Ground Ambulance Providers and Suppliers: Data Collection System Listening Session

Moderated by: Diane Maupai
June 28, 2018—1:30 pm ET

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® Event. All lines will remain in the listen-only mode until the feedback session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect.

I will now turn the call over to Diane Maupai. Thank you. You may begin.

Announcements & Introduction

Diane Maupai: Thank you, Dorothy. This is Diane Maupai from the Provider Communications Group at CMS in Baltimore, and I will be your moderator today. Welcome to this MLN Connects® Listening Session on the Ground Ambulance Data Collection System. MLN Connects events are part of the Medicare Learning Network.

During this call, you'll have an opportunity to recommend what we should consider in developing the Ground Ambulance Data Collection System required by the Bipartisan Budget Act of 2018.

Before we get started, I have a few announcements. If you've not already done so, view or download the presentation from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the webpage, select National Provider Calls and Events, then select June 28 from the list. And that's actually the first item on the list.

We are recording this call and we'll post the audio recording and transcript to the MLN Connects call website. We have two MS – two CMS speakers today: Kim Campbell, Technical Advisor of the Hospital and Ambulatory Policy Group, and Amy Gruber, Health Insurance Specialist, the Division of Ambulatory Services.

I'll now turn the call over to Kim.

Presentation

Kim Campbell: Thank you, Diane. Good afternoon, this is Kim Campbell. I would like to personally thank everyone for taking time out of their busy schedule to join us for our first discussion of the legislation Congress passed back in February 2018 to collect cost and other information from ground ambulance providers and suppliers.

On behalf of myself and the rest of the CMS team, we'd like to take this opportunity to recognize all the dedicated personnel and their support staff that serve and protect their communities every day. And we're looking forward to working with all of you on this project.

I'd first like to emphasize that the success of this project is very important to all of us at CMS. And we are dedicated to being as collaborative with the entire ambulance industry as we can to ensure that we collect the information Congress needs to better understand the adequacy of payments for ground ambulance services as well as the geographic variations in the cost of furnishing the services.

Amy Gruber will provide you with an overview of the legislation and its requirements in a few minutes. But I wanted to take – I wanted to give you a brief snapshot of the activity CMS is currently engaging in. CMS is in

the early stages of working with our research contractors to gather as much information as we can to help inform our proposals regarding the data collection tool and the sampling plan.

Our information gathering will involve such things as analyzing Medicare data, analyzing existing literature sources and reports, and other documents that will help us to better understand the ambulance industry and the many kinds of business models the industry utilizes. But a critical part of our initial research is listening to your helpful thoughts and suggestions throughout – through stakeholder engagements like this one. Equally important, we'd like you to know that we're receiving and taking into consideration the information some of you have already provided, and we will continue to do so as more of you share information with us.

I'll take a minute to highlight some of the information sharing resources that are specific to the ambulance industry. First, the Ambulance Open Door Forum. CMS periodically hosts Ambulance Open Door Forums to share information and receive input from the ambulance industry. We strongly encourage you to sign up for our listserv, if you haven't already done so, so you'll be alerted to upcoming meetings where we will continue to share information about this project as well as other information relevant to the industry. Also, we invite you to reach out to us through our Ambulance Open Door Forum mailbox to share your ideas on implementing this legislation.

Links to these resources are provided on slide 10 of the PowerPoint presentation. Please share this information with your colleagues or members who cannot be here with us today.

Now let's move to slide 3 and talk about the agenda for today's meeting. Our plan for today's presentation is to first give you an overview of Section 50203 of the Bipartisan Budget Act of 2018. Also on slide 10, we have provided a link to the legislation.

We would then like to hear your thoughts on the legislation and what we should be thinking about from your perspective as we begin implementation. We have provided some initial questions to guide the discussion on slide 8. We ask that you please be respectful and allow time for the rest of your colleagues to provide their input as well.

I will now turn the microphone over to Amy Gruber, who will give you a brief overview of the legislation. Thank you.

Section 50203 of the Bipartisan Budget Act of 2018 Overview

Amy Gruber: Thank you, Kim. Moving to slide 5, I will be providing a general overview of the statute under Section 50203. Listeners should refer to the BBA of 2018 for more detailed information regarding the statutory provisions.

