GAPB Public Meeting 3 – Day 2 (Afternoon Session)

Welcome back, we will now begin our afternoon session with the discussion of recommendation number 13.

All right, so welcome back.

Here is the area that I think as we move into the next recommendation, 13 and 14 will predominantly be around the non-emergency components.

And so, we will actually be looking at recommendation 13, which looks very similar to the recommendation number 8.

And this is something that we'll be looking at the very end, based upon the voting that happened in recommendation number 8, which is technically a maximum out-of-pocket or cost-sharing amount provision that's separated into three options.

So, I'm going to discuss this recommendation first, the same options are going to apply that applied to recommendation number 8.

Because there was a motion made by two committee members regarding this, and it looks like there was a pretty much a unified consensus, except I believe for one no vote on recommendation, AB, which is going to be the same exact -- it just covers the non-emergency ground ambulance medical services.

That we may want to make a modification, so I'll take discussions that do we need to go through the round of voting of A and B together or just opt for 13B.

And also, the option of 13C through that process.

So, I'll read this motion.

One thing that I would like to say, and to make sure it's on the record as far as a discussion point is, as the public is viewing this, and as we have viewed this as a committee, when we put the recommendations on how the prevention of surprise billing works, there's a reason why option A and option B for both of these, the non-emergency provision and the emergency provision, is being voted on.

It is within the entirety of the mechanisms to that option that you see.

It is not recommended to Congress, and from my perspective that Congress begin to look at the different elements and cherry pick which ones they want, which ones they want to do.

Because that would mean that that recommendation would begin to have the -- we have unintended consequences to what the spirit of the recommendation was about.

And so, as you're looking through this, there was a lot of dialogue.

While the committee agrees there needs to be some maximum cost of sharing that option of that amount for the participant or enrollee, there were different solutions on how to get to that.

So, I'll read this recommendation.

We'll dialogue through that.

If you have a strong point one way or the other, we can go through those three options and vote, or we can do what we talked about yesterday that we're going to come back and do on recommendation 8 and just look at the option B portion.

So, this is relative to non-emergency.

The recommendation is establish a maximum cost-sharing amount for the participant beneficiary enrollee for non-emergency ground ambulance medical services.

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

And so I think several of you have raised your hand, so I will start with Pete.

Yeah, Asbel, I think you've got the right process here.

People voted for the 8A because they wanted to ensure that something was in place, because 8C wasn't going to work.

But 8B was really what everybody wanted, so I think starting with 13B is going to keep us from having the same issue we had with the 8s.

So, if we start with 13B and 13B passes, then 13A kind of becomes immaterial and then it's just between 13B and 13C.

So, I would recommend if possible that we start with 13B as you've identified.

Loren.

Sure.

I mean, I guess that's fine.

I think I mostly just wanted to state that I do think there's a very important distinction in a cost-sharing protection for emergency medical services that we were talking about previously, where we were recommending or voted on a recommendation that is a stronger cost-sharing protection than exists for basically anything in our healthcare system, preventative services being the lone exception there.

When we are now moving over to talking about non-emergency ground ambulance services, to say cost-sharing can be no higher than $100, I do feel like that comes off a little bit odd in some sense that you would be saying the surgery that will put you in the hospital, you know, you're just whatever you're in-network cost-sharing limit is what's going to apply.

But for the ground, the non-emergency ground ambulance transport, that that has this stronger cost-sharing protection than the care for your surgery or for your cancer treatment.

And while we can have a broader discussion about like lower cost-sharing across the board and all healthcare plans, I don't think that's what we're really voting on today.

So I do think that is why at least I think there should be different protections between the emergency and non-emergency side here.

I still think you can just vote between B and C.

And then lastly, I just wanted to make a technical point in the language here.

It says respect to non-emergency ground ambulance emergency medical services.

I think that emergency shouldn't be there, right?

Because we're explicitly saying these aren't emergency medical services, right?

I think you are right on that.

There's a difference between the bottom and the top from the technical perspective.

That will be noted.

That needs to be cleaned up in the recommendation.

Yes, the first word of the third line.

I'm seeing it now.

So, you're exactly correct.

That would need to be clear in that.

So, this is non-emergency medical services.

Patricia.

Yeah, really, just a clarifying question.

I know that we have a definition for emergency ground ambulance medical services.

We didn't specifically define non-emergency ground ambulance medical services, maybe because it's everything except.

But just for the benefit of all of us, if we could just remind ourselves, you know, what the definition is of emergency ground ambulance medical services.

And then I would benefit from some of the people who run these services to describe the types of situations that patients would find themselves in that would need something that fits within the non-emergency ground ambulance medical service.

And I think that that is an important point that Patricia just made as well.

And so, I see many of the individuals are raising their hands.

I'm going to let you guys run first through that process, but I'm going to, and I actually have a statement that I'm going to make as well related to your question, being involved in this for 24-plus years, specifically in this space around emergency and non-emergency services as well.

However, I do want to point to what the definitions that have been recommended and voted on.

One was there was a recommendation around what ground ambulance emergency medical services defined, which is around the prudent layperson's definition of that emergency.

And we'll opine on that very similar to some stuff that was codified in California law that was adopted by the committee.

There was also a very other important definition that was noted as well.

And this was the emergency inter-facility transport.

And so, in the context of what you voted on around those two definitions, where some have indicated in that nomenclature, some were concerned that maybe it was emergency versus not.

This gave some clarity to some of the discussion that appeared either in public comment from some of our patient advocates, for instance, like you, Patricia, where individuals may have received a bill for a transport where this is where the higher level of care was omitted and it was where the services were not available to be treated in the consumer's perspective, I feel need treatment.

It's emergent to them, that would have been codified within that definition.

This would technically be a lot of those transports that fall outside of that realm.

So, think of transports where a patient's being discharged back to their residence.

They're going from hospital to home.

They might have a -- this is important dialogue because I'm opining on something that I have some concerns about some of these recommendations, not particularly around the prevention of the balance bill.

But do we do we take out consumer choice as well?

And so, it would be those transports that really would fall outside those auspices.

I'll stop talking there as we move into some other things.

But, Shawn, I see your hand's raised.

Yeah, thanks.

And I think I'm just going to kind of follow up on your comments to try to get to some examples like Patricia was asking about.

And I think of things in my mind, like repatriation to the appropriate health system.

Let's say you were admitted to a hospital that was out-of-network.

Maybe you were traveling and it's going to be arranged that you're going to be transferred some distance to get back to your normal health system hospital, whether it's in your immediate area or maybe even in another state.

And there's time there that it gets figured out and who's going to take it and those things and also discharges, as you mentioned.

And they may not even be at home.

There may be discharges to, you may be a resident in some sort of care facility, and you require an ambulance.

Because, again, remember, we're thinking about things that meet medical necessity for an ambulance.

So, it's not just a stretcher car, which is allowed in some jurisdictions or other form of transportation.

So those are the kind of examples that come to mind.

Perfect.

Rhonda, I see your hands raised.

Yeah, kind of along the same things that Shawn was saying.

Just, you know, EMS, the third word there, emergency, it's emergency medical services.

And we are providing that service, whether or not it's an emergency, it's the same system.

We are a local system taking care of the needs of our community, our residents.

And it may be a hospital to a nursing home transfer, a hospital to a rehab center.

But we are providing those that medical care and that health service to that person who's needing that care.

So, I think that that's why emergency may still be there.

And I think that those are the reasons why it should be supported.

It may not be a life-threatening emergency, but it is still being provided by EMS.

I think Rhonda brings up a good point.

In some communities, it's the same service providing the 911 or equivalent for emergencies also providing the non.

In some jurisdictions, that's not necessarily the case either.

So, I think sometimes that's kind of where this nomenclature, what does this mean?

I mean, that's further contextual background that we can put into the final report about what some of these examples are.

What does non-emergency ground ambulance mean in those jurisdictions where it might not be the same service doing both work?

Because in some jurisdictions, it's basically the entire city or county is done by the same service.

And others, you might have multiple.

In some areas, you might have a certificate of need that establishes how many ambulance services come in to do non-emergency transport either.

Or a contract, yeah.

Yeah, or contract, too.

So, Pete, I see your hand's raised.

I was just going to give a personal experience.

My mother went septic last month.

We had to get her transported to the emergency room.

We got her into the hospital stabilizer.

We still had, you know, the need for IV antibiotics and everything else.

She was weak, could not shed oxygen.

So, we had to have a non-emergency transport.

An ambulance showed up at the hospital and took her to a care facility.

And that was, you know, a non-emergent transport.

And that's the situation that sometimes is needed by these individuals.

Ted, I see your hand's raised.

A little bit also just to add on that non-emergency does mean usually clinical monitoring.

So, they're monitoring EKGs, IVs, providing oxygen, fracture management.

So that's the reason why they need an ambulance.

So, it is also generally a lot of the same skill set the emergency side uses.

So, you've got to make sure the patient's getting from point A to point B safely, not having any patient deterioration, and the continuity of care from the two different service levels.

So, there is a distinction between emergency and non-emergency also, in that the non-emergency can be a little bit planned.

And I think that's why you see here in the recommendations as we go through it, you know, that is a little bit more of a structured approach in how you can plan for that to occur, both from a facility standpoint and the right resource to do it.

But you still have to have all that patient monitoring and the same medical direction usually between the areas to make sure it's all consistent.

And remember, we're taking this from an individual’s perspective, to answer your question, Patricia.

So, in some areas, it may not be as planned as Ed is discussing either.

But remember, we're kind of just giving contextual concepts around what non-emergency means.

Ritu?

Yeah, just two things.

Number one, I think also, you know, if somebody simply needs a stretcher, that's not necessarily considered the same thing.

And so, we just have to remember that component, which makes Ted's comments even sort of more important, that there's a skill set that's provided.

But I think the other piece, too, is one of the reasons why we've gone, we've talked about no surprises billing is this sort of lack of patient choice.

Now, there may be times where the patient has a choice to pick a service in something like this.

And I think we're going to talk about that later on.

But the reality is in most situations, the patient doesn't really have a choice.

You know, my hospital is full all the time.

If there's a bed now available at a care facility and that patient requires ambulance transport, we're going to call the service that can do it, you know, in the most expeditious manner, because we need to get that bed freed up.

Or if the patient is on a ventilator, there may only be, like on a chronic ventilator, there may only be one service that can handle that.

So, I think that the fact that the patient often does not have a choice as to who the service is, also sort of plays a role in making sure that there's patient protections involved.

Good dialogue.

So, what I'm hearing is, and I heard originally, is to maybe look at 13B and 13C.

Is there anyone that is opposed to just reviewing those two recommendation options, or do we want to go through A, B, and C?

Patricia, I see your hand raised.

Sorry, one more clarifying question.

So, I'm thinking in this scenario, the patient does actually not have a balance billing protection.

Am I right?

In this scenario, we are talking about consumer protections right now to max, and then when we move into 14, we are going to be voting on a recommendation to give them a protection.

Right now, you're just voting on the establishment of a maximum cost-sharing amount, specifically for just the non-emergency component.

But this is a piece of the balance billing.

That is correct.

You are exactly correct.

So, I mean, I took this as this is like a, you know, we're taking out the piece of the balance billing.

It is working in conjunction with 14.

Yeah, it's like, what does the cost-sharing protection look, after balance billing has been billed and a minimum payment or whatever, what is the -- -It sounds like you guys are going to be voting differently than maybe you voted on emergency.

It might be a little different on the non-emergency side of it.

And so, this is why we broke it out to not include it in the same recommendation number 8.

Okay, thank you.

Yeah.

So, there's another point of clarity, this is in conjunction with recommendation number 14.

When you see that provision referenced in one of the options, this is just establishing a maximum cost-sharing amount.

So not hearing anything against it.

What we're going to do, Terra, is we are not going to vote on recommendation 13A.

We're going to move directly to recommendation 13B option.

And so, the 13 option B is very similar in the same to what you saw on recommendation 8B that was governing the provision within the preventing surprise billing and creating a reasonable for ground emergency medical services.

This is more relative to the non-emergency recommendation.

And it's the same recommendation of the patient cost-sharing requirement.

Maybe the lesser of $100 adjusted by the CPI annually or 10 percent of the rate established under recommendation 14, regardless of whether the health plan includes a deductible.

So, I will open that for discussion with the group.

I see Loren's hand raised.

I just wanted to quickly clarify, since this wasn't on the screen before, that this is sort of what I was referring to, where this right here, now that we're talking about non-emergency ground ambulance services, while obviously still very often a vital and critical service, this would be a stronger protection

than exists for other, you know -- take the No Surprises Act, where you're also dealing with very important services, surgeries, emergency medical care, you know, anesthesia services.

But in those situations, it is just that your out-of-network cost-sharing can be no higher than it would be if the service had been in-network, not sort of capped at $100 or something along those lines.

Anything around this piece, I'm going to make a statement around this, especially from the non-emergency and cost-sharing, especially if an out-of-network provider is used or if we begin to say that we're going to prevent surprise billing.

Oftentimes what we see is large cost-sharing amounts which impact the consumer.

And so sometimes what you could see is an entire non-emergency transfer actually be their total cost-sharing amount.

We see this and we made some recommendations under findings that we're strongly suggesting that CMS look at this in the Part C plans, where we're seeing the success of cost-sharing shift to ambulance providers, specifically in the non-emergency.

And there is concern with this exactly the same thing happening to where if we do a prevention of balance billing without doing something like this, there'll be a cost share to the non-emergency, which ultimately impacts the consumer of receiving an inordinate bill for a 10-mile transfer.

That might be the total cost of the bill or an egregious amount of the bill.

That could be three to four to five hundred dollars that they have to pay out-of-pocket to get home.

Or maybe there's not an alternative service outside the medical necessity provision.

I don't mean to get too granular into it, so I understand where Loren's coming from, looking at that piece of it.

But the data continues to show specifically around -- which we can opine on it here.

But it began to show itself in other data points around the Part C plans where we do see some of this cost-sharing.

So to create some type of requirement like that, I think, would be beneficial to the consumer.

And so, as you can see, I'm going to be voting yes for this.

Any other comment or discussion on the maximum out-of-pocket for this?

All right, Terra.

Patricia, I see your hand raised.

Yeah.

Just to clarify my upcoming yes vote.

