Ground Ambulance and Patient Billing (GAPB) Advisory Committee Public Meeting #1 – Chat (Day 2)

From Shaheen Halim to Everyone:

The Meeting Agenda can be downloaded using this link https://www.cms.gov/files/document/may-2-3-2023-meeting-agenda.pdf

From Matthew Smith to Everyone:

This is a key distinction between the private companies and Fire services. Private companies are not subsidized through taxes and take on the entire financial risk of providing service.

From Isaac Sobel to Everyone:

Peter Lawrence, great point about ALS2 criteria. Should certainly be revisited.

From Jerry Grubb to Everyone:

Private companies don't get subsidized with tax dollars for retirements, retirement health care, work comp claims, etc. either.

From John Ungaretti to Everyone:

Many private services have to pay fees when contracting with cities and counties. Increasing the costs to patients.

From Kim Latham to Everyone:

Great point, Shawn!

From John Ungaretti to Everyone:

Thank you Shawn Baird

From Kim Latham to Everyone:

Great point again, Shawn!

From Dennis Rowe to Everyone:

Great Job Shawn!

From Loren Adler to Everyone:

Shawn, to clarify, are you saying that Medicare Advantage plans cover a lower share of the Medicare rates than Traditional Medicare? Or just that MA plans pay rates that ~40% of your billed charges, on average? That is, are you saying MA plans are worse payers than Traditional Medicare?

From Shawn Baird to Everyone:

Loren, yes MA plans are worse payers than traditional, they shift more of the allowable to patient with higher co-pays and deductibles.

From Jamie Pafford to Everyone:

Loren, Want to second what Shawn is saying about MA plans... becoming a major issue in many areas

From Loren Adler to Everyone:

Interesting. I think getting data out there on patient cost-sharing differences between MA and traditional Medicare for EMS services would be useful

From Dennis Rowe to Everyone:

Loren, Jamie and Shawn are absolutely spot on.

From Sonia Coleman to Everyone:

I agree with Shawn and Jamie regarding MA Plans. They essentially shift the burden of payment to the patients and many patients do not pay these copays, making this an uncollectable/bad debt.

From Matthew Smith to Everyone:

It's worth noting that Oceanside, CA is a pretty affluent area in Southern CA, and the fire department still requires subsidization with tax dollars. Private ambulance providers providing service in less affluent areas continue to struggle with reimbursement issues.

From Patricia Kelmar to Everyone:

Even in affluent areas, there are people who have less than $400 in their bank account.

From James McPartlon to Everyone:

I agree regarding the MA plans, they pay a much lower reimbursement than traditional Medicare and shift most of the responsibility to the patient.

From CAROLINE COVERT to Everyone:

We are in Pennsylvania. Our Medicaid rates have been adjusted/raised over the past few years. We do not/cannot balance bill Medicaid patients. Our problem Is Medicare Advantage plans. They PAY nothing and apply Copays which are crazy for the Patients to pay.

From Matthew Smith to Everyone:

In many instances the MA Plan does not reimburse anything on a BLS non emergent rate because the Medicare allowable for the transport is less than the MA copay. Unfortunately, many times the patient does not pay their copay either, resulting in no reimbursement to the ambulance provider.

From Gabrielle Ferguson to Everyone:

Why does CMS want to encompass all of the providers operations instead of just EMS related revenue recovery?

From Scott Moore to Everyone:

Because as many presenters have highlighted, each EMS system has a total cost of operation which impacts the system's ability to respond to medical needs of the communities that they serve. To only look at revenue without also examining the total costs of the system will provide only a small piece of the picture.

From Andrew Mulcahy to Everyone:

On your question Gabrielle: The scope of the GADCS is ground ambulance operations which for some organizations goes beyond EMS.

From Loren Adler to Everyone:

Re: MA, I'd love to follow up with folks to help nail down the best way to look for this MA vs. traditional Medicare (TM) dynamic in the Medicare data. My email is LAdler@brookings.edu if anyone is able to email any additional details. Are the MA vs. TM patient cost-sharing differentials more focused on certain types of transports? Are there certain services that MA is significantly less likely to cover at all compared to traditional Medicare? Is this a longstanding trend, or something that's diverged more recently? Thanks!

From Butch Oberhoff to Everyone:

Might be worth mentioning that it's true that virtually all health plans cover emergency ambulance service to one degree or another, but that is not necessarily true about non-emergency, medically necessary ambulance service.