Section 50203(a) of the BBA of 2018 includes an extension of the Ground Ambulance Add-on Payments under sections 1834(l)(12) and (13) of the Social Security Act (the Act) that were set to expire December 31st, 2017. They're now extended through December 31st, 2022. The Temporary Add-on Payments include a 3-percent increase in the base and mileage rate for ground ambulance transports that originate in rural areas, a 2-percent increase in the base and mileage rate for ground ambulance transports that originate in urban areas,

and a 22.6-percent increase in the base rate for ground ambulance transports that originate in super rural areas.

Section 50203(b) of the BBA of 2018 adds a new paragraph, (17), to section 1834(l) of the Act, which directs the Secretary to develop a data collection system (which may include the use of a cost survey) to collect cost, revenue, utilization, and other information determined appropriate by the Secretary with respect to providers and suppliers of ground ambulance services.

For those not familiar with the process, CMS will develop a data collection system and intends to publish proposals to implement this legislation and a *Federal Register* Notice of Proposed Rulemaking. The public usually has 60 days to comment on the proposals. The public may submit their comments in four ways: electronically through www.regulations.gov, or by regular mail, or by express mail or overnight mail, or by hand or courier. Each comment received timely will be reviewed. Comments will be summarized, and responses to the comments will be provided in the Final Rule. Final determination for the proposals will be published in the Final Rule.

Section 50203(b) states that such a system should be designed to collect information needed to evaluate the extent to which reported costs relate to payment rates; on the utilization of the capital equipment and ambulance capacity, including information consistent with the type of information described in section 1121(a) of the Act, and on different types of ground ambulance services furnished in different geographic locations, including rural and super rural areas.

Not later than December 31st, 2019, the Secretary must specify the data collection system and identify a representative sample of providers and suppliers required to submit information under the data collection system for the first year. The provision states that no individual provider or supplier should be included in the sample in 2 consecutive years to the extent practicable.

This provision includes a 10-percent payment reduction to the ambulance fee schedule payments made to a provider or supplier that is required to submit information under the data collection system with respect to a period and does not sufficiently submit such information as determined by the Secretary. The Secretary may exempt a provider or supplier from the payment reduction with respect to an applicable period in the event of significant hardship, such as a natural disaster, bankruptcy, or other similar situation, that the Secretary determines interfered with the ability of the provider or supplier to submit such information in a timely manner for the specified period. The Secretary must establish a process under which a provider or supplier may seek an informal review of a determination that the provider or a supplier is subject to the payment reduction.

Moving to slide 6, not later than March 15th, 2023, the Medicare Payment Advisory Commission (MedPAC) must assess and submit to a – must submit to – a report to Congress on information submitted by providers and suppliers through the data collection system, the adequacy of payment for ground ambulance services, and the geographic variations in the costs differentiating such services. Contents of the report are to include an analysis of information submitted through the data collection system, an analysis of any burden on providers and suppliers associated with the data collection system, a recommendation as to whether information should continue to be submitted through such data collection system, or if such system should be revised and other information determined appropriate by the Commission.

This provision also states that the Secretary should post information on the results of the data collection on the CMS website as determined appropriate by the Secretary.

Back to you, Diane.

Information Gathering

Diane Maupai: Thank you, Amy. So on slide 8, you will find the five topics that we would like your input on today.

Number 1, What specific comments or concerns do you have with the legislation? Please include potential solutions or things to consider to alleviate those concerns.

2. What data elements should we collect and why?

3. What costs would be difficult to define and report and why?

4. How can we address potential cost variations among providers and suppliers?

5. How else – what else should we consider?

Feedback Session

We're now going to take your comments. But before we begin, I'd like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, please limit your comments to 3 minutes or less. Your comments are important. And if you have more, I'll tell you a few ways you can pass them on to us. All right, Dorothy, we're ready to take our first comment.

Operator: To provide feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you are providing your feedback, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the roster.

Please hold while we compile the roster.

And we have Kathy Lester online.

Kathy Lester: Hi, thank you. This is Kathy Lester on behalf of the American Ambulance Association. First, Amy and Kim, thank you so much for having this call. We're very pleased with CMS providing the opportunity for broad input from the entire ambulance community.

