; and I don't recommend we change this as it currently sits. Any more comment on this? I'm hearing generally from many of the committee members.

Gam?

Yeah, I'll withdraw my comment about the period. I think since we have and support the continuum of care that that would keep that committee appropriately broad in its scope. What I would recommend adding would be a specific sentence advising the Secretary to use the Secretary's discretion to create a committee. So, here's some recommendation for maybe a lead-in sentence. Using existing authority and appropriations, the Secretary of Health and Human Services should establish a federal advisory committee to advise CMS on ground ambulance reimbursement policy. And then it would lead right into Congress to establish the statutory federal advisory committee. So, I have a question maybe for Shaheen or Rog based on upon that. Because does our authority give us the ability to advise the Secretary on payment authority that is outside the scope of the Public Health Services Act or writs or whatever? Because I think CMS is governed under, if we're looking at CMS payment authority, Gam, that falls under the Social Security Act. Is that correct, or am I off somewhere?

I know we put that in the findings, to recommend on that piece, Gam. But if we're talking specifically around Arista, PHSA or whatever, you're going to have all three Secretaries involved -- not just Health and Human Services.

Right, so I would think, Asbel, anything like that would -- to the extent that they are not within our existing authorities would be a recommendation pointed at Congress. Gam, does that change anything on what you're recommendation? Because that's substantive, so we'll have to make another, we can maybe vote on this and then vote on another on that piece as well.

Yeah, I agree, Asbel.

Okay, any further discussion? Okay, let's take --

Sorry, can you just clarify that there will be a separate recommendation? Is that what we're thinking about related to--?

No, there won't be. Because it doesn't fall under the purview, it's going to be a key finding, Patricia. It's in the key findings because our purview does not, we can't direct substantive changes because it falls under the Social Security Act?

So we're just voting on what we see here on the screen here today?

That is correct. Any further discussion on this vote? All right, Terra, if you will take the vote.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Abstain.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Yes.

Gary Wingrove?

I'm 'Yes' but, Asbel, the wording here is different than what we have on our spreadsheet. What we have on our spreadsheet is basically what Gam said. So, I wonder if we're voting on the right one. It's what's on my spreadsheet, so I'm going to defer to Terra to confirm that the recommendations that are stated in that version, what version are you looking at, Gary?

Boy, that's a good question. I thought it was the one I grabbed this morning. It should be the most recent one on Box.com. I'm not sure I have the one, let me check. Okay, so we'll move from this, thanks. If you'll just let us know in Chat, or something like that, Gary.

That is passed. There was no 'No's on that. So, we'll move into the next recommendation, #5. Recommendation #5 -- and this goes to a question that Rog asked earlier about the emergency health benefit requirement, which technically is under the ACA, a little different than what you voted on in Recommendation #3. This is basically a recommendation that says: Ground Ambulance Emergency Medical Services should be incorporated in the definition of the emergency services under the Essential Health Benefit requirements.

Before we move to discussion on that point, I'm going to ask and put Rog on the spot to just discuss that essential health benefit so you realize and understand the context of what you're voting on. There may be some questions about how does that relate or not.

Right, so under the Affordable Care Act, there are a list of what Congress referred to as 'essential health benefits' that had to be covered by all comprehensive health insurance plans. What that means is that once it is an essential health benefit, there can be no lifetime annual limits; and they must be covered. So, in terms of ground ambulance emergency medical services, already within the scope of the

essential health benefits are emergency service. However, Congress did not further define what 'emergency services' actually means. So, one of the things that I think the Committee discussed is that because right now we have different plans that provide different levels of coverage for ground ambulance emergency medical services is that the industry, the public, consumers, would benefit by clarity under federal law that ground ambulance emergency medical services are within the definition of emergency services under the Essential Health Benefits rules.

So that's where we are here, and I think we have, as the Federal Government, we've received this question before, and we have not responded with a direct rulemaking or a direct clarification. So I think the point of this recommendation was to provide clarity in that area and make clear that ground ambulance emergency medical services are essential health benefits that must be covered under every ACA-compliant plan.

Asbel?

Perfect, thanks. Any further questions? Gary, I see your hand is raised.

I didn't unraise it, but I just did put something in Chat for you.

