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Purpose & Background

The Balance Billing Protection Act (BBPA) RCW 48.49 was enacted by the Washington state legislature in 2019 and took effect on January 1, 2020. The law protects consumers from balance or "surprise" billing practices in specific settings where consumers have no opportunity to choose their provider. Examples of such settings include emergency services, air ambulances, and non-emergency services provided at in-network hospitals or ambulatory surgery centers.

The federal No Surprises Act (NSA) went into effect January 1, 2022, and protects consumers from many of the same billing practices as the BBPA. In response, Washington state enacted E2SHB 1688 in March 2022 to bring the BBPA into alignment with the NSA. It also expands the services covered by the BBPA to include air ambulance transportation and emergency behavioral health services.

In all three enactments, ground ambulance services were omitted from balance billing protections, despite consumers having no ability to choose their service providers in these situations. Ground ambulance services were omitted from the federal and state protections due in large part to the complexity of emergency medical services (EMS) systems organization and financing at the local and county level.

Ground ambulances were also excluded from the federal Emergency Medical Treatment and Active Labor Act (EMTALA) passed in 1986. EMTALA requires that hospitals with emergency departments provide medical examinations and treatment for emergency medical conditions (including active labor) regardless of a patient's ability to pay. Per EMTALA, this also means that no emergency department visit can be considered out-of-network and consumer cost-sharing must be billed at the in-network cost-sharing rate.

Between 2017 and 2023, ground ambulance billing charges and payments have only increased per the health insurance carriers surveyed for this report. The greatest increase was for non-participating providers' billed charges for nonemergency services. However, there have been increases across the board regardless of the provider's network status or whether the service is emergent or not.

Non-Participating	Emergency services	Nonemergency services
Billed charges	69% increase	75% increase
Allowed amounts	66% increase	62% increase

Participating	Emergency services	Nonemergency services
Billed charges	46% increase	40% increase
Allowed amounts	50% increase	50% increase

The burden of increasing billed charges largely falls on consumers who are balance billed and unable to afford the bill, too often leading to medical debt and other serious financial and health repercussions.

This burden can fall disproportionately on consumers who live in rural and frontier communities, due to longer distances that EMS providers have to travel to reach hospitals and other facilities.

Due to the complexity of the ground ambulance system, E2SHB 1688 (2022), directed the Office of the Insurance Commissioner (OIC) to submit a legislative report related to how balance billing for ground ambulance services can be prevented. It instructed the OIC to consult with a broad range of interested entities and submit the report to the legislature on or before October 1, 2023:

RCW 48.49.190

(1) On or before October 1, 2023, the commissioner, in collaboration with the health care authority and the department of health, must submit a report and any recommendations to the appropriate policy and fiscal committees of the legislature as to how balance billing for ground ambulance services can be prevented and whether ground ambulance services should be subject to the balance billing restrictions of this chapter. In developing the report and any recommendations, the commissioner must:

(a) Consider any recommendations made to congress by the advisory committee established in section 117 of P.L. 116-260 to review options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing; and

(b) Consult with the department of health, the health care authority, the state auditor, consumers, hospitals, carriers, private ground ambulance service providers, fire service agencies, and local governmental entities that operate ground ambulance services, and include their perspectives in the final report.

(2) For purposes of this section, "ground ambulance services" means organizations licensed by the department of health that operate one or more ground vehicles designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation.

The OIC formed Ground Ambulance Balance Billing Advisory Group to meet the consultation requirement of the statute, and more importantly, to learn from ground ambulance subject matter experts.

As directed in the No Suprises Act, the federal government established the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) to advise Congress on any recommendations to protect consumers from balance billing in events where emergency ground ambulance services are required. Their first meeting was May 2, 2023. Their report to Congress is due 180 days after their first meeting.

Advisory Work Group Members

As directed in RCW 48.49.190, the Ground Ambulance Balance Billing Advisory Group members include the Department of Health (DOH), the Health Care Authority (HCA), consumers, hospitals, carriers, private ground ambulance service providers, fire service agencies, and local governmental entities that operate ground ambulance services. OIC consulted with the Washington State Auditor prior to initiating

the project. The Advisory Work Group is comprised of the following representative organizations. For a complete list of members, please see Appendix X.

Advisory Group Member Organizations:

- AARP
- Association of Washington Counties
- Northwest Health Law Advocates (NoHLA)
- Olympic Ambulance
- Patient Coalition of Washington
- South Kitsap Fire Rescue
- Systems Designs West-Billing Agency
- Washington Fire Chiefs
- Washington State Council of Firefighters
- Washington Ambulance Association
- Washington State Hospital Association
- Association of Washington Healthcare Plans (AWHP)
- Association of Washington Cities

Advisory Group Project Team:

- Office of the Insurance Commissioner
- Department of Health (DOH)
- Health Care Authority (HCA)
- University of Washington Health Systems Collective/ The Value & Systems Science Lab (VSSL)

Advisory Work Group Meetings

The Advisory Work Group held six (6) meetings in January through August 2023 to share resources, review data and materials, and develop policy and finding recommendations. The Advisory Group has had an opportunity to review and comment on a draft of this report. All written comments received, including those related to the report, are posted on the project website.

Research Activities to Inform the Report

Emergency Medical Services (EMS) Licensing Applications

The University of Washington Value and Systems Science Lab (UW/VSSL), under contract with OIC, conducted a comprehensive look into licensure of EMS systems in Washington state to assess the organizational structure, business practices, and financing of EMS systems. VSSL used a two-pronged approach in their analysis, first by gathering systematic data through the following available data elements:

- Type of EMS Service- Aid or Ambulance
- Level of service being provided- Basic Life Support (BLS), Intermediate Life Support (ILS), or Advanced Life Support (ALS)
- Geographic Area

- Types of Calls- 911 and/or inter-facility transports
- Number and type of vehicles

To ensure capture of additional unique information, the second part of VSSL's approach analyzed a sample of full EMS applications to provide a more in-depth analysis of EMS licensees. This analysis assisted the advisory group in better understanding the organizational structure, business, practices, and financing of EMS systems.

The findings of this study are reported later in this report and the full findings appear in Appendix X.

All Payer Claims Database (APCD) Ground Ambulance Services Analysis

The OIC analyzed commercial health insurance ground ambulance claims data for the period of 2019-2022 available through the Washington All Payer Claims Database (APCD). The data elements below are broken out by provider type, in-network (INN)/out-of-network (OON) provider status, payer type, EMS transport type, and location of service (urban or rural):

- Claim Count
- Charged Amounts
- Paid Amounts
- Copay Amount
- Coinsurance Amount
- Allowed Amount
- Deductible Amount

To corroborate this data and provide a better understanding of the disparities between dispatch volume and transport volume, the EMS Data Registry maintained by the Washington State Department of Health (DOH) also was reviewed. The data elements assessed in the EMS Data Registry are as follows:

- Primary type of service
- National Provider Identifier (NPI)
- EMS transport method
- Organization type
- Organization tax status
- EMS dispatch volume per year
- Type of service requested
- Primary method of payment
- Insurance company name
- Payer type
- EMS patient transport volume per year

The findings of this study are reported later in this report. The full findings appear in Appendix X.

Survey of Health Carriers

The OIC surveyed 18 health carriers to gain an understanding of rates charged and paid for ground ambulance services, contract status of ground ambulance providers, and primary concerns of carriers related to contracting with ground ambulance providers. A draft of the survey was reviewed by the Advisory Group. It was sent to carriers on May 1, 2023, with responses due June 1, 2023.

The findings of this survey are reported later in this report. The full findings appear in Appendix X.

Survey of Ground Ambulance Providers

UW/VSSL, in collaboration with OIC, designed a survey assessing the financing and business practices of ground ambulance providers. The survey was distributed to EMS licensees by DOH. A draft of the survey was reviewed by the Advisory Group. The survey was sent to the licensees on May 1, 2023, with responses due June 1, 2023.

The findings of this survey are reported later in this report and the full findings appear in Appendix X.

Ground Ambulance Services in Washington State

The EMS system in Washington state is integral to providing time sensitive care to Washington residents in need. As an essential part of the Emergency Care System Continuum of Care, Washington statute authorizes local and county governments to establish and finance these systems. The complexity of this network of systems was a primary reason that ground ambulance balance billing protections were not originally included in the BBPA. Per the Washington EMS Information System (WEMSIS) there were over 800,000 emergency calls to EMS in 2022 83.6% resulting in an EMS transport. This complex network is composed of many and varied means to create, operate, and finance local systems.

Note: Throughout this report there are many acronyms and descriptions of services offered by EMS providers. Please refer to the glossary at the end of this report for definitions. Key terms are hyperlinked to Glossary located at Appendix X.

How Ground Ambulances Services Work in Washington

Among the 39 counties, there are 482 licensed EMS systems (including air ambulances), 302 which can provide transport for people in need of such care. Three types of services are provided: Basic Life Support (BLS) (most common), Intermediate Life Support (ILS), and Advanced Life Support (ALS), with different sets of services provided at each level of care.

Types of EMS Licenses

Not all EMS licenses are the same. Defining features of licenses include the type of EMS services provided, whether they transport patients, and if they are trauma verified*.

- Emergency Services Supervisory Organization (ESSO): an organization such as law enforcement agencies, search and rescue operations, and businesses with industrial organized safety teams provide initial medical treatment for on-site medical care prior to dispatch of EMS services.
    - ESSO's do not have vehicles, do not respond to 911 calls, and do not transport patients.
    - ESSOs Examples: Sheriff departments, ski patrols, Boeing Fire, etc.
- Aid Services: an EMS service that operates one or more aid vehicles to respond to calls and provide initial care on an emergency scene.
    - AID services respond to 911 calls and only provide initial treatment, they do not transport patients because most AID vehicles are not designed to carry stretchers and are only licensed as a first response service.
- Ambulances (includes air ambulances): EMS service that operates one or more ambulance vehicles that respond to calls, provide patient care and transport patients to facilities.
    - Ambulances can carry stretchers.

*Verification is the process by which an aid or ambulance service are endorsed by DOH to respond to 911 calls and treat and/or transport trauma patients to hospitals designated to provide trauma care.

