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September 25, 2019

The Honorable Seema Verma, Administrator  
Center for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Administrator Verma:

Thank you for the opportunity to provide comments on the establishment of an ambulance data collection system (CMS- 1715-P). While we support the draft data collection system developed by the Center for Medicare and Medicaid Services (CMS), we would like to offer several recommendations for your consideration as you finalize this proposal. We have organized our comments into general themes, specific comments on the proposed rule, and specific comments on the data collection tool.

Formed in 1975 and more than 72,000 members strong, the National Association of Emergency Medical Technicians (NAEMT) is the nation's only organization that represents and serves the professional interests of all EMS practitioners, including paramedics, emergency medical technicians, emergency medical responders, and other professionals providing prehospital and out-of-hospital emergent, urgent or preventive medical care.

NAEMT members also work in all sectors of EMS, including government service agencies, fire departments, hospital-based ambulance services, private companies, industrial and special operations settings, and in the military.

We want to express our strong support for the proposal and provide more detailed comments on the specific proposal in the rule and the data collection instrument in the pages that follow.

We also are grateful to CMS and its contractor, RAND, for engaging in an inclusive process with stakeholders as it develops the proposed rule and data collection tool. NAEMT looks forward to continuing this partnership as the cost data collection process is more fully developed.

To develop this feedback to the proposed rule, we convened a diverse workgroup representing the perspectives of the following provider and supplier types:

- Large, urban
- Small, rural (including volunteer)
- Hospital-based
- Fire-based
- Public Utility Model (PUM)

The Proposed Rule aligns well with the Congressional intent to set the foundation for reforming the Ambulance Fee Schedule (AFS). The collection of cost and revenue data from all types, sizes, and geographic distributions of ground ambulance providers and suppliers, the data obtained from the cost collection system will provide the information that stakeholders and policy-makers require to strengthen the program and ensure the long-term stability of the ambulance benefit. Equally important, this information will permit the community, the Congress, and CMS to modernize the benefit to align it with new and innovative delivery models.

We are very impressed with the comprehensive approach taken for this project. CMS and RAND have been exceptionally inclusive in the preparation of this proposed rule. They attended in person and telephonic focus groups facilitated by NAEMT and throughout the project, sought additional feedback and clarification on several important components. Overall, the proposed rule reflects the extensive dialog with the industry, and as such, is generally very well designed, objective, and reasonable.

The pages that follow highlight areas we feel would benefit from additional clarification, or our suggestions for consideration as the data collection moves forward.

Should you have any questions, would like additional information, or if we can be of assistance in any way, please do not hesitate to let us know.

Sincerely,

A handwritten signature in blue ink that reads "Matt Z." with a stylized flourish at the end.

Matt Zavadsky, MS-HSA, NREMT  
President, NAEMT

## **Primary Issues**

### *Costs for First Response*

The Cost Collection Model seems to allow some cost allowance for dual-role EMTs assigned to non-ambulance functions within the same agency (i.e.: some non-transport/first response unit personnel, vehicles and equipment). How will these costs be captured for agencies in which the First Response and ambulance role are not within the same agency? For example, a fire department that provides both First Response and ambulance units seem to be able to include some costs for the non-transport capable engine that co-responds with the same agency's ambulance. In communities where the ambulance service is provided outside of the fire department, will the ambulance agency be able to report costs associated with First Response in the same way that the costs reported for the fire-based ambulance agency?

### *Response Times*

Reporting of average response time data does little to help measure cost/performance benefit or results. Fractile measurement of all emergency calls in addition to the average would be a better measure (e.g. what is your emergency response time in minutes and seconds at 90% reliability). Capturing both data elements will help to better capture cost/benefit of the specific EMS system for comparison and benchmarking purposes. Also average should be collected in minutes and seconds.