I just wanted to comment a little about the legislation and the structure of it because I think this is something the American Ambulance Association, as you know, spent a lot of time with The Moran Company as well as non-AAA members trying to identify what was the best way to collect costs. And so as they – Moran Company concluded an Acumen when it looked at the issue for HHS, the traditional Medicare cost reporting system, which was created for cost-based reimbursement, doesn't really work for this industry. So we were very pleased that the Congress did not move in that direction.

We also know that there was some discussion around providing Medicaid cost data or using the Medicaid cost report system. But as you know, Medicaid cost reports are really nothing like the data that Medicare or the Congress would need to reform the ambulance system. So as we work on this, it's important to make sure that we get systems that are implementing – that get the right data to allow decision-makers to really take a hard look at the ambulance fee schedule and other potential future programs like community paramedicine to be able to move this benefit forward.

And I think our concern around the Medicaid cost reporting has focused on the fact that you have different states and different data elements, and there's no standardization of that information even in the states, let alone across the states. Not all the states require reporting costs. And those that do, many of them, it's only a voluntary option for certain state-level programs, so it doesn't seem to fit into the model that Congress intended.

And then finally, you know, the state Medicaid cost reports do not follow the CMS data elements, the accounting principles, or the allowable costs. So we hope that in this exercise, what you all are looking at is creating a system that uses the data elements, the accounting system that you use for traditional cost reporting, but have a different structure that really aligns with where I think the Congress was moving forward to keep it as a minimal burden on providers and suppliers, but yet get that statistically appropriate information to make decisions with. So thank you, appreciate the opportunity to comment.

Diane Maupai: Thank you, Kathy.

Operator: Your next response comes from the line of Erik Rohde.

Erik Rohde: Good afternoon, Erik Rohde with American Medical Response. We are the largest ambulance service provider nationwide. And I currently work with AMR on a large urban service. I also agree that cost survey is the right approach. Ambulance providers are paid on a fee schedule, not off of cost reports. It doesn't make much sense in my eyes with regards to government or ambulance services taking on a burden of that magnitude, which a Medicare Cost Report would be, without having the upside of some immediate increases in rates. I'd urge CMS to get the right data so that, on the going forward, stakeholders and policymakers can reform the system, stabilizing emergency services, but also with an eye on the future to bring forward innovative care models in this market, specifically looking towards things such as community paramedicine and assessment and treatment without transport. Thank you.

Operator: Your next response comes from the line of Darrel Donatto.

Darrel Donatto: Hi, this is Darrel Donatto. I'm with the Town of Palm Beach Fire Rescue and the Florida Fire Chiefs' Association.

I just wanted to make sure that there's consideration given to the wide geographic differences, differences based on locality difference, volume of emergencies and runs, demographics of the population, including age, health, access to care. All of those things and others are going to create different costs in different localities. And so both variable and fixed costs will be different depending upon those things. And so that has to be a reality to the system. There are going to be areas of the country that it's going to cost more to provide service than others as it does today.

Also, want to make sure that it's important that, in considering the way costs are currently structured, a lot of those costs are not being reimbursed through Medicare. The taxpayers are subsidizing a significant portion of costs in most governmental-based providers, and that needs to be taken into consideration: How much of this is being supplemented by taxpayers as well?

I do want to suggest that, under the current Medicaid system, there are cost reporting mechanisms that are being used. They're being used widely throughout the State of Florida with great success. And so they may provide some insight into some of the things that should be considered when tallying total costs. Thank you.

Operator: Your next response comes from the line of Aarron Reinert.

Aarron Reinert: Good afternoon. My name's Aarron Reinert. I'm the President-elect of the American Ambulance Association and ambulance provider in rural parts of Minnesota and Wisconsin. I just wanted to, again, as many of the speakers have done so far, thank you for this opportunity to be part of this conversation. This will obviously be a big undertaking for the ambulance industry, especially providers in small rural parts of our nation.

As you began your comments, you had mentioned that part of this process might or would include the publishing in advance of the process, the data elements, the definitions, and maybe even things such as the cost collection, spreadsheets, and tools. I just wanted to thank you for that if that's the process moving forward and just really validate how important that step would be in allowing the ambulance providers and the ambulance industry to be able to get accustomed to those, but most importantly to ensure that that process works well and the quality and quantity of data collected through that is very much meaningful and accurate and reflects the actual operations. Thank you very much again.

