GAPB Public Meeting 3 – Day 1 (Morning Session)

Good morning, and welcome to the Ground Ambulance and Patient Billing Advisory Committee meeting. My name is Terra Sanderson, and I will be serving as the facilitator for today's meeting. Today's session is being recorded. By your attendance here today, you are giving consent to the use and distribution of your name, likeliness, and voice during this webinar. Before we dive into the discussion today, there are a few logistics that may be helpful for participation. Your meeting controls are in the toolbar at the bottom of your screen. If you need to connect your audio, follow the audio prompts that appear when you join Zoom. We recommend using the Call Me or Computer Audio options to ensure your name is synced with your audio. If you select Call Me, enter your phone number, including area code. If you have an extension, you can enter your phone number, followed by a hyphen, and then your extension. We hope that everyone has a great experience today. And I will now turn it over to Shaheen Halim.

Thank you for joining us for the third public meeting of the Ground Ambulance and Patient Billing Advisory Committee. I think that you will find that over the past five to six months, this committee has engaged in very robust deliberation and has reviewed the public comment that we've received throughout the course of the year in drafting the key findings and recommendations that will be discussed over the next two days. Next slide, please. So, I'll refresh everyone on the background for this advisory committee. The Ground Ambulance and Patient Billing Advisory Committee was authorized by the No Surprises Act of 2001 -- I'm sorry, 2021. This legislation authorized the establishment of this committee by three departments, the Departments of Health and Human Services, Department of Labor, and Department of Treasury. And this committee is governed by the Federal Advisory Committee Act. Next slide, please.

So, the statutorily mandated scope and purpose for the Ground Ambulance and Patient Billing Advisory Committee is, one, to review options for improving the disclosure of charges and fees for ground ambulance services, options for better informing consumers of insurance options for ground ambulance services and protecting consumers from balance billing. This committee is to submit a report that includes recommendations to the secretaries of the Departments of Health and Human Services, Labor, and Treasury, and key congressional committees on the issues listed above that are mandated by statute. And these topics also can include potential legislative and regulatory options and enforcement options. Next slide, please.

The timeline of activity for this committee. So, in November of 2021, the departments received approval of the charter for this committee and established the committee at that point. We published a notice, notified the public of the charter approval, and solicited nominations for membership. In December of 2022, we published a notice that announced the roster of 17 committee members. And this committee convened throughout 2023. That first public meeting was in May of 2023, during which we provided an overview of the ground ambulance industry and issues pertaining to surprise billing. And we established subcommittees at the end of that public meeting in which research would be done and potential recommendations would be drafted. In August of this year, we held the second public meeting to review the preliminary findings from the subcommittees and to provide transparency on the workings of the committee, the subcommittee, and the research that had been compiled to date. We also solicited public comment on 14 key issues during a public comment period that ended September the 5th. The public comments that had been received during that period of time and during the year earlier have been digested by the committee and have been used in drafting the key findings and the recommendations that will be discussed. Next slide, please.

So, there is an agenda for this meeting posted on the GAPB website that's hosted on CMS.gov. During the next two days, the key findings from the subcommittees will be discussed and deliberated upon by the committee, as will the recommendations that will potentially be included in the report. There will be committee discussion. There will be voting on the recommendations to include in the report by the committee, and there will be an opportunity for the public to provide public comment. Next slide, please.

There will be a period in the afternoon on October 31st during which the public will be provided an opportunity to provide oral comments to the committee. We ask that you announce your name and organizational affiliation, and you will be given approximately two minutes to address the committee. We seek to include as many public comments as possible during this allotted time period, so we ask that you, you know, keep your comments brief. Additionally, you can submit written comments to the GAPB Advisory Committee email that is shown on your screen. Next slide, please.

And after this committee meeting, we will be posting all of the meeting artifacts on the GAPB Advisory Committee website. Additionally, the committee will be compiling its report that will be issued to the secretaries. We anticipate that this will happen in early 2024, and this also will be posted on the GAPB Committee's website, and that website address is available on this slide that you see here. So, without further ado, I will turn it over to PRI and Asbel Montes to present the key findings.

Thank you. For our first session of today, we have Asbel Montes and Rogelyn McLean, who will provide us with an overview of ground ambulance and patient billing.

Well, good morning, everyone. It's a good morning, and it's really good morning for some of you that are on the West Coast. We're really glad you got to join us today as well. And my colleague, Rog McLean, who's on this committee and a representative for CMS, we kind of wanted to take the time to just first kind of give an overview of where we have been over the last six months as we have discovered, discussed, deliberated, and then came to a point where we have formed some of these recommendations that you will begin to hear later this afternoon that we will take a vote on and into tomorrow, which will culminate in the recommendations that we will be giving in this final report to Congress and the secretaries on what we should do to first make sure that there is consumer protections and disclosures, as well as to prevent surprise billing in the confines of what we have here. And so, I will go to the next slide.

And so, Rog, I'm not sure if you joined us or are on camera or whatever, but if you would like to say something as well, she and I will go back and forth and make this as conversational as possible over the next 30 minutes. Then we'll take a quick break and then we will go into some of the key finding's discussion before we get into public comment and recommendations.

Right, Asbel. I just wanted to say that I recommend that everyone listen with a very curious ear. The committee had a very specific charge to speak to Congress and the secretaries of certain federal agencies about what the committee feels led to, not only how we can address balance billing, but as we work through this, a lot really focused on how we got here today. So, to the extent that we talk about things, everything won't be all about ground ambulance. There's going to be some history. And we just invite you to listen intently and also see, you know, whether there are any other areas that the public has to offer the committee on the subject matter. But a lot of work has gone into this. And so, we appreciate the opportunity to present it to you today. Back to you, Asbel.

Perfect. And to that point, as we kind of work through some of what to expect, Terra will provide more commentary on when we move into public comment for the two to three minutes that we would like for you to engage as well, how that will happen. But to continue to capture as you hear some of the key findings and what we talked about today as well. We will go into at the very end of this presentation how we will work through the voting of the recommendations. But the next hour or two will be more of a dialogue as we continue to kind of walk through some of the information that was deliberated through and discussed and discovered. And then we'll move much more into the voting process of these recommendations and what that's going to look like and what to expect through the rest of the afternoon and into tomorrow. So next slide.

So, this is a little bit about what Shaheen kind of talked about. But we started and kicked off our meetings first in May. And that was our first public meeting. And we heard from a lot of subject matter

experts and others. And then we branched out into two different types of subcommittees. And these subcommittees looked at consumer protections and disclosures as well as a lot of dialogue in another subcommittee around the cost to provide ambulance care and what that looks like. And then what different reimbursement components could happen as well that has formed a lot of the recommendations that you're going to hear today. Through that subcommittee deliberation also came out some things that were findings that may not have necessarily been under the purview of our committee charge, but also was very essential in understanding the reason why there were surprise bills happening, how to prevent that. And then how we kind of looked at the consumer protections of that. After that second public meeting, we actually consolidated the committees into one subcommittee that deliberated, and that was chaired by myself and Rog McLean, to kind of move us through the final iterations of what you're going to hear today as well. And then after this culminating of the meeting, once we get through the recommendations and we make that through the voting process, there will be a final report that will then be crafted and then that detailed report will be released to Congress and to the secretaries and others as well. Next slide.