Okay, any discussion around the essential health benefits? All right, not hearing that, Terra, if you'll take the vote.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

All right, so our next consumer protection is going to be Recommendation #6. This recommendation is relative to billing a patient for a service while you're seeking insurance information. The general context around it I'll give. From the context perspective, I'll ask Patricia and/or Loren who really worked extensively on a subcommittee around this. So, I'll give them the opportunity to kind of give more context for the record relative to this before we do the vote and then open it up for comment. 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... is the recommendation. So I'll put Patricia on the spot and see if she wants to give some context around that as well.

Absolutely, happy to, thank you. Yes, as we all know, medical bills are really confusing. Between explanation of benefits and bills and bills that we get before they get submitted to insurance, it's really hard for consumers to always know whether they actually owe the bill that's in front of them. So this is an attempt to get a little bit better clarity and make sure that patients aren't receiving a bill too soon and making sure that the insurance company and the ambulance providers are doing their best to share the insurance information back and forth so that if and when a bill is sent out, it's reflective more accurately

of what insurance has paid, whether the claim was submitted, and that information. So that's the point behind this.

I do have a clarifying question though for folks because we only just put in this 3-to-7-days thing, and I've been thinking about it in terms of our earlier discussion around prompt payment. So, in the prompt payment situation, we're thinking that there might be, that we're giving the insurers 30 days to decide whether they deny the claim or are going to pay it. But this is a much quicker time frame. So, I'm wondering, is this actually solving the problem that a patient will get a bill too soon when the payment determination has not yet been made? Have we closed that loophole with this wording?

I see, I'm trying to look and see, I see, Pete Lawrence, your hand is raised for discussion now.

Yeah, Patricia, this has nothing to do with the insurance company making the determination. This is that we won't send a bill to the patient until we've sent it to the insurance company and the determination of payment has been made. So, there's that 30-day time frame. The only time that this comes into play is if we've been unable to get insurance information either from the hospital, which for those people listening, the subcommittee, we've got future recommendations coming that require hospitals to provide the information to ambulance services. If we can't get that information, then we will send a notice to the patient after the 3 to 7 day time frame that we've been trying to get it. And I believe that the future stuff is going to say, 'This isn't a bill; we're looking for your insurance information.' So, kind of two separate things here, but the patient will, we're still going to give the insurance company the 30 days to figure it out before we send a bill to the patient because they have to come back with a ruling. But this is about how long do we wait before we send information to them or a letter saying, hey, could you give us your insurance info.

Thanks for the clarification. Rhonda, your hand is raised.

Yeah, thank you, my question is what if the patient doesn't have insurance at all? What type of a time frame do we have to wait before we can send a bill to a patient if it's known that they don't have insurance? Right now the way this is on the book, if you basically have intent to get it, within 3 to 7 days. So, you have to make a reasonable attempt. After 7 days, technically if Congress was to adopt this -- put this into some type of congressional statute around this, then theoretically you wouldn't be able to bill them until after day 7.

Good question. Ayobami?

Yes, thank you. My only reticence about this is our use of the phrase 'reasonable attempt.' To me, the phrase 'reasonable attempt' seems weak and not deterministic. So, what should we use to... reasonable attempt...

Thank you. I'm thinking, I believe if I can repeat back what I believe that what you are attempting to do here is that 'reasonable attempt' seems vague and that maybe we need to be a bit more specific or maybe remove that and just say obtained, we've remove that 'reasonable attempt.' Is that what I'm hearing you say?

Yes, the point of an attempt being reasonable is weak. We should not include any ambiguity. The 'reasonable' language I believe is being used throughout some of our documents. It's used throughout other policy payment mechanisms as well. From a reasonable perspective and in this instance, 'reasonable' may not be the appropriate word.

Ted, I see your hand raised.

Yeah, I think it's because there's multiple different ways in which providers attempt to communicate with the patients after we've completed a transport from either information from public health information

exchanges, facilities information, phone numbers, and electronically communicating with them, e-mails. So there's a lot of different ways that that happens, and it's really getting away from -- I think as Patricia talked about -- just sending a bill or by mail to the patient because that isn't necessarily the most effective way. It's working with the patients to communicate to get all that appropriate information on what their insurance information is so that we can appropriately then notice the insurance company. So that's why the 3 to 7 days allows for that process to happen, but it's the multiple different ways in which those occur.