### *Cost of Readiness*

Calculation of the cost of readiness does not appear to be fully addressed within the proposed rules. We believe it should be a measured factor as this one variable is a significant driver of EMS cost. While the tool collects "average trip time" into six discrete time bins, we believe CMS should look at trip times by the agency's actual performance stratified by the proposed service areas and also in aggregate (primary and secondary). This would enable determination of utilization and cost of readiness by using the following formula:

Total trip time x total responses / Total Scheduled Ambulance Unit Hours (Total ambulance labor hours reported for a week divided by 2 as typically there are 2 personnel on an ambulance).

The resulting output would yield a utilization factor known as a Unit Hour Usage or Unit Hour Consumption ratio. This ratio shows how much idle time (cost of readiness) vs. how much productive time the reporting EMS agency experiences. This ratio, when compared against fractal response time performance and cost per response / transport could yield valuable data and insight to substantiate a reasonable "cost of readiness" / productivity factor that can be applied for benchmarking, value determination, ROI calculation and a determination of an RVU for reimbursement reasonableness determination.

This coupled with the Agency demographics will enable comparisons of high and low priced EMS system designs amongst diverse geographic types and measure their respective outputs (response time reliability) as an output measure. This data, coupled with future appropriate evidence based quality outcome metrics, enables an ROI/value calculation for existing and future EMS funding investment.

### Costs for Mandated Fees

Many jurisdictions mandate franchise fees for exclusive operating areas (EOA), or non-EOA for ambulance service contracts. While the fee charged by the local jurisdiction vary, in some cases, ambulance services pay millions a year for the ability to operate via the franchise fees. For example, in Solano County, CA, the ambulance service that operates in an EOA is required to pay an annual franchise fee of \$500,000.00.

Additionally, the ambulance service must also pay the local Advanced Life Support (ALS) Fire Departments at total of one million six hundred thousand dollars annually (\$1,600,000.00). If the ambulance service does not make this required payment it will be in breach of contract with both the municipalities and the county, and their authorization to operate will be revoked. Many ambulance services throughout California and the nation are mandated to make these types of “pay to play” payments.

How will these mandated franchise fees and other payments to local governments as a condition of participation in the EMS system be accounted for in the cost collection process?

### Costs for Contracted Services

Ground ambulance transport agencies often utilize patient assessment/care services provided by EMTs and paramedics who are employed by, and respond on behalf of, a non-transport EMS agency such as a fire department or law enforcement agency. In some of these cases, the transporting agency provides a reimbursement to the non-transporting agency for the costs associated with the care provided to a patient. We believe CMS should collect data to understand the cost of the services provided to a ground ambulance transport agency by a non-transporting EMS agency which frequently responds in conjunction with a supplier or provider of ground ambulance services.

### Responses for Deceased Patients

Ground ambulance transport agencies continue to struggle with CMS' inadequate reimbursements for responses and care provided to patients who are pronounced dead before being transported. The protocols of many advanced EMS systems provide for rapid response and strong resuscitative measures at the scene. In those cases where the patient does not respond to the treatment, the patient is then pronounced dead. These patients received ALS 2 level care such as numerous rounds of medications and advanced medical interventions before declaring a patient as deceased on scene. As a result, these agencies incur significant financial and labor costs (\$655.55 according to a recent cost breakdown provided to the House Ways and Means Committee), but since the patient was not transported, CMS only provides reimbursement at the BLS non-emergent rate (about \$250 in most cases). This may serve as a disincentive for ground ambulance agencies to not transport patients to an ED when there is no chance for survival. We hope that through this cost data collection process, CMS will recognize and acknowledge that the reimbursement termination of resuscitative efforts should be based on an ALS-2 level reimbursement.

### Evaluation after First Year

We recommend that after the first round of cost collection surveys are collected, CMS and RAND conduct a careful review of the data collected to assure the information was collected as anticipated. If not, it would be logical to make adjustments to the process to assure the next round yield the expected results.

### Accessibility to the Data

The data collected through this process will be exceptionally valuable for agencies, payers, policy makers and other stakeholders. We recommend that the data collect from the surveys be made publicly available through either Public Use Files (PUF) accessible through the web, or other formats that will facilitate the use of the data for other purposes. We feel this will leverage the cost collection process for other initiatives.