I do think that like these nuances really make a lot of sense to the ambulance providers and maybe the doctors in the hospitals.

But when it comes to a patient, you know, they don't think about the difference between the ambulance to the nursing home versus the ambulance to another hospital.

So just to help folks understand and know what their obligations are and knowing how difficult it is to get advanced information about prices.

I just think that this, you know, although it might be a little more generous than some of the other cost shares that patients face, it's a good way to protect folks.

Thank you.

Thank you.

Any other discussion points around this?

Okay, Terra, we'll go to vote.

Okay.

Loren Adler.

No.

Shawn Baird.

Yes.

Adam Beck.

No.

Regina Crawford.

Yes.

Rhonda Holden.

Yes.

Patricia Kelmar.

Yes.

Ali Khawar.

Peter Lawrence.

Yes.

Rogelyn McLean.

Raj, you're on mute.

I'll come back to Raj.

Asbel Montes.

Yes.

Ayobami Ogunsola?

Dr. Ayo, you on mute?

Yes.

I'm sorry.

Yes.

Okay, so you're voting yes?

Yes.

Okay.

Suzanne Prentiss.

Yes.

Ritu Sahni.

Yes.

Edwad Van Horne.

Yes.

Carol Weiser.

Abstain.

Gam Wijetunge?

Gam, are you on mute?

I do not see Gam on the list.

Okay.

And then we have Gary Wingrove.

Yes.

And I'm going to come back to Raj, Rogelyn McLean.

I think we have quorum even without the three votes.

I think we still have quorum.

Okay.

So now I'll just give the opportunity for those that voted no to speak on their vote.

And we'll start with Loren.

Sure.

I think I've explained why not.

If we wanted to do something broader and lower cost-sharing across the whole healthcare system, all for that.

I just think sort of picking and choosing individual services opens up a game where every -- there's a lot of important medical services, and it opens up a sort of game that's going to be difficult to -- well, maybe that's a good game if everything just has lower cost-sharing in my eyes, but that's sort of where I'm coming from here.

Okay.

And Adam.

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

Okay.

So then we will move to option C for the same recommendation.

And option C is similar to what you saw in recommendation 8, option C.

And this is specifically, again, for non-emergency.

And 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 service provider or supplier.

And just a note here that we will be changing that nomenclature appropriately to ensure it matches.

So, I'll open for discussion.

Adam.

Yeah.

So, I'll be voting yes on this particular option.

One thing that's not spelled out here, but I'm going to vote based on the assumption or the belief that this is reaching covered non-emergency ground ambulance medical services, which means that, A, they are a covered benefit as part of the patient's health insurance plan, which would also, B, allow them to be subject to any of the utilization management rules that would apply to any other covered service.

So voting yes based on the belief that this is applying to covered services and not non-covered services.

And I think as long as, if it works within the recommendation number 14, Adam, that your assumption would be correct.

So, this is not a standalone.

This is a recommendation that is tied to number 14.

Loren.

I'll only just sort of add on one more point, basically the same ones earlier, that -- because Adam's point kind of jogs through my memory here, is one potential risk here when you sort of require lower cost-sharing for one type of non-emergency service is that the insurers may just deny more types of that service or try to deal with things that way rather than, you know, having 10 percent or whatever cost-sharing.

So that is sort of one other reason why I'll be voting for this option, just because I think it would be difficult to actually come in and require coverage for every specific instance of non-emergency ground ambulance transport, although even though I do think there is some value in, you know, requiring some level of coverage of inter-facility transports.

All right.

Any other discussion on this particular recommendation?

All right.

Terra, we'll go to voting.

Okay.

Loren Adler.

Yes.

Shawn Baird.

No.

Adam Beck.

Yes.

Regina Crawford.

Yes.

Rhonda Holden.

No.

Patricia Kelmar.

No.

Ali Khawar.

Peter Lawrence.

No.

Rogelyn McClain.

Rogelyn McLean -Abstain.

Asbel Montes.

No.

Ayobami Ogunsola.

No.

Suzanne Prentiss.

No.

Ritu Sahni.

No.

Edward Van Horne.

No.

Carol Weiser.

Abstain.

Ayobami Wijetunge.

I don't think Yam is on.

So Gary Wingrove.

No.

Okay.

So now I'm just going to give the opportunity for those that voted no to speak, and we'll start with Shawn.

Thank you.

I think that the non-emergency -- I'm trying to sum up my comments briefly, and it gets really hard on this particular topic.

I think the protection for the patient offered in Option B is appropriate, and I think as we revisit Item 8 on the emergency, we'll see that there was a consistent interest in keeping those protections strong and consistent.

I heard a lot of the discussion around having various cost-sharing different between services on insurance, and my own insurance has different cost-sharing requirements for different service lines in it, and it's with a major insurer.

So, I think that is actually fairly often done.

The straight-across percentage, I struggle with it when we've had such an ineffective marketplace to determine what in-network and out-of-network really should be or is in an ambulance when so few ambulance providers are in-network.

There just isn't enough to know what the cost- sharing requirement would be under Option C.

Okay, and Rhonda?

I agree.

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

Okay, Patricia?

Yeah, just Option B seemed better, so that's why I voted.

Okay, Peter?

Option B seemed better.

Okay, Asbel?

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

Okay, Dr. Ayo?

Yes, it seems to me that Option B offers more protection than we can get in Option C.

That's why I voted B as yes and no for C.

Thank you.

Okay, Suzanne?

Quite simply, B is the better option, and I do think we need to be concerned about adequacy with, you know, having the number of participating providers available, especially, as Rhonda pointed out, for our more rural areas.

This could become an issue.

Thank you.

Okay, Ritu?

Nothing to add.

Edward?

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

Carol?

I had abstained.

I did not vote no.

Oh, I'm sorry.

And Gary?

Nothing to add.

Okay, thank you.

Okay, we are going to move into our next to final recommendation before we review something similar to what we just went around at the very end here.

But let's move into the Recommendation 14, which is the next slide.

And so, this prohibition is prohibiting balance billing and guaranteeing reasonable payment for covered non-emergency ground ambulance.

And I think we have non-emergency ground ambulance medical services.

So, this is the prohibition that I believe generally, in general consensus, very similar to what was discussed when we did the Recommendation Number 12 to prohibit balance billing and guarantee reasonable payment for covered emergency or ground emergency ambulance -- ground ambulance emergency medical services in the afternoon now.

This is the same prohibition.

And so, we had general consensus that we needed to keep the patient out of the middle.

How we get there is the options that we are going to discuss in the next Option A and Option B.

And so, I'm going to stop here and see if there's any discussion around this prohibition as well.

And to avoid discussing the options until we get to them, so that way the public will know exactly what we're working through on those options.

Any discussion?

Shawn, I see your hand raised.

Thank you.

And yes, again, I'm very happy that we're able to find when we get into the options that there's an option that I'll be able to support to achieve this aim of prohibiting balance billing in the non-emergency part of the ambulance world.

I did want to just briefly comment because I think, as well, you alluded to it earlier.

And it bears sort of saying again that many of the things we voted on today are intertwined and they don't really work if it's all parsed apart.

So how I vote on what we just did on 13 is directly tied to how I'll vote on 14, which is directly tied to how we defined emergency transport and services, emergency medical services.

So really, this is more for the viewer listening people out there and for the record that when this report gets written and moves forward to Congress, I feel it's important that it be understood that those recommendations are really a package because everything's intertwined.

It would be very not in the spirit of how they were voted on if they were broken apart and acted on as single items once we're done with our committee process.

So I just kind of wanted to preface that as we go into this discussion.

Thank you, Shawn.

Patricia.

Yes, thank you.

Yeah, this is a really important consumer protection because, as has been stated, you know, when you need that level of care that can be provided in an ambulance versus, you know, hopping in your friend's car or your parent's car or your child's car to get to the next location for your care, you know, there aren't really a lot of options for the patient in general.

Usually, it's one ambulance service that's in a community.

If you're lucky, you have a few.

So, shopping around or finding one within your network might be impossible and not always clear how to go about doing that because often these are transportations that are arranged for by the hospital.

So, it's really hard to, you know, put the power in the patient's hands in that situation and give them enough information to be able to pick a, you know, less expensive option.

So, stepping in to help protect them is a really important part of the solutions that we're offering here.

It may not be like an emergency as it has to happen right now, but it is still necessary, and it is something that people aren't really getting to choose for themselves.

So, I think just in general this recommendation is really important to prohibit the balance billing in those situations where you haven't been able, or they didn't order in-network for you.

The other thing I just want to point out for the benefit of people who weren't in some of the earlier presentations in the public meetings, it's my understanding that most of these types of transports are not done by your community fire departments.

Many of them are done by privately owned and operated ambulances.

And we all know that amongst those private entities there are very large private equity-owned companies who are providing those services.

So, I just want to clarify kind of the distinction of who is doing a lot of this type of transportation in communities.

Thank you.

Thanks, Patricia.

Loren?

I just wanted to echo what I think is the importance of including protections for quote-unquote non-emergency ground ambulance services.

These haven't been in every state law that's tried to address this issue.

And I think there's a reason people naturally gravitate first towards the emergency service, but for the non-emergency, these are often sort of borderline.

They're very often needed services, borderline, whether you might call it an emergency or not in many situations.

And look, while there are some incentives and some market factors here where, you know, if a hospital is arranging transport, Patricia's right, there are private actors here.

There are insurers, hospitals, and a private ambulance company who should have some incentive to negotiate here, at least sort of in your standard design here.

But from the data we saw during this committee, it's still the case that about half of quote-unquote non-emergency transports are still delivered out-of-network today.

And that, you know, even if that is sort of -- for whatever reason that happens, I think that's a key reason why it's important to have this balance billing prohibition specific to non-emergency services as well.

Thanks, Loren.

Ted?

Thanks, Asbel.

And I think the out-of-network discussion is not just around, as we talked about emergency, but heavily around the non-E, allowing for patient choice, but recognizing it's not just private equity or private ambulances.

It's also hospital-based ambulances.

You also have public utility models where you have non-emergency happening within the system.

So, this is about protecting, I think, the patients, all the pieces on how non-emergency does work because it does have a lot of subsets.

And when you start looking at the non-emergency in more rural areas, it is the same provider.

Sometimes it's not just a private company.

There may not even be a private company out there.

In large parts of America, it's done with other agencies like that, either hospital-based, volunteers, rural healthcare.

So just to put a fine point on that, it's a lot of providers that do provide the non-E.

Granted, urban areas where you have maybe more capacity and more operations and more companies, you have that patient choice, and you do have the ability then to build out a network and negotiate a good rate that's good for both the provider, the patient, and the payer.

So, I think that's the emphasis of making this work.

So, I appreciate it.

Thank you, Ted.

Gary?

Yeah, I'd just like to say, especially in the rural areas, some funny things happen.

When the rural providers are in trouble, sometimes they need that non-emergency business in order to keep their 911 operating.

And in other cases, if they can only operate 911, then they can hang on to volunteers a little bit longer.

So even having a second resource when you're the 911 provider is even more important to them as they try to have the community ambulance do the 911 work and have some access to something for the non-emergency work.

Thank you, Gary.

Suzanne?

Thank you, Asbel.

I think Gary and Ted have hit my key points, so I'll just summarize by saying that this, in large part, is about choices that patients in hospitals either have or don't have.

This is a needed service to be able to move patients between point A and point B, and that we shouldn't disregard or categorize this in a way because a private ambulance service doesn't.

We must look at the whole system.

Some places, it's municipal.

Some places, it's private.

Some places, they team up and do it together because these patients need to be moved.

So that characterization worries me at times when we're thinking about this.

Thank you.

Thank you, Suzanne.

Great discussion to get further context around this recommendation, and I'm sure there will be further dialogue as we move into the options.

But any more discussion just around the distinction here and the information provided?

Okay, let's move into the first option.

So, some of this is going to look similar to what you've seen under recommendation number 12, but there is a distinction between the option A and option B.

What I'm going to do is walk you through what option A is, and then I'm going to walk you through what option B is, and then we will go back to A.

And so that way, we are fully dialoguing around the differences between the options because they're very similar except for key distinctions, and then we will start to have discussion around those options.

I think it will be the use of time to just ensure that we're not talking where the public may not be aware yet of what these options are.

So, option A has five distinct components to the same option, very important, I think, as we alluded to earlier that Shawn says that these options are entwined into one.

So, there's a reason why we're not voting on each different component.

So, number one, it establishes an out-of-network rate, and that out-of-network rate is a minimum required payment rate methodology established by the Congress and secretaries.

So, this means if you are not in-network, then there is an out-of-network rate defined by the minimum required payment.

And so, this basically uses the same nomenclature, the group health plan or health insurance issuer offering group or individual health insurance coverage must pay the following amount minus the cost-sharing amount for non-emergency ground ambulance services provided to a participant beneficiary or enrollee.

Next slide.

And then it defines the minimum requirement.

This is very similar and is the same exact language from what was voted on in recommendation number 12B, I believe.

It's the amount specified in the state balance billing law that's addressed.

If it's not addressed there, it then looks at no state balance billing law and moves to the state and local regulated rate with those sufficient guardrails we discussed.

There's nothing there.

Then if there's neither a state balance billing law or a state local regulated law, then whatever you may be mutually agreed upon in a reimbursement rate.

There are many examples.

We gave examples of those earlier under recommendation number 12.

That could be something that was done through a single case agreement or other agreements that may not necessarily be establishing you as an in-network provider, but there's a mutually agreed upon rate between the issuer and the provider supplier.

And then if none of that exists, then it is an amount that is going to be established by this as a set percentage of Medicare if Medicare covers the service.

And if Medicare doesn't cover the service that's being billed, either some fixed amount set by Congress or percentage of a benchmark as determined by Congress.

So, we'll move to the next option -- or not the next option, but the next component.

Then it talks about the timing of payment.

This is where it's the same language we used in the other recommendation.

So, 30 days of receipt of bill, which was defined and we adopted what bill means.

And it moves to patient share can be built after the group health plan or insure pays or denies the claim.

Number three is it's a prop pay provision.

So, health plan or health insurance makes payment directly to the non-emergency ground ambulance service provider supplier.

And the number four, 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.