Operator: Your next response comes from the line of Nancy Horn.

Phil Horn: Yes, good afternoon, this is Phil Horn. I'm Vice President for Medical Compliance Services. And my response is kind of on the same lines as what Darrel from Florida talked about where tax-based services can afford to pay their paramedics and EMTs a higher rate than a non–tax-based subsidized service. There are services in Kentucky that pay paramedics $12 an hour. So when you are reporting costs from tax-based services vs. non–tax-based services, there's going to be a huge variance in what's subsidized by the taxpayer. So that's definitely something that needs to be addressed.

Operator: Your next response comes from the line of James Finger.

Jim Finger: Hi, this is Jim Finger. Thank you for the call. I'm from Regional Ambulance Service, a rural service in Rutland, Vermont. As I look at the data elements from CMS and using the traditional Medicare cost

reporting, it seems a lot of those will align in the accounting where – goals will work. However, there are some exceptions that I'd like to highlight and be happy to send a followup letter on. For example, important to distinguish among the different types of labor and ambulance services; EMTs; paramedics; AEMTs; critical care paramedics; nurses; and drivers; as well as the different types of costs, including medical directors; communication equipment, including interoperability devices, are all – other devices with costs that – like the vehicles that might not be included in your survey that are currently out there: maintenance, gasoline, leases, depreciation, tools, operating costs, storage—they're all things that I think have to be taken into consideration for the cost. And they're very high in a lot of areas. I just wanted to make you aware of those and thank you for your time.

Operator: Your next response comes from the line of Tim Wolters.

Tim Wolters: Yes, thank you for the call and the opportunity to comment. I work with a rural hospital in southwest Missouri. We operate ambulance services in four rural counties. And as a hospital-based provider, I would acknowledge the hospital cost report is not the best tool for this data collection. But I would say there are some principles that are used throughout the hospital cost reporting process and in particular things like the Wage Index Survey and the Occupational Mix Survey that might have useful guidance as CMS develops their reporting tool. For example, the hospital cost report only collects salaries by department of the hospital. I'm sure you'll want a greater breakdown of labor into various categories of personnel. And that's where things like the Occupational Mix Survey principles might be useful as you develop your tool. I would also mention that, as far as certainly the volume of services will be important to report, using Medicare definitions will be very important as far as the number of transports and mileage, things like that.

And I would encourage CMS to use tools already in place, at least for hospital-based services billing on a UB where the PS&R system collects claims data. I'm not positive on the freestanding side how – what kind of collection is already available. But I would encourage CMS to use tools that are already in place to avoid the need for providers and suppliers to invent collections where CMS already has tools in place that would offer opportunity to collect that data. Thank you again for the opportunity to comment.

Operator: As a reminder, to provide feedback, press star followed by the number 1 on your touchtone phone. Your next response comes from the line of Rebecca Williamson.

Rebecca Williamson: Hi. And like many others, thank you so much for allowing us to have this input. I'm – I am from Pafford EMS in Arkansas. And I wanted to highlight the importance of having a separate category, much like Mr. Wolters said, for the differences in medications and equipment that are kept on an ambulance and to make sure that these items are not lumped into some other category. Medical supplies, pharmaceuticals, medical equipment, and even some telemedicine items are some of the most expensive costs that ambulances incur. Different states have different rules on the impacts that impact the cost of these services. An example could be – excuse me – that, in some states, ambulances are required to provide certain medications or pharmaceuticals but not in others. And it's important to keep these costs separate so that CMS understands the impact of them on the ambulance services. And this data could be used to think about case-mix suggestors or other outlier payments in the future as well. And I appreciate you allowing me to comment. Thank you.

Operator: Your next response comes from the line of Jamie Pafford.

Jamie Pafford: Yes, thank you. I'm Jamie Pafford with Pafford EMS in Hope, Arkansas. And I also represent the Arkansas Ambulance Association as well. My family operates many small rural and super rural ambulance services in communities that basically depend on us. And many of those do not have hospitals available. So our services need to become more vital at that point.