### Specific Comments

#### **Pg. 544 – 545**

We believe that a methodology that includes the analysis of all ambulance responses and transports, regardless of provider classification (supplier or provider), or payer type (Medicare vs. other) is a more accurate reflection of service costs. In many systems, the non-transport rate may average 20-25% of the total response volume, and Medicare patients may reflect only a percentage of the ambulance transports. Further, since non- transports are generally not covered by payers (including Medicare), they would not be reflected in an analysis that looked simply at Medicare ambulance claims data. However, there is a substantial cost related to responding to calls that result in no transport.

#### **Pg. 547**

The desire to exclude costs completely unrelated to ground ambulance services is reasonable, however, some allowance should be made for costs associated with community education on ground ambulance use.

We believe that costs for resources shared for ambulance and fire duties be specifically delineated. For example, the staff of a fire-based ambulance *MAY* respond to a fire and perform firefighting duties, however, they are assigned to the ambulance, and therefore their costs should be assigned to the cost of ambulance service provision, regardless of times they may be on a fire scene. Ambulance suppliers who are not dual-role would account for the on-duty time in the same fashion, so it would be an accurate cost comparison across service provider types (fire vs. non-fire).

#### **Pg. 555**

We are pleased to see discussion related to the response times and service levels defined by local community as a cost driver for the cost collection tool. This is a major cost driver for many ambulance suppliers and providers.

#### **Pg. 557**

Reporting of total responses, including responses when a ground ambulance is not deployed, is discussed on bullet 1 on this page. We are not sure of the value of this data point, since a response that did not include a ground ambulance response would logically not result in a ground ambulance cost. In some agencies, these activities could be fire only responses or even community paramedicine visits.

In this section, there does not seem to be a consideration for a single incident that resulted in a multiple ambulance response, such as a motor vehicle crash. The measure here should be the number of ambulance responses (deployments), removing non-ambulance deployed incidents from the reporting number of incidents.

**Pg. 559**

Paragraph 3 contemplates asking all respondents to report total annual costs, inclusive of costs unrelated to ground ambulance provision. Does this mean that a fire-based agency would report their entire fire-department budget, even though only a portion of the budget may be attributable to the provision of ground ambulance service?

**Pg. 561**

We are pleased to see the desire to collect the relative value cost of 'supplied' services. This not only applies to stations, but applies to many agencies who are supplied medical supplies and drugs from hospitals. Not reporting those 'benefit' costs could significantly under-report costs.

**Pg. 566**

We know there has been significant discussion regarding the cost allocation for volunteer labor. The approach described to account for the cost (or lack thereof) for volunteer labor seems reasonable and will likely allay some industry concerns about this important topic. We do believe that ambulance supplier or providers that use volunteer labor should be included in the data collection process.

**Pg. 568**

The proposed methodology for collecting facilities costs seems reasonable. We know there was much industry discussion about this process as well.

**Pg. 570-571**

The process described seems to allow the reporting of costs related to the operation of vehicles that support ground ambulance operations. We concur, with one possible exception – fire trucks. Since the personnel assigned to first response for ambulance calls seem not attributable to ground ambulance operations, it seems odd that fire trucks would be an allowed cost. SUV's, paramedic response and even supervisor vehicles that are directly operated by the ambulance provider seem reasonable to include, but not fire trucks.

If fire response vehicles are an allowed cost, ambulance suppliers who are not in a fire service would need to get this data from their first response fire or police entities to account for these costs. Further, if those costs are allowable, how will they be factored into a new FS and paid back to the first response agency, if the ambulance agency is a separate agency?

**Pg. 578**

The proposed method for revenue collection is reasonable. However, the allocation of uncompensated care could be dramatically impacted by fees charged. We also suggest that the issue of uncompensated care may be less relevant if only revenues collected are attributed to the services provided.