From Christopher Vandenberg to Everyone:

Another definitional issue: Putting coverage of non-emergency ground ambulance services (presumably non-emergency ambulance services since there already is "emergency services") under the term "ambulatory services" is a misnomer and inappropriate because "ambulatory services" in layman's term implies no medical care is necessary, while ground ambulance services either are for non-ambulatory patients or patients in such a condition that medical care is necessary during the transportation.

From Sonia Coleman to Everyone:

To add, they only cover emergency ambulance services that meet their definition of an emergency, not the layperson's definition.

From Beth Jones to Everyone:

Good point Sonia, their definition or interpretation of definition varies by payor & subjectivity of the claims reviewer.

From Suzanne Prentiss to Everyone:

Doug and Steve - you talked about a requirement for a competitive selection process using and RFP. Is this state or local? Is it enabling language for local government or does it apply statewide?

From Brian Levine to Everyone:

A comment on the presentation from Adam Beck. Patients are frequently put 'in the middle' of the billing process due to inaccurate claims made on the explanation of benefits they receive from their insurer. For example, as an out of network emergency ambulance service we routinely deal with EOBs sent to patients that falsely claim that we have agreed to accept a discount or cannot balance bill the patient due to the no surprises act. The patient is then forced to decide if their insurer is correct or we are. I would urge this committee to investigate this issue.

From Patricia Kelmar to Everyone:

Thanks @Maggie -- why not both? Often and in multiple forms might be best practice - language skills, computer literacy skills all come into play for understanding and access to trouble-shooting and understanding patient rights.

From Jerry Grubb to Everyone:

Will posting prices for all to see violate the Sherman Act or other antitrust acts?

From MARTHA BIRD to Everyone:

@Brian Levine - precisely! The patient needs their insurance to follow their policy and not post false statements on their EOB's - why is this allowed?

From Suzanne Prentiss to Everyone:

Thank you Doug and Steve - go it -

From James McPartlon to Everyone:

NYS has it in place for emergencies only.

From James McPartlon to Everyone:

does not provide guidance on reimbursement

From Patricia Kelmar to Everyone:

Patients admitted to an out-of-network hospital for emergency services cannot be charged out-of-network rates for “post-stabilization” care unless all of the following conditions are met:

You can travel safely without medical transportation to an in-network facility

That in-network facility is willing to accept your transfer

The transfer will not cause you unreasonable burden, and

You provide written consent to the transfer.

From Loren Adler to Everyone:

Mark, it's back running again, and they're definitely getting through disputes much more quickly now. But there are still big backlogs to be worked through.

From Loren Adler to Everyone:

Definitely IDR is a big and expensive administrative undertaking

From Jack Hoadley to Everyone:

As Loren said, the IDR process was suspended briefly after the latest court decision, but it is back in operation. The pace of case resolution has been gradually increasing.

From Amanda Riordan to Everyone:

Professor Hoadley, would you mind sharing a link to your deck?

From Loren Adler to Everyone:

David, I'll speak to this some later this afternoon, but especially when you're talking about something like EMS, I would expect any law banning balance billing to also require insurers to allow at least a certain amount. For instance, Maine's law had originally set that tied to 180% of the relevant Medicare rate. Colorado ties that to 325% of the relevant Medicare rate.

From Ritu Sahni to Everyone:

In many ways that is the core mission of this group

From Loren Adler to Everyone:

Agreed

From Asbel Montes to Everyone:

The charge of this committee is to put together a list of recommendations. We appreciate all comments. Each committee member may have their proposed solutions but the committee recommendation will include input from all members in order to meet the charge outlined by statute.

From Katie Arens to Everyone:

Curious if there is data to show what % of medical debt is related specifically to cost sharing, i.e. co-pay and deductibles vs. uninsured, non-covered benefits, etc.? Is there a commonality of medical debt going up at the same rate as the cost-sharing amounts we've seen over the last decade?