So first of all, we wanted to thank, and Rog and I wanted to really thank this committee because there were many, many people that volunteered their time to present. We had a lot of presenters, a lot of subject matter experts as you see here on the screen that provided much, much needed information to the committee as we begin to discover and begin to discuss through this process on how to form these final recommendations that come up with key findings. So first of all, as the committee, as the designated federal official Shaheen and the committee members and the chair, we would really like to say thank you for everybody that took the time to provide this subject matter piece as well as present information to this body as we deliberated through the process. The next slide.

And then I would like to first thank every committee member here. We actually did a round from each of the committee members to introduce themselves on here as we continue to deliberate. This will give you who they are and who they represent as a part of the committee charter as well. But wanted to say thank you. I wanted to call out specifically, though, Loren Adler and Patricia Kelmar, who actually co-chaired one of our subcommittees in the beginning around consumer protections and disclosures, really brought a lot of value to add. And we really appreciate them taking that upon them. And then Rog McLean, as well as one of her cohorts, Lee Resnick, also provided much needed information as they co-chaired another subcommittee as well. But really want to say thank you to every single committee member here that really put a lot of work and effort into drafting these final recommendations and key findings. The thing to be noted is everyone is passionate. Everybody advocated. Everybody provided much, much information that was needed for this committee to come to the recommendations that you'll hear before you today. Rog, anything to add there?

Asbel, I just wanted to echo the thanks. There's a lot of blood, sweat, and tears that have gone into this. So, thank you so much for the significant time commitment. And that goes to also to our representatives who are our colleagues in the government. We have representatives from Treasury, DOL, and I am from HHS. So, I just wanted to echo that thanks to everybody and for all the effort that's gone into getting to where we are today.

And we wanted to take the time to, I wanted to say just one thing and take just a moment and a pause. One of our committee members suffered a deep personal loss during this time. And we'd like to just have a quick moment of silence for Rhonda Holden relative to that loss with our thoughts going out to her and her family through this time. All right, next slide.

All right, and then we received numerous, numerous public comments, well over 100 plus public comments. Shaheen referred to that earlier in the opening. But these public comments came from the ambulance industry, came from different associations, varying associations, as well as insurers, consumers, advocacy organizations relative to the work of this committee. There were many questions that were put out there in the second public hearing that there was quite a large response to as well. And it really helped to form some of the recommendations that you will hear today. It'll also form some of

the detailed information that you will see in the report to that we may cite as well. So you will hear some of that in the key findings that we were able to review and look at as well with these public comments. We want to thank you for the public being extremely involved in this process, not just the committee members, because that source information was really utilized at that time to understand the workings of this committee. The next slide.

So, I'm going to turn it over to my colleague Rog to kind of go through what our charges, because you're going to hear a lot of stuff today and wonder maybe why it was a key finding, not necessarily part of a recommendation. And so, our charge was very, very specific. So, Rog is going to kind of lead us through the next few slides.

Okay. So, we're looking at section 117 of the Consolidated Appropriations Act of 2021. It's in division BB, section 117, that gives us our charge for this committee. We were put together to not only advise Congress, certain committees of Congress, but also the secretaries of Health and Human Services, the Department Of Labor and the Department Of The Treasury regarding three basic areas. One would be options, best practice, and identified standards to prevent instances of balance billing. Under this first charge is where you're going to hear us talk a lot about that history, a lot about how we got here and the best practices that have developed in the best practices that may be needed to continue to be developed to overall prevent instances of balance billing in the ground ambulance emergency medical services space.

The second part of our charge is to outline steps regarding consumer protections that the government could take both state, federal local government that could be taken by state attorneys, general state insurance regulators, state legislatures and other state officials. Again, to feed into preventing balance billing, those consumer protections that may work around notice and making our consumers more educated health care consumers. Of course, there are some terms here because we are dealing heavily with emergency medical services when folks simply may not have the capacity to know what's going on in that moment. And then as part of that, there are also legislative options for Congress that may prevent balance billing. So, it's sort of a holistic approach, how we can adopt standards, how we can make consumers more knowledgeable through the process and legislative options we can take here in the federal government to prevent balance billing. All of this culminates in a report to Congress that all of us will work together to produce, make public and produce to the recipient. Next slide.

So of course, we are focused on that No Surprises that within division BB of the Consolidated Appropriations Act of 2021. The no surprises that amend the Public Health Service Act, also amend certain areas of ERISA and of the internal revenue code and also certain aspects of the federal health benefits program, all to make sure that the enrollees in the plans governed by those laws have the benefits of the No Surprises Act and not being balance billed under circumstances that are not their cause or responsibility. Of course, the No Surprises Act right now is overseen by the secretaries of Labor, HHS, Treasury, and the director of OPM. It is quite a big operation to get, you know, four federal buildings together toward implementing one program. But we all do work together. And again, I'd like to just say another shout out to my colleagues in those federal agencies, because it is, as we all know, a brand-new program in its infancy. But I think moving forward and working hard to stabilize. Next slide.

So here.

So, let's talk about that, Rog. What is a surprise bill or a balance bill? And oftentimes they're used interchangeably. And for surprise bill or a balance bill, according to our charge, it's kind of synonymous with each other. And how is that actually defined? What we need to understand and what most people and when we keep reiterating this is really the balance bill is the difference between what you actually bill and what the allowed amount is. And that is how it's currently defined when you're talking about what is a balance bill. And that is our charge, how do we prevent balance bill? And so, you're going to hear a lot of things around, as we went through the discovery phase and when we get into key findings, talking about things that are maybe not covered, or a lot of things result in a no coverage and that is why a

patient is receiving a bill. And sometimes it's a surprise to them on why they received a bill as well. And so, we'll talk through a little bit about that. And there was some great information that was presented by others and by the National Highway and Transportation Safety Administration under GAM and DOT with the NMSIS data sets that gave us a lot of data into what to expect through that process. So, you'll hear a little bit about that as we work through that. Anything to add there, Rog?

No, I think you got it.

Let's go to the next slide.

And so, let's -- go ahead. Go ahead, Rog.

No, Asbel, go ahead.

So why does a consumer receive a balance bill or a surprise bill? And that's the key question that we are answering and trying to answer. And that is the reason for the charge of why we just weren't necessarily inserted into the No Surprises Act, because there was a lot of information that was received that Congress had to begin to understand. What is it about the ground ambulance industry and this way that they're so heavily regulated on the local level? You saw that come up, but there needs to be a recommendation to ensure patients who call 911 and they don't have the opportunity to choose who that provider is at the point of 911 and oftentimes results in them receiving some type of bill and understanding what is out of network or in network when they don't have a choice. And so ultimately, they receive a surprise bill. And in this discovery phase, what we began to learn was that oftentimes maybe there wasn't the ability for the ground ambulance service agency to contract data that was presented by some of our subject matter experts. One was some data that was presented by one of our committee members, Lauren Adler, that had data that showed that a large percentage of ground ambulance providers were out of network. And was that strategic or not? Was that a part of them not wanting to? And what we came to find out was some of it might be dealing with a lot of these entities are local government, fire departments, third service governmental entities, and some of these areas are also operated where governments look to for

profit companies. And so, there was a whole mixture of a lot of different information that began to come out in discovery that precipitated some of these surprise bills as well. Anything else to add there, Rog?