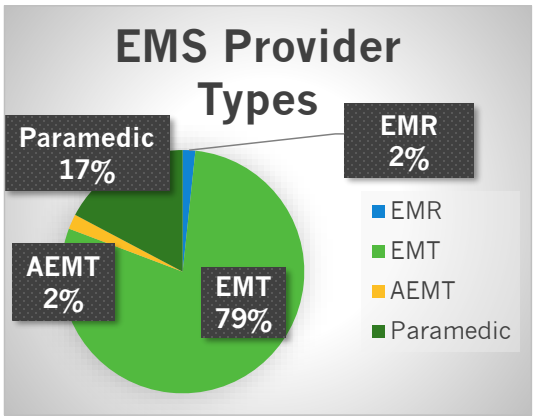
Who Staffs EMS Systems

As of December 31, 2022, there are 16,993 EMS providers in Washington state. Of that, 1 in 4 are reported by EMS services to be volunteers. Rural counties often struggle to maintain advanced EMS personnel and often rely more heavily on volunteers to staff their EMS systems, creating disparities in access to care for rural residents.

There are four levels of certified EMS providers, distinguished by the types of services they can provide:

Level of EMS Staff	Acronym	Description of Services	Skill Level/ Education
Emergency Medical Responder	**EMR**	✓ Responds to calls ✓ Provides Basic Life Support (BLS)	➢ 48-60 initial training hours ➢ Can perform CPR, provide oxygen, use AED, take vital signs, splinting, control bleeding, use EpiPen, administer Naloxone.
Emergency Medical Technician	**EMT**	✓ Respond to calls ✓ Provides Basic Life Support (BLS)	➢ 150-190 Initial training hours ➢ EMR services, plus administer Nitroglycerine, Aspirin, Glucose, apply cervical collar, assess blood glucose level.
Advanced Emergency Medical Technician	**AEMT**	✓ Respond to calls ✓ Provide Intermediate Life Support (ILS)	➢ 150-250 Initial training hours ➢ EMR and AEMT services, plus start an IV, administer additional medications, initiate cardiac monitoring.
Paramedic	**n/a**	✓ Respond to calls ✓ Provides Advanced Life Support (ALS)	➢ 1200-2500 Initial training hours ➢ Can perform all of the above plus intubation, chest decompression.

The most common type of EMS provider are EMTs at 79% (13,438). This is followed by paramedics at 17% (2932), and AEMT (338) and EMRs (285) at 2% each.



Services Provided by EMS systems

EMS organizations offer the three levels of service described above (BLS, ILS, ALS). This care is provided in the following ways:

- **Dispatch**: Dispatching aid or ambulance services based on an emergency (911) or non-emergency call.
- **Assess**: An on-site assessment of a patient's health condition by trained personnel.
- **Treat & Refer to Services:** A patient is treated on-site and is referred to secondary sites for additional care. Secondary sites can include physician care, behavioral health treatment, etc.
- **Transport to Emergency Department:** Transport can be done only by a licensed or verified ambulance services staffed by certified EMS providers.
- **Transport to Alternative Sites**: EMS services can transport patients to alternative sites directly from an emergency scene, or it can be scheduled in advance as an inter-facility transport if a patient needs to be transported between two health care facilities.
    - Alternative sites include behavioral health treatment centers, substance use disorder treatment centers, dialysis centers, or doctor's appointments.

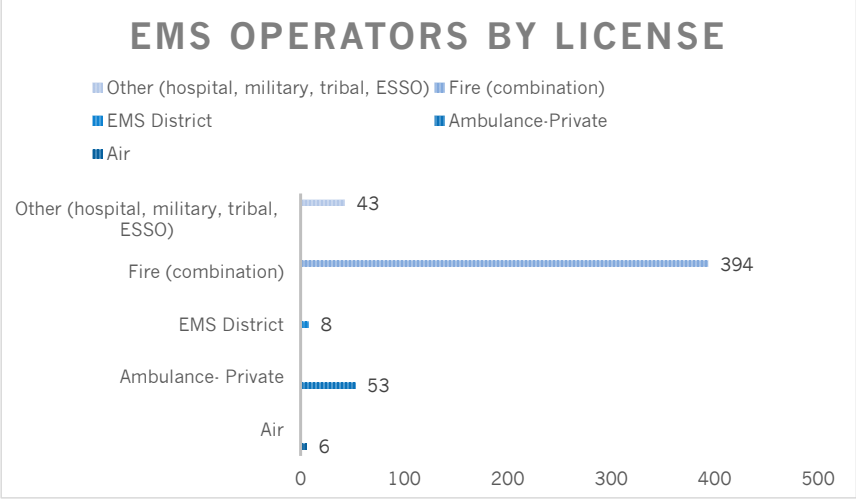
Operation of EMS Systems

EMS systems are operated by multiple types of collaborating entities. While they all respond to 911 emergency calls, they are not all established or function in the same way. UW/VSSL's grouped EMS systems into13 organization types and three broader organization types:

Public	Private
City Fire Department City/Fire District Combination	Private for Profit Private Non-Profit

EMS District Federal Fire Department Fire District Hospital District Industrial Fire Department Military Municipality	Private Volunteer Association **Tribal** Tribal EMS

The licenses of EMS systems are issued, monitored, and tracked by DOH to ensure EMS services and personnel meet minimum standards for training, services, vehicles and equipment, and that proper care is provided to patients. Below is a graph of the types of entities that operates EMS systems in Washington.



Note: information per DOH Prehospital EMS licensed and Verified Services by County (2022).

Public and Private Ground Ambulance Providers

While many believe that ambulances are operated by cities and local governments, private ambulances play an important role in the care provided to Washington residents. The differences between private and public ambulance providers are broadly laid out below:

Private	Public
Privately owned and operated and can include: ➢ Private ambulance that works out of a public agency (i.e., fire department) ➢ Private operation with own facilities	Publicly owned and operated and can include: ➢ Fire Department or District ➢ Public Hospital ➢ EMS District
Responds to 911 calls in partnership with or at request of public EMS services.	Responds to 911 calls as top priority
Provides interfacility and specialty care transports with specially trained EMS and other healthcare providers such as critical care nurses (sometimes specializing in this care).	Provides very limited specialty care transport and limited interfacility transport, usually when no other services are available to provide transport.
Funded through third party payers, e.g., Medicare, Medicaid, and private health insurance	Funded through local government taxes, levies, as well as third party payers

EMS Statutes and Rules

As a necessary and vital service provider that is managed by local government entities, the Legislature has enacted laws related to creation, maintenance, and funding of EMS systems. A list of the relevant statues and rules is noted in the table below:

RCW	Name of RCW	Summary
Chapters on Establishing EMS System		
Chapter 18.71 RCW	Physicians	Established licensing and certification of EMS services, providers, physician medical program directors and Trauma Care System.
Chapter 18.73 RCW	Emergency Medical Care and Transportation Services	Governs licensure of Emergency Medical Care and Transportation Services
Chapter 70.168 RCW	Statewide Trauma Care System	Establishment of statewide trauma care system, specifically designations for trauma hospitals and verification for ambulance services.
Chapters on Authority to Establish EMS Systems		
Chapter 35.21 RCW (RCW 35.21.762 – 779)	Miscellaneous Provisions	Addresses authority for local governmental entities to create EMS services, provide financial support or revenue for those services, set rates, designate their service areas/districts, and allow volunteer EMS personnel to be compensated. Establishes the Community Assistance Referral and Education Services (CARE program and

		provides some protections to private ambulance providers.
RCW 35.23.456	Additional powers—Ambulances and first aid equipment.	Allows a second-class city to operate an EMS system when other ambulance services are not readily available.
Chapters on Financing EMS Systems		
RCW 35.27.370	Specific powers enumerated.	Allows towns to operate ambulance service and collect fees for such a service.
RCW 36.32.470	Financial assistance to ambulance or EMS	Authorizes counties to furnish financial assistance for fire protection, ambulance, and EMS services
RCW 41.05.730	Ground emergency medical transportation services—Medicaid reimbursement—Calculation—Federal approval—Department's duties.	Created GEMT program and stipulated its management and regulations.
RCW 84.52.069	Emergency medical care and service levies.	Sets $00.50 per $1000 of assessed value of property as levy limit on levies for EMS services.
RCW 84.52.070	Certification of levies to assessor.	Allows counties and cities to set up levies for EMS systems.
EMS Systems- WAC		
WAC 246-976	Emergency Medical Services and Trauma Care Systems	Rules associated with EMS and Trauma Care System.

Rural communities establish public EMS systems when commercially available ambulances are not readily available. They are characterized by covering a greater geographic area with less population density per square mile while relying on fewer staff, vehicle, and funding resources They also tend to rely more heavily on volunteers. These more limited resources lead many rural areas to share ambulance services across multiple towns and cities.

Funding EMS Systems in Washington

EMS Systems in Washington respond to 911 calls 24 hours a day, 7 days a week, 365 days a year. Divided into eight trauma care regions, they respond to emergency situations such as car accidents, search & rescue, heart attacks, stroke, substance use, mental health crises. Per WEMSIS in 2022, it is estimated that the Washington EMS Systems responded to over 818,000 dispatch calls. That would be like filling T-Mobile Park and Lumen Field seven times. Of those 818,000 dispatch calls, 684,000 (83.6%) resulted in transport to a secondary location including emergency departments, hospital-to-hospital transfers, medical transfers, and more.

The magnitude of the work EMS systems provide comes at a cost. In the Ground Ambulance Provider survey, the 65 provider respondents estimated the cost of various components of their services. It was roughly estimated that a single EMS system costs $7.6 million to operate annually. The largest share of that cost being EMT response staff, at just over $5 million. Providers responding to the survey varied greatly in size and provider type. Of the 65 respondents, 58 (89%) were public providers and 7 (11%)

were private/non-government providers. The providers also varied greatly in the size of their paid and volunteer staff. Responding providers noted that the amounts provided were estimates and that costs can vary greatly from year to year. However, these numbers provide an important window into how much EMS providers themselves estimate it costs to operate an EMS system in Washington.