From Amanda Riordan to Everyone:

Professor Giovannelli, do you plan to provide any of these insights in written or slide format by any chance, please? It is a little challenging to follow the nuances of your EMS-specific vs general NSA healthcare insights verbally

From Jamie Pafford to Everyone:

Not understanding State and local EMS regulations for coverage area presents challenges for network adequacy---

From Corinne Wittman-Wong to Everyone:

I don’t think you will find the frustration being with no patient balance billing, the frustration comes with the many current issues and fights to get insurance to pay today for emergency transport. Real world scenarios are Insurance pay an arbitrary amount citing “Usual and Customary,” not according to any in-network amount or the patient’s

plan. Providers are forced to get the patient involved, as the beneficiary paying their premiums, and low and behold a secondary payment comes in leaving only a Copay. Without requiring a certain amount i.e. % of Medicare allowed, taking this away only gives leverage to the insurance companies (and their professional negotiators and attorneys), leaving the ambulance providers, who provided a vital service that CANNOT be denied or refused, fighting harder for less.

From Steve Rydquist to Everyone:

That would be South Dakota

From Asbel Montes to Everyone:

All presentation will be posted to the GAPB website.

From Beth Jones to Everyone:

@Corrine makes good points, the insurance companies are obligated to their members & not the providers. Insurance does not want to talk to the provider. Citing "you are not a network provider". This leaves the healthcare provider, who has already provided services, at the mercy of the patient (the insured) to have them reach out to their contracted insurance agency to review the payment or lack of payment. Patients are very frustrated & providers are failing due to lack of adequate reimbursement for services provided without question. Costs to provide care continue to rise while reimbursements are not guaranteed.

From Philip Salamone to Everyone:

I am going to say the quiet part out loud. Due to the state of EMS today, agencies are forced to find ways to finance the organization and pay their staff. When all other avenues fail, the ONLY option providers have to utilize is to use those with better insurance and payment capabilities to shoulder the burden for those that are unable or unwilling to pay, or do not have a health insurance plan that covers the cost of ambulance service.

From James McPartlon to Everyone:

amen

From Beth Jones to Everyone:

Higher deductibles, individual service deductibles, higher copays & coinsurance. Insurance companies passing more & more of the costs to cover healthcare back to the patient (insured). It seems to be less about balance billing & more about surprise coverage limits.

From Ritu Sahni to Everyone:

I'm just a simple emergency doctor, but it seems that the patient doesn't have a choice in their EMS provider and the EMS agency can't pick their patients - the idea of "in-network" makes no sense

From Jamie Pafford to Everyone:

YES BETH!!! -- took the words from my fingers--while many insurance companies are posting record profits.

From Beth Jones to Everyone:

@Ritu you are correct. As an ER doctor, should a patient with chest pain be concerned with finding an in network ambulance or taking home aspirin?

From Jerry Donahue to Everyone:

While we should all welcome the cost collection process my concern is the concern that requiring insurance companies to process EMS claims correctly properly the first time and paying appropriately may result in increase in insurance premiums. I would suggest that a review of the extremely high compensation paid insurance executives drives premium cost much more that the below cost EMS allocations in current practice

From Beth Jones to Everyone:

@Jamie, yes. Patients are frustrated about the lack of their insurance companies paying on their behalf. The result is a refusal to call for help in future emergencies.

From Gary Wingrove to Everyone:

If there is no ambulance service to respond, there is no consumer protection. There is no other consumer protection anything that matters more than having an adequately funded ambulance service.

From Beth Jones to Everyone:

@ Jerry yes! Follow the money. It’s not with the patients or the providers. Unfortunately I believe insurance will pass the cost to patients by way of increased premiums & higher deductibles which does not help consumers & hurts providers.

From Jerry Donahue to Everyone:

I would suggest the current framework places the ambulance company in an impossible situation. You call we come and then we worry if we will ever be appropriately compensated.

From Jamie Pafford to Everyone:

Please be sure to dive into state regulations preventing network adequacy in a subcommittee for all members to understand why EMS networks are unique

From James McPartlon to Everyone:

Jerry, is right. if dollars continue to be removed from providers who are unable to recapture any of those funds, the system will be crippled. The insurance companies hold all the strings and money.

From Dennis Rowe to Everyone:

Perhaps I misunderstood...Anecdotal information being cited or alluded to as factual, is dishonest. Very disappointing. This subject is tough enough without subjective and play on emotional information being utilized. These tactics elongates payment,. This delay increases cost. Peter Lawrence is spot on set and require a rational and validated payment. Ritu and Beth great points

From Dia Gainor to Everyone:

Bravo, Mr. Wijetunge, that "treated without ambulance transport percent of 7.5%" is exactly the point I was making yesterday about the power of NEMSIS data in this process.