You know, Asbel, we talk about surprise bills, one of the other situations in which this often comes up is one we're all familiar with. That's when you show up to an in-network facility that you know is in your network. And let's say you're having surgery, and you have the surgery, you go home, and you get that bill from that out-of-network anesthesiologist or an out-of-network lab. Again, under circumstances that you really did not have a choice. So, under the No Surprises Act, the current act that we know ground ambulance is currently not within its scope. However, the way it works is if you don't receive adequate notice of those circumstances, the No Surprises Act is going to protect you from that surprise bill. So that's another situation in which we have people coming up with surprise bills that we're trying to -- that Congress has already addressed in the current No Surprises Act and that we are working to inform Congress on addressing those same circumstances in the ground ambulance space.

So, as we move forward, you're going to hear things, and we thought it was important to kind of talk through what we've discovered over the last six months. If you've been a part of some of the public hearings, you heard some great information from many, many, many presenters that is posted to the ground ambulance website. So, in some of your spare time, if you'd like to go back and review some of those presentations, as well as a lot of the commentary produced, give you a bit more historic. And it's important to know as we move into the recommendations and the voting, why some of the recommendations are there that we will be voting on as well. Next slide.

So, let's talk a little bit about from the discovery perspective, what we begin to learn and what really came out. And this came out through some actually before it was even implemented into the No Surprises Act as well. But the primary role of state and local government in regulating and setting rates for ground ambulance services. And so, you begin to see a lot of this. We begin to see and we begin to understand we have presenters present to us on several of the state laws that have already began or states that begin to pass regulations around ground ambulance. We begin to see more and more of that over the last year. The Policy Institute with Georgetown provided us with some great information. We really appreciate the work that they have been doing, trying to keep up with the state balance billing laws that are happening from California to Texas. And there's, I think, 12, 13, 14 of them now that are out there begin to look at and understanding this primary role of state and local government. So, what does that look like? So, the committee began to discover that. The committee began to understand different guardrails. We had several presenters from different states, for instance, like the state of Connecticut, we have provider groups from that group talk about that process that they may have to provide in order to raise their rates in the state of Connecticut. Or in Arizona. We heard from the state of Arizona that looks at different things relative to that as well. So, there's a lot of different ways of doing it across. Nothing was consistent, but we really understood that there was some primary role of state and local government in regulating and setting ground ambulance services as well. Next slide.

We then begin to look at this as well and understand, too, that there were many services that were really not covered by private insurance carriers, as well as we begin to understand, and a lot of information began to come out about certain governmental payers that may be under different statutes. For instance, like Medicare under the Social Security Act. And so, you'll begin to understand some information relative to that. What we knew is that there were different types of services that may have been provided from advanced life support, this first response -- you'll hear about this in some of our key findings, and we'll have some of our committee members talk about that. This community pair medicine concept that was out there that may not be currently covered and might result in patients getting some type of bill when they call the 911 service.

This treatment in place concept or an ambulance response that there was no transport. We saw data that was presented to us by the national EMS information system that we call NEMSA data set. It looks at, it appeared about 30 percent of calls that the 911 or equivalent response receives doesn't equate to an actual transport anywhere. And so, does this also provide some type of a surprise bill to a patient or a patient that may not have received or was not covered or something? So, lots of different things we begin to discover through this process that formulates some of our key findings and recommendations that you'll hear later this afternoon and into tomorrow. Next slide.

Then the next thing that we saw was that there was a move by insurance carriers. A lot of them when we saw this, we saw that they used the Medicare ambulance fee schedule as potentially like a benchmark of how they currently pay certain types of rates relative to ambulance. Not in all circumstances, but we did hear a lot of public comment from that. We did get an understanding from some of the data sets that sometimes there was this conversion factor that happened. So, we knew that the Medicare ambulance fee schedule did play an important role in this. And while it wasn't under our jurisdiction because it falls under the Social Security Act to say and mandate the Congress do something, you might see -- we'll talk about this in some of our key findings on how the Medicare ambulance fee schedule transitioned and happened. In the first public hearing, we did hear from the Centers for Medicare and Medicaid Services relative to the Medicare ambulance fee schedule as well. We heard from some of our other presenters from the Ground Ambulance Association side provided us the more historical context. So, we'll review that as well because as it lends into some of our key findings, as well as into some of our recommendations when we're talking about some type of percentage of Medicare or something that's happening with that ambulance fee schedule. The next slide.

And then we discovered that ground ambulance includes a lot of different services outside of just a transport. And so, what was happening there is it appeared when we kind of did some discovery work on that, that there are some response services which may not require transport. And we alluded to some of

that in some of the coverage issues around this advanced life support, first response around the response where maybe no transport occurs. This came out in some of the NMSIS data sets that NHTSA provides that falls under one of our committee members here, Dan, with the Department Of Transportation. We saw some stuff that looked at the responses where treatment may have happened, but no transport actually occurred, or this other concept that you'll hear about in key findings that might need to be looked at as well around this community paramedicine or mobile health care component that will look at some EMS and emergency services looks at as well. Go ahead, Rog.

I wanted to say on that point, one of the things that was most enlightening to me is to know that to the extent ground ambulance transport may be equipped with drugs for the patient, those are not reimbursed either. And so just as a person who is outside of the ground ambulance industry, as far as working within it, that was very surprising. So again, as we look into all the things that feed into why providers balance bill and what circumstances lead to that, all of these things culminate into the circumstances that we found.

And so, what you'll find to Rog's point is some of our recommendations as well as key findings may address very similar issues, but may urge Congress under a different act, like with Medicare or others to possibly relook at this current program and how it actually is working. And so, to give some context around that, but also ground ambulance isn't just a 911 or emergency response. It also does some things as Rog alluded to, patients in a hospital need to be transferred somewhere else because services were not available at that hospital. And sometimes that results in them getting a bill currently. And then also what is with this non-emergency ambulance transportation as well. So, a lot of discovery, a lot of things that we found that ground ambulance services include. The next slide.

And then there was a lot of discussion, we begin to understand from some of the presenters to subject matter experts to a lot of public comment on this around the different various cost sharing obligations for consumers. And this is where we begin to understand, we looked at the different things. So, if you are a Medicare part B consumer, we begin to understand that sometimes your out-of-pocket or your cost sharing amount is going to be 20% of whatever the fee schedule is. We begin to understand that if a consumer elected like a Medicare Advantage product or something like that, that there was different varying methodologies of how these cost sharing obligations to consumers might look like in various regions or based upon various Medicare Advantage programs.