It should be noted here, as it was noted in recommendation 12 around this penalty provision, we will do some technical writing around this to one of the points that were made that this shouldn't be in addition to some other penalty provision that may already be out there.

So, the secretary shall also be authorized to impose civil monetary penalties for each violation of the cap on those multiple violations.

We'll go to the next slide.

It will then look at that maximum patient cost-sharing that we just voted on in recommendation number 13.

And then D.

We also then look at the minimum guardrails and the state local regulated rate for non-emergency is going to look very similar to recommendation number 11.

That's why you saw us voting on emergency and non-emergency within those guardrails in that recommendation.

So, I'll move to option B, kind of outline it.

It works the same way.

So, it still establishes this minimum required out-of-network payment rate.

Next slide.

I'm not going to go through each one because I just went through them.

Number two is defining that minimum required payment rate.

It didn't change.

Number three is the timing of the payment.

Same components apply with the same caveats of the technical wording that will ensure to the intent of what that recommendation in bullet number four is.

And then the next slide will review the maximum patient cost, that recommendation that we just voted on.

Number five will be the minimum guardrails discussed in recommendation number 11 and voted on.

And then number six is the change.

And this is a notice and consent for certain non-emergency ground ambulance medical services.

As you heard earlier, when we were talking about prohibition, there's many nuances around non-emergency.

While it may not be emergent or urgent at the time, there is some necessity around getting patients moved, whether you're in rural areas, super rural areas, suburban, urban areas, multiple providers, sometimes in communities.

But ultimately, as you can do it, get them off the wall, wall times are issues, getting them out of bed, opening beds, things like that.

So, there's a lot of different nuances that you might see in the non-emergency market versus the emergency.

So, there has been a recommendation for a notice and consent provision.

And what this says right now is the non-emergency ground ambulance services provider -- we'll clean all this up.

Services provider supplier may not bill or hold liable the patient for more than the cost-sharing amounts consistent in recommendation number 13, unless it has provided notice with the information required by the current NSA within 72 hours prior to the date of service.

And the patient has signed a written consent consistent with the information requirements in the current NSA.

So basically, it is indicating if you can inform the consumer to consent to out-of-network services prior to 72 hours from the date of service, then you would be able to bill the patient in excess of their cost-sharing amounts if they consent to the notification based upon that.

So that is the difference between option A and option B.

So, we'll go back to option A.

The one has the notice and consent provision in it.

The other one does not.

And so, I'll stop there and open the floor for discussion.

So, Loren, I see your hand raised.

Sorry, I just wanted to ask a question.

So, are both of these options kind of ignoring ERISA and telling ERISA self-funded plans to do with the local governments say here?

Both of these options are the minimum required payment.

So, it is looking at ERISA.

Yes.

But both of these, right, use the locally set rate?

Right.

If your locally set rate addresses non-emergency transportation, then yes, it would.

Okay.

Are there options that don't supersede ERISA?

There are options on the vote with that.

Oh, I thought we had agreed to do that.

That's sort of the -- ignoring ERISA seems sort of my core objection here.

Otherwise, it's fine.

So there's just no option that doesn't just get rid of ERISA, basically?

All right.

So are you suggesting, Loren, that we have another recommendation to add here?

Very similar to not ignoring it, kind of setting a rate or a floor rate as well as generally from recommendation number 12.

Yeah, I thought we were having this sort of parallel discussion that we had for emergency where there was one that didn't tell ERISA plans to -- sorry, that didn't require ERISA plans to pay a locally set rate.

Sorry, ERISA self-funded plans, to be clear.

And then one that did.

So, we have the sort of same two options as before here.

I think Patricia is making a suggestion to put it on option A within the slide.

Sorry, I missed it.

I miswrote it.

I'm just asking, can you call up slide option A?

Oh, sure.

Go all the way.

First, I think it's the first slide.

First slide, okay.

I'm sorry.

Second slide, then.

I just want to read this one again.

Thank you.

So, I need to understand more what Loren's saying, if you could say it again.

So, I was just saying, right, if you read this one, this is equivalent to -- I forgot if it was the first or second option.

12B.

12B.

But the bullet two here, as I read it, would say in a state without a state balance billing law, then the state or local regulated rate would bind for ERISA self-funded plans on what they owe.

That's my understanding.

Right.

This is directing that ERISA follow this.

So, we would need to change it and maybe add another option similar to recommendation 12A, but for non-emergency.

Yeah, sorry.

I thought that's what we had talked about.

I'm sorry.

Could have been.

That could have happened, Loren, but it didn't make it up to this that everybody got around and looked at.

So, I don't see an issue with putting that in there if we need to vote on that.

And I'll look to Shaheen for the order of that, if we just add it, or could we insert a similar recommendation tied to non-emergency and make that option C?

Can you hear me?

Yes.

Okay, great.

So, let's see, the choices are another recommendation versus adding it into this existing recommendation?

But one is with consent and one right now is with no consent.

We can do one of two things.

We can make option B with consent and minimum required payment and then change option A to look very similar to the same option that was presented under recommendation 12A that is specifically only for non-emergency services.

I think that would be my recommendation.

That makes more sense to me, but back to you, Loren, on that.

Is that applicable to what you're wanting to do?

Yeah, I mean, like the least words to do it would just be if there's like a side option to this one, that prongs one and two do not apply to self-funded.

Or, you know, do prongs one and two apply to self-funded ERISA plans or not?

Yes or no.

It's sort of the least words to get at the question.

But either way.

We'll let the technical wordsmiths get to it.

But one and two, basically the intent of option A does not apply to ERISA self-funded plans.

Yeah.

So, we'll just modify option A and ensure that it follows the same guardrail protections that recommendation 12 did.

And one and two do not apply to ERISA.

So that'll be option A's recommendation modified unless anybody has anything against it.

And then B will stand as it is.

It'll be the same minimum required payment, walk through the same general construct with a notice of consent provision added for anything where a service is scheduled 72 hours before the date in order to bill a patient.

I'm having a lot of trouble understanding what each of these are doing now.

No problem.

We're going to walk through that.

Great.

So, option A will be, basically it's going to look very similar to this.

Except one and two will be amended that those provisions do not apply for ERISA-funded plans.

So, in the event, if you have a state balance billing law, your balance billing law will apply, or if you introduce one, it will only apply to those plans that are regulated by the state.

If there is nothing there and they don't have any of that, then it goes to -- if Medicare covers the service, whatever Congress comes up as a set percentage of Medicare.

So, think about a federal backstop is going to happen here.

And then if it's not covered, it's going to create a fixed amount set by Congress or percentage of benchmark determined by Congress.

And then the other provisions will apply.

And so you'll have the timing of payment, the penalty provisions that are in there, direct payment, denial, 30 day.

And then you'll have the recommendation that was done under 13, which allows for the maximum out-of-pocket that everyone talked about.

And then you'll have the guardrails around the information that's mentioned in one and two.

Can you explain how the consent provision would work -- the option with the consent provision?

Since we have a cost-sharing, we voted through a cost-sharing cap, the consent is that the patient is consenting that their health plan will have to pay an out-of-network rate?

I'm not sure.

What is the patient consenting to?

But this gives the ability for the notice and consent provision that if they are going to access, the patient may want to use another provider than what the hospital's choice preference is in some areas.

In some areas, there's only one provider.

And so, this is who the hospital usually calls, unless if I'm calling -- because you're looking at all non-emergency.

You're not looking at necessarily -- this is the issue that I have with this current notice and consent provision personally.

And I'm trying to figure out if I'm gonna vote on any one of these options at this point, specifically because this covers all non-emergency.

It's not specific to just a hospital back home.

But if a consumer wants to go from their residence somewhere else, and it's not emergency, it basically doesn't allow them to choose.

In a community, they would have to go through and figure out the in-network piece of it.

If it's an out-of-network provider, they don't have the ability to choose that without some type of notice and consent, or it automatically would prohibit them, or they might see somebody exclude and say, we can't transport you at the current rates that are currently there without you consenting to use our service and pay for it.

That is some of the issues here.

It does get to some of the examples that you're giving now.

So, where's this hospital back?

Maybe they weren't given that piece.

They're coming from an ED, and they're being discharged back to their residence or back somewhere else.

And that happens within three hours.

And so, the notice of consent right now is requiring a 72-hour to get at those points where if you wanna use -- because you've got a choice of 15 ambulance services, but the one that you want to use may not be in-network, that you can negotiate something with that ambulance service to be able to go.

This allows you to notice and consent to do that.

That is what that notice, and consent provision is doing.

If there is no choice, and I'm given that notice and consent, and there is no other option, am I agreeing to be balance billed?

You would be.

Based upon the way the notice and consent is, you would basically, yes.

Unless there is some state balance billing law or something like that in place.

But if there's not that going on, a consumer could actually get billed with that notice and consent.

Rhonda, I see your hand's raised.

Yeah, I kind of have the same question.

I know I was probably absent whenever the committee talked about this notice of consent, so I apologize for that if you had a robust discussion and I missed it.

I'm having a hard time just seeing how that would operationally work for an EMS provider, especially coming from a rural area where we don't have choice.

And a lot of our country is rural and we don't really have a choice in providers.

So that's one thing.

And then what happens if the patient says, well, okay, I'm just not going to consent.

The backup that that would cause in a hospital or an emergency department, what do they do then?

Is it just a notice of non-coverage?

Well, I'm sorry if you're not gonna agree to be transported by this ambulance, then you're just gonna have to stay here in the hospital and you'll be responsible for your bill because you aren't qualified to be here and your insurance won't cover.

So did you guys have those types of discussions?

No, and I'll tell you that this is something as most of the conversations happened around the emergency side, there was some stuff that came into the non-emergency and you're getting into the complexities of this prohibition around non-emergency ground ambulance services.

And while it makes sense on the protection to protect them, there's so many nuances surrounding this piece that just to create a broad prohibition without understanding what could be an access issue that still is a consumer issue, I think Rhonda that you're getting at.

And so, to me, these options while they're here, I think this is good discussion that we're having to see, are these actually something that we need to be looking at or what have you, or should there be some other finding that looks at something more appropriately on the non-emergency side?

And I think this is some of the context around the current provisions within the NSA and certain things that were allowed from what would be considered non-emergency that was prohibited outside of the notice of consent.

Does that really apply instance for ground, for non-emergency ground ambulance in certain instances?

We covered a majority of it when we talked about the emergency inter-facility transfer and a lot of that work that was going on.

But when you start getting into the complexities of the non-emergency, there's a lot more that goes into non-emergency than just some hospital transport back to a nursing home or a residence.

And that's what we're talking about now.

Loren, I see.

So, Rhonda, any other further clarification?

But as you can tell, we did some dialogue, but not enough to really vet through the right solution.

This is my opinion.

At this point, for the option B that is including that, then I would have to vote no for that reason.

Thank you, Rhonda.

Loren?

I was just going to clarify.

So, if we have the two different payment options for each of them, are we kind of voting on whether there is this notice of consent exception, or is that like randomly just in one and not the other or something like that?

Because in theory, right, it seems like we have a lot of debate about like what exactly should a notice and consent exception provision look like.

For these non-covered services, you're talking about, like home to a nursing home where it's not even going to be covered by insurance, then like you can always like -- -Well, there are some things that they are covered, Loren.

Yeah?

So, I wouldn't make a blanket statement that they're non-covered, because of course, if something's non-covered, and then it wouldn't even be covered under this.

But there are many times that these services are covered currently.

Now, it could be that health insurers change their coverage terms and stop covering it.

And that's a very, very -- I mean, that is an area that actually could happen.

Yeah.

So, I only wanted to say, I feel like we should be voting on, is there a notice and consent exception to the balance billing prohibition for each of these?

Because that seems like an important piece of this.

And I think I'll echo what I think Patricia was trying to get at, is that you want the notice and consent exception to really be getting the patient consent and not having the patient be under duress with no real option to saying you get balance billed, but you literally have no other option of another ambulance provider, really isn't meaningful choice to the patient.

And in that situation, I don't think there should be an exception and the ambulance can balance bill the patient, right?

They still would be getting paid whatever this sort of minimum required payment amount is, but they wouldn't be able to balance bill the patient on top.

I only mean that I think making sure that the notice and consent exception here is meaningful and that you are truly getting consent from the patient is a very important piece of this, just to kind of put a little bit of the other side on this question.

Okay.

Shawn?

Okay, wow.

I'm still trying to coalesce all of these different parts myself.

But I think where I'm seeing things and I'm asking a question almost more than making a statement, but I think that Loren's comments about maybe what we need is to separate out the notice and consent and then decide, vote on something with that.

And whether it's the exact language that's in there or whether it's a statement that Congress needs to address notice and consent for situations in non-emergency, I'd even be open to something like that.

So that leaves us with kind of the other thing that was brought up, which is a change to option A to make it look more like the emergency recommendation where it sort of eliminates the tiered hierarchy of things on the slide we're looking at right now.

I think it would take the, like item two, for example, the state and local regulated rate would be removed, that kind of language.

I almost think that we're getting to a point where we have three, we have an A, B, and C recommendation where we leave A and B alone and then add an option C, which gets rid of the one that Loren was talking about with dealing with ERISA, because it's getting too muddy to try and fix it all up into one recommendation in my mind.

I would agree, Shawn, on that point that this is probably we have three recommendations so far, that we allowed one very similar to what happened under recommendation number 12, same similar concept, and it gets at kind of a max out-of-network rate, basically.

And then you move into this and then one with the notice and consent as well, one that doesn't have the notice and consent and one that does.

Loren, I see your hand's raised.

Sorry, that's just up from before, my bad.

So, here's what I'm gonna do.

Any more discussion around this?

Because what I would like to do is to go back.

We're gonna take a break, not yet.

I'm gonna move to the next one, which is an independent dispute resolution process.

And then we'll take a break and pause.

And then Shaheen and I will meet and come up with what that recommendation with PRI, so you can see it on the screen.

And then that way we can make a very concerted effort on what those recommendations should possibly look like.

So, any more discussion around -- we went through option A and B, we are gonna add in an option C.

So, A will stay like as is, it doesn't have the notice and consent provision, allows for this to go through the normal process, this tiered approach.

Then it adds, so that does with no notice and consent.

And then there'll be one where you allow for a notice and consent, and then there'll be an option C that will look very similar to what 12A looks like, but specifically for non-emergency, okay?