One of my points today is that without the rural and super rural add-ons that we currently have, we would not be able to operate in these areas. And although I currently do not file any type of cost report, I am very supportive of a statistical sampling approach because I believe it will give you meaningful data while not burdening suppliers that have not ever done this before. We feel that we're already being paid less than what it costs to provide the services in these rural and super rural areas, and we want to make sure that you do take this into consideration. Thank you for the opportunity to give you our comments today.

Operator: Your next response comes from the line of Alan Guggenheim.

Alan Guggenheim: Yes, I am an owner of a Sensible EMS in core rural South Texas and also member of the Texas Ambulance Association board. In rural areas, obviously as many people have said, it is impossible to break even and to cover costs to the current reimbursement level. So one thing we want to insist on is to make sure: (1) that all the members of the industry, including the software providers and all the other technology providers that might be used more and more by some of the ambulance providers, are early on involved so that we can reduce the cost of putting in place that cost reporting structure, and number (2), one of the big issues also is that, frankly, tax-supported ambulance companies, states, cities, counties have a lot more money and use very high–end expensive equipment that the small providers might not be able to afford.

So just reporting the cost of how we do business today does not mean we do everything we should be doing with the right people, equipment, the right pay level that somebody else has mentioned. So there must be a dimension also in the reporting saying not just what is your current cost, but what should your cost be if you want to provide good service. Thank you.

Operator: Your next response comes from the line of Katrina Sanders.

Katrina Sanders: Hi, thank you. I'm calling from the Matanuska–Susitna Borough in Wasilla, Alaska. And I just wanted to also thank you for the time that you're putting into this so that we can get a good idea of what we're looking at. But I'm – my main question is that, in a – I hope that there's some way we can include some of the rescue costs of getting to some of our patients. As a super rural community, a lot of times we can't get directly to the patient without an additional vehicle that goes, say, into a snow machine or a four-wheeler type environment to begin the service at that point and then put them on the bus. And the only thing we get reimbursed for, of course, is from the moment they are actually put in the ambulance, where we are spending a lot of money just to get the ambulance – to the ambulance – or the patient to the ambulance in the first place.

I'm wondering if those kinds of expenses are going to be included in your research and part of the cost of getting those patients. Thank you.

Operator: Your next response comes from the line of Matt Zavadsky.

Matt Zavadsky: Wow, you did that very well. Congratulations. Hi, Matt Zavadsky with MedStar here in Fort Worth, Texas, also the President-elect for the National Association of EMTs. And much like others have said, this is a great way to kick this off. So, thank you, CMS and team. Much as a couple of other folks have said, you need to look at variations based on system design. So you could have urban areas that are served by very different types of providers that generate very different types of costs. So, balancing efficiency with potentially inefficiency, not rewarding inefficiency or crediting efficiency, if you will—in Texas, they have a rather robust Medicaid reporting system. And much like Kathy Lester had reported and others, that may or may not have any applicability. But the state has given all of the providers the costs that were reported by the various providers, and there are groups of providers that work in very urban areas that have two to three times the costs of other types of systems, like high-performance EMS, public utility models, etc. So, you're going to have to try and work with us to balance that out, maybe through representative sampling for different types of urban or rural, or super rural models so that we can account for all of those different costs.

I know that any EMT and a number of folks are also very interested. And as you go through this process – and the legislation is very specific to the cost sampling for and data sampling for traditional "you call, we haul" ambulance service, but as you go through this process, begin to evaluate alternate payment models for EMS, like many of the commercial providers or commercial payors are starting to do, that will yield much more benefit for CMS as well as for the patient. Thank you.

Operator: Your next response comes from the line of Rebecca Williamson.

Larry Clark: Hi, this is Larry Clark with PEMS. We operate in multiple site, urban, super rural, and urban areas. As many of the commenters have already commented, I want to reiterate the importance that CMS will get collecting the fiscal and general information as part of the cost collection process. This way, information needs to be about the type, size, the service area of the ambulance services, as well as utilization patterns. This information allows CMS to identify the appropriate sample of each group of ambulance services and to assure the collection is done in a statistically appropriate manner, and the costs for these different types of services are represented accurately in the resulting data. Again, thank you for the opportunity to comment.

Operator: Your next response comes from the line of Angie McLain.