## **Comments Specific to the Rural Provider Community**

### Volunteer Labor

In various places in the CMS form the issue of volunteer labor is an aspect yet there is no clear definition of volunteer and how to measure the hours provided. State and federal laws define the term volunteer for wage and hour issues and thus there may be variation between states, and we noted variation between agencies on how volunteer was defined.

We considered that some volunteers will provide service by having a pager to be summoned to an ambulance call. Some of those with a pager are paid for the disruption to the person to be immediately available and others are not paid. In either case these personnel are considered volunteer (any hourly or per shift rate paid is nominal). The personnel for a back-up ambulance (as typically mutual aid from a nearby but separate service is not an option due to time) could be paged to report for service.

These personnel are not on a schedule. Are personnel that have pagers on duty? If yes, does their hours (which could be 24/7/365) count as hours used to provide staffing for the ambulance service? In one case the mix of the local volunteer ambulance and volunteer fire department meant 80 local volunteers with a pager. While there was a schedule for the primary response ambulance the back-up (used if a second call came in or if there was need for a second ambulance at a car wreck) was a general page to all 80 staff members with a pager. So, are all 80 members with a pager and qualified to participate considered when calculating the number of hours of staffing for the ambulance service?

In reality it would appear that there is no difference between the volunteer at home or work waiting for a call or the person paid sitting at the station. But it would appear that the form intends for the hourly paid person has their time calculated and included onto the form while the volunteer aspect is not clear. We are not sure how many volunteer agencies would assume that the "on call" time should be considered as hours worked for the purposes of this cost report form.

Some volunteer services pay their staff based upon hours of the actual call. The personnel will get paid for the hourly time between when they are paged and when the call is completed. They may be paid a wage of \$16.00 / hour for that time period, but they are still considered a volunteer. Due to the low call volume this "per call" payment may be the only payment that the person receives for that week or month.

The Bureau of Labor Statistics may be one source for the valuation of volunteer labor; however, the federal government often uses a resource called Independent Sector ([www.independentsector.org](http://www.independentsector.org)) to determine the relative value of volunteer labor. Independent Sector identifies the value of volunteer labor in each state, allowing for regional and state cost differences. Their 2018 national estimate of volunteer labor from Independent Sector is \$25.43 per hour. We recommend CMS use this resource to determine the valuation of volunteer labor in the state in which CMS receives a cost survey.

If a person is paid to cover a shift, they might earn \$1,000 for being on shift but not cover a call. Some of this is based upon the volume of staff and thus the number of open shifts a person can cover.

Some services will pay personnel a stipend for each call but again they are considered a volunteer.

Many small services will pay personnel a typical hourly wage for weekday, normal daytime coverage due to the difficulty of getting volunteers during those time periods. After that set time period when they respond they are considered a volunteer yet during the day they may do administrative work.

The definition of a volunteer impacts who is counted and that impacts how the personnel needed to provide the service are considered when determining the number of hours to provide coverage for the ambulance.

### Emergency and Non-Emergency

Classically volunteer services exist to provide emergency services in their communities. They do two types of services emergency and transfers. Many of the transfers are emergency calls. The super rural areas do few of any “non-emergency calls” as occur in urban areas. Culture of the area. The communities use the local volunteer service for fewer types of calls than urban areas. The transfers are critical calls in that there is no other mode of transportation in many super rural areas to get the patient to a major hospital thus transfers are emergency calls just as much as 9-1-1 calls to a home.

What patients can be handled at a small rural hospital is less than at a major urban hospital. Thus, getting patients to the major hospital is often a critical thing.

### Dispatch

Almost all of those in the focus group reported they would have serious trouble getting additional data from the dispatch agency. Cost data would be near impossible. The rural dispatch is run by the sheriff who is elected and asking them to split out costs for a CMS report would not be met with a smile. They thought that good info from dispatch would be difficult to get.