And so, I know if PRI is listening or whatever, we'll talk through that, but that might be to get that slide ready and we'll make it 14 option C, and we'll just make it relevant to the non-emergency.

And then that way you can throw that up and see it in its entirety.

Any further discussion on that?

Okay, so we're gonna pause here and we're gonna move to the last recommendation, which is number 15.

And recommendation number 15 is around the independent dispute resolution process.

It is a process that originally when we were talking was gonna make it into several of these recommendations when we were talking about the preventing of surprise billing, based upon information that we received from subject matter experts and presenters around the functionality of the independent dispute resolution process, where you stand on that, how does it work.

There's a lot of issues that we have seen played out in the media, in the court system under the current independent dispute resolution process.

Many in this committee felt like it was not a process that really would work for the ground ambulance industry, just due to the complexities of the ground ambulance and really some of the data that began to show how small some of the ambulance agencies were, especially in rural markets, super rural markets, not having the resources to be able to go through an independent dispute resolution process.

However, there were many on the committee as well that felt the independent dispute resolution process may or may not need to be, based upon where Congress went.

So, if they did not put in some of those provisions as discussed in recommendation 12 and recommendation 14, that an independent dispute resolution process would be appropriate.

And so, it would provide an avenue for a health insurance issuer, as well as a ground ambulance service provider or supplier, the ability to work through the independent dispute resolution process in order to come to a reasonable rate.

So that was kind of the context around why you see this independent dispute resolution process.

And so, I'm gonna walk through the recommendation on this IDR process.

And basically, it is this, the ground ambulance emergency and non-emergency medical services providers or suppliers and group health plans or health insurance issuers may access the independent dispute resolution process only when the out-of-network rate -- and this will be 12 and 14.

We've already did recommendations on 12, we have not yet done them on 14.

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

Go to the next slide.

The committee recommends that the IDR process set forth in the NSA be adopted for ground ambulance services with the following modifications.

And these modifications would apply while most of the independent dispute resolution processes would be there.

These are the modifications that the committee is recommending.

Both parties would have the ability to request an IDR process, but only when the out-of-network rate, based upon the recommendations of 12 and 14 is a set percentage of Medicare or if Medicare covers the service or if Medicare does not cover the services, either a fixed amount set by the Congress or a percentage of a benchmark determined by the Congress.

Next slide.

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

The ground ambulance specific out-of-network rate, the level of ground ambulance service being provided, the acuity of the individual receiving the services or the complexity of furnishing the services to the individual, the type of vehicle, including the clinical capability of the level of vehicle, the population density of the location where the patient was met.

Next slide.

The time on task, including but not limited to wait times and hospital wall times.

Number seven would be the distance from the destination, including but not limited to the lack of access to providers within a reasonable distance.

And then certain state and local protocols and requirements that might be germane to that jurisdiction.

C would be a prohibition on the IDR entity considering other rates, would be amended to remove Medicare rates from the list of prohibited factors since that is a part of one of the minimum required payment standards or a local rate.

The current provisions exclude you allowing to use Medicare as a benchmark, so you would need that prohibition.

And then D would be the mileage and base rate elements of a single claim should be required to be batched together.

So, this would allow for you to batch elements of the same transport together, which has been an issue that has went through the court system.

The next slide.

And then 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.

And so, for the administrative fee to be limited to $50 updated annually, such as by the CPIU, and for the IDR entity charge, the amounts could be a percentage of the value of the claim in dispute.

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

And the secretaries would also be authorized to impose civil monetary penalties for each violation with a cap for multiple violations.

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

And so that is the independent dispute resolution process and when it would be triggered based upon the components listed, I think in 105 or 205, if you will go back to that slide, Terra, or Matthew.

Okay.

All right, so I'll stop here and allow for any discussion point on the independent dispute resolution process.

All right, I'm not seeing any hands.

I see Patricia's hand.

Go ahead.

I know you want to move through this, but I have some thoughts.

Go for it.

This is really important.

Absolutely, absolutely important.

Having now had a year or so and a half of experience with the independent dispute resolution process under the No Surprises Act, I'm really hesitant to support a recommendation for bringing that process into the ground ambulance area.

And if you move back to, I believe slide three and then it does carry over onto four, we're seeing the kinds of factors that the arbitrator could consider.

We've had this problem with the No Surprises Act with double counting.

It's like a shorthand for the billing already reflects the coding and the billing already reflects many of these factors.

And so, to count it again in an arbitration process would be double counting and allowing some bump-ups of rates or at least arguments to be considered as a bump-up of rate.

For example, the acuity of the individual.

Well, that is reflected in whether it's a BLS rate, basic life support or advanced life support.

The acuity of the patient is already based in the coding.

On the next slide, on slide four, we've got the distance.

They are already able to bill by mile.

So that's already accounted for in the original bill, and why it should be counted in the second consideration is unclear to me.

So those are some of the double counting.

The other areas that concerns me is I'm not sure how the density plays out.

If you just go back to the previous slide, number three, we're allowing to look at the population density, but here there's no indication to the arbitrator whether more density should mean a higher payment, less density is a lower payment.

So, I wouldn't even know how as an arbitrator to consider this factor as far as whether they were underpaid or overpaid.

So those are just like some specifics around IDR.

I also think bringing the feedback down to $50, as we've seen these cases take a lot of energy and work by the department.

And I think they're going to need more than $50, particularly if you're allowing batching.

I just don't see how it's going to be an effective way.

I feel like it will just add costs to the system.

So, I'll be voting no.

Thanks Patricia, for your comments.

Shawn.

Thank you.

Yeah, this is a very difficult one because I think we've had a lot of discussion within the subcommittees about some of the dysfunction around the current process.

And I completely understand the frustration with that from many different provider types.

And I also appreciate the comments around, are these things, aren't they already going to be sort of taken account into the rate setting process?

And certainly if Congress takes a recommendation and does defer to locally set rates, it's likely that those would take all these into account.

This particular recommendation is intended to be when those local rate setting things weren't addressed and a national rate was established as the backstop under that tiered system, that everything defaulted back to this percentage of Medicare or something.

And that will be one percentage applied to every provider everywhere that doesn't have some other way of getting to it.

And this IDR process is intended to address that specific situation only.

And there is some variability that probably won't be captured by that one single national rate.

And so, this was an attempt to kind of outline what those situations might be.

It's very important, very important that whatever recommendation on payment move forward, we recognize that we are not at this stage determining what that rate will be.

Congress will be determining that.

We want to have an appropriate body of knowledge for Congress to understand when they set that rate, that if it's right on the mark, if they get the number right, that supports everything that needs to be supported and protects the patient, this tailored process would rarely if ever need to be used.

And at some point, maybe it even goes away.

But without the pressure of knowing that there's some way to arbitrate if that rate is set too low, and then it's in statute, and there's no other avenue for anybody to pursue anything because you're not in one of these other situations, it becomes your only protection.

And that's why Congress put it in the No Surprises Act.

And that's why we would not want to necessarily give that right away to protect access to care.

Thanks, Shawn.

Pete, I see your hand's raised.

Yeah.

I look at things a little differently on this.

All the insurance plans have a dispute resolution process.

We're establishing in our report, based on the votes that we've taken, that the state balance billing laws are going to be put into effect, that the local laws are going to be, or rules and regulations and ordinances are going to be taken into account.

If you don't have that, then you can come up with an agreement with the company, with the insurance companies.

And then we get to Congress and they're setting a rate structure, a percentage of Medicare.

Well, yes, there could be a percentage of Medicare, but we still, you know, it's not the standard rate.

It's not the rate being applied across the country because we still have the Geographic Practice Cost Index, the GIPC, that does impact and does take that same single rate from the area, you know, from Congress and increases it, adjust it to the locals.

I think if we've got all these other things built in, we don't have a need for this process because we're going to have Congress make the decision.

And if Congress doesn't apply all of the other stuff we've already voted on in the report, Congress isn't going to care that the independent dispute resolution process was voted on.

They wouldn't do it.

I think, in my opinion, the IDR process, and it's just my opinion, the IDR process gives Congress the ability to punt it down the road to say, you know, guess what?

If you guys don't like the rate we come up with, you guys deal with it with the insurance company.

And it creates the problem, versus Congress saying, we have to come up with a percentage and not let everybody then have to go deal with it separately.

And I believe that's what the IDR process does.

And it doesn't need to be in place.

It's not something that, you know -- people talk about a backstop, but it's not necessarily going to work in my opinion.

And I don't support it.

I've said it in subcommittee meetings before.

I think this just basically allows Congress to punt and force everybody to come up with their own resolution.

So, I'll be voting no, unless I can get convinced otherwise.

Thanks, Pete.

Gary.

Hi, I agree with what Patricia said.

I've got a question.

I thought the administrative fee that we were alluding to was to the ambulance service, but I think I just heard now it might be the CMS.

Part of the problem is if you have 100 claims in a year and an insurer wants to do IDR on one, it's not just the $50.

There's a lot more fees and time and stuff that has to be contributed.

But can you clarify me, Asbel, that $50, is that what CMS fee gets to charge or is that what it costs the ambulance service?

The administrative fee that you have to pay to start the process, and then there's a fee that you'll pay if you lose as well.

And so, we're talking about the administrative fee associated here.

Okay, so if the ambulance service wanted to start the IDR, they would pay $50.

Pay $50, that is correct.

Okay, but if they have to defend themselves against the insurance company that paid the $50.

Yeah, and if they wind up paying, it's kind of the constant of the current provisions within the No Surprises Act.

All right, so if you have one claim for an entire year, I just see it problematic in having somebody that's capable of even going through the process.

Loren, I see your hand raised.

I think some of these points have been raised here already, but I think in my eyes, especially when we're talking about, especially for the emergency medical services, where we're talking about 60% of these being public sector or 60% of the transports being public sector entities, the idea of a municipality, challenging a bunch of bills to arbitration where they're paying this administrative fee and then paying some 50-50 shot of winning or losing, where you're gonna pay the $500 or $600 or whatever fee it is for the arbitrator, and really just sort of all of the bureaucracy and time and manpower it takes to go through this process just seems really difficult when you're talking about local governments or all of the small ambulance services that we're hearing about.

Yeah, American Medical Response can handle this, but there's just a lot of smaller services where this seems, I think, very difficult to imagine working out well.

I also, just from the ambulance company's perspective, I don't think it's clear that it's an up-only ratchet here in this context.

Most of the recommendations we're talking about here are setting a minimum payment standard that is higher than today's rates on average.

It seems perfectly plausible insurers who will have a lot more money and resources to throw into this than any other ambulance entity, sort of like AMR, will be arguing, look, I was paying half this rate yesterday.

Why shouldn't I be paying that rate still?

So, I also don't think the outcome is as clear as some people are thinking that it's sort of an up-only ratchet here.

So, I think folks should just sort of keep that in mind.

But I also just think this is a huge bureaucratic boondoggle.

We're adding a bunch of administrative costs to the system in my eyes for no purpose, and those administrative costs are passed on to all of us in higher premiums and cost-sharing.

And in this context, it really just seems -- I also think it doesn't make a lot of sense in the broader No Surprises Act, but I think it makes even less sense when we're talking about ground ambulance entities here.

Ritu, I see your hand's raised.

Yeah, just again, or just to clarify, so this is only applicable in this scenario where the federal backstop rate applied, is that correct?

So right now, Ritu, this is not in any of the recommendations that have been offered on the prohibition of balance billing.

This has been pulled out on its own to make a recommendation that in the event there is a backstop, Congress can consider this recommendation of inserting the independent dispute resolution process.

And it's only around when determining the payment amount of the ground ambulance specific of the out-of-network rate.

So theoretically, it could be inserted into the other recommendations, but only available if the backstop is the Medicare rate or whatever Congress comes up with as that benchmark.

Could be in both of them, actually.

So, this isn't complicated at all.

So, if the rate is a locally set rate with all the proper guardrails and everything, it would not apply.

That is correct.

Okay, which then, so if you were a local agency, would there not be impetus to then lobby to make sure that state and local laws allow you to set rates based on your costs, et cetera, et cetera?

So that is kind of the construct of that tiered approach.

In the event there is not a local rate that has been established with the appropriate guardrails and it moves to a backstop of, and we're calling it a backstop of that Medicare, that congressional set.

This would allow, if you disagree with that backstop, giving you the ability to go into independent dispute resolution if you wanted to.

Remember, this is not a requirement.

You do not have to go into the independent dispute resolution process.

Okay, that's helpful.

Thank you.

I think the only other clarity, and then I'll get to you here too, Ed, because I will tell you that as we work through the recommendations specifically around the non-emergency and those prohibitions that we are going to be given to a non-emergency ground ambulance service and to the consumer and those consumer protections, without an independent dispute resolution process, it doesn't work.

And I'm really concerned about the consumer access to these continued services.

I'm concerned regarding some of the provisions on is there adequate good faith effort negotiations that have been happening amongst ground ambulance services with the health insurers and the health insurer payers or whatever.

Been personally involved in that for many years, working through those constructs on what is really a good faith effort negotiation.

So, I have a lot of concerns regarding what that access could look like.

In some areas where there is limited resources, in some areas where there's multiple resources available to consumers regarding that piece.

And sometimes we assume things are out-of-network because that has an elected reason why ground ambulance services are, and that is not necessarily an assumption that I would make because for as many examples there are on ground ambulance services not participating, there's many examples that they have actually went into wanting good faith.

And there has been sometimes good faith negotiations that have happened for 10 years, 12 years, and more regarding this or fixed rate structures.

So, without some very specific parameters around, the only way to remove the patient out there and do that prohibition would be to allow for an independent dispute resolution process through this.

For that reason, I'm voting yes to the IDR concept within that same construct around that non-emergency as well.

So, Ted, I just wanted to make a note there because there's a lot of assumptions being made here.

We're assuming if Congress makes those recommendations relative even on the emergency side and they focus on that local state regulatory because there's been many varying options and votes on the options to get to those recommendations that we're making an assumption.

If they look at local rates, you will not need IDR.

I'm not sure I'd make that assumption.

Remember, this is part one and part two.

Congress is gonna be mandating a lot of stuff here.

So, I'll stop there.

That is my statement as my position on this committee and I normally haven't said too much on that but I wanna just be strong around that piece of it, but Ted.