I know from my discussion point ' and I'm seeing if you have any further discussion, but I do want to be on the record here that based upon my background and understanding some of the nuances of working with ambulance organizations that a typical key performance indicator, or what we would call 'days to bill,' is typically between 5 to 7 days. That's best practices. Some do better than that. I have concerns with this limitation specifically because I believe it's administratively burdensome without some additional recommendation passing that would require the interchange of information depending upon the facility that you might be, the destination facility and that incorporation of it, especially around the emergency side of things.

Most times, depending upon that acute medical condition of the patient, they do not have the ability to tell you what type of insurance they have. So, you're really relying on other sources and disparate sources to find that. There are technology solutions that many incorporate or within billing departments to try to find that information on behalf of the patient. But to put a finite date and number around that could be a little more administratively burdensome or create a delay in the process that really may not be consumer-friendly or consumer-protection outside of getting a bill. So, I do think that this recommendation does work in tandem if other recommendations are also adopted, and there is a requirement for this sharing of information in an expeditious manner.

Other than that, I think the number should be very relatively or we should further define what 'reasonable' is to Dr. Ayobami's point as well. Regina, I see your hand raised.

Yes, Asbel, as we discussed this earlier in our Subcommittee meeting, that was my concern. There's already a process in place, and we were just trying to find some kind of reasonable attempt for the collection. That's why I threw out the 3 to 7 days. I'm open to other suggestions; but at that point we were trying to say if this would go along with the other things in place, this would be a reasonable time frame. But it would be burdensome to add anything. Billing companies already do this, and they go through the process of health exchange to get data. They work with insurance companies to get data. Their process is already existing and in place. But there's help to change process as we go through, and there are several databases that are cross-referenced with that face sheet. So, I'm not real sure what the other solution would be to this concern.

Any further discussion on this very particular recommendation before we go to vote on it?

It is a consumer protection.

Anything further? Okay, Terra, if you will take the vote.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Abstaining.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes. All right, so let's move to Recommendation #7. This will probably be our last recommendation depending on how long it goes. Oh, this will be an easy recommendation for the most part, I believe, before we move into the next one as well. Recommendation #7 was another very consumer protection. Some of this is currently covered within the No Surprises Act. We wanted to call this out to make sure that this was given, for the lack of a better word, some air time to make sure that it's really, really clear that the consumers have the ability, and this should be something when we get through a few more recommendations down the road, around certain elements. 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. This was something that was dialogued with the Subcommittee on Consumer Protections and Disclosures that the committee felt to bring forth as a recommendation. So again, I'll defer to Loren and Patricia.

Committee, this is where it came out. We dialogued as an entire Subcommittee, and this recommendation is on the books for that.

Patricia, if you'll just give context for the public around this. Then we'll move to discussion.

Sure, yeah, so one of the most difficult things when we pass new consumer protections is to help people know and understand their new rights. When the No Surprises Act was passed, there was a lot of effort to make sure -- because it's so complicated, billing is complex, that there would be a one-stop shop for folks to be able to call an 800-number or to write to one e-mail explaining their situation. Understanding under the No Surprises Act that states also have the state laws and that there was going to be different levels of state enforcement or federal enforcement, it would be impossible for a consumer to understand where to go and how to get their questions answered. So, there was created the No Surprises Help Desk, and their job really is to kind of understand and figure out what the problem is that the consumer is calling about and then connect them to the right source of a solution. So there you can see in the slide some of the different places that they will send patients, but sometimes they handle the issue themselves if it's under their purview, under CMS's purview.

So just thinking that people will think about medical billing all as one and won't necessarily think about whatever new protections they have around ambulance billing, I just thought it would be a good recommendation if we just sent people to the exact same place that we're already trying to tell people about and send them to.

All right, so we will open up to discussion. Patricia, thank you for that context for the public as well. Any discussion on this recommendation? Not seeing any hands raised, we will ask Terra to do the vote.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

Okay, so thank you, everyone. Our next is going to be the consumer protection, #8. This one has three options around it, and there will be two of these consumer protections that we will talk about. This is really around the maximum cost-sharing amount, what is going to be around the ground ambulance emergency medical services. Then we will vote on one later on down the road around non-emergency ground ambulance emergency medical services. This was a lot of discussion that happened. This happened in the Subcommittee right after the first comment period or public meeting when we had our subcommittee chaired by Loren and Patricia that really talked a lot about maximum cost-sharing. You've heard about that. It's one of the key findings of background information that we shared earlier today.

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 the 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-teamwork provider or supplier.