And then we also look that there was no consistency in how third-party payers or private payers looked, whether you were out of network or in network outside of this, where the consumers were obligated to pay for certain non-covers versus paying this. We learned from some insurers that presented to us that some of them actually paid for services that weren't relative to transport. But we noticed in some of the data that was presented to us by the Fair Health Organization, as well as from data that one of our committee members, Lauren Adler showed, that a small percentage outside of transport showed a payment, whether that was for services that may never have been billed by ground ambulance provider, or if they did, it didn't culminate in some type of payment. So, we just begin to discover and begin to see that there were various cost sharing. There wasn't anything uniform or standard, but the only one that we saw really where there was a standard was within the Medicare Part B program where there was like a 20% cost share on the services provided. Anything to add there, Rog?

Nope. Nothing yet.

We'll move to the next slide.

You can tell we've done a lot of work here. We did a lot of discovery in this first two or three months. And it's really important to build. We also understood what was some of the consumer protections related to insurance or provider disclosure rates of the insurer. So, we kind of then begin to look and see what kind of disclosures were out there. And we asked for public comment on this. We actually asked for some of our subject matter experts, our presenters, especially in that first public meeting. And so, we begin to

understand that there were in some states and they actually required the disclosure of rates from ambulance providers via websites. For instance, Arizona was one of them that we paid attention to. Then we had a presenter present to us from an actual system in the Austin, Travis County area, which was Austin, Texas area.

And how did they actually disclose rates? Their rates were in ordinance and then posted via their website. We had some that made public comments or whatever, where maybe it was inconsistent with how they reported. Some reported, some not at all. So, we saw that there was not really a uniformity on the disclosure of rates, the transparency of rates. We even found some things on the insurer side as well, which we found that there's probably a bit more uniformity there and there's some guidance from CMS and things that they might have to put on EOB or an explanation of benefits in disclosure to some consumers after the fact. And then we saw that, and this was some information that was presented to us by some of the billing organizations that we asked to present on, is there some instances where consumers never receive a bill? And we understood that that was also a practice across the United States in some areas that wasn't consistent, but it was a practice known as what we call insurance only billing. And if you paid a tax or something in your area, there were some areas that didn't send a bill or a bill to the patient based upon that. And so it was not standard. But we also begin to understand that there was some of that out there as well. And so the next slide.

And so then we moved into discussion. So a lot of the first few months of the committee was on doing a lot of discovery, asking for a lot of subject matter experts to come in, digging down into some of the questions, going back to the stakeholder communities that we represented as members on this committee to get an understanding more, soliciting comment. You saw a lot of the consumer advocate organizations doing that, the insurers to that ambulance community, to the medical direction community, engaging with stakeholders in their area to really begin to understand and get information so we can begin to have discussion and deliberation on the formation of these recommendations. And hence the reason why we put together two subcommittees to look at this, because it was a lot of information to parse through and to be able to get to some type of quasi recommendations with all of the strong personalities available to make sure that we continue to provide the consumer access, but as well as to ensure too that patients weren't surprised in the balance billing process. And so what we looked at was in three different components based upon our charge. We knew that the charge did not currently apply to enrollees of Medicare, Medicaid, Indian Health Services, Veterans Affairs, or Tri-Care. We knew that our charge didn't fall into that purview. But what we did find out was that oftentimes the purview of these different programs kind of set kind of the tenor of where this conversation was going to go. So we knew it had to be discussed. We knew we had to come out.

And so you're going to hear after our break today, when we get into the key findings, a lot about that, that we couldn't make a recommendation, but we can make some key findings relative to that. It also looked at, how can this be included within the current No Surprises Act? Can you just insert ground ambulance services into the No Surprises Act within its current confines without any recommendations? And so you'll see something around that as well. And then we looked at this in three different categories, cost and payment structures, coverages. And then we looked at it from the provider payer consumer disclosures and protections. It's kind of formed the formation of our discussions as we begin to build recommendations and key findings around this, as well as background information for the final detailed report that you'll see issued at the closing of the charter of this committee as well. Anything to add there, Rog, before we move to the next slide?

All right, I'm going to move to the next slide.

And then Rog will kind of take through exactly where our decision point and what you're going to see in the culmination of these recommendations and findings.

So Asbel's been talking about the development of recommendations and findings. And so as a general rule, I think we can think of these things when you think of a finding, something that the committee

identified and decided was important to I'll say the evolution of balance billing in the ground ambulance space. And then the development of actual recommendations for how we suggest that Congress, that the secretaries, may actually address some of these issues and do more to prevent balance billing again in the ground ambulance space. So first again, we have our major recommendations stem around first options around preventing surprise billing. And into this goes what kind of requirements can we put in place, what kind of, again, process for landing on the appropriate rate for, again, out-of-network services would we recommend to the secretaries and to Congress?

Part of this, we believe is very important are rules around prompt payment and direct payment. First, that when these claims are received from out-of-network providers, assuming that they have the information necessary to process the claim, a recommendation around making sure that those payments are on time, that they are prompt and that when they are paid, those payments are sent directly to the provider instead of being sent directly to the patient, because that too causes a bunch of confusion. A patient gets a check in the mail and the natural tendency is to cash it. And at that point, they are still indebted to the provider and the provider has not been paid. So we do have some recommendations around direct payment. Lastly, there are recommendations on consumer protections and disclosures, both before a transport and after, if possible, that can be given to the patient to educate them about what's going on and again, further prevent the delivery of a balance bill or a surprise bill to that patient, because these disclosures are going to help them know exactly what they're in for. And woven throughout all of this will be the development and the introduction of what we call key findings that may, you know, reach back into history to basically tell the story of why we're here and how we can change course based on that history to get to a better place.

All right. Next slide.

And so what we want to do here is just at the very end, and then we're going to take a really quick break, is what can you expect and how is this going to happen? And so for our committee members, which we've already discussed this with as well, but just for the public that's listening in, how is the next piece going to continue to happen through this after we get through key findings, public comment? So I want to tell you how we've broken up the recommendations. We've broken them up into three topic areas as Rog just aligned. So you're going to hear very quickly.

You're going to see a recommendation on the NSA framework. You're going to hear some recommendations on some definitions, and definitions to ensure that everyone understands that this is how we're defining it. And so there will be recommendations made and a vote happen on certain definitions that make up the key findings, as well as the recommendations that you will hear in the votes and that we will review. Here is how the rules of the recommendations and the voting will happen. And so as chair, I will lead the recommendation. I will give the recommendation out. We will open it up for discussion with the committee. Once discussion has finalized, there will be a vote taken. And so Terra from PRI will do this the old fashioned way and we will go down the list of committee members in alphabetical order and they will either vote yes, no, or they will abstain from the vote. We will be giving the no votes the ability for up to two minutes of a comment on the record on why they have voted no. And then we will close the vote and then the motion will either pass or fail on that recommendation. You will also see that you might have a recommendation, but with several options for that recommendation.

Think of this as giving Congress a few different solutions to get to the same outcome. And that is where as a committee, we deliberated and where we defined that, you know, there's probably a few solutions to get to this same recommendation. And so you'll hear in some of the recommendations, a few solutions that will actually be voted on. There is a total of 15 recommendations that we will make. There are several of those recommendations, though, that will have several options to them where we will take a vote on each of those options as well. So this will be quite a lengthy process as we start to move through that this afternoon as well. So I will stop here. I will say thank you to all the committee members. Thank you to Rog for helping give us a historical look. We will move into key findings and I will turn this over to Terra to for a brief break.