Yeah, Asbel and I, I appreciate that.

And I also support the IDR because we've been trying to do everything we can to solve.

And we really started with emergency.

We then moved to emergency interfacility, recognizing that's a big piece.

And then we have this non-E piece that we've been talking about and we're trying to solve for a lot of different components.

I'm hoping we solve for most of them, but I know we're going to have some of those gaps and we're going to have some areas where potentially that's where you do need this IDR process at the end of the backstop.

Also, because we don't know what Congress is going to say on what Medicare rate would be that piece there, because that's been a big challenge is that Medicare hasn't kept up with the cost of service, and the amount of investments everybody's had to make in the last number of years to keep ambulance services even as much alive as we can, knowing we still had closures, it has been very difficult.

So that Medicare rate and how that changes, we talked about it earlier with rebasing, that is so essential.

So, you've got to have that IDR in case those pieces don't happen or the timing of that doesn't match with some of the recommendations we're doing here.

So, it's important to have a backstop and that's why I'm going to support this.

Thank you.

Adam, I see your hand raised.

Yeah, Asbel, could you elaborate on something you just said about how -- it sounds like you were saying an element of the consumer protections only work if there's an IDR mechanism.

I'm curious how you see a relationship between a post-minimum payment IDR and any of the consumer protections that you talked about.

Sure, so the consumer protection would be access to the actual ambulance service for the provision of the non-emergency transport that they might need.

So, for instance, in some areas, there are communities where patients are actually waiting four, five, six, seven hours, they're missing appointments because there are non-emergency services that are not currently available to them.

And so, in these areas where there might be limited non-emergency resources, to where they might have to reschedule an appointment to get to an appointment because we're covering all non-emergency services.

And so, once we take that piece away, does that exacerbate the issue that's already prevalent -- and we haven't even began to pass the prohibition of a surprise bill.

So, does that further exacerbate an issue that's already relevant in some of the communities nationwide?

That is concerning to me, that when we're talking about a consumer protection, it's not just from getting a bill, it's also from even getting the opportunity to get a bill because you can't even get to the service that you need.

And so, I think that that construct needs to be thought through.

And to me, this provides with a stopgap measurement to keep the patient out of the middle.

And if there was an issue between the issuer and the ground ambulance service provider or supplier in those areas, is to let them work through arbitration if they need to on that, but to make sure that we are providing that service through the process.

That's where my standpoint is coming on that.

And Loren, I see your hand raised.

Yeah, I mean, I'd add on that point, right?

It is important to remember here, there is a minimum required payment here.

You were talking about like Congress might not do anything, but we've always been talking about this as like, this is a whole package.

And I don't think we can like pretend they don't do something -- sort of the whole thing falls apart.

At that point, right, there is a minimum required payment here that will be intended to be reasonable.

Obviously, there's going to be cases where a company wants to get paid more than that.

I think it's important in the non-emergency context to understand here that there is some, if the non-emergency ambulance provider is amazing and patients really love it and the hospitals really like it because it helps get them to another appointment and stuff like that.

And we've now carved out emergency and sort of made emergency have its own actual kind of like more functioning system here, there are market forces there.

So, the sort of minimum required payment now, when we're talking about non-emergency, that is not going to be like what everyone gets paid for non-emergency ground ambulance services.

There is still going to be some element of market negotiations between the facility, the ambulance company, and the insurance company here.

You know, look, market forces are not perfect in healthcare.

I don't wanna pretend that, but also, I think it's important to note here that like that does exist, right?

We've seen this in some of the non-emergency context under the No Surprises Act.

And I think that's relevant here where you've seen, yes, there are certain cases where an anesthesiology staffing company may have seen a reduced reimbursement from an insurance company or isn't getting as much money out of the arbitration process as they would have hoped.

But you're also seeing a lot of stories about them now going to the hospital and saying, look, you need us, we're anesthesiologists, we're a critical part of the care and they're getting higher hospital subsidies.

So, the hospital is paying them more money.

So, like, just to exemplify that when we're talking about some of these services, there are some more market forces here to help sort of get at the access to care question that Asbel I think is importantly raising.

Because I do think that is an important piece, the access, the question here, even if it's not like your technical balance bill, but it is a very important piece of what we're dealing here, but I don't mean to say that's sort of like some overall salvo or anything, but I think it's an important piece of context.

I think that's really important what Loren's saying there about the market forces.

And that can sometimes be more regionally than others, but because we're looking at this on the domestic United States at this point, we do have to allow for some of those corrections to happen and in my opinion, the IDR assists with that.

Maybe not long-term, but it helps in those areas where there may not be that market force that Loren's talking about.

He's exactly correct.

Gary, I see your hand is raised.

Yeah, and again, I'd like us to consider the other end of the equation where you have the panhandle of Nebraska where our regional hospital that used to serve 10, 12, 14 communities with non-emergency service in the past, all of a sudden pulled out of all of them.

And these are not in Lincoln, they're not at Washington DC, they're in the panhandle on the tundra of Nebraska.

And we ought to be talking about, this is population density.

When you get to the density where there's more cows than people, there aren't market forces, you're lucky if you have one.

And then you have groups of 10 to 15 communities that all of a sudden lose all of their service on the same day.

That's the other end of the market force that is problematic.

Thanks for that perspective, Gary.

Any more discussion around this IDR process?

As you can tell, it's complicated and a lot of varying opinion as we work through this as a committee.

Any further discussion?

Then we'll call it for a vote.

Not seeing any hands raised.

Terra, if you will take the vote.

Okay, Loren Adler?

No.

Shawn Baird?

Yes.

Adam Beck?

No.

Regina Crawford?

Yes.

Rhonda Holden?

Yes.

Patricia Kelmar?

No.

Ali Khawar?

Peter Lawrence?

No.

Rogelyn McLean?

Rogelyn McLean.

Abstain.

Asbel Montes?

Yes.

Ayobami Ogunsola?

No.

Suzanne Prentiss?

Yes.

Ritu Sahni?

No.

Edward Van Horne?

Yes.

Carol Weiser?

Abstain.

Gam Wijetunge?

Gam?

I don't think we have Gam on.

And Gary Wingrove?

No.

Okay, so now I'll go back to those that voted no and allow you the option to speak on that.

And we'll start with Loren.

I think I've said my piece on this.

Okay, Adam?

Yeah, I mean, the independent dispute resolution process was a mistake to write into the No Surprises Act, and it has proven in the years since to be an abject failure, both in terms of any policy outcomes as well as just the administrative functioning of an IDR process that has been egregiously overutilized primarily by the same private equity-backed emergency staffing firms that would likely end up being the actors that are most likely to pursue IDR under this approach.

So, I think setting up any IDR system is ill-advised.

To recommend it when you have, in contrast to the No Surprises Act, you have an approach that we appear to be recommending where there is essentially a federal benchmark, a mandatory or required minimum payment that should eliminate the need for any subsequent independent dispute resolution.

The reason, ostensibly, that Congress set up an IDR process followed by, you know, preceded by an open negotiation process under the No Surprises Act is because there is no mandatory initial payment, and there was a concern that initial payments would end up being insufficient or too low, and this gave an opportunity then for parties, primarily the providers and facilities and the air ambulance providers, to be able to seek what they believe to be a more reasonable out-of-network rate through IDR.

Our earlier recommendations on required minimum payment flat out say that this is the out-of-network rate.

So it is, to me, illogical to say out of, you know, one side of your mouth that this is the appropriate out-of-network rate, but we are going to, despite declaring that the appropriate out-of-network rate, allow for certain actors to be able to seek really a windfall on top of the already, you know, additional payments that they are getting as a result of the mandatory payments through this IDR process.

I think there are flaws in the considerations that are laid out, and there's an open question about what exactly this penalty is that would be assessed for noncompliance.

I think there are weaknesses in how this IDR process is set up, but the fact that it's even a part of the recommendation when it's so clearly failed with the No Surprises Act is, for me, a clear enough reason to vote no.

Okay, and Patricia?

Thank you.

As I mentioned, I am concerned that there will be a huge amount of costs, administrative burden added to the system overall if we open up an IDR process.

I'm confident that Congress will be sensitive to the needs of making sure that access continues in all the communities.

We've seen states that have relied on a percentage of Medicare to be quite generous in that rate when states have passed surprise billing.

I would expect Congress would act in a similar manner.

Obviously, as consumer groups, we would be making sure that the minimum amounts are not the Medicare rate would be one that would support 24-hour, seven days a week, good ambulance emergency care.

So, I just see this as an added cost, and that's why I voted no.

Okay, Peter?

As I've said before, we've got all these other rate structures and all these other processes in place to establish appropriate rates, and I think we've made great strides to get there.

I understand everybody's concern expressed that we need one more backstop.

I think the IDR process, if we came forward to Congress with the IDR, I think it gives Congress the ability to basically shoot low and then force everybody to go into the IDR process.

And I don't think that that's the way we need to go.

We need to have Congress set the rate.

Am I being altruistic?

Possibly so.

But the bottom line is that the IDR process, in my opinion, creates a crutch and allows Congress to say, you guys don't like what we've done, go use IDR.

So that's why I voted no on it.

I want Congress to take our recommendations, deal with them appropriately, and then establish a rate with everybody providing input, understanding that the GPCI is going to adjust for differences in geographic area and the rural, super rural adjustments will provide additional adjustment.

I don't think the IDR process was appropriate for giving Congress an out.

Okay, Dr. Ayo.

Yes, I voted no because I think it would be counterproductive and it's not cost effective.

That's my judgment about it.

Thank you.

Okay, and Ritu.

Thanks, Terra.

I voted no.

This was very difficult though.

This was not straightforward by any stretch.

There were a couple of factors that led to my no vote.

Number one, no matter who you talk to, probably the least effective and least popular portion of the No Surprises Act has been the IDR process.

I mean, I guess there is a philosophy that if nobody likes it, then it must be doing something right.

But I think that's been part of what has driven me to vote no.

The other piece is, I don't necessarily share Patricia nor Peter's faith that Congress will set the right rate.

What I do see as an additional backstop in this process is that a community or state could create its rate-setting process.

Everything we've done until now has said that that would be the minimum payment.

The combination of those two led to my no vote.

Okay.

And Gary.

Yeah.

I am generally concerned about the cost with this one, and that's all the cost.

It's hiring the firm that's going to go through it for you.

That's not even spelled out.

But anyway, I'm concerned about the cost, and I'm not sure that it adds value to any part of the equation.

Okay.

Thank you.

All right.

So, we are going to take a break.

We will come back at 3:15 Eastern time.

During that time, me, Shaheen, and PRI will huddle to ensure that we have captured the recommendation for number 14C.

We're going to keep A like it is, B like it is, and we're going to introduce C.

That's going to look very, very similar to what the 12A is.

The only thing that is being suggested is to maybe pull the notice and consent and vote on that separately or a part of that.

I believe, Loren, that that may be what you are requesting as well, and just want to float that to C, because if that's the case, we have another recommendation.

To me, I think we should just keep it where it is right now, but I'll leave that for the general will of the committee.

That's fine with me if you just want to say -- I was going to vote against the notice and consent exception, and I think if Patricia was as well, and I think we're the main group on the option C here, but I'm not sure.

It just seems like it is something people could support C but with a notice and consent exception.

But I don't feel strongly.

I'm wondering if we have A, B, and C, so we're going to have three recommendations.

A is generally speaking where it doesn't apply to ERISA.

Two is where it applies to everything, goes through that tiered approach, and then one does, it goes through that same approach, but there is also a notice and consent.

Rhonda, I see you raised your hand.

Yes.

I just wanted to add one more comment about that notice and consent to be thinking on as we go into a break, is that so many times in healthcare, the patient can't give consent.

They aren't mentally able to, and we have to then track down a durable power of attorney.

I just don't think operationally that some of those things have been thought through, and so I would just like to leave that thought with you to consider.

I think that's an important thing to make as well.

Sounds like we'll have a hefty debate through the process or understanding when we come to these different voting on the recommendation.

So, we will take a vote.

Let's move it.

We need probably 20-25 minutes, so I'm thinking let's do 3:20, and we will come back at 3:20 Eastern time.

Welcome back.

We will now continue our review of recommendation 14.

Well, hello, committee.

Sorry.

We're on the final stretch of our last recommendation piece as well, and if you're listening to the music or the hold music or whatever, it makes you want to do a little jig as well.

We'll keep it a little light because I know you're probably doing the same thing.

We are now going to move to recommendation 14, and then following our vote on option A, B, and C, and thank you to Terra and the PRI team for allowing us to review this piece as well.

So, if we'll just go back and we'll look at option A, B, and C, just make sure we're all on the same page relative to that.

Option A is basically the minimum required payment, and it walks through the parameters.

Thank you, PRI.

So, it's looking at the parameters around the out-of-network rate as the minimum required payment.

It is walking through to 205.

If we look at the next slide, it's going through the minimum required payment process.

So, this does refer to the ERISA funded plans as well.

So, if your state or balance billing law addresses it, it is going to move it to there, and then it's going to move through the different tiers.

Same tier rate structure of the emergency side.

If you go to the next slide, this also has the timing of payment provisions and the penalty provisions with the note that we will work through this and wordsmith this to make sure that there is not double penalties happening throughout different code provisions.

That will happen through the technical drafting of the report.

The next option, not option, but the next component, it's looking at that maximum patient cost carrying where you made a recommendation under the 13B and C that we did.

We consolidated and admitted A, so we had two options in 13.

And then if we move to the next one, the component D was the minimum guardrails around that for the state as recommended in recommendation number 11.

Option B is the same thresholds except it added the notice and consent provision as we discussed.

So, we'll just walk through that, Terra.

We can just kind of move through that.

I'm not going to go through that.

So, two, three is the same construct, except you have that notice and consent provision under E, I believe it is.

So, we'll go to six of six.

And this is where we talk through what the recommendation on the cost-sharing amounts are.

It does allow for the patient to make a choice through that notice and consent, depending upon the non-emergency service requested.

And then option C is the one that we worked on during the break.

And basically what we looked at here was the out-of-network reimbursement rate as a national set rate by Congress and the secretaries as it deals with the ERISA funded plans.

And so if we look at the next slide.

This is walking through -- here's where I think the issue is, Terra, when we work through this.