Now, there were three options to get at this recommendation, different ways to do it. We will take a recommendation on all three options. But I will stop here on this recommendation and open for discussion to see if there's any questions about the recommendation. Then, we will vote on the different options to get to the same one. It's just different solutions to the same recommendation. So I'll open the floor for discussion on the recommendation. Gary Wingrove?

Yeah, I just have a general comment. I sort of think we should give direction. Options are okay, but I'm not going to vote 'Yes' for all of these. I think there's a specific one that's a standout. That's just my general comment.

Okay, any other discussion before we get to the options? Patricia?

Just to give a little context for folks on the phone who maybe weren't involved in a lot of these discussions, the second paragraph there, I just wanted to point out, is mirroring what we see in the No Surprises Act. Just recognizing that oftentimes if it's an out-of-network payment that you're making, that doesn't count towards your deductible or your out-of-pocket maximum. But under the No Surprises Act, people were getting those protections in the cases where balance billing was happening frequently. So we're trying to mirror that same kind of protection. If you are having to pay something, a cost share or something, to an ambulance provider that is not in your network, it still would be recognized as an amount that goes towards your maximum out-of-pocket or your deductible.

Great point. Any more discussion on the recommendation before we move into the first option?

Thanks for that. Okay, so let's move. There are three options that you can vote on to recommend to Congress and the Secretaries and others that will be reading this report on how to get to this consumer protection. We'll start with Option A.

The patient cost-sharing requirement is 10% of the rate established under a recommendation that we will talk through on the preventing of balance billing, which is #12, subject to any out-of-pocket limits with a fixed dollar maximum. So this recommendation of an out-of-pocket is going to refer to 10% of a rate methodology that the Committee will vote on in a subsequent recommendation when we get to talking about rates. Patricia, is your hand still up; or was that for something else? Okay, I'll go to Loren.

Hi, thank you. I just wanted to give some context around at least why I'm going to vote 'Yes' on this and the next recommendation here. I think folks might notice that this is somewhat different than the sort of standard cautionary protection under the No Surprises Act. So in the No Surprises Act, and in basically every state law including those addressing ground ambulances, it just basically says 'cautionary' and can be no higher than it would be for an in-network service, so an in-network ground ambulance emergency service. I think that is inadequate in the context of ground ambulances where really there is,

in the research I've seen, 85% of transports are out-of-network. And if you just say 'cautionary' and has to be no higher than it is in-network, you are leaving open an area where the insurer's incentive, especially when there's a generous payment requirement there, is to simply say, 'Fine, there's no balance billing anymore; but we're going to change our in-network cost-sharing amounts such that it's much higher,' and you really don't necessarily, I think you don't solve the problem of the sort of balance bill. All you've done is now, sure, there's no balance bill; but there is higher cost sharing than there was before. I think that's a big weakness in sort of the California and Texas laws that we've seen recently, that it might not actually reduce out-of-pocket costs. But these sort of protections where it says, sure, no higher than 10% or no higher than a fixed dollar number really get at that, what I view as a key issue here.

Any further discussion?

Great points, Loren.

Any further discussion on this Option A that you'll be voting on? Thanks for that context. All right, Terra, if you will take the vote.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

Yes.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

No.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

No.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Yes.

Gary Wingrove?

No.

Okay, so we will now give an opportunity for those that voted 'No' to speak. We'll start with Adam Beck.

No comments on that particular vote.

Okay, Patricia?

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.

Okay, Dr. Ayo?

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.

Okay, Gary?

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. All right, so I think we've closed that out. Everybody's been given the opportunity that said 'No' with varying differing opinions on that. So, let's move to Option B. Option B to the same definition gives another solution to this same recommendation.

The patient cost-sharing requirement may be the lesser of $100 adjusted by the CPI-U annually or 10% of the rate established under Recommendation #12, which we will be talking through -- the prevention of balance billing, basically the prohibition, regardless of whether the health plan includes a deductible. So this is basically establishing a fixed number as well. I will open this for discussion. Ritu?

Yeah, just like -- similar to Recommendation #3, I voted 'Yes' on A because that would be better than nothing. But I would agree with Patty's statement that this is a better solution and will be voting 'Yes' on this.

Loren?