Thank you. We will now take a short break and resume at 10:25 Eastern time with the discussion on key findings. Welcome back for session two of our morning session. We will now begin with Asbel Montes with the discussion of key findings.

Perfect. And thank you, everyone. We've allotted about an hour and 10, 15 minutes to kind of walk through some key findings. I've asked a few of the committee members on some of the key findings to give a little more context to the public as well around the findings too, that they will have up to five minutes to have a discussion about these findings too. So I will be speaking to that as we walk through a few of the key findings. But before we get to that, I want to give a little bit of background. We talked about that in the overview Rog and I did around the prominence of the Medicare ambulance fee schedule in a lot of our discussions as we were doing some discovery work. And the tie that a lot of it had from data from subject matter experts that presented, from people that presented to us. And the ambulance fee schedule was involved in some of the discussions. And while it didn't come under some of the purviews of the acts that we were talking about, the No Surprises Act, and it falls more into the Social Security Act, we thought it was a relevant point of discussion. And so what I decided to do on this initial piece moving up into these key findings was to do a little rewind on the ambulance industry as well. Many that may or may not know, while I am the chair of this, I have been involved in the ground ambulance and air ambulance industry for many years. That is my specific area of expertise, specifically on the reimbursement side of things.

And so next slide, I'm going to take you through a walk back or a look back in the ambulance fee schedule and how it came about. The ambulance industry is a relatively young industry. What I mean by that is it really branched out in the late '50s into the '60s out of the funeral home industry or out of the volunteer market. And so most people don't realize that. But in many areas of the United States, actually the funeral homes used to transport the live bodies and the dead bodies. Or it might have been a part of a volunteer system or it may have been a part of the hospital system way back in the day. Or it could have been like even if you wanted to rewind back even further where the American Red Cross was involved in doing transports. And so what happened is when we moved into the Medicare side of things and the ambulance industry began to build a Medicare program, it used to bill it under a reasonable cost or charge concept. And so many that are on this committee can probably date ourselves if we raise our hand and remember those different reimbursement methodologies under the ambulance fee schedule. You used to send a bill and it used to bill it a few different ways. You could bill it under what they called a bundle bill, meaning that you would bill everything into kind of the ambulance base rate or the mileage. Or you could actually bill it out, as Rog was alluding to, on the drugs. You could bill for drugs and different things like that.

Fast forward to 1997 and there was an act passed at that point in time to take the ambulance fee schedule under this reasonable cost into the current fee structure as people know it today. And so it was moved more into a prospective fee schedule system, more like how physicians would get paid. But in that process, they put together what they called a negotiated rulemaking committee. And basically this was comprised of several committee members, very similar to this GAPB committee, but comprised a little differently. And they worked over five years to come up with a program with the Centers for Medicare and Medicaid Services and others to develop what we see today as the ambulance fee schedule. Now was the ambulance fee schedule constructed off of data and really looking at the inner cost of things? There was a lot of work that happened through that. But ultimately the industry was given a pot of money and basically they had to distribute it amongst the different levels of service that you would see now. And so some of it became a deliberative work. Some of it became, think of it like with anything that would happen, is if one party held out and wanted more money in a certain code or others like that, then what might happen is money was put into a different fee structure code that may not necessarily have been baked in cost or anything like that. And that is what's formed the ambulance fee schedule today. And then it transitioned. So it transitioned over a five-year period to alleviate some concerns that some states have, some geographies have that might have seen a major reduction which would have caused an access issue. And Congress recognized that.

And then in 2002, these ambulance or temporary extenders happened to where there was some concern by Congress at the time that there could be access issues in super rural areas, rural America, as well as in some of the urban markets that really worked with a lot of the underserved populations. And so there has been this extender that has been a part of the ambulance industry since 2002. And it's a temporary extender. Most of us talk about this facetiously, as it's really temporary since 2002. And we're still using that extender today. And so more than likely, it's probably not temporary anymore, but it still is, and it does require a charge. And then what we talked about is there was a reiteration of maybe looking at ambulance in a different light outside of just a normal construct, you call 911 and someone takes you to a hospital. And so really, if you think about the evolution of this happening from the '80s to current, it's a relatively finite amount of time. It's not anything like some of the other payer systems, but it's relatively new as it works through some of these iterations of the reimbursement fee schedule from the Medicare perspective. And so because we're tying things to Medicare and there's a lot of discussion in the discovery work, really to understand what the Medicare ambulance fee schedule is doing within the industry. So let's move to the next slide.

And so this is typically what the current Medicare ambulance fee schedule looks like. You did see this iterating in several of the presentations in the first public meeting. They gave you just a basic background of how that formulary comes up relative to the Medicare ambulance fee schedule. So you have a base payment. So think of it like this really covers the construct of labor and other administrative type of components. And it was based off of the physician fee schedule. So it looks very similar. Like there's some areas here that it's saying, hey, when they went through that negotiator rulemaking process, they decided at the time that 70% of a portion that should be adjusted for great geographic factors was related to the labor. And so they looked at the Bureau of Labor statistics on things like that. And so you would see a geographic factor, and then there's 30% of it that is related to what they call non-labor related portions. And it looked at the relative value unit. I'm not going to go too complex into that, but that RVU system is very similar in construct to how the position fee structure works. And then there is a conversion factor that they implemented for ambulance, and all this took place within that negotiated rulemaking for that five years of that committee that put together a recommendation on how to transition the ambulance industry from a reasonable cost model and charge model into this fee structure, like a position fee structure. And then mileage is pretty straightforward. They came up with a mileage rate and it was adjusted. They did actually add a conversion factor for rural America to allow for a higher reimbursement rate from the Medicare program for the first 17 miles that you might go in a rural area as well when you're looking through that conversion factor. To the next slide.

And so what's happened here -- and a lot of discussion began to come out in, well, how do we know the cost? Because cost is really hard to find in the ambulance industry. There are some areas where you can find costs at the state level. There was some discussions around that. There was some subject matter experts and presenters that discussed around different cost models or cost reporting that would be done at a state level from Medicaid financing reports and to see if there was some work around that and information that was available to that. But in 2018, under the Bipartisan Budget Act, remember those extenders that I talked to you about since 2002? Well, they expired and Congress made them permanent in 2018 as a five-year extender, basically indicating that we also want you to do this ground ambulance cost data collection system. And so they were given a few years to onboard that, do it over time through a random sample, and then MedPAC would issue a report.

That was stalled, unfortunately due to the public health emergency of COVID-19. And so as the next slide goes, when the extender was to expire, the Consolidated Appropriations Act extended it another two years. And then there was a caveat that was put in another passage that basically indicated that the MedPAC report was going to be due to Congress after looking through the initial data, once CMS releases this initial data set, that they would have two years to provide a report to Congress on what to do with the Medicare ambulance fee schedule as it currently exists and what should be done about that fee schedule. They weren't necessarily mandated to look at different types of coverages that may not currently be covered by Medicare, but it was to take a look at the current program, take the data that

was collected from the ambulance providers that were randomly sampled to provide cost data, and then basically come back and say, in order to continue to preserve access in the communities, whether you're an urban provider or you operate in rural or super rural frontier states, what you should be doing about that program. And so after looking at all of this information, really understanding, we heard a lot of presentations in the first public committee relative to the Medicare program data related to that.