From Beth Jones to Everyone:

@Dennis, yes move EMS to true healthcare providers, make the services essential nationally, require reasonable reimbursement & validated payments directly to providers.

From Philip Salamone to Everyone:

Thank You, Loren. I agree completely. Emergency services should not be in or out of network. All emergency providers should be in 'one' network where the costs associated and the reimbursements provided are comparable to the services, supplies, and equipment being utilized.

From James McPartlon to Everyone:

network adequacy has nothing to do with access to care.

From Jamie Pafford to Everyone:

Just remember 77% of the providers are small..covering hundreds of miles.. have been selected and are vetted charges locally by elected officials- so the choice is local- to ensure EMS coverage..

From Katie Arens to Everyone:

Yesterday Loren Adler shared that potentially 28% of emergency transports resulted in a potential balance bill. Today Patricia Kelmar cited 51%. Why the large gap in the stats?

From Ritu Sahni to Everyone:

Certainly not a market dynamic in EMS

From Patricia Kelmar to Everyone:

@Katie -- my slide is 51% "potential" surprise bill -- the study I cite was measuring in and out of network status. You have a 50% chance of getting an OON bill --- which means that you COULD get a surprise bill. Loren looked at claims and could see the differential of paid amount v billed amount. So the stats are looking at different things.

From Patricia Kelmar to Everyone:

@Katie, happy to share the study I rely on.

From Loren Adler to Everyone:

Katie: They come from data from different sets of insurance plans. But the 51% number she cited is actually directly comparable to the 85% of emergency transports that were out-of-network in our data (from United, Aetna, and Humana). The study she references did not perform the next step of identifying the situations where the insurer allowed the ambulance organization's full billed charges (in which there really isn't a potential balance bill to the patient).

From Peter Lawrence to Everyone:

The best part is Kaiser pays the appropriate amount without having to negotiate!

From Patricia Kelmar to Everyone:

Just a clarification -- The $450 is a MEDIAN amount, not an average. Big difference.

From Beth Jones to Everyone:

Matt, excellent presentation. Very important points & I second requiring insurance companies to pay providers directly. Part of putting patients in the middle is paying patients when they didn’t provide the service.

From christopher stawasz to Everyone:

spot on Beth.

From Gary Wingrove to Everyone:

I disagree with Adam's assertion that it is ok for Medicare and Medicaid to have a policy that requires low-volume ambulance services (the 75% with less than 3 runs a day), to operate with volunteers without also having payment policies that require other healthcare providers that are low volume to manage their costs by requiring volunteer professional providers.

From Tristan North to Everyone:

@Adam, Could you provide some information how the $225 Medicare Base Rate was determined. What do you mean by set-price?

From Gary Wingrove to Everyone:

I want to be transparent. Adam and I have had a private chat and he disagrees that he said what I interpreted.

From Matt Zavadsky to Everyone:

Loren is spot on about the network market failure for EMS.

From Matt Zavadsky to Everyone:

PLUS, most EMS agencies will tell you insurers do not care if EMS is in network or not, we're < 1% of their spend and won't even return our calls, unless they want to pay for non-traditional services.

From Kim Latham to Everyone:

Guaranteed payment from insurance AND Medicare/Medicaid.

From Matt Zavadsky to Everyone:

It was an honor!!

From Loren Adler to Everyone:

Good point, Matt. In the analysis we did, EMS was only 0.3% of insurer claims spend: https://s3.amazonaws.com/ajmc/AJMC_09_2020_Duffy_Table.jpg

From Matt Zavadsky to Everyone:

Our capitated agreement with the payer was exceptionally successful with reduced spend And Patient centered navigation from a 911 call because the incentive to transport to get paid was removed.

From Matt Zavadsky to Everyone:

PLUS, we did community paramedicine services for their high utilizers. Reduced ED visits in the enrolled members over 60%

From Beth Jones to Everyone:

As EMS providers & patient advocates, we thank each of you for wisdom, experience & attention to the need for resolution for all parties.

From Loren Adler to Everyone:

Thanks to all of the presenters. I learned a lot the last two days. Looking forward to the rest of the committee process!

From Patricia Kelmar to Everyone:

Fabulous work!

From Kim Latham to Everyone:

Thank you all for all your time!