Cost category	Average cost
EMT/Response staff	$5,231,170
Administration/Facilities staff	$946,449
Owned ground ambulance	$275,468
Leased ground ambulance	$61,224
Other vehicles (non-ambulance)	$48,788
Capital medical equipment	$117,820
Capital non-medical equipment	$57,495
Medical equipment, supplies, and consumables	$64,797
Medications	$7,725
Other	$780,043

Covered and Non-Covered Services

As any emergency response team will tell you, it is free to call 911, and they actively encourage people to call if they fear for their life or health because the alternative is too great a risk. As noted above, there is considerable variability in the services provided by EMS systems. The advisory group deliberations revealed differences in payment for those varied services, both by service and across payers as displayed below. In most cases, transports to a hospital emergency department are covered by Apple Health, Medicare, and commercial health plans. For all other services, coverage varies depending upon the payer and its policies.

Name of the service	Medicare	WA Medicaid FFS	Commercial
Emergency transports (to higher care)	Yes, when meets medically necessary criteria	Yes, when meets medically necessary criteria	Yes
Non-Emerg transports interfacility, higher level	Yes	Yes	Only if covered, often not in full
Non-emerg transports, lower level (H-Res/SNF)	Conditional, medical necessity is stringent	Conditional, medical necessity is stringent	Only if covered, often not in full
Patient is in-patient	No, facility is responsible	No, facility is responsible	Only if covered, often not in full
Treat, No Transport	No	No, unless Treat & Refer enrolled	Conditional, generally no.
Specialty Care Transport	Yes	Yes, but pays as ALS	Yes
Transport to Alt. Destination	No	Yes, if criteria are met	Conditional, generally no.
Transport from Jail - Hosp	Conditional	Conditional	N/A
Involuntary Mental Health (various origin/destination)	Conditional	Yes	Yes
First response service (another agency transports)	No	No	No

FFS= Fee for Service

Ground ambulance providers in the advisory work group believe they are not fully compensated for the following services:

- **Loaded vs Unloaded Miles:** Providers are reimbursed for loaded miles, i.e., the number of miles during which a patient is in an ambulance. For example, if they transport someone one-hour outside the county to a higher-level trauma care hospital they can bill for the mileage to get to the hospital, but the miles they drive to return to their base county are not billable.
- **Throughput Delays:** If a hospital, facility, or other care site is unable to accept a patient when they arrive, the ambulance provider cannot bill for the time they spend waiting for the patient to be admitted. Nor can they bill if they are unable to transfer the patient to the new facility and have to bring them back to the original facility.
- **Treat, No Transport:** This refers to an emergency response where the patient is cared for by ground ambulance providers but is not transported to a hospital or other facility for treatment. As shown above, this is generally not covered by any insurance carrier.
    - *Community Assistance Referral and Education Services (CARES) Program:* Per RCW 35.21.930 any fire department can develop a CARES program to improve community outreach and public health through assistance and education services. While the statute authorizes the development of this program and allows the fire department to seek grants and private gifts to fund this program, it does not explicitly dedicate any government funding source for this program. Participation in the program is not mandatory; some agencies provide treat, but no transport services without establishing a CARES program.
- **Interfacility Transport:** This broadly covers multiple types of transport that are not considered emergency transport to a hospital, including specialty care transport for people with special needs, transport to alternative destinations such as nursing or hospice facilities, and transport to mental health or substance use treatment centers. These may be covered at varying levels by insurance carriers and can result in large cost-sharing and balance bills for patients.
- **Cost of Supplies and Medications:** While this is a relatively small fraction of the total cost of the operating budget for EMS Systems, these services are not directly billable.

Funding Sources for EMS Ground Ambulance Providers

EMS providers rely on a complex network of payments to cover the cost of operating their systems.

Local Government Funding

There are three general funding sources that allow local and county governments to fund public EMS services within their jurisdiction:

- **Levy**: Per RCW 84.52.069, local governments can impose a property tax levy of no more than $0.50 per $1,000 of assessed value of property for emergency services. It must be voter approved and can last for 6-years, 10-years, or be permanent. In addition, levy revenue cannot increase by more than 1% over the course of one year, also referred to as the 1% cap.
    - According to the latest All County Levy Data from 2022 provided by Washington State Department of Revenue, the average EMS levy amount was $0.39.

- Hospital, fire, and excess levies can all contribute to EMS funding, but this funding also is used to fund other services, such as fire departments and public hospitals.

- **Utility**: RCW 35.21.766 allows local governments to create a fee structure that can fund ambulance transport services for all users or local residents.
- **Local Government General Funds:** RCW 35.27.370 and RCW 36.32.480 allow cities to fund and share ambulance services between municipalities.

Third-Party Payers

Third party payers include Washington Apple Health, Medicare, commercial health plans and other government-funded health care programs.

- **Health Carriers**: This includes all commercial health plans that provide coverage to Washington residents. They provide coverage at in- and out-of-network rates, which can vary widely depending on the health plan, the geographic area where the service is provided, and the EMS provider.
- **Medicare**: The federal Centers for Medicare and Medicaid Services (CMS) sets fixed rates for services. Some advisory group members stated that Medicare rates are below providers' costs. CMS intends to submit a report gathered and analyzed by the Medicare Payment Advisory Commission (MedPAC) on ground ambulances after January 1st, 2024, when data collection from the sample of ground ambulance providers ends.
- **Washington Apple Health:** Washington Apple Health pays fixed rates for specific covered services. Due to the low payment by Apple Health, there are two additional federal funding sources to supplement Apple Health payments for ground ambulance services.
    - *Ground Emergency Medical Transportation (GEMT*): Established through RCW 41.05.730, GEMT payment supplements Apple Health payments made for Apple Health-only patients who receive services from a publicly owned and qualified GEMT ambulance service. The program is not available to private ambulance providers. Public EMS providers can choose whether to participate in the program. As of July 2023, 140 EMS providers, or 35% of public providers, participate in the program. . Local funding is matched with federal funds. The program is designed to cover the difference between Medicaid reimbursement and actual costs.
        - In 2022, CMS indicated a potential change in the costs that could be included in the calculation of a public EMS providers' costs. The key concern was whether "allowed costs" could continue to include costs associated with "treat but no transport" services. The Health Care Authority has submitted a state plan amendment to CMS that proposes to continue to include those costs in the program. HCA is awaiting a determination from CMS.
            - Per HCA in SFY 2022 the average cost per transport was $2,742.
    - *Ambulance Transport Quality Assurance Fee Program (QAF*): Per Chapter 74.70 RCW, this program obtains additional revenue for private ground ambulance providers. A mandatory fee is assessed on private, non-profit, and non-government emergency only services. Providers are assessed at the rate of $24.50 for every transport. This

assessment is then matched with federal Apple Health matching funds to make enhanced payments to private ground ambulance providers.

  - The current enhanced payment for Apple Health patients requiring emergency only ground ambulance transport is $231.23.
  - The enhanced payment is not made for non-emergency transports or mileage, but it can be made for specialty care transports.

- **Other Government Health Carriers**: Tricare, Veteran Affairs (VA) health coverage, and Indian Health Services funding account for a relatively small portion of transports for EMS.

Cost, Charges, and Payment for Services

The advisory group gathered information related to several components of ground ambulance payment for services by commercial health plans. Information on the seven most common ground ambulance billing codes was compiled and analyzed to attempt to arrive at the average cost, payment, and billed charges for the services.

Cost of, and payment for, ground ambulance services are analyzed with respect to:

- Cost: Most commonly used by providers and refers to the calculation of total cost of their service based on supplies used, mileage traveled, hourly rate of response team, etc.
  - All cost information is self-reported by providers via survey.
- Billed Charge: The total amount charged and submitted by the provider to the health carrier for reimbursement.
- Allowed Amount: The maximum amount the health plan will pay for a specific covered health service. This includes both the carrier's payment and applicable consumer cost-sharing.
- Allowed Amount as a Percent of Medicare: The maximum amount the health plan will pay for a specific covered health services as a percent of the Medicare allowed amount for the same service.

		Non-Participating				Participating			
Transport type (procedure code)	**Average cost from provider survey*** **	**Billed Charge-public**	**Billed Charge-private**	**Allowed Amount as % of Medicare-public**	**Allowed Amount as % of Medicare-private**	**Billed Charge-public**	**Billed Charge-private**	**Allowed Amount as % of Medicare-public**	**Allowed Amount as % of Medicare-private**
BLS nonemergency transport (A0428)	$1,370.87	$840.09 (34) **	$1,310.79 (712)	243%	406%	$943.96 (64)	$1,490.90 (1672)	347%	396%

BLS emergency transport (A0429)	$1,382.25	$802.92 (1,383)	$1,195.53 (1,308)	172%	229%	$781.62 (1,734)	$1,410.04 (2,262)	190%	327%
ALS nonemergency transport lvl 1 (A0426)	$1,559.06	$1,113.82 (33)	$2,399.96 (224)	258%	586%	$1,079.50 (50)	$2,276.97 (420)	311%	646%
ALS emergency transport lvl 1 (A0427)	$1,732.82	$1,039.89 (1,586)	$1,714.00 (777)	186%	293%	$991.13 (2,038)	$1,505.27 (1,095)	207%	340%
ALS emergency transport lvl 2 (A0433)	$1,923.59	$1,189.17 (112)	$1,575.12 (43)	152%	191%	$1,092.63 (156)	$1,590.50 (61)	157%	244%
Specialty care transport (A0434)	$2,246.61	<11 claims	$4,009.27 (235)	<11 claims	374%	<11 claims	$3,774.20 (582)	<11 claims	342%
Ambulance response and treatment, no transport (A0998)	NA	NA	NA	NA	NA	NA	NA	NA	NA

**Both commercial and Medicare claims are from 2021. Medicare allowed amounts are derived from the CMS Medicare Physician & Other Practitioners – by Provider and Service file. Medicare data was joined to commercial data on shared provider NPI in an attempt to account for variations by geography. Private providers include those categorized as independent, non-profit, private equity-owned, or publicly traded. The allowed amount for both commercial and Medicare data include the amount paid to the provider by the health plan and the total patient cost sharing component (sum of deductible and coinsurance amount that the beneficiary is responsible for paying).*