Some of the recommendations that you're going to hear later this afternoon and into tomorrow formed around some type of composite of Medicare, that we looked at this piece of it and said, okay, Medicare does take a role in this dialogue of how ground ambulance services are functioning today and how they're negotiating or lack of negotiating with insurers, as well as how does this fit into some of the local and state regulations where they are regulated. And so some of the states were starting to pass laws, balance billing laws that we begin to see from the state of Colorado that presented to us, the state of Washington that presented to us, up into some of the Northeastern states that we're looking at, they were passing balance billing laws as a conversion of Medicare if you were an out-of-network ambulance provider. And so we knew that Medicare had a primary role in this, but we also knew that our charge was not reflective of the Social Security Act. And so this is an area where we looked at this and said, okay, probably there was some key finding around this, and we need to have a discussion around this and it will be part of the final report as well. The next slide.

And so what was cost? What did cost look like? You're going to hear it discussed in one of our definitions. We're going to refer to it in a definition as well when we talk about a recommendation. But CMS actually hired a contractor to do this information and to come out, and they interviewed and they went around to many numerous ambulance services to really understand the cost, whether you were a volunteer ambulance service to a private, to a nonprofit, to a fire department, to a county-only or municipality-run service to understand the different costs. And so you see them separate that out into several different sections relative to cost, as well as also looking at how revenue and what is revenue and what other types of revenues are augmenting or offsetting costs. Because unlike other industries, what was found is that maybe there was a lot more uncompensated care that wasn't reimbursed through other types of grants or other types of programs that might be happening in other health care sectors as well. And so understanding the full picture in order for MedPAC to make a comprehensive report back really came through. And this cost data element began to look at some things like that. And so you'll see some information relative to some of the formations that are definitions around costs. And when we refer to some things, there are some things that it's actually referring to that maybe the Medicare program or CMS has already begun to do some of that deliberative work. Next slide.

And so the last slide that I'm going to land on is because why isn't the data collection available to you? And as we see from the time that that bill passed in 2018 to current, there have been several delays on the implementation of this. A lot of this was really related, unfortunately, to COVID-19 and the public health emergency through that deliberative process. Others was just trying to assimilate with thousands of ambulance services to get that data collection and work through that. And so we have subsequently been delayed with a two-year time frame from whenever CMS releases. So there has been a round of ambulance services that have already provided data collection and the contractor for the Centers for Medicare and Medicaid services are already working through that data. And once they issue their initial report on the data, the MedPAC will be able to take that data and then provide a report to Congress. But you're still looking at a few years out. And so any of the recommendations that we're talking through, all this construct is really important and has found its way into some of the recommendations, as well as many of the findings. Next slide.

So let's get into some of the key findings that we saw here. And number one was just relative to some of the cost data that we just kind of shared with you in some of this background information. And so many of the committee kind of in general, as we begin to talk through this, is really recommending that Congress continue to work with stakeholders relative to the data that comes out of here in this MedPAC report as they modernize the Medicare ground ambulance benefit. So not just look at the current way that it's reimbursed, but should it be modernized? Because the current way that it is currently

reimbursed really dates all the way back to 1997 through a negotiated rulemaking process. And so we are in 2023 with that being said. So, it has been 20 years since this payment system has really been looked at. And so, are there some different ways? You're going to see a lot of different recommendations. We could recommend to Medicare, but Medicare being one of the largest payers for ground ambulance services, probably something that needs to be looked at or Congress needs to look at. The next finding.

And so, here's where I'm going to ask some of my colleagues on the committee to kind of work through. But there are some things that really was teased out in the data. I alluded to this earlier, to where we saw data come out of the Department of Transportation under the purview of GAM, one of our committee members, through the National EMS Information Systems or NEMS, the NEMS data set, that really showed that there was a lot more responses than just transports that were coming in through the 911 or equivalent type system with some consumer calls 911 or for an emergency transport. One of those was this concept around community paramedicine or mobile health care. So, I asked Gary Wingrove, who is a representative and has done a lot of work around that, up to five minutes to provide just a contextual concept around this key finding. That wasn't a part of the recommendation, but around the key finding of some work that's been done around this that largely remains non- covered and is a non-covered component of the current Medicare program under the Social Security Act and as well as largely uncovered under anything else as well. So, Gary, I'm going to ask you up to five minutes if you will present and give general context that I know you probably share in the public need.

Thanks, Asbel. And I think we discussed me also covering the rural.

Yeah. If you'll work through community, then I'll get to that in the subsequent finding. But yes.

Okay. All right. So, thanks, everybody, for taking some time to listen to me. There are some things that we as the committee could work on and some that we couldn't. I'm going to give just a general background about community paramedicine today, but want to say that if you go to the website that Shaheen, the GAPB website that Shaheen put the link to earlier on, you can go back to May 2nd and you'll see an expanded version of what I'm going to say today. So, I'm just going to do a broad, short overview, but you can get the longer version if you go back to the May 2nd and 3rd meeting materials on the GAPB website. A couple of things I'd like to disclose. I'm the president of the Paramedic Foundation and chair of the International Roundtable on Community Paramedicine, Secretariat for the Global Paramedic Leadership Alliance and on the Government Affairs Committee for the National Rural Health Association. I'm also a fellow of the American College of Paramedic Executives and a certified community paramedic. So, what's happened over time is that community paramedicine has exploded, not only in the United States, but across the world. And we're starting to see agencies now where the volume of work that they do, they used to do 100% 911 work, and the volume that they're doing now is higher community paramedicine visits than going to ambulance calls. So that's the transition that's occurred over the last 20 years, not only in the United States but in countries that are more developed than we are in community paramedicine.

So, you'll see a definition that we're going to vote on a little bit later today and that it was an international research project. So, it covers not only what's going on in community paramedicine in the United States, but around the globe, because we'll continue to evolve. And I'd like to get to the words community paramedic. It doesn't mean just paramedics as they're necessarily defined, because the United States is the only country that doesn't have three levels of paramedic. So, it's intended to be for everybody. There is a standard, an ANSI standard that has come out of Canada for community paramedicine. The one thing that's really telling about all of the programs is they're unique and different and are tailored to the needs in their specific communities. So, no two are really alike. And in terms of history, in 1999, Kevin McGinnis coined the term community paramedics. I'm sorry, community paradox, community paramedic and community paramedicine. And that was first published in 2001 in rural health news. So, the terms have been around longer than the programs. The National Rural Health Association published the Rural and Frontier EMS Agenda for the Future. Someone in another country found that and started the

collaboration among several of us that led to the development of the International Roundtable on Community Paramedicine. And the U.S., Canada, Australia, and the United Kingdom have all been marching forward for, we'll be celebrating our 20th anniversary in Quebec City in June 2024. So a lot of things have happened. There's an international curriculum that was first developed in 2007. Version 5 will be released next year. The models, though, are the same that they were first identified in literature, generally primary health care substitution and community coordination.