Thank you, I have two points. One is a technical one, which I don't know how to do it at this point, but I feel like the language really should be 'patient cost-sharing requirement may be no higher than the lesser of...,' because otherwise it's just a may statement and doesn't read like it actually has the force of law. I know what's intended, and I know it's intended to be the actual maximum. But for technical purposes, I don't know that that may need to be amended in the language of the recommendation.

Second, just sort of on the broad point, again I think this is, not I think, this is my preferred solution as well. I think Patricia and Ritu's point, well, I did want to sort of vote for the other one as well in part because I do view this level of protection as really only viable. I think one of the advantages of choosing a sort of minimum payment standard or some sort of payment requirement that does have some limit in dollar terms or in a percentage of Medicare because it is really only when there is that sort of guardrail on a payment that you really can be this protective of consumers, which I do think is a core goal of this Committee. I know this sort of goes above and beyond what we do for other even very important medical care; but I think the point that Patricia has made, I do think emergency medical services do hold a sort of special regard in terms of an expectation of limited or zero cost sharing. There are many localities who do zero out cost sharing for these services already, so there are already some areas making that choice. Often, it is sort of basically if they have enough financial means to make that decision. So, I do think that makes sense as a federal policy to sort of do this and that it goes, this is a strong protection because this applied even before your deductible. I think that point is well made by Loren.

The intent here would be to make sure of that. So in the final report as we put more detail around that, the spirit of the recommendation may be modified slightly. It won't take away from the substantive part of what you're going to be voting on as well. So this is that. Any more comment here? I know there's several options, several strong opinions about having one; but the Committee landed on different solutions to this. I'm on the record as well as I actually agree with the points that Patricia has made, as well as Loren and others here have made too, that this is the best protection for consumers -- is to have some finite number that allows them to know if I access EMS or emergency services for ground ambulance, whether it's that or for the emergency interfacility, it's a maximum number I'm going to have to pay. Gary, I see your hand is raised.

This is another one where the language on the slide is different than the spreadsheet. I think the slide actually has it correct. It's Recommendation #12. The spreadsheet says Recommendation #5. But before we vote tomorrow, could somebody just make sure that the language is consistent because I'm using the spreadsheet a lot.

I'm not sure again. We'll talk later about that because you seem to be the only one having that issue, so we'll try to figure that out, Gary. Any other discussion before we take a vote on this piece?

You know, I just looked at a comment to Gary. Remember the conversation yesterday, and they've changed the numbering. So, what is now Recommendation #12 used to be Recommendation #5. So #12A/12B was old #5A/5B. So, if you're using the old spreadsheet, then that is the reason why you're seeing #5. Oh, okay, that's probably what's happening. Any further discussion before we go to vote on Option B? All right, Terra, if you'll take us through the vote.

Loren Adler.

Yes.

Shawn Baird?

Yes.

Adam Beck?

No.

Regina Crawford?

Regina, are you on mute?

I did say, 'Yes.' Sorry; then I went on mute.

Okay, Rhonda Holden?

Yes.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

Yes.

Rogelyn McLean?

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

Yes.

Ritu Sahni?

Yes.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunga?

Yes.

Gary Wingrove?

Yes.

Okay, Adam, we want to give you an opportunity if you want to speak to your vote.

Just one of the other options is my preference here. No other comments on the first two. Okay, so we will move to Option C; and this will be our last vote of the day before we adjourn. Recommendation #C, our Option #C of Recommendation #8 regarding consumer practices on maximum out-of-pocket. 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 emergency medical services provider or supplier. This is very similar to what is currently within the No Surprises Act that Loren was alluding to earlier for just a point of reference. So we'll open this up for discussion. I think everybody is getting excited about adjourning the recommendations.

Okay, hearing none or seeing none, hands raised. Sorry. Go ahead, Adam.

Yeah, just one comment, I'll be voting 'Yes' on this. I think aligning this with the cost-sharing approach that applies to other services or the No Surprises Act has worked and makes sense here. Operationally, I think one of the things that's going to be challenging is since we're not recommending an approach like the No Surprises Act has 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 particular recognized amount or QPA, that's really what makes this work in the No Surprises Act. We're it seems like going to be recommending this required minimum payment, which for a while kind of talked about in the vein of a QPA; but it is still different. So, I think this could work, but there are some dots in the approach that it looks like we're going to be recommending. I don't know that they're going to fully connect. So, I think it would be on Congress to connect some of those dots so that there's a measure of what the in-network amount would be so that you can calculate the enrollee's cost sharing. Otherwise, I think directionally this is my preferred option of #8.