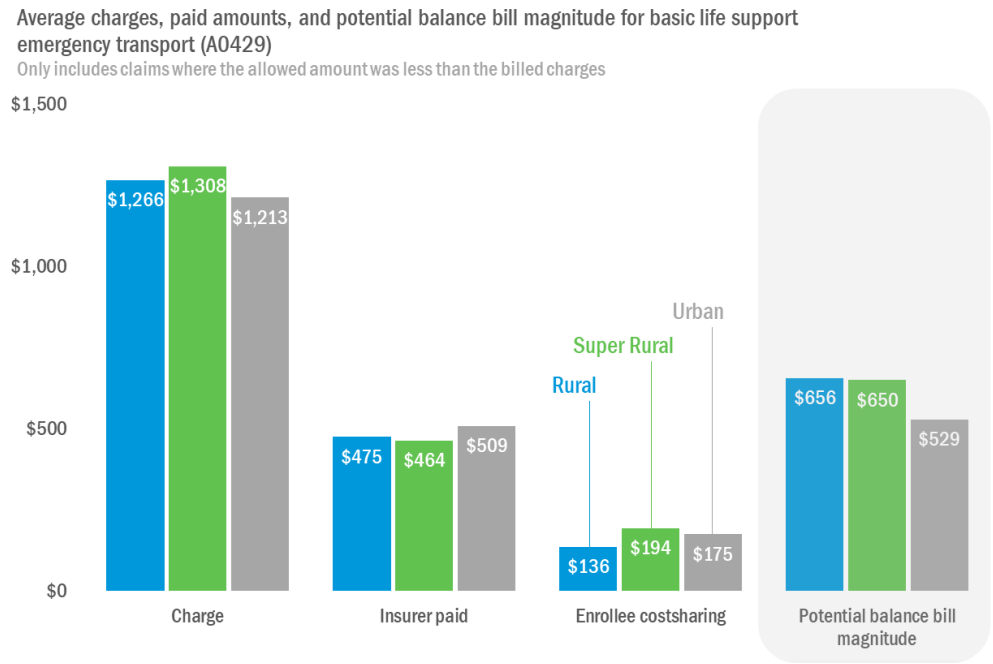
***Number of claims for each CPT code used to calculate average amount per CPT code.*

**** Cost calculated from provider survey. Total of responding providers was 65, with 58 public providers and 7 private providers. Thus, skewing results towards providers estimated costs.*

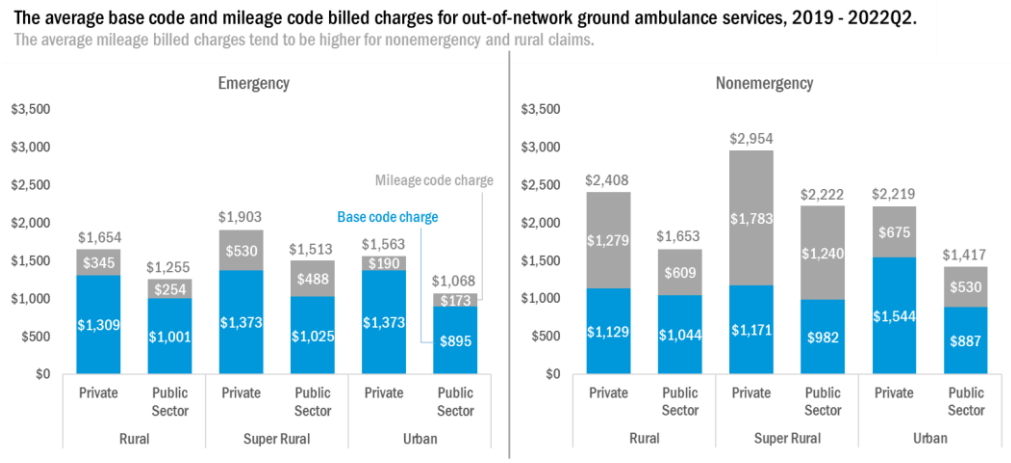
The increases in billed charges and allowed amounts reported by the 18 carriers surveyed for this report results in increased magnitude of balance bills that patients can receive.

To gather a full picture of the impact of ground ambulance balance billing, the OIC reviewed its analysis of APCD claims data with advisory group. The analysis assessed ground ambulance billed charges, payments, and cost-sharing from 2019-2022.

Currently, emergency transports are most likely to be covered by commercial health plans. For one of the most common types of services provided, BLS-emergency transport (CPT A0429) the difference between cost-sharing and billed charges for the service resulted in potential balance bills of over $500 in all geographic area designations.



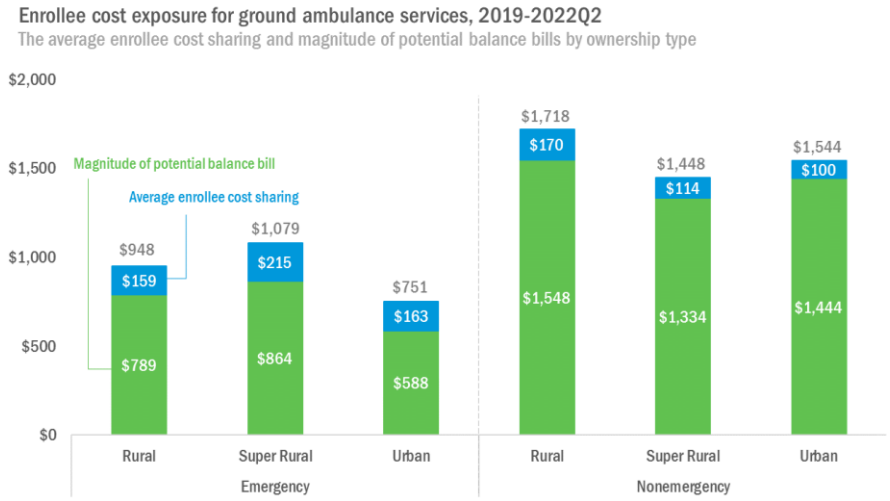
Mileage is a separate component of ground ambulance services and is usually paid separately from the transport. The difference between the allowed amount and billed charges for mileage are another potential source of balance billing for consumers, with greater burden falling on consumers in rural and super rural communities.



Even with insurance, the high cost of ambulances can be surprising to consumers who have yet to meet their annual plan deductible or who have cost-sharing based on co-insurance rather than a fixed deductible. In the APCD analysis, even when appropriate cost-sharing was factored in, consumers still faced a balance billing in excess of $500 no matter their EMS provider or geographic location. A report completed in 2021 found that 1/3 of insured patients cannot afford a surprise medical bill of $1,000 or more and 47% of insured patients cannot pay an emergency expense over $400 without borrowing money or selling assets.

Commented [EB1]: We suggest flagging the burden of ground ambulance surprise billing on consumers more strongly earlier in the report, such as in the introduction.

One additional data point that may be helpful: any trend information OIC may have about consumer complaints it has received about ground ambulance services.



The burden of balance billing is currently falling on insured consumers who are increasingly subjected to medical debt as a result of high cost of covered services and balance billing. While EMS providers do often provide charity or hardship care to patients, they must also sustain enough revenue to maintain their services for the general public.

Commented [EB2]: We suggest highlighting the potential consequences of medical debt, per the presentation of Julia Kellison to the Workgroup.

Commented [EB3]: It should be noted that unlike hospital charity care, there is no statutory requirement for EMS providers and there is no oversight of how much charity care is provided - this is entirely voluntary.

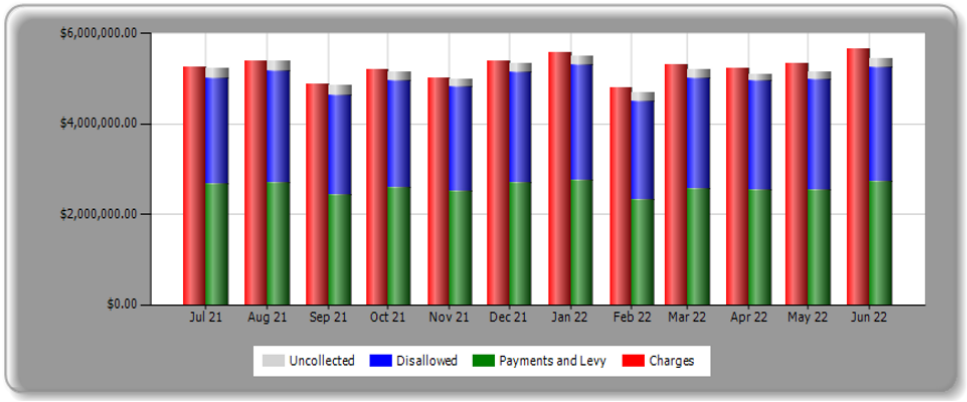
Provided by Systems Design West, LLC, an EMS and ambulance billing service, the chart below depicts annual collection statistics between July 2021 and June 2022, of a subset of public EMS providers in Washington. These EMS providers responded to and transported 62,653 patients. The total charges for those services were $62,999,208.88. Over half of the billed charges were either disallowed, uncollected, or still pending in collections from patients.