Angie McLain: Yes, I'm with Oklahoma City in Tulsa, with one of the largest providers in Oklahoma. And I just want to reiterate what some others have said and especially what you've spoken to about providing the information out to the stakeholders prior to the release of the cost survey, and how important it is to have standardized definitions for the cost surveys so that we can protect our add-ons in moving to new payment models and we're providing and submitting correct data that CMS wants. We would like to see – it would be nice if we can preview the standardized definitions prior to the release of the cost survey to have an understanding and to have input into that information. Once again, I also appreciate this call today.

Operator: Your next response comes from the line of Jason Albert.

Jason Albert: Thank you for giving us this opportunity. I think that this has been great and really useful. I'm Jason Albert. I'm with Fort Bend County EMS in Fort Bend County, Texas. And again, I'm going to say some of the same things. We've had the benefit of the cost reporting here in Texas for some time with the Medicaid. So I think that there are standards out there that wouldn't be burdensome to get. But I think it's important to

understand, in whatever survey that you do, that we capture the distinct difference between emergency ambulance service and non-emergency ambulance service in those agencies that do a combination of. Because as some of my colleagues have said, costs are more expensive for the government providers who are able to provide for their constituency a robust emergency ambulance service that does have higher costs to attract the right ambulance provider to take care of those patients. But with the artificially low reimbursement rates that we incur from CMS and from Medicaid, it tends to inhibit anybody other than a government entity to be able to give those high standard – higher standards to the beneficiary.

The other thing that I think would be beneficial for HHS to consider in collecting data would be the untoward impacts that the ambulance industry incurs, specifically to the emergency ambulance service from private, non-CMS payors when they use the CMS Pay Fee Schedule as a basis to reimburse for ambulance service rather than the cost. Because there's an increased cost, if you will, for us to provide those services that, because the government—again, as my colleagues have said—has the benefit to be able to endure, a private organization may not be able to endure that cost. And so I think there needs to be a way to quantify what the farther reaching impact of the fee schedule is beyond just the government's budget. Thank you.

Operator: To provide feedback, press star followed by the number 1 on your touchtone phone. Again, that is star 1 followed by – star 1 to provide feedback.

Your next question comes from the line of Ashley Galvin.

Britney Tomcheston: Hi, yes. I'm representing St. Christina's EMS. On behalf of Ashley Galvin, my name is Britney Tomcheston. And once again, thank you so much for including us in this. We most certainly do appreciate it. One of the things that I want to touch on and I've heard several other providers touch on is just making sure that we add in the ALS, the BLS, and ICU. Of course, the cost for each of those differs. And there's some private ambulance companies that do offer both of those. And then also establishing are you a private fee-for-service? Do you get a subsidy? And then the type of ambulance service—we're considered rural. And so, mileage is definitely important. Also, were you affected by any natural disasters and the cost of that? Some people or some ambulance services were able to get reimbursed for that. And then, you know, other ambulance companies were called upon because they were in such a rural area. And so, the mileage differs and the resources differ.

Also, the types of patients that are serviced and, again, just touching on the different types of patients in the areas: Are you further from a hospital? Are you closer to a hospital? Are you – do you have free dialysis centers in your area? Different things like that that you take into account as far as this goes because it's very important to touch on those different things because I noticed in the fee schedules, you know, those are subject to change and those do change. And we definitely need to take that into account. And thank you so much for taking the time to go over all of these things with us. And that is all of my suggestions for now.

Operator: Your next response comes from the line of Gary Wingrove.

Gary Wingrove: Hi, Gary Wingrove from Mayo Clinic Medical Transport. We're the sole provider of ambulance service in 12 different parts of Minnesota and Wisconsin. In each of those areas, we're surrounded by volunteer ambulance services. And while lots of different kinds of health care organizations might utilize volunteers, they don't in the same way that the ambulance services do. They can be up to 100 percent of the

practitioners that are providing the care to the patients. And so, our concern is that the cost of volunteered labor, which is currently borne by the volunteer, be a factor in the report. And one way you might accomplish that is to use a principle that CMS is familiar with: a floor of one, where anyone that would be reporting into the cost system that does not have a crew configuration of two full-time people, that two full-time people be considered the floor for the basis of the calculation of labor. Thank you.

Operator: Your next response comes from the line of Bryan Hector.

Bryan, your line is open.