Okay, Pete, I see your hand is raised.

Yeah, I think back to Loren or Patrica made that comment that under this proposal basically if an insurance provider says that, okay, the participating ground ambulances, your cost share is going to be

$400. Most people don't look at their insurance plan before they sign up. They don't look at the individual aspects of it, and they're never going to call an ambulance. What this does though is this establishes that the number is going to be huge. And I think to Patricia and Loren's comments that we need to have something that is limiting so that the individuals are not saying, 'I wonder what it's going to cost me to call the ambulance.' So, I'm going to be voting 'No' on C. Any other discussion?

If you're going to be voting 'No,' you'll have a point to make a discussion piece. But if you are, any more discussion relative to this option? Okay, Terra, if you will take the vote.

Loren Adler.

No.

Shawn Baird?

No.

Adam Beck?

Yes.

Regina Crawford?

No.

Rhonda Holden?

No.

Patricia Kelmar?

No.

Ali Khawar?

Peter Lawrence?

No.

Rogelyn McLean?

Abstain.

Asbel Montes?

No.

Ayobami Ogunsola?

No.

Suzanne Prentiss?

No.

Ritu Sahni?

No.

Edward Van Horne?

No.

Carol Weiser?

Abstain.

Gam Wijetunga?

No.

Gary Wingrove?

No.

Okay, now we'll open it up for those that voted 'No' if you would like to speak to your vote. We will start with Loren.

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.

Okay, Shawn?

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.

Okay, Regina?

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?

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. Okay, Patricia? Nothing additional to add. Thanks. Peter? Nothing additional to add.

Okay, Asbel.

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.

Okay, Dr. Ayo?

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.

Okay, Suzanne?

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.

Thank you. Okay, Edward?

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?

Nothing to add, thank you.

Gary?

Nothing to add.

Okay, I think I got everyone. Did I miss anyone?

You did miss me, Terra.

Sorry.

So just make sure that you know that I voted 'No.' I don't have anything to add though.

Okay, thank you. All right, so we are at the top of the hour. It is four o'clock Eastern Time, if you are on the East Coast; and it is ready for Halloween. So, we're going to be adjourning this meeting, and we will wrap up. But if there's anybody with any final closing remarks -- Rhonda, I see your hand is raised.

Yes, I was wondering if tomorrow we could go back and vote on #3A, #3B, and #8A and #8B. That way, we could have a consensus that we take forward in the report.

I think that we do have that consensus. It's just reflected because we had those additional options. So, I'm going to defer to Shaheen on that as a matter of running the Committee and taking votes if we have the ability to go back and amend the vote. I'll defer to you, Shaheen, on that; or maybe that's something you need to research. Asbel, I sent you an e-mail with the same question actually. Yeah, if there are other members that feel the say way, I think, yes, we can revisit these two items tomorrow.

Great, so we will put that as a revisit, revisit those two recommendations that have those two options and possibly call for another vote to solidify that recommendation. Thanks for bringing that up, Rhonda. Any other further discussion before we adjourn?

So tomorrow here's what to expect, and then I'll turn it over to Shaheen for any final comments that she may have as well. But we will start as Recommendation #9. But before we get that, we will work through the constructs in PRI. We'll come back and revisit what Rhonda and a few of the others have probably e-mailed that we haven't got to, to re-look at those recommendations and maybe take another recommendation for the record regarding that vote as well. So, it'll still be on the record. Just know, we are in public meeting; so everything is on the record. But we'll go back and take another vote on that particular option as well. So just remember that everything that we are doing today is on the record. So that will be recorded in the minutes and available to the public as well. So tomorrow we will begin at, I think, 9:30 a.m. Eastern Time as well. Then we will work through the final recommendations and work through until we get to Recommendation #15.
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Once we're finished with that, then we will wrap up and then tell you what to expect next and then adjourn the meeting. So, I'll turn this over to Shaheen for any final closing remarks.

Thank you, Asbel. I would like to thank all of the Committee members for all the hard work they have done. It certainly shows in the care that you've taken in crafting these recommendations. So we're at the halfway mark; we're almost there. Tomorrow we'll do the final bit. I want to thank members of the public who provided their perspective today after the midday break. Thank you very much and we will see everyone tomorrow morning. Happy Halloween trick or treat, trick or treat!