ANNUAL COLLECTION STATISTICS

Date Of Service	7/1/2021
Date Of Service	6/30/2022

Month	Tickets	Charges	Payments	%	Levy	%	Disallowed	%	Uncollected	%	Pending	%
Jul 21	5279	5,259,176.81	-2,352,910.18	45 %	-329,160.20	6 %	-2,339,169.23	44 %	-208,727.01	4 %	29,210.19	1 %
Aug 21	5394	5,392,777.94	-2,388,974.41	44 %	-312,822.19	6 %	-2,476,232.06	46 %	-193,071.06	4 %	21,678.22	0 %
Sep 21	4904	4,876,383.62	-2,133,740.70	44 %	-297,681.73	6 %	-2,190,789.83	45 %	-217,510.11	4 %	36,661.25	1 %
Oct 21	5207	5,196,225.63	-2,298,658.62	44 %	-297,279.69	6 %	-2,370,742.80	46 %	-189,018.54	4 %	40,525.98	1 %
Nov 21	5086	5,020,101.03	-2,215,046.76	44 %	-301,062.16	6 %	-2,290,987.87	46 %	-162,038.41	3 %	50,965.83	1 %
Dec 21	5403	5,391,933.20	-2,364,624.83	44 %	-339,163.90	6 %	-2,435,030.22	45 %	-201,229.97	4 %	51,884.28	1 %
Jan 22	5470	5,577,297.21	-2,376,705.20	43 %	-369,689.46	7 %	-2,552,321.07	46 %	-187,285.30	3 %	91,296.18	2 %
Feb 22	4705	4,791,782.29	-2,044,513.11	43 %	-289,960.74	6 %	-2,174,198.02	45 %	-187,978.21	4 %	95,132.21	2 %
Mar 22	5250	5,301,529.93	-2,258,288.33	43 %	-319,522.69	6 %	-2,429,075.46	46 %	-181,206.15	3 %	113,437.30	2 %
Apr 22	5131	5,211,898.92	-2,251,684.78	43 %	-294,330.40	6 %	-2,407,668.98	46 %	-133,108.89	3 %	125,105.87	2 %
May 22	5310	5,319,254.22	-2,233,247.80	42 %	-292,397.40	5 %	-2,445,780.10	46 %	-162,912.71	3 %	184,916.21	3 %
Jun 22	5514	5,660,842.08	-2,413,474.30	43 %	-321,483.11	6 %	-2,523,779.25	45 %	-186,484.24	3 %	215,621.18	4 %
	62,653	**62,999,202.88**	**-27,331,869.02**		**-3,764,553.67**		**-28,635,774.89**		**-2,210,570.60**		**1,056,434.70**	

All amounts shown relate directly to each month's charges.



The current burden is falling primarily on commercially insured patients and health plans who despite only accounting for 19% of transports between 07/01/2021 and 06/30/2022, contributed 33% of the payments received by the EMS Systems.

Current Ground Ambulance Balance Billing Protections

The data shared above illustrates the financial burden that balance billing for ground ambulance services can have on consumers who have experienced an unanticipated emergency. Steps have been taken or are being considered to address this problem at both the federal and state level.

Ground Ambulance Balance Billing Protections-Federal

As directed by Congress in the No Surprises Act, CMS has assembled the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) to assess ground ambulance balance billing. They have been charged to review options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing. Their report to Congress, with any findings and recommendations, is due in November 2023. To date, the committee has held public meetings in May and August, and has meetings scheduled in October and November. The committee established two subcommittees that have each held additional meetings as well.

At the time of this report, no formal recommendations have been made by GAPB. OIC will share any final recommendations with the appropriate policy and fiscal committees of the Washington legislature.

Ground Ambulance Balance Billing Protections-Other States

Thirteen states have enacted ground ambulance balance billing laws. Legislation also is pending in the California legislature where it has passed the Assembly and is currently in the Senate. The laws vary with respect to the route chosen to protect consumers. Some set rates for out-of-network ground ambulance provider payments and some use a negotiated rate approach. All but Arkansas expressly prohibits ground ambulance balance billing.

State (Year of Enactment)	Protects Consumers from Surprise Bills	Regulates Reimbursement Rates for Out-of-Network Providers	Rate of Reimbursement Guidance	Protections Apply to Public/Private Providers?	Notes
Arkansas (2023)	Yes	Yes	Minimum allowable reimbursement at: (1) Rate set by local government entity or; (2) the lesser of; (i) Rate established by the Worker's Compensation Commission or; (ii) the provider's billed charge.	Both	Requires payment be regarded as payment in full, with exception of applicable enrollee cost-sharing. Does not explicitly ban balance billing or limit applicable cost-sharing to in-network amount.
Colorado (2019)	Yes	Yes	(1)325% of Medicare; or (2) a negotiated independent reimbursement rate	Private only	
Delaware (2001)	Yes	No	N/A	Both	Does not apply to volunteer fire departments
Florida (2016)	Yes	Yes	Lesser of: (1) The provider's billed charges; (2) The usual and customary provider charges for similar services in the community where services were provided*; or (3) The charge mutually agreed to by the insurer and provider within 60 days of claim submittal	Both	Applies only to HMO Plans
Illinois (2011)	Yes	No	N/A	Both	
Louisiana (2023)	Yes	Yes	Minimum allowable reimbursement rate to out-of-network provider at: (1)a rate set or approved by local government entity or; (2) If no rate set or approved, the lesser of	Both	Cost-sharing must be based on applicable in-network amount

			325% of Medicare or the provider's billed charge.		
Maine (2020)	Yes	Yes	Out-of-network provider's rate	Both	Through Dec. 2023 carriers are required to reimburse out-of-pocket network providers at the lower of the provider's rare or 180% of Medicare, plus any adjustments for transfer of Medicaid recipients by providers in rural or super-rural areas.
Maryland (2015)	Yes	No	Sets minimum payment at amount paid to an ambulance service provider under contract with the carrier for the same service in the same geographic region.	Public only	Balance billing protections only apply if the ambulance service provider obtains an assignment of benefits from the insured.
New York (2015)	Yes	Yes	Usual and customary rate, which cannot be excessive or unreasonable*	Both	-Does not apply to interfacility transportation -Usual and customary rate is not defined in law or regulation and is set forth in insurance contract.
Ohio (2020)	Yes, for emergency services	Yes; reimbursement at the greatest of three rates and provides for negotiation/arbitration process.	Insurer must reimburse at based on greatest of: (1) median in-network rate (2) Usual, customary, and reasonable amount; * (3) Medicare rate; or (4) Provider may negotiate reimbursement. If not successful in 30 days, may proceed to arbitration.	Both	
Texas (2023)	Yes	Yes	(1) an amount set by a political subdivision and filed with the state or; (2) the lesser of; (i) 325% of Medicare or; (ii)the provider's billed charge	Public	Law expires on Sept. 1, 2025. Separate statutes apply to HMOs, health benefit plans, and insurers.

Vermont (1994)	Yes, for emergency services	No	N/A	Both	
West Virginia (1997)	Yes	Yes	Provider's normal charges	Both	Does not apply to PPO plans

To be Added: Policy Recommendations

Section 1

Text

Heading 2

Text

Heading 3

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Heading 4

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OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Ground Ambulance Balance Billing Study Report

Legislative study report
October 1, 2023

Mike Kreidler, *Insurance Commissioner*
www.insurance.wa.gov

OIC WA | 360-725-7009 | P.O. Box 40255 Olympia, WA 98504-0255

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Purpose & Background

The Balance Billing Protection Act (BBPA) RCW 48.49 was enacted by the Washington state legislature in 2019 and took effect on January 1, 2020. The law protects consumers from balance or "surprise" billing practices in specific settings where consumers have no opportunity to choose their provider. These settings include emergency services, air ambulance services, and non-emergency services provided at in-network hospitals or ambulatory surgery centers.

The federal No Surprises Act (NSA) went into effect January 1, 2022, and protects consumers from many of the same billing practices as the BBPA. In response, Washington state enacted E2SHB 1688 in March 2022 to bring the BBPA into alignment with the NSA. It also expands the services covered by the BBPA to include air ambulance transportation and emergency behavioral health services.

In all three enactments, ground ambulance services were not included in balance billing protections, despite consumers having no ability to choose their service providers in these situations. Ground ambulance services were not included in the federal and state laws due in large part to the complexity of emergency medical services (EMS) systems organization and financing at the local and county level.

Ground ambulances were also excluded from the federal Emergency Medical Treatment and Active Labor Act (EMTALA) enacted in 1986. EMTALA requires that hospitals with emergency departments provide medical examinations and treatment for emergency medical conditions (including active labor) regardless of a patient's ability to pay. Per EMTALA, this also means that no emergency department visit can be considered out-of-network and consumer cost-sharing must be billed at in-network cost-sharing amounts.

Between 2017 and 2023, ground ambulance billed charges and payments have only increased, as reported by health insurance carriers surveyed for this report. The greatest increase was for non-participating providers' billed charges for nonemergency services. However, there have been increases across the board regardless of the provider's network status or whether a service is emergent or not.

Non-Participating	Emergency services	Nonemergency services
Billed charges	69% increase	75% increase
Allowed amounts	66% increase	62% increase

Participating	Emergency services	Nonemergency services
Billed charges	46% increase	40% increase
Allowed amounts	50% increase	50% increase

Provided from OIC Carrier Survey presented at Advisory Group on July 26th, 2023

The burden of increasing billed charges largely falls on consumers who are balance billed and unable to afford the additional charges, often leading to medical debt and other serious financial and health repercussions. Consequences of medical debt for consumers include wage garnishment, damaged credit reports, and court fees in the event debt collectors sue the consumer for payment. This burden can fall disproportionately on consumers who live in rural and frontier communities, due in large part the longer distances rural EMS providers travel and to being less likely to have contracts with health carriers.

Due to the complexity of the ground ambulance system, E2SHB 1688 (2022), directed the Office of the Insurance Commissioner (OIC) to submit a legislative report related to how balance billing for ground ambulance services can be prevented. It instructed the OIC to consult with a broad range of interested entities and submit the report to the legislature on or before October 1, 2023:

RCW 48.49.190

(1) On or before October 1, 2023, the commissioner, in collaboration with the health care authority and the department of health, must submit a report and any recommendations to the appropriate policy and fiscal committees of the legislature as to how balance billing for ground ambulance services can be prevented and whether ground ambulance services should be subject to the balance billing restrictions of this chapter. In developing the report and any recommendations, the commissioner must:

(a) Consider any recommendations made to congress by the advisory committee established in section 117 of P.L. 116-260 to review options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing; and

(b) Consult with the department of health, the health care authority, the state auditor, consumers, hospitals, carriers, private ground ambulance service providers, fire service agencies, and local governmental entities that operate ground ambulance services, and include their perspectives in the final report.

(2) For purposes of this section, "ground ambulance services" means organizations licensed by the department of health that operate one or more ground vehicles designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat patients before and during transportation.

The OIC formed Ground Ambulance Balance Billing Advisory Group to meet the consultation requirement of the statute, and more importantly, to learn from ground ambulance subject matter experts.

As directed in the No Suprises Act, the federal government established the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) to advise Congress on any recommendations to protect consumers from balance billing in events where emergency ground ambulance services are required. Their first meeting of the committee was held on May 2, 2023. Their report to Congress is due 180 days after their first meeting.