### Admin Staffing

Many small services have 1-2 fulltime staff while using volunteers to fill the bulk of the schedule. The full time may have a variety of functions such as admin, training, maintenance etc. They will also work as volunteers in answering calls. We are not sure that this variation of staffing is considered with these questions.

### Opportunity Costs

There is a cost to consider in the operation of a volunteer service. Volunteers leave their normal job to cover the ambulance. That is a cost to the volunteer and/or business where they work or the business they run. This issue is very different from a paid service. There is a very real cost to offering a volunteer service that we do not consider when looking at the full economic impact of the issue.

### Impact of Penalties on Rural Providers

The majority of patients in rural/super rural areas are Medicare. While they may have a small call volume a 10% penalty would endanger the agency due to the financial impact of Medicare in general. Since there will only be 25% of the agencies at one time completing the survey, an agency may not understand how to successfully complete the survey the first time and thus the penalty might be handed out to an agency still in the learning phase.

### Hidden costs

Volunteers use their own vehicles to respond to calls, respond to the station using emergency notification lights and siren and so insurance can be an issue. Laundry services, personnel phones etc.



### Impact of Position Vacancies

Some agencies have a difficult time recruiting EMTs and Paramedics. As a result, many ambulance services have unfilled responder positions, resulting in a reduction of deployed in-service ambulance units. In these cases, the labor market has created a condition where the number of ambulance units in-service is sub optimal, creating known gaps in budgeted and needed coverage, and consequently reducing operating costs. These gaps in coverage only exist because of the workforce shortage and reduce the ability of ambulance services to adequately support their communities.

We ask that CMS must account for these types of unfavorable conditions in the analysis of cost data. Without such consideration, CMS may institutionalize the under-spending caused by workforce shortages into their analysis, thereby making the reduced costs in a workforce shortage the norm on which payments systems are built. As ambulance services struggle with recruitment and retention initiatives to alleviate the workforce shortage, it would be significantly damaging if the EMS field was successful in increasing the number of available EMTs and Paramedics for hire and then found that the funding for these additional units of ambulance service are not accounted for in the cost collection system, since the costs were not incurred during the reporting period.

### Under-Funding Capital Equipment Replacement

Due to low reimbursements, ambulance services are keeping high-cost equipment, such as ambulances, beyond their useful life, out of financial necessity. Many ambulance services are extending ambulance's years in service because they simply don't have the financial resources for timely replacement. As a result, many ambulance services have fallen behind in their capital cycles and are operating with equipment that would have surely been retired for fleet management and safety concerns, if replacement funds were available. If we do not account for this reality in the data analysis, we could risk institutionalizing the lengthening of the capital cycle beyond established norms and therefore re-engineer the payment system to ensure that providers can never catch up with investment needs for maintaining a safe and modern ambulance fleet.

We ask that CMS use the proposed rule on ground ambulance cost data collection to examine not only the actual costs currently being incurred, but also what opportunities are being foregone due to circumstances beyond ambulance service control and how to prevent ambulance rates from permanently decoupling those unmet needs from the payment system. This comment brings us to the edge of broader and vital topic, how this nation ensures EMS readiness and how the Medicare program contributes to that readiness.

## Comment on the Proposed Ground Ambulance Data Collection Instrument

### Overall:

The survey instrument, like the proposed rules, is exceptionally well laid out and appears logical in its progression.

### Time to complete Survey Instrument

The estimate that this will only take 20 hours is not considered valid. The estimate of the group was 40 hours and that would not include the time taken by others when they ask the dispatch for data or the medical director etc. as the time they need to find the requested data is not part of the 40 hours our team estimated would be needed. The volunteer services do not collect a lot of data that is not directly needed for their operations and thus much of this will be new data.

### *Specific Comments:*

#### **Item 2: Q8 – Agency Classification**

We had a 501 c 4 agency. Private yet volunteer. They pay sales tax but no other tax, yet they are not a “for profit” agency. We were not sure they fit into the choices offered.