It should mirror exactly what 12A was in the construct that this is non-emergency related and then walks it through what the payment methodology was as well.

So, if we would just refer back to 12A, it's going to be the same wording.

So, if you'll go back to recommendation 12 option A, and then I'll let you guys kind of fix that moving forward.

All right.

So 12A is what this will look at, but it's for the non-emergency ground ambulance service component.

So, if you'll go to the next slide.

The payment methodologies will basically still keep and preserve any state billing, balance billing laws or all payer model agreements that are already there as it deals with non-emergency ground ambulance services.

In the absence of a state balance billing law or an all payer model agreement, then it will refer to if Medicare covers the service, the congressional set percentage of Medicare.

And then if they do not cover the service, then either some fixed amount that Congress set or a percentage of that benchmark.

And then the next provision, if you'll go to the next slide, will mirror here.

So everywhere where you see ground ambulance emergency medical, it will say non-emergency ground ambulance services.

They'll discuss the timing of payment.

It'll talk about the patient share after someone is billed or not.

And then whether the payment, the prompt payment directly to the non-emergency ground ambulance service provider as well as this penalty provision technically modified to ensure that there is not duplication happening amongst different state laws or what have you relative to that provision.

And then option four, I'm sorry, number four, will refer it back to the maximum patient cost-sharing that we discussed in recommendation number 13.

And so, we'll modify that to be able to put on there, but this is exactly what option C will be for 14.

So, I'll stop there to have a discussion around what 14A, B, and C are before we do the voting process again.

But I think we did get to what the general spirit of those recommendations were.

So, Pete, I see your hand raised.

See, I just want to make sure I understand.

So 14A -- 14C is the equivalent of 12A.

Is that what I'm hearing?

That is correct.

Okay, so 14C is the equivalent of 12A.

That is correct.

14A and 14B, the only difference is, and they're what we had before, the difference is the notification process in 14B.

That is correct.

The same exact option, except one has a notice of consent, the other does not.

So, there's technically no notice of consent.

Okay, so Alpha does not have that notice and consent.

Bravo does.

Charlie is the same as 12A.

That is correct, except modified for non-emergency ground ambulance service.

Basically, it does not include any of the ERISA funded plans.

Copy that.

Okay.

State balance billing laws for those that the state covers.

Copy.

I got it.

Thank you.

Adam?

And to clarify, this recommendation, I think this was on the slide that just had recommendation 14 as kind of the thematic idea before we get to the options.

There, it referred to covered non-emergency items or services.

So, I want to clarify that that is going to apply throughout now all three options.

Because that word covered was not part of the emergency recommendation, so that does make a difference, at least for me, for Medicare, non-covered service.

Right here is where that component is, the group health plan or health insurance offering.

Group or individual health insurance coverage must pay, and that's where your coverage comes in.

Now we can insert it into, but this is based upon if it's covered.

Okay, I wasn't asking about -- yeah, I'm not asking anything about that.

This was on the first slide.

Oh, for 12A?

Oh yeah.

Oh, yeah, it's going to follow.

No, sorry, I think it's answered by the fact that it was on the slide.

So, I'm going to go ahead with the language that was on the slide.

Okay.

And we'll note that for the record as well, Adam, that this is basically about coverage.

And so, when we're writing the report, that's what the intent of these are as well.

It's there, but we'll make sure that's clearly defined what your statement is as well.

Yeah, I know it's about not covered.

I wasn't asking about whether this is referring to covered items or services, which again on the recommendation 14 slide, it uses that term.

So, I'll interpret that as applying across the board to all of these options.

That would be correct.

Can you just show that one again?

Just recommendation 14 without the options, like the introductory part.

Yeah.

It says for covered non-emergency ground ambulance medical services.

So, if they're non-covered, then the plan just doesn't offer coverage for that.

So, patient would get a bill, but it's not necessarily a balance bill.

Any more discussion?

If you would raise your hand or whatever as we're walking through this.

Any questions, discussion points?

Quiet.

Are we ready to start the voting process on each of these options?

Okay, so let's start with option A.

Okay.

Terra, did you say something?

Are we ready for option A?

Yeah, I'm going to just walk through this again to make sure everybody understands what they're voting on and then I'll have you take the roll.

So, option A is specific to non-emergency if coverage is option based upon 14 if it's a covered service.

The out-of-network rate.

If you're in-network, this does not apply.

If you're out-of-network, the rate is a minimum required payment rate methodology established by the Congress and secretaries.

So, the next slide will do a minimum required payment, which is this tiered model.

Basically, if your state balance billing law addresses it, then it's going to refer to that.

If there is no state balance billing law, but there's a state or local regulated rate for the process, determining the rate has those sufficient guardrails that were already identified, if that does not happen, then it's going to look and see if you have any mutually agreed upon reimbursement rate amount, that's going to be similar to those single case agreements.

Or if you have some type of other agreement with an insurer that may not be codified into some type of structure or contract that still has you as out-of-network that will apply.

If none of that exists, then the amount that Medicare covers for the service, a congressional set percentage of that Medicare amount.

If Medicare does not cover the service, then either a fixed amount or a percentage of a benchmark amount.

Next slide, then we go to the timing of the payment.

So, pay within 30 days of the receipt of the bill as defined in the definition.

Patient share can be billed after the group health or health insurance payer pays or denies that claim.

Then you're looking at the prompt pay directly to the non-emergency ground ambulance provider supplier.

And then the payment penalty provisions to ensure that they are not duplicated.

That'll be worked through the technical component of that.

The next slide.

And then this looks at the recommendation that was made in 13 regarding the maximum patient cost-sharing.

And then D would be your minimum guardrails for state and local regulated rates.

And this is only to the non-emergency standpoint side of it and recommendation 11.

Okay, any further discussion on this before Terra takes the vote?

All right, Terra, I'll let you take the vote.

Okay, Loren Adler?

No.

Shawn Baird?

No.

Adam Beck?

No.

Regina Crawford?

No.

Rhonda Holden?

Yes.

Patricia Kelmar?

No.

Ali Khawar?

Peter Lawrence?

No.

Rogelyn McLean?

Abstain.

Asbel Montes?

No.

Ayobami Ogunsola?

Dr. Ayo, are you on mute?

I'm sorry, no.

Okay, Suzanne Prentiss?

No.

Ritu Sahni?

No.

Edward Van Horne?

No.

Carol Weiser?

Abstain.

Gam Wijetunge?

And Gary Wingrove?

No.

Okay, so I'll now just go back and give each person that voted no the opportunity to give comments, and we will start with Loren.

Sure, I mean, I think we've discussed this a little bit as well.

For this one, I'd say this is a more weakly held no than the previous ones, given that there aren't that many non-emergency set rates to begin with and given that there are sort of market factors and some coverage decision processes that can still happen behind that, yeah, sort of after the fact stuff, so I don't think this is quite as determinative.

As long as it is a pretty weakly held no, but basically the main reason is just the encroaching on ERISA issue here for my hesitation here.

Okay, Shawn?

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

Okay, Adam?

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

Okay, Regina?

Sorry, I was muted.

Same reason, I want to support the state authority to have some say in this, so option B is better for me.

Patricia?

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

Okay, Peter?

Pete, are you on mute?

He looks frozen.

Okay, I'll come back to him.

Asbel?

No comment at this time.

Dr.

Ayo?

Yes, there's no protective no, that's why I voted no.

Okay.

Suzanne?

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

Ritu?

What she said.

Okay, and Gary?

What she and he said.

Okay, and I'll just come back to Pete to see if you have any comments.

Looks like he might be still having technical difficulties.

He just popped back in.

I'm back.

Okay.

I just prefer option B.

Everything else has been covered by everybody else.

Okay, thank you.

All right, so let's move to option B.

And option B is the exact same provision of option A outside of when we get to number six if you'll just fast forward to that.

Six of six, it gives the ability if you are in an out-of-network situation for a non-emergency ground ambulance service provider or supplier for certain services that fall within the current notice and consent provision within 72 hours prior to the date of service that they'll have to follow the current provisions within the No Surprises Act in order to bill a patient for out-of-network services.

And so that is the main provision within this.

So, I'll open for discussion on that before we go to a vote.

And so Patricia has raised her hand.

Thank you.

So, we do have experience with notice and consent both in the No Surprises Act as well as in some state laws.

And just borrowing a situation to kind of put the patient in mind's eye when you're talking about notice and consent.

So, I've spoken to a woman, Judy, who was in Texas.

She was getting surgery by an in-network doctor at her in-network hospital.

She got a consent notice in the same kind of time frame.

She'd already scheduled her surgery.

She'd taken time off of work.

She'd arranged for all the childcare and other household care that she needed to manage that.

And then she found out the assistant surgeon was out-of-network, and she was presented with a consent form.

Her surgeon would not work with anyone else.

She really had no choice.

There was no option for another in-network assistant surgeon to do that surgery.

So, she signed the notice and consent form and she was subject to the balance bill.

Now, I know it's a different situation with ground ambulances, but we've all heard that there are communities that don't have an option.

If the facility cannot help the consumer get an in-network option, it's not true consent and it would set up patients for owing a lot.

And it's just an unfair provision if there's no in-network option that they are offered.

So, I'll be voting no.

Loren, I see your hand raised.

Yeah.

I mean, I really just want to echo Patricia's point there that if you want this to be a balance billing prohibition, there needs to not be situations where you can effectively get non-consent consent, where it is, you literally have no option, patient, ha-ha.

Like I'm going to balance bill, like you basically have to sign this or you don't get treated and you're going to get balance bill, then I'll charge you what I want.

That's not a balance billing protection anymore.

I only mean that to say that if you were going to have a notice and consent exception to get around what is the core balance billing prohibition here, right?

If you're going to have a notice and consent exception around that, it does need to be strong and actually have there be an option like under the NSA, to be fair, where there is an actual option to get an in-network or an ambulance provider who will accept the required minimum payment and that there needs to be actual oral consent here in time to -- there need to be other options.

I think that can be crafted in a notice and consent language, but I just want to echo that that is a very important piece to me if we're actually thinking of this as a balance billing prohibition.

Because I think to Patricia's point, and we've all been patients ourselves at some point, the idea of sort of giving consent in a quick turnaround sense is like not really consent because often there is not really an option there.

And Gary, I see your hand raised.

Yeah, I thought I had this one and now I don't think I do.

I sort of have a question.

And again, my concern is if you're lucky, there's one non-emergency ambulance service to serve you for most of the geography of this country, and they're closing.

And so, if you've got an option and the insurance company gives you, here's the urban rate, take it or leave it, or here's 22.6% extra on Medicare, take it or leave it.

And that isn't covering -- I've sort of lost here now where consent comes in.

And you can quote Gary Wingrove on that thing.

If you fix this problem for rural, it will automatically fix urban.

If you fix it for urban, we're going to struggle with rural and it's rarely even going to be a band-aid.

So, I think we need to fix this for rural.

And I thought I had it, but now I think I've lost it in this discussion about consent and market factors.

There aren't market factors in most of the country.

You're lucky to have one if you can get that and the insurers don't want to pay a cost for that.

So I'd like that to be straightened out, Asbel, before we vote.

For the discussion, I think right now the way the provision is the ground ambulance service provider or supplier, which is the ground ambulance company, would have to get notice and consent from the patient.

Meaning we will not transport you -- if we transport you, you will have to sign here that we are out-of-network.

We're not accepting what the current minimum required payment is.

And this would have to be done 72 hours before the date of service.

That's what would happen here in the notice and consent provision that you're currently seeing in front of you.

To Patricia's point, she's given you examples of how that doesn't work.

It leaves the patient in a bind in areas where that might be a problem.

That is the current discussion of the notice and consent provision in this.

Rhonda?

Yeah, for reasons that I've said before, I will vote no on this related to this consent.

That's why I voted yes on the one above it, because that was the only difference between the two.

And I think, you know, it just hasn't been vetted out as to how this would happen.

And I can see a patient in a hospital needing an ambulance transport, non-emergency, back to a nursing home.

And what?

How many people have dementia and they can't even sign their consent?

You're going to have to hunt for their durable power of attorney.

And who is that?

It might be a child living in another state or time zone, you know.

It just really seems crazy to me that the paramedic is then going to have to be the one to come to the hospital to pick up a patient and get that consent.

The patient's not going to sign it.

Now they've just wasted their entire time coming over there.

I don't think we've thought this through, and I just simply can't support it.

And like I mentioned previously, if the patient does refuse, then what?

If you stay in the hospital and it's not a qualifying illness that your insurance is going to cover or even Medicare will cover, you're going to be responsible for that bill.

And that hospital bill is going to be a heck of a lot more than what your ambulance transport is.

So it's just putting everybody in a really bad bind.

Suzanne, I see your hand raised.

Yes, thank you, Asbel.

Rhonda covered a lot of my ground.

So I'm concerned about this, and I don't know if this is a no or an abstention, because I feel a little bit like Gary, too.

But here's the thing that's key to me.

If we're working to take patients out of the middle, then we haven't done it with this.

But we also need to think about the EMS professionals that are put in the middle, and they don't belong in the middle at the bedside sorting this out.

The third piece is that there are some areas in the country, and including, I can think of multiple areas in the state where I've predominantly worked, where there is a large group that are not in-network for a whole varying set of reasons.

That's between themselves and a provider or becoming a participating private insurance company.

It's been a long day.

But all of these things make this almost impossible.

So I think we're putting patients back in the middle.

I think we're putting EMS professionals in the middle.

I don't think we have -- you know, predominantly, the rural areas are really going to be squeezed by this.

So I'm not sure if this is a no or an abstention, but I have concern.

Loren, your hand's raised, and then I'll go to Ritu.

Yeah, just, I just wanted to -- I mean, I think, I take Rhonda's point very well, that the idea of getting consent from some of these folks is going to be difficult to impossible in certain circumstances and puts the paramedics in an odd spot in certain circumstances.

I think they, to be clear, right, this is only if you want to balance bill the patient, you need the consent, right?

If you're willing to accept the required minimum payment, the locally set rate, whatever, the state set rate, whatever it is, if you're willing to accept that, you don't need the like, I mean, I guess you may need consent to the patient to be transferred if they fight you on it, but like, you know, this provision doesn't apply in that situation here.