In 2018 Congress also directed CMS to collect data on Medicare payments for ground ambulance services. CMS created the Medicare Ground Ambulance Data Collection System (GADCS) which will collect information on ground ambulance costs, revenue, and utilization during the period of January 1, 2020 to January 1, 2024. This information will be reported to the Medicare Payment Advisory Commission (MedPAC) who will in turn analyze the data and report to Congress.

Washington State Advisory Group Members

As directed in RCW 48.49.190, the Ground Ambulance Balance Billing Advisory Group members include the Department of Health (DOH), the Health Care Authority (HCA), consumers, hospitals, carriers, private ground ambulance service providers, fire service agencies, and local governmental entities that operate ground ambulance services. OIC consulted with the Washington State Auditor prior to initiating the project. The Advisory Work Group is comprised of the following representative organizations. For a complete list of members, please see Appendix A.

Advisory Group Member Organizations:

- AARP
- Association of Washington Counties
- Northwest Health Law Advocates (NoHLA)
- Olympic Ambulance
- Patient Coalition of Washington
- South Kitsap Fire Rescue
- Systems Designs West-Billing Agency
- Washington Fire Chiefs
- Washington State Council of Firefighters
- Washington Ambulance Association
- Association of Washington Public Hospitals (AWPHD)
- Washington State Hospital Association
- Association of Washington Healthcare Plans (AWHP)
- Association of Washington Cities

Advisory Group Project Team:

- Office of the Insurance Commissioner
- Department of Health (DOH)
- Health Care Authority (HCA)
- University of Washington Health Systems Collective/ The Value & Systems Science Lab (VSSL)

Advisory Group Meetings

The Advisory Group held six (6) meetings in January through August 2023 to share resources, review data and materials, and develop policy and finding recommendations. The Advisory Group had an

opportunity to review and comment on a draft of this report. All written comments received, including those related to the report, are posted on the project website.

Research Activities to Inform the Report

Emergency Medical Services (EMS) Licensing Applications

UW/VSSL, under contract with OIC, conducted a comprehensive look into licensure of EMS systems in Washington state to assess the organizational structure, business practices, and financing of EMS systems. VSSL used a two-pronged approach in their analysis, first by gathering systematic data from EMS licensure plans submitted to DOH:

- Type of EMS Service- Aid or Ambulance
- Level of service being provided- Basic Life Support (BLS), Intermediate Life Support (ILS), or Advanced Life Support (ALS)
- Geographic Area
- Types of Calls- 911 and/or inter-facility transports
- Number and type of vehicles

To ensure capture of additional information, the second part of VSSL's approach analyzed a sample of 22 EMS applications to provide a more in-depth analysis of EMS licensees. This analysis assisted the advisory group in better understanding the organizational structure, business practices and financing of EMS systems.

The findings of this study are reported later in this report. The full findings appear in Appendix B.

All Payer Claims Database (APCD) Ground Ambulance Services Analysis

The OIC analyzed commercial health insurance ground ambulance claims data for the period of 2019-2022 available through the Washington All Payer Claims Database (APCD). The data elements below are broken out by provider type, in-network (INN)/out-of-network (OON) provider status, payer type, EMS transport type, and location of service (urban or rural):

- Claim Count
- Charged Amounts
- Paid Amounts
- Copay Amount
- Coinsurance Amount
- Allowed Amount
- Deductible Amount

To corroborate this data and provide a better understanding of the disparities between dispatch volume and transport volume, the EMS Data Registry maintained by the Washington State Department of Health (DOH) also was reviewed. The data elements assessed in the EMS Data Registry are as follows:

- Primary type of service
- National Provider Identifier (NPI)
- EMS transport method
- Organization type
- Organization tax status
- Type of service requested

Commented [CH1]: UW/VSSL evaluated individual applications for EMS services. The individual applications may not accurately reflect an entire "EMS system" and is only a reflection of that one service.

I recommend saying "EMS Services" instead of EMS systems.

Commented [CH2]: I recommend saying "EMS service licensing applications" instead of plans.

This is because we do have Regional EMS & Trauma Care Plans and do not want to confuse the two as they are related, but substantially different in purpose and content.

- Primary method of payment
- Insurance company name
- EMS dispatch volume per year
- Payer type
- EMS patient transport volume per year

The findings of this study are reported later in this report. The full findings appear in Appendix C.

Survey of Health Carriers

The OIC surveyed 18 health carriers to gain an understanding of billed charges and amounts paid for ground ambulance services, contract status of ground ambulance providers, and primary concerns of carriers related to contracting with ground ambulance providers. A draft of the survey was reviewed by the Advisory Group. It was sent to carriers on May 1, 2023, with responses due June 1, 2023.

The findings of this survey are reported later in this report. The full findings appear in Appendix D.

Survey of Ground Ambulance Providers

UW/VSSL, in collaboration with OIC, designed a survey assessing the financing and business practices of ground ambulance providers. The survey was distributed to EMS licensees by DOH. A draft of the survey was reviewed by the Advisory Group. The survey was sent to the licensees on May 1, 2023, with responses due June 1, 2023.

The findings of this survey are reported later in this report and the full findings appear in Appendix E.

Ground Ambulance Services in Washington State

The EMS system in Washington state is integral to providing time-sensitive care to Washington residents in need. As an essential part of the Emergency Care System Continuum of Care, Washington statute authorizes local and county governments to establish and finance these systems. Private entities also provide ground ambulance services, often with a role in public EMS systems. The complexity of this network of systems was a primary reason that ground ambulance balance billing protections were originally not included in the BBPA or NSA. Per the Washington EMS Information System (WEMSIS), there were over 800,000 emergency calls to EMS in 2022, with 83.6% resulting in an EMS transport. This complex network is composed of many and varied means to establish, operate, and finance local systems.

Note: Throughout this report there are many acronyms and descriptions of services offered by EMS providers. Please refer to the glossary at the end of this report for definitions. Key terms are hyperlinked to a Glossary located at Appendix F.

How Ground Ambulances Services Work in Washington

Among the 39 counties, there are 478 licensed EMS systems (including air ambulances), 299 of which can provide ground transport for people in need of such care. Three types of services are provided: Basic Life Support (BLS) (most common), Intermediate Life Support (ILS), and Advanced Life Support (ALS), with different services provided at each level of care.

Types of EMS Licenses

Not all EMS licenses are the same. Defining features of licenses include the type of EMS services provided, whether the system transports patients, and whether the system is trauma verified*.

- Emergency Services Supervisory Organization (ESSO): an organization such as law enforcement agencies, search and rescue operations, and businesses with industrial organized safety teams provide initial medical treatment for on-site medical care prior to dispatch of EMS services.
    - ESSO's do not have vehicles, do not respond to 911 calls, and do not transport patients.
    - ESSO examples: Sheriff departments, ski patrols, Boeing Fire.
- Aid Services: an EMS service that operates one or more aid vehicles to respond to calls and provide initial care at the scene.
    - AID services respond to 911 calls and only provide initial treatment, they do not transport patients because most AID vehicles are not designed to carry stretchers and are only licensed as a first response service.

Commented [CH3]: I recommend saying "EMS services". An EMS system is comprised of more than just EMS services. There are 478 licensed EMS services - who may in addition to other emergency care partners make up an EMS system - which is a part of the larger statewide Emergency Care System - a total continuum of care comprised of injury prevention programs, EMS, acute designated and categorized hospitals that provide care for trauma, cardiac and stroke emergencies...etc.

Commented [CH4]: "service"

Commented [CH5]: "service"

Commented [CH6]: I recommend using language from the statute which defines ESSO's.

(14) "Emergency services supervisory organization" means an entity that is authorized by the secretary to use certified emergency medical services personnel to provide medical evaluation or initial treatment, or both, to sick or injured people, while in the course of duties with the organization for on-site medical care prior to any necessary activation of emergency medical services. Emergency services supervisory organizations include law enforcement agencies, disaster management organizations, search and rescue operations, diversion centers, and businesses with organized industrial safety teams.

- Ambulance (includes air ambulance): EMS service that operates one or more ambulance vehicles that respond to calls, provide patient care and transport patients to facilities.
    - Ambulances can carry stretchers.

*Verification is the process by which an aid or ambulance service is endorsed by DOH to respond to 911 calls and treat and/or transport trauma patients to hospitals designated to provide trauma care.

Commented [CH7]: Verification and trauma verified are the same thing. I recommend making the terms from paragraph one and this paragraph the same to avoid confusion.

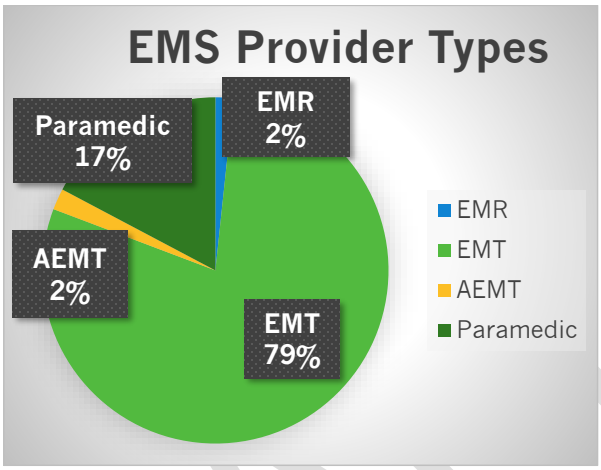
Who Staffs EMS Systems

As of December 31, 2022, there are 16,993 EMS providers in Washington state. Of that, 1 in 4 are reported by EMS services to be volunteers. Rural counties often struggle to maintain advanced EMS personnel and often rely more heavily on volunteers to staff their EMS systems, creating disparities in access to care for rural residents.

