NAEMT Responses to GAPB Advisory Committee Questions
Submitted September 5, 2023

Below are responses from the National Association of Emergency Medical Technicians to questions posed by the Ground Ambulance Payment Billing Advisory Committee. Any follow up questions or requests for further information may be sent to naemt_president@naemt.org.

1. Should balance bills for ground ambulance services be prohibited (as with services currently under the purview of the No Surprises Act)?
Patients should not be caught in the middle of a billing dispute between the payer and provider. However, the current provisions under the NSA have been problematic for payers and providers, specifically, the Independent Dispute Resolution (IDR) process. Balance billing can be eliminated if the reimbursement from commercial insurers is appropriate for the local jurisdiction. Several states have passed and implemented model legislation that assures fair reimbursement by commercial payers (Colorado, Michigan, Texas) that can be used on a federal level to eliminate the need for balance billing.

2. Would it be appropriate to incorporate ground ambulance services into existing NSA protections?
No, due to the failed provisions in the NSA, specifically related to the IDR process. There should also be a distinction between emergency and non-emergency, inter-facility transport provisions related to network status and billing.

3. Should any protections apply to non-emergency transports? If so, should those protections differ for emergency transports?
Non-Emergency, pre-scheduled, inter-facility transfers (IFTs) are a much different service line than emergency services. The economic model created under IFTs is more conducive to ambulance agencies contracting with payers for in-network services. A negotiated rate, that may be lower than the prevailing rate, could be offset by likely higher service volume resulting from preferred provider status. As such, IFTs should be regulated differently than 911 ambulance services.

4. Should any protections apply to assessment, first responder, or other non-covered fees?
CMS has long held that First Response is a cost to be borne by the taxpayer, and not a covered Medicare expense. Coverage for first responder services should be contemplated after the GAPBAC process is completed. Ambulance service should remain the primary covered benefit. However, ambulance treatment in place (TIP) and transport to alternate destinations (TAD) should be included. The clinical outcomes, experiential measures and cost-savings have been reviewed by CMS, and they have the Net Savings to Medicare (NSM) data for alternate dispositions.

5. How can meaningful public and /or consumer disclosures be crafted?
For emergency services, they cannot. 911 responses, by nature, are stressful situations for most patients and the patients in most communities do not have a choice of providers. A local government has made the decision as to which 911 provider will respond on the patient's behalf. For non-emergency, IFT

services, an advance beneficiary notice (ABN) can be provided to the patient, and the patient could make an informed decision to use the provider they choose.

6. Should there be cost-sharing limitations for EMS in Medicare Advantage?
Consumers who choose Medicare Advantage plans should be provided full disclosure by the payer regarding coverages and patient financial responsibility for covered services. The same should be true for other consumers and employers making commercial health insurance coverage decisions on behalf of their employees.

7. Should there be a federal, universal EMS benefit?
Yes, at least for emergency (911) services. Most patients assume EMS is an essential health service, and many are surprised to find out their health plan does not cover 911 EMS use.

8. Should EMT's and Paramedics be classified as providers?
No. The scope of their current training, certification and local credentialing process, as regulated by states, is not conducive to provider credentialling. However, EMS Agencies should be classified as provider agencies, thereby requiring adherence to strict Conditions of Participation, to potentially help quell fraud and abuse issues.

9. Should state and local governments specify the out-of-network reimbursements?
Many of have attempted this in the past by having language in state statutes and rules that require a % of "Usual and Customary". The challenge is that payers determine what they feel to be 'Usual and Customary', which often is the Medicare allowable rate. It's likely that was not the intent of the 'Usual and Customary' basis. Forward thinking states have specified that insurers must pay billed charges, or a % of the current Medicare Fee Schedule (localized) as a minimum payable, i.e.: 325%. In so doing, the states have effectively stopped balance billing by assuring commercial payment adequacy.

10. Should a public utility model be deployed?
Not sure what the reference is here – a PUM is a type of EMS delivery model in which a public authority owns the assets of the EMS system, most importantly, the accounts receivable, and either contracts out the personnel, or operates the system themselves with public employees. If referring to EMS system design, PUMs are among the most clinically advanced, operationally effective, and financially efficient models in the country. There are currently 9 such systems.

11. Should emergency ambulance services be considered "in-network" since the consumer has no choice when they call 9-1-1?
No. If the goal is to assure payment adequacy, there are more effective ways to achieve that goal. A payer could consider the fee schedule for an 'in-network' provider to be lower than the community's usual and customary fee. If the goal of 'in-network' is to prevent balance billing, then the aforementioned strategies would be more effective.

12. We are seeking information related to examples where consumers receive bills from ambulance providers for services not covered by an insurance carrier.

13. What communities or areas in the United States are without emergency ambulance service coverage?
Please see recent examples from news reports:

https://www.wric.com/news/local-news/one-louisa-fire-agency-dissolves-after-volunteer-numbers-decline/

https://www.ems1.com/rural-ems/articles/health-care-deserts-rural-communities-grapple-without-ems-hospitals-or-doctors-fdTtFng3dOq7RKUq/

https://www.dailydispatch.com/NationalNews/2022/July/22/Ambulance.providers.warn.of.EM.Sdeserts.across.Connecticut.aspx

https://www.nbcconnecticut.com/investigations/ems-deserts-multiple-factors-upping-arrival-times-in-conn/2843455/

https://www.pbs.org/newshour/show/rural-shortages-lead-to-worsened-ambulance-deserts-and-delayed-medical-care

https://www.cbsnews.com/news/ambulance-emergency-health-care-rural-hospitals/

14. Should NSA protections apply to volunteer ambulance service agencies?
Billing policies recommended by the committee should apply to all ambulance agencies that bill, irrespective of their staffing model.