So as long as you're willing to accept the required minimum payment here, right, it's not about -- the insurer can't go, I'm just going to pay you Medicare rates in this situation, right?

They have to pay, they would be required, if it's not a network service, to pay this required minimum payment however we vote on it being defined.

I think that's just important, right?

This notice of consent is only so that you can balance bill the patient here.

It's not a requirement.

That's a good point, Loren, to make as well.

Suzanne, is your hand still raised?

Okay, Ritu.

I guess the way I was looking at this was that with the 72 hours sort of written in that basically, if there was a call, if you accepted a transport for tomorrow, then you do the transport, but you don't really have the opportunity.

But if, you know, I'm setting up my own ride to something in a week, and I like Asbel's House of Ambulances better than the other ambulance service, maybe my nephew works there or something, and I want to support them, that gives me the opportunity to say, yeah, I'll chip in a little extra.

Versus this idea that, oh, you're going to be discharged tomorrow, and I need you to sign this consent so we can bill you extra.

The way I read this before, which is -- I mean, I agree with Patricia, we don't want to put the person in that role.

So that was how I was looking at it.

And Ritu, that's a really good example of how to say it's also not required, to Loren's point.

So if somebody could call you five days ahead of time, you would have the option to discuss with them their options, or you could just accept it.

It just allows the notice of consent.

That's a really good analogy, Ritu.

Shawn?

Thank you, Asbel.

I think this discussion of the last few minutes has been incredibly illuminating for me, and thinking about some of these different scenarios, and it reinforces my view that non-emergent is really just not fully baked for a recommendation at this time because of all of these potential effects on patients.

Absolutely, the examples that Patricia brought up are things that are concerning and would need to be thought through.

And I am also concerned about the potential to undermine access to care at the same time by being too aggressive with a recommendation when we really don't know and did not spend anywhere near the depth of discussion on non-emergent that we did on emergent, where I'm much more confident that we understand what the ramifications of the recommendations will be.

So my thinking has evolved on this, and I will not be supporting the general recommendations on non-emergent.

Any other discussion about this particular recommendation?

All right, Terra, if you will take the vote.

Okay, Loren Adler?

No.

Shawn Baird?

No.

Adam Beck?

No.

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 Wijetunge?

And Gary Wingrove?

No.

Okay, so I'll just go back and give each person that voted no the opportunity to speak.

And we'll start with Loren.

Nothing further on this point.

Okay, Shawn?

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

Okay, Adam?

I'd say, in particular, concerns about the notice and consent provision here.

Regina?

It's all been covered.

Nothing further.

Rhonda?

Yeah, just the notice and consent I couldn't support.

Patricia?

Nothing to add.

Peter?

Nothing to add.

Asbel?

So I just want to go on the record.

I'm generally supportive and want to make sure that, regarding the recommendation number 14, very, very supportive of making sure that we prohibit surprise billing and create some reasonable environment in the non-emergency when individuals are requesting it.

I'm generally supportive of the notice and consent if it's done in enough time frame to allow that patient to have a choice of who they want to select, as not all non-emergency happens within less than 72 hours, or what have you.

And this is also an elective procedure as well.

My biggest issue that I have is, we're making assumptions around the required payment amount.

And that required payment amount is a tiered approach if Congress adopts it.

But in the event that it does not, and the market factors will correct in certain areas and markets across the country.

But there are many markets where it will not.

And so, with the failure of recommendation number 15 and the independent dispute resolution process in a very, very minimum capacity to be able to use that, in the event Congress opts to just this federal provision, and I am sure that option C will be voted on by a few as well in the affirmative, that doesn't look to the states to help with ERISA side of it.

We are making assumptions that there is going to be a percentage to a Medicare rate that will ensure that the markets do not fail in certain areas across the nation.

And right now, unfortunately, there is not enough data that allows for the ground ambulance side of it outside of understanding costs to ensure there's market failure do not happen.

So I really am probably more a no on most of these options relative to the absence of having some type of avenue while the patient is out of the middle that the provider and the insurer can agree on something if the market factor has not been an area that has been able to play out in those individual geographic areas.

So I'm going to be on the record for that.

Supportive of the prohibition, that definitely needs to happen, but how we're getting there is concerning.

Okay, Dr. Ayo.

Yes, my take on this is that it is more restrictive instead of being protective, and can also be described as being arm twisting, or at best to be thought of a bit of conflict to the patient.

And that's why I voted no.

Thank you.

Okay, Suzanne.

It's all been said.

Ritu.

I just wanna echo some of Asbel's comments and hearken back to what I said earlier too, which is that I think we have broad consensus in the group that the patient should be left out of the middle.

My concern was where we're going now and this process has been fascinating because I was planning to vote yes on this option until I heard a lot of this discussion.

So I appreciate the discussion.

My concern is that we are going to be left with no recommendation around non-emergency.

And I do think that one of the fundamental things that we as a group agreed upon or seem to have consensus upon is that the patient should be left out of the middle in non-emergency also.

And so I don't know if there's pallet or openness to discussing a more general recommendation that says something to the extent of what the overarching statement was for this section, which we would recommend prohibiting balance billing and guarantee a reasonable payment.

However, given the complexities of non-emergent ground transport, we could not reach a consensus as to how to move forward with that.

Something to that effect.

That would be my only addition.

Thank you.

Okay, Edward.

Yeah, everything has been said.

I think in general, still trying to get the patient out of the middle, recognizing non-emergency is very different than the emergency and emergency interfacility urgent work.

And I think the committee did a phenomenal job working through the pieces we needed for that.

The non-E on not only disclosures, but network adequacy and ability to reimbursement levels for the quality of care that's needed still needs some more work.

And that's why I voted no on that specific piece.

Okay, and Gary.

I also was planning to vote yes for this one, but in general, I absolutely support the notice provision.

It's the consent that I'm having trouble with.

And if it said something like in areas where a choice is an option, that may have made me do something different.

But I think notice is important, but the consent isn't going to work for most of the country.

Okay, thank you.

Okay, so then we'll move to option C and then discuss a few of the different recommendations in some of this dialogue that we're hearing here now.

So let's move to option C.

It is basically mirroring what we talked about, option A for 12, recommendation number 12, but under the non-emergency perspective.

And this is basically setting a national set rate for those plans that do not fall under a state balance billing.

I don't know, Terri, were you able to update through that process yet?

Or do we need to go back to what 12 says?

We'll go back here.

So basically it's going to be recommendation 14, option C, just so you can go through the payment reimbursement amounts are basically what the fully insured and other state plans are regulated.

As far as the state balance billing law, in the event that you do not have a state balance billing law or an all payer model agreement, then it will then move to more of what is happening that Congress has set as a percentage of Medicare.

If there is not a covered service that is able to be set as a percentage of Medicare, then it's a fixed amount as set by Congress or a percentage of that benchmark determined by the Congress.

And then we move into the timing of payment, which gives you 30 days.

It walks through the same construct that we've talked about in all the other recommendations.

Nothing's changed there.

And then the option under component four, it moves it to that maximum patient cost-sharing as was recommended in recommendation number 13.

So this will be modified in the recommendations we're using the components of recommendation 12, but it's tailored towards the non-emergency if things are covered.

So I'll stop there and allow for discussion.

And I see that Loren has his hand raised.

Sure.

So while I'm going to be supportive of this option, I sort of want to clarify, I think I'm like more or less supportive of all three of the options that we've discussed here.

And I wonder if there's something like getting lost in translation here.

But to be clear, those previous options, if there is support for prohibiting balance billing for non-emergency ground ambulance services, a version of those last options we talked about was let the locally set rates apply everywhere.

You can have an IDR process.

You can envision the congressionally set rate being as high as you want, right?

Like this is a pretty -- and there's a notice and consent exception there, unless I guess there's an argument that the notice and consent exception isn't broad enough and you're going to be able to balance bill whenever, but that's not a balance billing prohibition then.

So if you are supportive of a balance billing prohibition for non-emergency services, I would have expected there to be some support for a variation on one of these three options.

And I do think there is sort of like some amalgam of all of these that probably is agreeable as we move forward past this committee process.

And just sort of, I remain hopeful that there is some avenue here because this has been a little dispiriting in that sense.

All right, Rhonda, I see your hand's raised.

I think I was just a little bit lost.

I was looking at recommendation 12 option A, but I thought we voted and approved on recommendation 12 option B.

So I was just trying to figure out.

Sorry, we are using this as the premise for recommendation 14.

It's literally the same language, except we have, instead of it covering the ground emergency, it is non-emergency only.

We're just using this, it's the same verbatim.

We just didn't have time to modify all that.

PRI didn't have time to modify and put that into that.

So, for the record, just so you know, recommendation 12, it's actually recommendation 14 now.

It looks the same, except the nomenclature will change from emergency to non-emergency.

But so, my concern with option A -- are we still looking at option A under 12?

Yes.

Is that it doesn't allow local.

That is correct.

So that is correct what's going on right now with recommendation 14C.

It's basically indicating it does not allow for the local side of the rate piece of it.

Okay, thank you.

Okay.

Regina?

You answered my question, thank you.

And Shawn, I see your hand is raised.

Or is that old?

I'll drop it.

I think it was just my concern with local and it's been said.

All right, any further discussion on what recommendation 14C will be?

It'll look exactly like recommendation number 12A, except for non-emergency.

All right, we'll do the voting on that.

And I'll give that to Terra to do the vote.

Okay, Loren Adler?

Yes.

Shawn Baird?

No.

Adam Beck?

No.

Regina Crawford?

No.

Rhonda Holden?

No.

Patricia Kelmar?

Yes.

Ali Khawar?

Peter Lawrence?

No.

Rogelyn McLean?

Abstain.

Asbel Montes?

No.

Ayobami Ogunsola?

Yes.

Suzanne Prentiss?

No.

Ritu Sahni?

No.

Edward Van Horne?

No.

Carol Weiser?

Abstain.

Gam Wijetunge?

And Gary Wingrove?

No.

Okay, so I'll just go back and give those that voted no the opportunity to comment, and we'll start with Shawn.

My broad comment would be, again, that I think this whole non-emergent work is so complex and so different than the emergent.

And I agree, on the one hand, you know, another committee member said, well, it seemed like we had sort of broad consensus to cover non-emergent, but as we dove into more and more discussion on the options, including option C, it has become apparent that that is a very significant, complicated matter to try to take on.

Okay, Adam?

Yeah, actually, kind of similar.

I agree, you know, if it were just recommendation 14 without the options, that first screen, I could certainly vote yes.

And I think of the three options, this is, from my standpoint, the preference, because it keeps ERISA preemption intact, but I think there are too many outstanding questions about how the other mechanisms would work, including, like, the cost-sharing, that it looks like we're referencing directly back to recommendation, I guess, 13.

So just, I think too many unanswered questions in this to vote for the specifics.

Okay, Regina?

I would totally agree with what Adam said, and Shawn.

I just think this is too big to get our arms around, so I just think we have to continue to work toward finding something that will work.

Okay, Rhonda?

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

Peter?

Couple items.

Item one was the ability for local rates to be utilized was excluded, and that's critical in my opinion.

The second is, you know, I agree with the earlier statements that we have a broad consensus within the group that we need to work on balance billing with non-emergent as well as emergent, but this group spent most of our time dealing with the emergency aspect, and we didn't spend a lot of time with the non-emergent aspect, and I think everybody just took the assumption that we would drag them together, which is not the case.

We still, in my opinion, need to have some statements in the report that says that we need to be looking towards prohibiting balance billing on non-emergent transports, but there needs to be further discussion, and maybe it needs to be added into the recommendation we have earlier that identified that treatment in place and the cost of supplies and ALS first response needs to be established or discussed as part of a standing committee, and maybe we can add that into that that the Congress needs to look at it.

Thanks.

Okay.

Asbel?

So not to add much more to what everybody has said here as well, but I think when the committee came here through the charge and the introduction of Section 117 into the No Surprises Act, which established this advisory committee, was relative to the services that patients were receiving where they didn't have a choice.

And whether they called 911 or the equivalent or from the consumer receiving a bill because they were transported from one hospital to another for the continuous and furtherance of that emergency condition as they viewed that emergency condition within the prudent layperson standard of services that were not available to transfer them somewhere for them to get that care.

Now, I believe in a lot of our recommendations, we have addressed that.

We've addressed it through the way the definitions are, and then we've gotten to this more complicated component around non-emergency.

And I understand that we'd like to protect the insurer from everything, or the consumer, but I think that there needs to be a much more thought process through that that still allows for the markets to correct themselves.

And in those areas where the markets may not be correcting themselves, is how do we make sure that access stays.

And so, from that perspective, generally speaking, and I agree with Adam on this, recommendation number 14 and prohibit surprise billing and create a reasonable rate for the consumer for non-emergency services makes sense to me.

It makes sense to most people that look at this.

We get into the complexities of these options, and then we begin to determine that there's a lot more complexity to the non-emergency space that's outside of the purview of actually what we even begin to come in here with those lenses.

So, for that reason, I'm really strongly suggesting a key finding.

I like what Shawn has indicated as well.

So maybe we need to think through this and ask for some type of more work to be done around this piece as well in those areas where maybe the market conditions are not doing what they should be doing properly.

Suzanne?

Thank you, Terra.

So, a lot of this has been covered.

I think Asbel just summed it up nicely, and I don't feel that we can move forward.

I think it's premature here in a very complex area that is such an important part of the work that the EMS profession is doing for the entire healthcare system.

So, making this into a finding versus a recommendation so we can keep the spotlight on it and hopefully continue to work, I think is the best solution here, best possible outcome.

Thank you.

Edward?

I agree with that, that we clearly as a committee have found that we need to solve and work with the non-E complexity and get the patient out of the middle.

I think there's broad agreement on that.

It's how we do that with the nuances of rural, suburban areas that are in-network.

This space does have that done quite a bit still, right, where you've got providers in-networks and have that built, but how do you have the notice and consent?

There's a lot to it.

So, I like that idea on findings.

I do think this committee does need to come forward with something because we have been talking about it, but we've been broadly working on the emergency solve and the emergency inter-facility, and that's been an important piece of the main charter.

So thank you.

And Gary?

Nothing new to add.

Terra, you forgot me again.

Oh, I'm sorry.

Ritu.