#### **Item 2: Q15 – Volunteer Coverage**

Neither of these really cover the volunteer coverage. There is a fixed base with no staff on site. Staff will respond from home once a call is received. This type of service response changes the response times significantly and should be considered. This also does not portray the status of a backup ambulance in the rural setting. If a second call comes in, then a general page is made asking anyone who can help to respond to the base to pick up an ambulance.

#### **Item 3: Q3 Task Times**

Rural and super rural areas have a large number of calls that take much longer. Some of the services in the focus group had 100% of their calls over 150 min due to the time to the closest hospital. Is this question for emergency calls or all calls? Typically, the rural services handle the emergency and the transfers from the area hospital. Does this question cover the response time to the scene? Does it include the time it takes for the volunteers to report to the base? When does the clock start vs end?

#### **Item 3: Q4 – Secondary Service Area**

Not sure what the secondary service area is? In some cases, rural services will travel to other areas to handle transfers when the service in that area cannot or when the patient might be originally from the other service area. For example, if a service takes a patient to a local critical care hospital which then decides to transfer them to a major hospital, the original ambulance may take them as the person was from their town. Is this type of function a secondary service area?

Also, some pointed out that the whole state is the secondary service area as that is what allowed by the state license. There needs to be more guidance on how to answer this question. Was the intent of the question to ask if the service provided mutual aid for neighbors?

#### **Item 4: Q1 - Non-Emergency Transfers**

Similar comment regarding emergency and transfers that are considered emergency. Should this question include the transfers that are emergency as well?

#### **Item 4: Q3 - Fines**

The state EMS agency in Kansas can fine the ambulance service if they perform badly. Should this be included in the answer? Do you want transfers included or just emergency calls to scene? In Kansas the obligation to handle transfers is legally murky yet the state can fine you for failure to perform for on-scene emergency calls.

### **Item 5: Ground Ambulance Service Volume**

*Total Responses:* The definition makes sense, and, in reference to an earlier comment on the rule, does NOT include a response of a fire truck. This definition in the survey instrument is reasonable. Two caveats that you may wish to consider –

- Many agencies that are engaging in community paramedicine services assign incident numbers to CP home visits. This could skew response numbers, unless, the costs associated with providing CP services will be counted in the ground ambulance cost collection process.
- Some agencies use 9-1-1 nurse triage systems that manage low acuity 9-1-1 request without the dispatch of an ambulance. Again, if the costs associated with these services will be an allowable cost in the collection process, there should be some process for accounting for those activities.

### **Item 5: Responses vs. Transports**

If a police car goes to a scene and cancels the ambulance is that an incident that needs to be included as a response? What if the ambulance was never even requested as police went to check on welfare of a person? Are those to be included? The ambulance service would not know about those responses. Police do not track them and do not report them to the ambulance service.

### **Item 5: Q3 – Emergency/Non-Emergency**

Issue of emergency call vs transfer. Need further explanation of what is needed to answer the question

### **Item 5: Q7 - Funding**

Paid transport. If the agency gets some local tax funding to offset the patients who do not pay should that be attributed in some fashion to all patients? Thus meaning 100% of the patients are partially paid. We suspect that is not what CMS wanted but it needs clarity.

### **Item 6: Q1 - Emergency/Non-Emergency**

Transfers that are emergencies vs on scene emergency calls. Can it be made clear that an emergency call can be a transfer? Many transfers are a non-emergency response to the hospital and emergency response from the local hospital to the major hospital. We would request that you clarify the use of the term emergency to include transfers that are an emergency movement of the patient transfer. Transfers are a big financial aspect of many rural services.

### **Item 7: Medical Director**

How to define 'payment', many get a minor stipend, some get their insurance paid for, these payments do not cover the real cost of a medical director and thus the determination that they are paid is inflated. If the payment does not cover the cost, it would seem CMS would want the cost?

### **Item 7: Administration**

In small services one person will do all these functions, how should the question be answered? CMS does not want one FTE to divide out time nor is it fair to list one FTE in one sector alone.