So some evolution has gone on. Ambulance services or paramedic services started the original programs. Then the health care industry started getting into wanting to fund these programs. And that's where the term mobile integrated health care came along. Hospital at home programs now. And one thing I'd really like to point out to you is as you think about making public comment about the work that we're doing and think about community paramedicine as a not covered service, both for Medicare and for the insurers, the insurers are leading the way here. So, we see insurers employing community paramedics themselves. Those include Landmark Health and Elevance, insurers funneling specific patients to community paramedic agencies. That includes Medicaid managed care in Arizona, Missouri and Alabama, and a combination of payers and providers working together. Kaiser's got a hospital home program. There are post-discharge programs and primary care assistance. And then there are some independent or subscription direct to consumer products out there, including MedArrive and Dispatch Health. And there's others that I'm just not aware of. Research has been being done over the last 20 years. It's cataloged. And if you went to the National Rural Health Resource Center, you would see 10 years, there's 272 research articles that have been published across the globe. So, a little bit about the future. We have built a structure for colleges to go from certificate community paramedic program to a Ph.D. community paramedic program. There is now a master's program in Australia, and I'm sure they're going to end up here pretty soon. A lot of ACOs have integrated community paramedics into their service model.

The insurance companies are paying for it. And Medicaid in many states is covering community paramedic visits, but they're not covered by Medicare, and they're not covered by other insurances. And I think if you tie your comments directly to the consumer protection of balance billing, that would be helpful here because these services aren't covered and therefore, they're 100 percent balance billed to the patient if they're not covered. So that'd be a good thing for you to point your comments to. The National Advisory Committee of Rural Health and Human Services that the Secretary of Health maintains has also urged the Secretary of Health to start funding community paramedic programs. So how can we help? I think the states need to be careful about doing anything that stifles innovation. There is so much innovation that has happened and is currently happening in this arena that CMS and the insurance companies separate from Medicare should recognize and pay for the service as many state Medicaid agencies and insurers are, and that that be covered when it's performed by a state licensed health professional that is a board-certified community paramedic and that there be three levels of care, primary, chronic, longitudinal care, high-acuity care, unsynchronized, and high-acuity care with synchronization. And, Asbel, I'm done. I must not have went over because you didn't shut my microphone.

No, no, you were almost there. So, I thought you did a good job covering that, Gary. And to the point, a lot of this information will be in the final report, too, as we go through key findings as well as background information. As Gary alluded to, too, if you're wanting to know more information about this key finding, there is some work that was done by a lot of the subject matter experts in the public comments as well as the comments received. The next thing that we talked a lot about as a key finding was, and this came out in the NEMS data around responses that a lot of ambulance services received through 911 or equivalent that don't necessarily subsequently end in a transport. There's also another concept around where a lot of entities might provide an advanced life support first response, but it's not actually an ambulance unit. And so, I've asked Pete Lawrence, being the subject matter expert in this area to just provide a little context around. It's not something that is currently covered under any type of program under the Social Security Act. We can't really make a recommendation on that, but we did want to make that noted in the key finding based upon the conversations that could subsequently end in a patient

getting a bill, maybe not a balance bill. And then we like to talk through that if something's not covered, it is a balanced bill. But based upon the definition of the No Surprises Act, that they do receive a bill and they may not realize why they receive one. So, Pete, if you can take up to about four or five minutes, be helpful to keep us on track. Thank you.

All right. Thank you, Asbel. It is Halloween. So, get into a costume here. As the committee has heard, I'm Pete Lawrence, the deputy fire chief for Oceanside Fire in Southern California. As the committee has heard from me a bunch of times, EMS is a system and not just an ambulance transport. And we do have paramedic intercept that is ALS first response. But paramedic intercept is very, very limited in its scope. And that was upstate New York. And it's similar, though. So, the concept is out there. Many times, the first surviving paramedic that is getting to the scene of a medical emergency is not on the ambulance. It may be on a squad. It could be on a fire engine. It could be on a quick response vehicle, and it could be provided by multiple sources. By having these paramedics on these units, it allows for longer response times by ambulances and still allows the EMS system to meet the local standards that normally say you must have an ambulance in a certain period of time. This also allows for a quicker response by a paramedic when the ambulances are stuck at the hospital waiting for a bed, as all the EMS systems are dealing with right now, is the wall times. The ALS first response component is not reimbursable by many insurance companies or Medicare because they don't cover non-transport services. And the ALS first response entity critically does not have a national preventative provider identification number.

The NPI is only issued to transport entities. It's not issued to a health care provider here in the ambulance field, just the transport entity. If you don't have an NPI, you cannot bill the insurance companies. Many of the largest ALS first response services in the country, in the United States, for example, Los Angeles County Fire, Orange County Fire. They each respond to hundreds of thousands of EMS calls a year and they provide the ALS service for the community. They can't bill for it. The only way they can get reimbursed is if they bill the patient directly which causes a financial hardship, or they enter a billing partnership with the ambulance suppliers. ALS first response needs to be considered by all insurance companies and Medicare to be a covered service. And providers of this ALS first response need to be able to receive an NPI to allow them to bill directly for the service. They shouldn't have to bill the patient directly and the patient have to pay out-of-pocket or into a partnership, because some of those partnerships don't turn out all that well. The patient oftentimes receives the bill for ALS first response and is responsible for 100 percent of the amount. The lack of the insurance coverage and the lack of the ability by the NPI to be able to bill are the issues. This is a balance billing issue that is not able to be addressed by the Ground Ambulance and Patient Billing Advisory Committee. It's something, though, that Congress needs to convene a stakeholder group to address the issue. And I appreciate that the findings are going to address that. It is imperative that ALS first response be considered a covered service. It's an EMS service by insurance companies and Medicare. And it is also imperative that an NPI be issued to a non-transporting ALS first response service, regardless of whether they provide transport or not. The key issue is we're providing health care services and we are not being reimbursed for those services. So, Asbel, at three and a half minutes, I hope I made you proud.

I'm like blown away, like good for you. You did a really good job bringing that out. So, it must be the spirit of the holiday. So, you heard a little bit about some of the key findings here. There's also some things, and Rog reiterated this earlier in our overview slide, about beginning to understand that maybe the industry wasn't getting paid for certain types of high-cost drugs or ancillaries. I think a lot of us like to use at times when the EpiPen became very, very expensive at the time and a lot of other health care industries were passing that cost on. The industry wasn't able to do that. So, there's a lot of things happening around that that maybe needs to be looked at, medical equipment, oxygen, other type of ancillary supplies, and maybe the construct of the program or the system if you're going to tie something to Medicare, needs to take a look at that as well. And some of these different non covered pieces, too. So that's one of the key findings that we begin to find out through the process as well. The next thing that we looked at as well was relative to the next slide. Was relative to out-of-pockets and the out-of-pocket obligation. We talked about this and briefly just referenced it around the Medicare Advantage programs and those programs where it appeared to be different. Information started to come out on that.