Bryan Hector: Hi. Thank you for the opportunity to respond. This is Bryan Hector from the MAC in New Jersey. I'd like to recommend that we take into account all fully loaded indirect costs, which people don't think about at times or often aren't reported. Whether it's back office personnel in payroll or a billing cost, make sure all costs fully loaded are included.

And as a second thing, I think we ought to track the number of emergency patients that are medically treated in the field but not transported to a hospital, because ultimately we're saving taxpayer dollars by treating them and not incurring emergency room (ER) visits. Thank you.

Operator: Your next response comes from the line of Tracy Wold.

Tracy Wold: Hi, this is Tracy Wold, Louisiana Ambulance Alliance. I also wanted to appreciate the opportunity to speak. I just wanted to make sure we highlight the need to make sure the costs associated with the dispatch centers are included in the cost collection survey. Not many other providers have such costs, yet they're central to managing ambulance operations. So I encourage CMS to maintain a specific category just for that. Thank you.

Operator: Your next response comes from the line of Rachel Harracksingh.

Rachel Harracksingh: First, I'd like to say thank you for the opportunity. The one concern that we have at Life Ambulance and some of our TAA members is, if we're being moved from a Part B 1500 claim submitter to a Part A UB04 submitter, because we don't have experience in that area, will that be something that will be actually addressed or part of the training process? Anyway, thank you for the opportunity.

Operator: To provide feedback, press star followed by the number 1 on your touchtone phone.

Your next response comes from the line of Jamie Pafford.

Jamie Pafford: Thank you for the opportunity again. I know there's many people on the phone that haven't been able to ask their question. But one of the things that we want to assure that CMS continues to work with all the stakeholder organizations as we go forward. This today has meant a lot to us and being able to hear other people's comments. It's been very helpful. And we at the American Ambulance Association want to continue to work with you to make sure that everyone, all 13,000 ambulance providers across the United States, are able to go forward with this, with a positive attitude and see benefits across our Nation for our EMS professionals. Thank you.

Operator: As a reminder, if you would like to provide feedback, press star followed by the number 1 on your touchtone phone. That is star 1 to provide feedback.

Your next response comes from the line of Matt Zavadsky.

Matt Zavadsky: And since there was a pause in the action, I know a couple of folks had mentioned the Medicaid cost reporting that a lot of agencies, at least public agencies, have been completing throughout the country to take advantage of Medicaid reimbursement. We have participated in that, and I know a number of other agencies have as well. We really think that CMS and others should evaluate that tool since a number of the organizations that have been submitting cost reports have become relatively familiar with that. There are also a number of Medicaid-approved contractors that have been helping the agencies develop the data for those reports. So while it might not be the absolute best tool, it might be a format and one that the Medicaid side – I'm sorry – that the Medicare side of CMS might want to look at because, again, it's been used on the Medicaid side for a while. And then figuring out how we can bring in other organizations that may be part of the data collection sampling to use at least that platform and then determine what's the appropriate sampling to be done from those organizations across the country—rural, suburban, urban—and then provider types, as we mentioned earlier, to get that balance of different types of cost data collection.

Operator: And there is no further feedback at this time. I will turn the call back over to you, Diane.

Additional Information

Diane Maupai: Thank you. So thank you so much, all of you, for joining us today and providing your input from the real world. Slide 10 contains resources and email address. So if you think of some additional comments, see slide 10 and email that address.

We'll post the audio recording and written transcript of today's listening session on the MLN Connects call website. We'll release an announcement in the MLN Connects newsletter when these are available.

Hold on one minute, please.

Sarah Shirey-Losso: Hi, this is Sarah Shirey-Losso at CMS. And one comment, in particular, we just wanted to clarify: The person asked about changes to billing, I guess, and moving from the HCFA 1500 to the UB04, which is used for institutional claims. We just wanted to clarify that that is not something that's part of this initiative of changes in billing practices such as that. Thanks.

Diane Maupai: Thank you, Sarah. So on slide 11 of the presentation, you'll find information and a URL to evaluate your experience with today's listening session. Evaluations are anonymous, confidential, and voluntary. Please take a few moments to evaluate your MLN Connects listening session experience.

My name is Diane Maupai. Thank you and our presenters for participating in today's MLN Connects Listening Session. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.

And we are clear.