GAPB

GROUND AMBULANCE AND PATIENT BILLING ADVISORY COMMITTEE

Ground Ambulance & Patient Billing Advisory Committee

Recommendations

CMS

Recommendation #1

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

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

Recommendation #2

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

Recommendation #2A

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.

Recommendation #2B

Cost

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

Recommendation #2C

Emergency Interfacility Transport

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.

Recommendation #2D

Ground Ambulance Emergency Medical Service

(Prudent Person Standard)

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.

Recommendation #2E

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.

Recommendation #2F

Prompt Payment

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.

Recommendation #2G

Bill Triggering the Duty to Make a Minimum Required Payment or Issue a Notice of Denial of Payment

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

Recommendation #3

Congress should require coverage of ground ambulance emergency medical services.

Recommendation #3A

If a group health plan or health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to emergency services then the plan or issuer must cover ground ambulance emergency medical services. In addition, the group health plan and issuers must cover such services;

a. Without the need for any prior authorization determination;

b. Whether the ground ambulance provider or supplier furnishing such services is a participating provider or supplier with respect to such services;

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

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

Recommendation #3B

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

a. Without the need for any prior authorization determination;

b. Whether the ground ambulance provider or supplier furnishing such services is a participating provider or supplier with respect to such services;

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

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

Recommendation #4

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

Among the topics the Committee recommends that such an advisory committee consider community paramedicine/mobile integrated healthcare, 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.

Recommendation #5

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

Recommendation #6

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

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

Recommendation #7

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

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

Recommendation #8

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

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

Recommendation #8, Option A

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

Recommendation #8, Option B

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

Recommendation #8, Option C

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

Recommendation #9

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

Recommendation #10 (1 of 2)

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

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

Recommendation #10 (2 of 2)

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

Recommendation #11

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

Recommendation #11, Option A (1 of 2)

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

I. Meets one or more of the following requirements:

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

Recommendation #11, Option A (2 of 2)

AND

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

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

Recommendation #11, Option B

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

AND

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

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

Recommendation #12

Prohibit balance billing and guarantee reasonable payment for ground ambulance emergency medical services.

Recommendation #12, Option A (1 of 4)

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

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

Recommendation #12, Option A (2 of 4)

A. Payment Reimbursement Options

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

Recommendation #12, Option A (3 of 4)

B. Timing of Payment

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

Recommendation #12, Option A (4 of 4)

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

Recommendation #12, Option B (1 of 5)

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

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

Recommendation #12, Option B (2 of 5)

A. Minimum Required Payment

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

Recommendation #12, Option B (3 of 5)

B. Timing of Payment

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

Recommendation #12, Option B (4 of 5)

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

Recommendation #12, Option B (5 of 5)

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

Recommendation #13

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

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

Recommendation #13, Option A

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

Recommendation #13, Option B

The patient cost-sharing requirement may be the lessor of $100 (adjusted by the CPI-U annually) or 10% of the rate established under Recommendation 14, regardless of whether the health plan includes a deductible.

Recommendation #13, Option C

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

Recommendation #14

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

Recommendation #14, Option A (1 of 5)

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

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

Recommendation #14, Option A (2 of 5)

A. Minimum Required Payment

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

Recommendation #14, Option A (3 of 5)

B. Timing of Payment

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

Recommendation #14, Option A (4 of 5)

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

Recommendation #14, Option A (5 of 5)

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

Recommendation #14, Option B (1 of 6)

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

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

Recommendation #14, Option B (2 of 6)

A. Minimum Required Payment

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

Recommendation #14, Option B (3 of 6)

B. Timing of Payment

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

Recommendation #14, Option B (4 of 6)

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

Recommendation #14, Option B (5 of 6)

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

Recommendation #14, Option B (6 of 6)

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

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

Recommendation #14, Option C (1 of 4)

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

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

Recommendation #14, Option C (2 of 4)

A. Payment Reimbursement Options

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

Recommendation #14, Option C (3 of 4)

B. Timing of Payment

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

Recommendation #14, Option C (4 of 4)

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

Recommendation #15 (1 of 5)

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

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

Recommendation #15 (2 of 5)

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

A. Both parties would have the ability to request an IDR process, but only when the Out-of-Network Rate (see Recommendations 12 and 14) is a set percentage of Medicare or if Medicare covers the service or if Medicare does not cover the service, either (a) a fixed amount set by the Congress or (b) a percentage of a benchmark determined by the Congress.

Recommendation #15 (3 of 5)

B. The IDR entity should be required to consider the following ground ambulance emergency medical services and non-emergency ground ambulance medical services specific factors when determining the payment amount:

1. The ground ambulance specific Out-of-Network Rate;
2. The level of services being provided;
3. The acuity of the individual receiving the services or the complexity of furnishing the services to the individual;
4. The ambulance vehicle type, including the clinical capability of the level of the vehicle;
5. Population density of the location where the patient was met;

Recommendation #15 (4 of 5)

6. The time on task, including but not limited to wait-times and hospital wall-times;
7. Distance from the destination, including but not limited to lack of access to providers within a reasonable distance (such as being in a medically underserved area); and
8. State/local protocols and requirements.

C. The prohibition on the IDR entity considering other rates would be amended to remove Medicare rates from the list of prohibited factors.

D. The mileage and base rate elements of a single claim should be required to be batched (addressed) together. The process should also allow for batching of multiple claims that involve the same ground ambulance provider or supplier, insurer, level of service, and geographic area.

Recommendation #15 (5 of 5)

E. The cost of the IDR process should recognize the unique nature of ground ambulance service claims and their substantially smaller size when compared to claims of other providers. For the administration fee to be limited $50 updated annually (e.g., such as by the CPI-U). For the IDR entity charge, the amount could be to be a percentage of the value of the claim(s) in dispute.

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

G. The other IDR-related provisions of the NSA would apply without modification.