There were some presentations that the subcommittee received from other stakeholder groups that provided us with some background information, either in subcommittee as well as alluded to in some of the public comments, as well as many of the public comments that were received in the public presentations. And so, these Medicare Advantage programs are what technically are under Part C if you're a Medicare beneficiary. And because we couldn't look at certain things relative to the information relative to Medicare under the Social Security Act, the advisory committee did see that maybe the committee needed to look at doing some type of maximum out-of-pocket protection for beneficiaries or consumers that were under Part C program that utilized ground ambulance services. It was noted in several of the public comments that in some regions of the country, some were experiencing out-of-pockets of $300 or $350 depending upon the Part C program, and many of them may be under $100. But it was widely varying across the board. And so, this was another finding that came out of it where we urge Congress or the secretaries to look at the different types of Medicare and out-of-pocket programs relative to the Part C programs. And then the last finding, key finding number four is somewhere around there was a lot -- and this will be the next slide -- was around more around the rural, super rural and medically underserved areas. And while we couldn't really find anything under the Social Security Act to change that, there are some components of the ambulance sector, especially like under critical access hospitals where there might be an ambulance service. And I've asked Gary to provide up to a five-minute piece and just discuss some of the work that he personally has been involved in with the rural health associations and others relative to this as well.

But it should be noted, too, that MedPAC did provide a report to Congress in 2016 that actually specifically addressed some of this issue around incentivizing these areas to protect access to some of the rural and underserved areas that Medicare pays for by maybe looking at paying that in a different component in the way they currently do today under a system that's 20 plus years old as well. So, Gary, if you can take three to four or five minutes specific to that, kind of keep our comments as succinct as possible, we do have some time here and then we will take a lunch break. Go ahead.

All right, thank you, Asbel. And again, I'd encourage people if you're making comments about this to reference the consumer protection part of our charge, because whether you have an ambulance service at all is a consumer protection. So, a couple of disclosures. I'm a fellow of the American College of Paramedic Executives and a certified community paramedic, president of the Paramedic Foundation, and a member of the Government Affairs Committee of the National Rural Health Association. The big problem we're having with rural ambulance services now is it used to be easy to get people to volunteer to work on the ambulance and getting a payment for an urban area sort of fit that volunteer model so we never paid attention to it. The problem we have now is you can't get volunteers anymore. And we need to keep the education where the education needs to be for people that are going to make split-second decisions on whether you live or die. And so, the concept is that we should move to a model that has a floor of one full-time ambulance service anytime we're looking at cost, and that we look at doing a cost plus rural ambulance reimbursement like the critical access hospitals have.

The rural ambulance services are the same as every other ambulance service, their costs are relatively the same if you staff a full-time operation, it doesn't matter if you're in a small town or a big town, you might have a little bit more labor cost in an urban area than you have in a small town, but it still costs a lot of money to run an ambulance service. So, some work was done by the University of Maine that I got to participate in and a couple of papers have been published since I first delivered this talk on May 2nd or 3rd, which again you can find if you go to the link that Shaheen gave earlier and click on the meeting materials for that session. The University of Maine did some work with an expert panel and looked at the cost of providing ambulance service in three rural tiers. The first rural tier has to do with ambulance runs per year of less than 800 and then 1,500 and then 2,200. So, there's a paper now that scientifically came up with a method to describe what those costs are and of course the problem is the volume. If it costs you $1 million to operate an ambulance service, which it does, you divide that by 1,000 runs, it's a lot of money to do a run, but if you can push that to 2,000 or 3,000 runs, it's a lot less expensive.

The other paper of significance that came out since we had our session, and if you look at my talk from May, you'll hear me talk about a couple of slides that were missing, they should be in the new set, but that has to do with ambulance deserts. The University of Maine used some of the researchers and some of us as advisors to come up with areas of the United States that are not covered by ambulance service using a definition of there should be an ambulance station within 25 miles of where you're located. And so, there are maps for many of the states that are included in that report. If your state is missing, it's because your state didn't provide the location data for ambulance service locations, but that link for that should also be in the -- I haven't looked for it today, but it should be in the public meeting stuff for today or that we had in May. So how can the government help? Well, we need transparency from everybody. We need the insurance companies to be transparent about how they try to contract with rural ambulance service on whether they base it on cost. We need to have some cost reporting adaptations made, like a floor of one full-time ambulance service.

And what I think we really need is a critical access hospital-like cost plus payment option for rural ambulance services so they don't have to be volunteer anymore. I don't keep track of it, but Matt Zavadsky has a website somewhere where that shows there have been 72 failures of rural ambulance services. I believe that's the way it goes in the United States in the last two years. And so, the consumer protection of whether you even have an ambulance service is really important in this arena. And Asbel, I'm going to stop there. There's more available on the talk that I did in May.

Thanks, Gary. And thanks to several of you for talking about some of the stuff that kind of came out in the discussion and the discovery side of what we were doing. But really, there wasn't enough data around to make very specific recommendations on what should happen, given the charge, given the timeframe that we were under to produce this. And so, some of this is findings that we strongly urge Congress to continue to look at, to review the data that's already been out there, that's been published by, I know some, as Gary was speaking, but other entities such as the Medicare Payment and Advisory Commission, which advises Congress on different payment mechanisms and how they should look at something. So strongly encourage to maybe look at this type of report specifically as it deals with the Medicare program. And then as we move into our recommendations components later this afternoon, you will see some other recommendations that the committee will vote on relative around the charge that governs ERISA and others relative to this information as well. So, I appreciate some of the committee members talking about what their passions are, as well as providing information relative to some of these key findings.

There were a lot of findings and there's a lot of background information that is going to be available in the detailed report and some of the report as we work through the recommendations and some of these key findings. But these are some of the ones that were just brought to the surface that there was some dialogue on that maybe there couldn't have been a recommendation or position made as we went through the process, but was key in how the cost of services and providing that and how it is looked at in general when you're talking through the prevention of balance billing as well as consumer protections, too. And so, I think here is we're definitely ahead of schedule right now, but this is probably about the only time we're going to be ahead of schedule. And so, by this afternoon, we will be working through the recommendations in the public comment period. And so, Terra, I'm going to turn it over to you to give the public, especially those that I know are probably wanting to make oral public comment. What they can expect when we come back from our break, which is going to be 12:30 eastern time and 11:30 central, and you on the West Coast, it's probably your breakfast break as well. Terra so; give them an understanding of what to expect through this oral comment period. And then if they do not make it, then what to expect after that.

Okay, thank you. When we return, we will be doing the public comment. To participate, you will select the raise hand feature located in the bottom of your toolbar at the bottom of the screen. And then the host will see that you have your hand raised and invite you to speak. The participants will be given two to three minutes to provide public comments. And when providing the comments, we ask that you provide your name and organization. If we are unable to get to you today, you will be sent a survey link

via email at the conclusion of the two-day meeting to submit the public comment, or they can be submitted to the GAP mailbox. So, with that, we will take a midday break and resume at 12:30 eastern.