There are four levels of certified EMS providers, distinguished by the types of services they can provide:

Level of EMS Staff	Acronym	Description of Services	Skill Level/ Education
Emergency Medical Responder	**EMR**	✓ Responds to calls ✓ Provides Basic Life Support (BLS)	➢ 48-60 initial training hours ➢ Can perform CPR, provide oxygen, use AED, take vital signs, splinting, control bleeding, use EpiPen, administer Naloxone.
Emergency Medical Technician	**EMT**	✓ Respond to calls ✓ Provides Basic Life Support (BLS)	➢ 150-190 Initial training hours ➢ EMR services, plus administer Nitroglycerine, Aspirin, Glucose, apply cervical collar, assess blood glucose level.
Advanced Emergency Medical Technician	**AEMT**	✓ Respond to calls ✓ Provide Intermediate Life Support (ILS)	➢ 150-250 Initial training hours ➢ EMR and AEMT services, plus start an IV, administer additional medications, initiate cardiac monitoring.
Paramedic	**n/a**	✓ Respond to calls ✓ Provides Advanced Life Support (ALS)	➢ 1200-2500 Initial training hours ➢ Can perform all of the above plus intubation, chest decompression.

The most common type of EMS provider is EMTs at 79% (13,438). This is followed by paramedics at 17% (2932), and AEMT (338) and EMRs (285) at 2% each.



Provided by DOH Advisory Group Presentation on February 27th, 2023

Services Provided by EMS systems

EMS organizations offer the three levels of service described above (BLS, ILS, ALS). This care is provided in the following ways:

- **Dispatch**: Dispatching aid or ambulance services based on an emergency (911) or non-emergency call.
- **Assess**: An on-site assessment of a patient's health condition by trained personnel.
- **Treat & Refer to Services:** A patient is treated on-site and is referred to secondary sites for additional care. Secondary sites can include physician care, behavioral health treatment, etc.
- **Transport to Emergency Department:** Transport can be done only by a licensed or verified ambulance services staffed by certified EMS providers.
- **Transport to Alternative Sites**: EMS services can transport patients to alternative sites directly from an emergency scene, or a transport can be scheduled in advance as an interfacility transport if a patient needs to be transported between two health care facilities.

Commented [CH8]: "services".

Commented [CH9]: Recommend explaining the difference in the levels of service. For example:

Basic Life Support (BLS) services are staffed with emergency medical responder (EMR) and emergency medical technician (EMT) level personnel. Intermediate Life Support (ILS) services are staffed with advanced emergency medical technician (AEMT) personnel and advanced life support services (ALS) are staffed with paramedic level personnel.

Commented [CH10]: Recommend using the word "service" instead of "care" because "care" implies patient care, such as medical procedures. The activities noted below may include medical procedures but are more related to the operational service / patient movement component of the service vs. the actual patient care component of the service.

- Alternative sites include behavioral health crisis providers and treatment centers, substance use disorder treatment centers, dialysis centers, or doctor's appointments.

Operation of EMS Systems

EMS systems are operated by multiple types of collaborating entities. While they all respond to 911 emergency calls, they are not all established or function in the same way. UW/VSSL grouped EMS systems into 13 organization types and three broader groups:

Public	Private
City Fire Department	Private for Profit
City/Fire District Combination	Private Non-Profit
EMS District	Private Volunteer Association
Federal Fire Department	
Fire District	**Tribal**
Hospital District	Tribal EMS
Industrial Fire Department	
Military	
Municipality	

Provided by VSSL Report: Report on EMS Service & Vehicle License Applications August 2nd, 2023

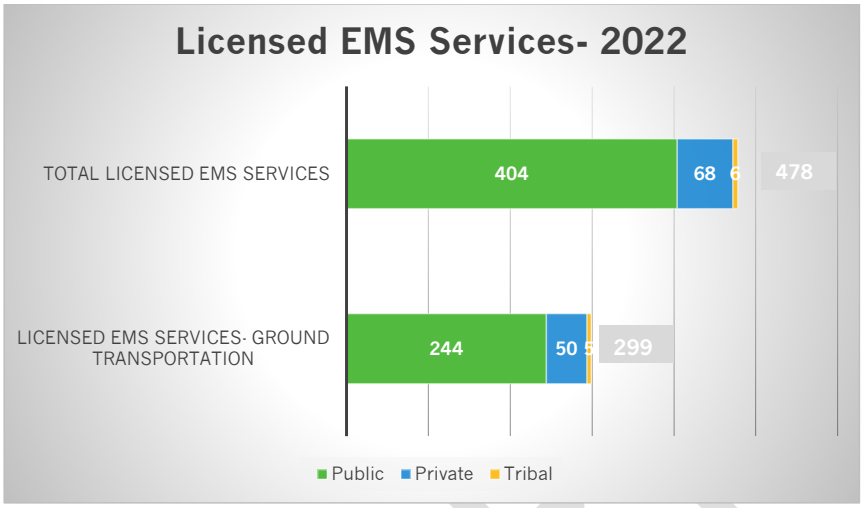
The licenses of EMS systems are issued, monitored, and tracked by DOH to ensure EMS services and personnel meet minimum standards for training, services, vehicles and equipment, and that proper care is provided to patients. Below is a graph of the types of entities that operate EMS systems in Washington and how many are able to provide ground transportation services.

Commented [CH11]: Recommend saying "may" instead of "all". Not all services in the box below may hold trauma verification. Some services are only licensed to provide inter-facility transport.

Commented [CH12]: "services"

Commented [CH13]: Recommend saying "operations" instead of "services" here to prevent the overuse of the word "services" in this sentence.

Commented [CH14]: "services"



Note: information per DOH 2022 Licensed EMS Services

Public and Private Ground Ambulance Providers

While many believe that ambulances are operated by cities and local governments, private ambulances play an important role in the care provided to Washington residents. The differences between private and public ambulance providers are summarized below:

Commented [CH15]: Recommend saying "private ambulance services"

Private	Public
Privately owned and operated and can include: ➢ Private ambulance that works out of a public agency (i.e., fire department) ➢ Private operation with own facilities	Publicly owned and operated and can include: ➢ Fire Department or District ➢ Public Hospital District ➢ EMS District
Responds to 911 calls in partnership with or at request of public EMS services.	Responds to 911 calls as top priority
Provides interfacility and specialty care transports with specially trained EMS and other healthcare providers such as critical care nurses (sometimes specializing in this care).	Provides very limited specialty care transport and limited interfacility transport, usually when no other services are available to provide transport.
Funded through third party payers, e.g., Medicare, Medicaid, and private health insurance	Funded through local government taxes, levies, as well as third party payers

There is vast disparity in the size, organization, and staffing of EMS services in Washington state. VSSL's analysis of 22 EMS license applications showed great variation in the size and organization of their EMS services. For instance, one organization reported 1,000 paid staff members, while the smallest reported only 20 paid staff members. Sixteen of the 22 EMS services reported having 0 volunteers, and one organization reported having 44.

This disparity was also reflected in the number of aid and ambulance vehicles. Only half of applications reported having any aid vehicles in their fleet, with the highest number of reported aid vehicles at 49. Among EMS systems with aid vehicles, they ranged from 4 to 53 vehicles.

EMS Statutes and Rules

As a necessary and vital service provider, the Legislature has enacted laws related to creation, maintenance, and funding of EMS systems. The relevant statues and rules include:

RCW	Name of RCW	Summary
Establishing EMS Systems		
Chapter 18.71 RCW	Physicians	Governs physician licensure, including emergency service medical program director certification.
Chapter 18.73 RCW	Emergency Medical Care and Transportation Services	Governs licensure of Emergency Medical Care and Transportation Services
Chapter 70.168 RCW	Statewide Trauma Care System	Establishment of statewide trauma care system, specifically designations for trauma hospitals and verification for ambulance services.
Authority to Establish EMS Systems		
Chapter 35.21 RCW (RCW 35.21.762 – 779)	Miscellaneous Provisions	Addresses authority for local governmental entities to create EMS services, provide financial support or revenue for those services, set rates, designate their service areas/districts, and allow volunteer EMS personnel to be compensated. Establishes the Community Assistance Referral and Education Services (CARE program and provides some protections to private ambulance providers.
RCW 35.23.456	Additional powers—Ambulances and first aid equipment.	Allows a second-class city to operate an EMS system when other ambulance services are not readily available.
EMS System Financing		

RCW 35.27.370	Specific powers enumerated.	Allows towns to operate ambulance service and collect fees for such a service.
RCW 36.32.470	Financial assistance to ambulance or EMS	Authorizes counties to furnish financial assistance for fire protection, ambulance, and EMS services
RCW 41.05.730	Ground emergency medical transportation services—Medicaid reimbursement—Calculation—Federal approval—Department's duties.	Creates GEMT program and stipulates its management and regulations.
RCW 84.52.069	Emergency medical care and service levies.	Sets $00.50 per $1000 of assessed value of property as levy limit on levies for EMS services. Levy is capped at 1% increase of revenue from previous year.
RCW 84.52.070	Certification of levies to assessor.	Allows counties and cities to set up levies for EMS systems.
EMS Systems- WAC		
WAC 246-976	Emergency Medical Services and Trauma Care Systems	Rules associated with EMS and Trauma Care System.

Rural communities establish public EMS systems when commercially available ambulances are not readily available. They cover a larger geographic area with lower population density per square mile while relying on fewer staff, vehicles, and funding resources They also tend to rely more heavily on volunteers. These more limited resources lead many rural areas to share ambulance services across multiple towns and cities. There are ground ambulance deserts in Washington where the nearest ambulance service is more than 25 miles away.

Funding EMS Systems in Washington

EMS Systems in Washington respond to 911 calls 24 hours a day, 7 days a week, 365 days a year. Divided into eight trauma care regions, they respond to emergency situations such as car accidents, search & rescue, heart attacks, stroke, substance use, and mental health crises. Per WEMSIS in 2022, it is estimated that the Washington EMS Systems responded to over 818,000 dispatch calls. That same number of people would fill T-Mobile Park (home of the Mariners) and Lumen Field (home of the Seahawks and Sounders) seven times. Of those 818,000 dispatch calls, 684,000 (83.6%) resulted in transport to a secondary location including emergency departments, hospital-to-hospital transfers, medical transfers, and more.