There's one other component I just want to add to this just to make it even more complex, but as a county regulator in my state, we have the authority to regulate all ambulance service, including non-emergent, and we have chosen not to regulate non-emergent pricing, et cetera.

But in other situations, the payer mix and just the breakdown of your emergent business could be such that it's difficult to make money.

It's difficult to basically cover your cost without some component of local non-emergent control also.

And so I think that reinforces why there has to be at least the option for local oversight of non-emergent and rate setting.

Okay.

Thank you.

So what I'm hearing is generally speaking, and I believe that some of the committee members are asking how the vote process or whatever, as we wrap up, that will go around unless you have that readily available, Terra, on how many voted for 14A in the affirmative, absentia, or no.

Do you have that readily available?

For 14A, I had 11 noes.

We had Gam and Ali absent, and then Raj and Carol abstained.

And I voted yes.

And Rhonda.

So we had one, two, three.

We had 11 vote no for 14A.

And so what we will do, too, and we'll do this upon wrap-up, we have a few more of the recommendations that came forward yesterday to see about consolidating.

That was three and eight that we will have a discussion today about that consolidation based upon the way the vote went, and then do a recommendation to maybe combine the two, eliminate one, and then vote on that.

And then we'll do some wrap-up and explain what to expect next, how the voting process will happen.

Some of you have some questions that Shaheen will address as well.

So let's go to what came up yesterday, and this was a recommendation around the mandatory coverage piece, which was recommendation number three.

And there was an option to A and an option B.

And most coalesced around the option B and voted only in the affirmative of A in the event B did not succeed.

And so there were several that asked to make a very clear recommendation.

Remember, for the record, the way you voted yesterday will still be on the record and will still be a part of the report, but it will be modified based upon this recommendation B.

And this was where we recommended that ground emergency ambulance services would be covered.

And so basically, this is a planner issue offering group must provide or cover any benefits with respect to emergency ground ambulance services, including the emergency inter-facility transport as we defined in definitions yesterday, and such services when an ambulance has responded, but no transport has occurred.

This is where the piece would be not just ambulance transport, but if they do respond, transport doesn't occur, then the plan must cover those services without the need for prior auth, without the ground, whether the ground ambulance or supplier furnishing such services is a participating provider, without imposing any restrictions or limitations, and then without regard to any term or coverage of such coverage.

And so based upon that, we are putting the motion before for a vote to consolidate 3A, 3B and retake the vote on this based upon where you voted.

I believe there were -- and Terra you may want to talk through the vote, and it could be that for the report that those of you that voted yes in 3A and 3B, that you are voting that your primary recommendation is related to 3B.

That would be my suggestion for the record to vote that way.

It's not like you're asking to change your votes on 3A, 3B.

It's basically based upon comment and based upon what people said in the discussion section of 3B is that those that were voting yes for 3A, their preference was 3B, but they voted 3A.

So, I'm going to have the discussion around that for adoption of you that voted yes on 3A that the recommendation is that 3B was your preference so it could be noted for the record in the comment when we're making the recommendations in the final report.

So, I'll leave that for discussion if anybody has any issues relative to that.

We don't need to really retake the vote, but we just want that for discussion that this will be part of the -- when the final report is actually drafted and it goes around, this will be alluded to that 3B was the primary recommendation.

Any hands on that that wants to discuss?

Okay, so Gary Wingrove, your hand is raised.

So, this is the one where I raised the issue.

I still feel like we should have a recommendation for number three.

And I'm not sure where everybody was.

Can I propose that we have another recommendation that deletes what we voted on yesterday and we have a new one written that was 3B and we just adopt a single recommendation, so we're sending a single message?

And that is the proposal, is that that will be the recommendation, but public is public.

And so, the way you voted yesterday is still a part of the public record.

But for the report that is sent to Congress, this would be the adopted recommendation based upon the vote count for 3B.

Because there was, I believe, a no vote and some abstaining votes.

Shawn, I see your hand's raised.

Thanks.

Yes, Asbel, I think the way you've summarized it would work very well for me.

I think because of the public process, I'd like my original votes to always be recorded and reflected, even as we coalesce around a particular single preferred solution.

Any further discussion about that?

So, for the final report, 3B will be the primary recommendation in the final report.

Okay.

And so, the recorded votes, the way the votes were recorded yesterday when we took 3B, that'll still be recorded.

This is the primary, this is the recommendation for recommendation 3B.

All right?

All right, let's move to recommendation, I believe it's number eight.

This is where we have three different options.

We discussed this already, I believe, in recommendation 13.

We were talking about the non-emergency piece.

So many of you know I'm going to suggest the same exact thing that happened that we did with recommendation number 13 that we adopt here on recommendation number eight, which is relative to the recommendation surrounding 12 around emergency ground ambulance medical services.

And so, this would be just coalescing option A and making the referred recommended option B or C based upon your vote.

So if you voted for A, your recommendation, a preferred recommendation in the final report would be on recommendation number eight, option B.

And that would be your recorded vote.

Any discussion around that or modification or discussion that you would want to discuss around that?

Adam?

But then if you're recorded a vote for option 8C, that remains intact.

So you're only consolidating A and B?

You're exactly correct.

We're only talking about A and B.

C stays.

Okay.

You would be correct, Adam.

Rhonda?

Yes, I voted for option A, just kind of like, you know, what happened on recommendation number three.

And I also voted yes for option B, and option B is my preference.

Based upon what Rhonda reiterated, that's what I think most individuals that may have voted for both.

And so that'll be recorded in the record that option B was the preference.

And so, B and C will stand in the way the recorded votes were.

So, there'll be basically two options because A, B, and C were voted on.

B and C will be the options recommended in the final report.

And it'll be structured accordingly.

Pete Lawrence, I see your hand raised.

All right.

When you say the recommendations based on the final report, there was only one yes vote for 8 Charlie, for 8C.

So, in terms of recommendation eight, the one that's going forward -- -It'll say that the recommendation fails, and then it will list out the no's and then those that voted for it.

Perfect.

I just want to make sure that 8B is the one that the report is going to show was recommended because 8C failed.

That would be correct.

So, you would see that whether they pass or fail, everybody's vote is recorded.

Copy.

Thank you.

You bet.

So as a good point of clarification from Pete, just so you know, as we're starting to wrap on this, any more on option B and what we're talking about for the final report?

Okay.

So, I'm going to move in and then I know Shaheen's got some wrap up stuff.

Some of you have some questions about that.

She'll kind of cover that regarding now that we are public meeting.

This information's here.

And then how the stuff will be posted to the GAPB website, what we're going to be doing moving forward as we start to develop the final report and get to the draft.

I'll let her kind of cover that.

But just as a general sense, just so you know, every recommendation here, whether it passes or fails, will be in that final report when you look at it.

So, you'll know the recommendation that was put forth and then failed.

To the point that we addressed in these last two options, we will make it in the final report that those options that people were voting for in the affirmative on both, the preference to one that they want will be absolutely reported in there, even though the public record will have how the vote taking happened as well.

So just as a general matter, there's a lot to go through now with the drafting of the report, deciding technical changes.

So, anything that is substantive, we will not be able to deliberate off the record.

Most of this will be technical, augmenting different things that are related to the recommendations within the spirit of the recommendations as well.

So, I'll stop there, let Shaheen kind of walk through some of the wrap-up around what to expect next, as well as answer some of the questions that I know many of you might have around the distribution of documents, things like that.

Shaheen, are you there?

Sorry, I was on mute.

Thank you so much, Terra, for putting up these slides.

Can we go to the next slide, please?

Can you change the slide?

Go to the next.

Thank you so much.

So first, I would like to congratulate all of you on such a job well done.

Over the past six months, you guys have delved into a lot of material, tackling some really complex issues.

And your work has culminated today in a set of recommendations that I think are very comprehensive and will definitely go a long way in informing Congress and the secretaries on what they need to do next.

So, on behalf of the three departments, I thank the committee for their time and efforts over the past six months and working on these issues.

And, you know, job well done, Asbel, facilitating all of these meetings and, you know, steering the work.

And PRI, for your expert facilitation of today's meeting and voting.

Next slide, please.

So now that we have, you know, our key findings and recommendations, this winter, the committee is going to be developing the content for the report.

You know, we have all the content in the form of, you know, our notes and artifacts from our meetings.

It's a matter of compiling everything, fleshing it out, explaining, and, you know, explaining the rationale and putting everything together into the report that is required under Section 117 of the No Surprises Act.

So, I anticipate this happening this winter, you know, over the next several weeks.

And then issuing the report in early 2024, you know, after we are all happy with the wording and the formatting and, you know, we've thoroughly edited it to our liking.

So, the report in early 2024, we're anticipating issuing that to the secretaries and the key congressional committees that are responsible for regulation and oversight of the No Surprises Act.

The report will also be posted on the committee's website.

Next slide, please.

And the artifacts from this meeting will also be posted on the committee's website over the next few weeks as they become available.

Probably the presentations and transcripts will be posted first, then the meeting summary and the recordings.

So, these might be posted in a couple of different phases.

So just keep checking the website for updates.

And next slide.

And this is the committee website.

So, you will have this in the meeting notes as well.

All right.

Asbel, any final words?

I think there were some questions relative to information that was shared today in the public if that could be shared proportionally as well.

And since it is public, it can be shared by the committee members, I believe, correct?

Yes, it can be.

And then just as a matter of point of reference for the committee, there is still a meeting scheduled.

I know it probably is in your calendars for next Wednesday.

We will probably keep that as a debrief and then discuss from there relative to the ongoing meetings that we would need to have as we work through the technical piece of it.

But I would go ahead and probably solidify that meeting.

It may not go the entire two hours, but it's probably appropriate to discuss kind of what your involvement is through the drafting process of the final report.

So, I see, Gary, your hand's raised.

Yeah, I'm wondering, Shaheen, if you could be a little bit more specific on what is public that we can share.

And it would, you know, it'd be nice if it was just on our website and able to link to and people to grab to make sure whatever shared is consistent as well.

But we've had our meeting.

It should be public now, at least the materials that were displayed and subject to, you know, open records, I would think.

Yes.

So the recommendations as displayed, you know, during this meeting are now public information.

So, you know, we will post these slides as soon as possible.

You know, but if someone is asking for a specific, you know, wording on a recommendation, you would use, you know, what we've shown during this meeting on these slides.

Yeah, I'm a country kid.

I need specifics.

So, is that the spreadsheet?

So, let me just ask you directly, is the spreadsheet that we've all been working from, which up until today, we've never been able to share with anybody, is that now public?

Or what is it specifically that's public today?

Because we don't have the slides that have been displayed here.

None of us have those.

Right, we should be sending those to you shortly.

So, these slides, the recommendations as shown on these slides, you know, for this public meeting.

So, you're going to give those to us and we'll, there'll be a clear message that this is what you can share with people?

Yes.

Okay, thank you.

And as a matter of point, just as a reference, there's a lot of chat from you guys.

PRI will send out; Terra will send you out the invite for the continuation of our Wednesday when we do our normal Wednesday meeting.

You will have a Wednesday invite in your email box for you that can attend.

And Pete, I see your hand is raised.

Yeah, just a question.

Is it possible, not to ask PRI to do any more work than they've already done, but is it possible for them to just give us a spreadsheet that identifies those recommendations that passed and those recommendations that failed so that we've got that for the subsequent meetings we've got?

And again, PRI has done a great job.

You, Asbel, have done a great job.

Raj, Lee, Loren, everybody that has done a great job in the group.

I'm trying not to create some additional work, but just so we all have that information, we've got the spreadsheet.

It says which passed, which did not pass, and that way everybody's got the right information.

Yeah, and to your point, Pete, there, that is information that I would begin to kind of work through this process as they do in normal.

So, this is where Shaheen was indicating it may take a week or two as we work through, but everyone will have that information as well as that is going to be required to be posted too.

Shaheen, anything to add there?

No, I think you've covered it.

The Wednesday meeting is normal.

If any of you have some issues with that, please send an email to the GAPB website and copy the FACA website as well so we can keep track to make sure that any of the materials that we discuss -- just know a lot of this information now, this will kind of work in the same manner that it has, and then the evolution of the final report will be in draft, and we'll talk through a lot of that, a lot of those details next Wednesday as well.

Patricia, I see your hand's raised.

Thanks.

I know that you have to, like, double count and double check and whatever, but is there any way that PRI could just right now go through and say which carried and which didn't?

Sure.

Terra, is that information available to you to do now?

I know you guys are going to have to go back and listen and just make sure you have it accurate.

Shaheen, unless there's something that is an issue, I'm wondering if we can do that.

Yes, we can certainly go through each one and say whether it passed or didn't.

Sure.

So, who wants to do that?

Shaheen, do you want to do that, or Terra, do you have the ability to go and talk through which recommendations passed and which ones failed?

I don't have that available at this time.

I could send it out, but I don't have it ready right now.

So, what we'll do is -- Shaheen, do you have that?

I know some of your committee members may be keeping up with it, but I think we probably need to save that to our contractor or a DFO.

Yeah, I don't have them all recorded.

I've got the majority of them.

So, I guess I would err on the side of caution and we can lead those up.

I agree.

One of the others, I know, Pete, you may have them, but as a matter of point of reference, it needs to either be our contractor or the DFO.

We're more than happy to send it to Patricia, but that would need to be a responsibility coming from the DFO or our contractor.

Good question.

Go ahead.

I'm sorry, Shaheen.

So, we can cover that possibly at our debrief next Wednesday.

Sorry to keep you all in suspense.

Yeah, it would be great if it could be sooner.

I mean if you're just counting votes.

I mean, it's a long time to wait.

Yes.

Okay, we'll see what we can do.

I appreciate that.

Thank you.

I was doing my best to count, but it was a lot.

I agree.

Any further questions from any of our other committee members?

We want to say thank you to the public for joining us for this long two days.

I know it was a lot of work, and I appreciate the committee staying so very, very engaged through this process.

And to continue that engagement as the drafting of the report comes out, that's where the real work is going to start again.

And so, thankfully to our contractors for developing that, but as we put together some of that material, as Shaheen was indicating, it's going to be extremely beneficial for active engagement of the committee.

All right.

Well, hearing nothing else, thank you guys so much.

If you need something, GAPB website, if you'll send it to the email to Shaheen or to FACA, and we will talk to you guys next Wednesday.

Have a great weekend.