### **Item 7.1: Admin Staffing**

The situation of the admin staff shifting to being a volunteer being paid by the call or extra hourly rate during the time period of the call being done.

### **Item 7.2: Maintenance**

Some this is the county shop, others a local firm. Paid hourly or paid under a contract

### **Item 7.3: Paid on Call?**

As noted before we have volunteers who are paid by the call with a stipend or put on an hourly rate during the call. These folks are still volunteers in most definitions yet we would encourage clarity in the document so that folks do not inflate the number of paid staff by noting that volunteers are paid due to the above. We had one service that paid staff \$1.75 per hour when they carried a pager while another did not pay them anything during that time. Either way those personnel are volunteers.

### **Item 7.3: Volunteer Hours**

As previously noted we are unsure how to account for volunteer hours. If a volunteer has a pager at home and is on the schedule to cover the ambulance is that time counted? It is really no different than a paid person sitting at a station.

Is a volunteer who is one of many with a pager who could be summoned as the planned process to provide the second ambulance response considered to be staffing that 7.3; Q2 would require for accounting of the hours? Or, is a volunteer only counted when the pager goes off and there is an actual call? If this question is not clarified, you will get vastly different answers from across the industry

### **Item 7.3: Q3 - Admin Duties**

The staff who are FT or PT to perform admin and other functions will also volunteer for calls. We did not want to answer these questions to indicate more actual people than really exist.

### **Item 7.3: Q2 - Work Week**

The term "Total hours in a typical week" does this mean for a volunteer the time they are open to call? Time they are on a real call? This is a big issue as volunteers are often on call, which typically means they are changing how far they drive from home, limit drinking, have a uniform jacket to put on etc....this Q needs more clarity

### **Item 7.3: Q5 - Medical Directors**

May not put in hours. They may respond to e-mails or phone calls or conversations in the clinic or at the hospital and may have very little if any formal time spent.

### **Item 8.2: Q1 - Depreciation**

The small agencies pay cash and do not record depreciation of buildings, vehicles or major equipment. They do not commonly have depreciation calculations to apply.

### **Item 8.3: Insurance**

Policies do not divide out vehicles etc., they are general and broad, no variation in the premium. Almost all used the state pool insurance which is broad and very hard to separate out the cost to attribute to a vehicle.

### **Item 9.1: Q4 - Depreciation**

How difficult will the depreciation worksheet be to use?

### **Item 9.2: Other Vehicle Costs (Non-Ambulance)**

Fire trucks are included in this list – there should be clear guidance in the final rule and survey instrument regarding whether, and how fire first response costs will be managed in this process. Allowed or not-allowed? What about ambulance agencies that are not in the same agency as the First Response agency? How will costs, and any adjustments to the AFS related to these costs, be managed?

### **Item 10.1: Q1 Medical Equipment**

Depreciation of medical equipment. These agencies do not do that now. Do you have guidance on how to do that?

**Item 10.1 vs 10.2: Cost Definition**

Many of the agencies report that they do not split these cost factors out. Why is this important?

**Item 13: Donations**

Several of the volunteer agencies have a separate mirror group i.e. Friends of the Volunteer Ambulance Service. This group gets donations that are often substantial. One group reported a \$100,000 donation from the family of a patient from the estate. Other amounts are very commonly donated to support the volunteers. This does not appear to need to be reported yet in fact this is essential revenue.

**Item 13.3: Revenues**

The table provided does not seem to delineate Managed Medicaid like it does not Managed Medicare. It may be important to provide this distinction as the rates and payer mix may be different.

The last entry in the table refers to "Patient Self-Pay". Does this include the self-pay portion of a covered service? For example, insurance pays \$1,000 of a \$1,500 bill and the patient is balance-billed \$500? Or, does this contemplate only the fees associated with the uninsured, or uncovered services?

**Item 13.5: Revenues**

In the table, consider revising the term ambulance "club" the more common terms such as ambulance "membership" or "subscription" programs.