The magnitude of the work EMS systems provide has a cost. In the Ground Ambulance Provider survey, the 65 provider respondents estimated the cost of various components of their services. It was roughly

Commented [CH16]: "services"

estimated by respondents that a single EMS system costs roughly $7.6 million to operate annually, the largest share of that cost being EMT response staff, at just over $5 million. Providers responding to the survey varied greatly in size and provider type. Of the 65 respondents, 58 (89%) were public providers and 7 (11%) were private/non-government providers. The providers also varied greatly in the size of their paid and volunteer staff. Responding providers noted that the amounts provided were estimates and that costs can vary greatly from year to year. However, these numbers provide an important window into how much EMS providers themselves estimate it costs to operate an EMS system in Washington.

Commented [CH17]: "service"

Commented [CH18]: Is this number only reflective of EMT level providers? Or is it reflective of staffing in general which could include all level providers? If so, consider: "cost being certified emergency medical personnel" to be inclusive of all levels of providers.

Commented [CH19]: "service leaders"

Commented [CH20]: "service".

Cost category	Average cost
EMT/Response staff	$5,231,170
Administration/Facilities staff	$946,449
Owned ground ambulance	$275,468
Leased ground ambulance	$61,224
Other vehicles (non-ambulance)	$48,788
Capital medical equipment	$117,820
Capital non-medical equipment	$57,495
Medical equipment, supplies, and consumables	$64,797
Medications	$7,725
Other	$780,043

Provided from OIC Provider Survey presented at Advisory Group on July 26th, 2023

Covered and Non-Covered Services

Emergency response teams will remind us that it is free to call 911, and they actively encourage people to call if they fear for their life or health because the alternative is too great a risk. As noted above, there is considerable variability in the services provided by EMS systems. The advisory group deliberations revealed differences in payment for those varied services, both by service and across payers, as displayed below. In most cases, transports to a hospital emergency department are covered by Apple Health (Medicaid), Medicare, and commercial health plans. For all other services, coverage varies depending upon the payer and its policies.

Coverage by Payer and Service Provided

Name of the service	Medicare	WA Medicaid FFS	Commercial
Emergency transports (to higher care)	Yes, when meets medically necessary criteria	Yes, when meets medically necessary criteria	Yes
Non-Emerg transports interfacility, higher level	Yes	Yes	Only if covered, often not in full
Non-emerg transports, lower level (H-Res/SNF)	Conditional, medical necessity is stringent	Conditional, medical necessity is stringent	Only if covered, often not in full
Patient is in-patient	No, facility is responsible	No, facility is responsible	Only if covered, often not in full
Treat, No Transport	No	No, unless Treat & Refer enrolled	Conditional, generally no.
Specialty Care Transport	Yes	Yes, but pays as ALS	Yes
Transport to Alt. Destination	No	Yes, if criteria are met	Conditional, generally no.
Transport from Jail - Hosp	Conditional	Conditional	N/A
Involuntary Mental Health (various origin/destination)	Conditional	Yes	Yes
First response service (another agency transports)	No	No	No

Provided from Systems Design West, LLC presented at Advisory Group on March 31st, 2023

FFS= Fee for Service
Yes= Covered to some extent
No= No coverage offered for service

Ground ambulance providers in the advisory work group contend they are not fully compensated for the following services:

- **Loaded vs Unloaded Miles:** Providers are reimbursed for loaded miles, i.e., the number of miles during which a patient is in an ambulance. For example, if they transport someone one-hour outside the county to a higher-level trauma designation hospital they can bill for the mileage to get to the hospital, but the miles and time they spend to return to their jurisdiction are not billable.
- **Throughput Delays:** If a hospital, facility, or other care site is unable to accept a patient when they arrive, the ambulance provider cannot bill for the time they spend waiting for the patient to be admitted. Nor can they bill if they are attempting to transfer the patient to a new facility and have to bring them back to the original facility.
- **Treat, No Transport:** This refers to an emergency response where the patient is cared for by ground ambulance providers but is not transported to a hospital or other facility for treatment. As shown above, this is generally not covered by any insurance carrier.

- *Community Assistance Referral and Education Services (CARES) Program:* Per RCW 35.21.930 any fire department can develop a CARES program to improve community outreach and public health through assistance and education services. While the statute authorizes development of these programs and allows the fire department to seek grants and private gifts to fund them, it does not dedicate any government funding source for this program. Participation in the program is voluntary; some agencies provide treat, but no transport services without establishing a CARES program.

- **Interfacility Transport or Transport to Alternative Sites:** This broadly covers multiple types of transport that are not considered emergency transport to a hospital, including specialty care transport for people with special needs, transport to alternative destinations such as nursing or hospice facilities, and transport to mental health or substance use treatment centers. These may be covered at varying levels by insurance carriers and can result in large cost-sharing and balance bills for patients.
- **Cost of Supplies and Medications:** While this is a relatively small portion of the total cost of the operating budget for EMS Systems, these services are not directly billable.

Funding Sources for EMS Ground Ambulance Providers

EMS providers rely on a complex network of funding to cover the cost of operating their systems.

Local Government Funding

There are three general funding sources that allow local and county governments to fund public EMS services within their jurisdiction:

- **Levy**: Per RCW 84.52.069, local governments can impose a property tax levy of no more than $0.50 per $1,000 of assessed value of property for emergency services. It must be voter approved and can last for 6-years, 10-years, or be permanent. In addition, levy revenue cannot increase by more than 1% over the course of one year, also referred to as the 1% cap.
  - According to All County Levy Data from 2022 from the Washington State Department of Revenue, the average EMS levy amount was $0.39.
  - Hospital, fire, and excess levies contribute to EMS funding, but this funding also is used to fund other services, such as fire departments and public hospitals.
- **Utility**: RCW 35.21.766 allows local governments to create a fee structure that can fund ambulance transport services for all users or local residents.
  - For example, the city of Bridgeport charges a monthly $3.00 utility fee per Chapter 12.24.
- **Local Government General Funds:** RCW 35.27.370 and RCW 36.32.480 allow cities to fund and share ambulance services between municipalities.

Commented [CH21]: This may imply only people who are differently disabled. Consider: "for people who need medical care and treatment provided by higher qualified personnel such as nurses and specially trained paramedics,"

Commented [CH22]: Transport to alternative destinations means from a 911 call to a location other than a hospital receiving facility. This can include locations such as, a free standing emergency department, behavioral health or substance use disorder facility, or urgent care center operated by a hospital system.

Transport to nursing or hospital facilities only occurs during an inter-facility transport. Consider:

"transport to alternative destinations such as a free standing emergency department, behavioral health or substance use disorder facility, or urgent care center operated by a hospital system, or inter-facility transport such as a hospital discharging a patient to be transported to nursing or hospice facilities.

Commented [CH23]: "services"

Commented [CH24]: "types of activities"

- For example, North County EMS is a shared service between Clark County, southeast Cowlitz County, and west central Skamania County.

Third-Party Payers

Third party payers include commercial health carriers, Medicare, Washington Apple Health (Medicaid), and other government-funded health care programs.

- **Health Carriers**: This includes commercial health plans that provide coverage to Washington residents. They provide coverage at in- and out-of-network rates, which can vary widely depending on the health plan, the geographic area where the service is provided, and the EMS provider.
- **Medicare**: The federal Centers for Medicare and Medicaid Services (CMS) sets fixed rates for services. Some advisory group members stated that Medicare rates are below providers' costs. CMS and is beginning to collect ground ambulance cost reports for submission to the Medicare Payment Advisory Commissioner (MedPAC) for their analysis and findings.
- **Washington Apple Health (Medicaid):** Washington Apple Health pays fixed rates for specific covered services. Due to the low payment rates, there are two additional federal funding sources to supplement Apple Health payments for ground ambulance services.
  - *Ground Emergency Medical Transportation (GEMT*): Established through RCW 41.05.730, GEMT payment supplements Apple Health payments made for Apple Health-only patients who receive services from a publicly owned and qualified GEMT ambulance service. The program is not available to private ambulance providers. Public EMS providers can choose whether to participate in the program. As of July 2023, 140 EMS providers, or 35% of public providers, participate in the program. Local funding is matched with federal funds. The program is designed to cover the difference between Medicaid reimbursement and actual costs.
    - In 2022, CMS indicated a potential change in the costs that could be included in the calculation of a public EMS providers' costs. The key concern was whether "allowed costs" could continue to include costs associated with "treat but no transport" services. The Health Care Authority has submitted a state plan amendment to CMS that proposes to continue to include those costs in the program. HCA is awaiting a determination from CMS.
    - Per HCA in SFY 2022 the average cost per transport was $2,742.
  - *Ambulance Transport Quality Assurance Fee Program (QAF*): Per Chapter 74.70 RCW, this program obtains additional revenue for private ground ambulance providers. A mandatory fee is assessed on private, non-profit, and non-government emergency only services. Providers are assessed at the rate of $24.50 for every transport. This assessment is then matched with federal Apple Health matching funds to make enhanced payments to private ground ambulance providers.
    - The current enhanced payment for Apple Health patients requiring emergency only ground ambulance transport is $231.23.

    - The enhanced payment is not made for non-emergency transports or mileage, but it can be made for specialty care transports.
- **Other Government Health Carriers**: Tricare, Veteran Affairs (VA) health coverage, and Indian Health Services funding account for a relatively small portion of transports for EMS.

Cost, Charges, and Payment for Services

The advisory group gathered information related to several components of ground ambulance payment for services by commercial health plans. Claims information from the APCD on the seven most common ground ambulance billing codes was compiled and analyzed to attempt to arrive at the average payment and billed charges for the services.

Cost of, and payment for, ground ambulance services are analyzed with respect to:

- Cost: Most commonly used by providers and refers to the calculation of total cost of their service based on supplies used, mileage traveled, hourly rate of response team, etc.
    - All cost information is self-reported by providers via survey.
- Billed Charge: The total amount charged and submitted by the provider to the health carrier for reimbursement.
- Allowed Amount: The maximum amount the health plan will pay for a specific covered health service. This includes both the carrier's payment and applicable consumer cost-sharing.
- Allowed Amount as a Percent of Medicare: The maximum amount the health plan will pay for a specific covered health services as a percent of the Medicare allowed amount for the same service.

		Non-Participating				Participating			
Transport type (procedure code)	**Average cost from provider survey*** **	**Billed Charge-public**	**Billed Charge-private**	**Allowed Amount as % of Medicare-public**	**Allowed Amount as % of Medicare-private**	**Billed Charge-public**	**Billed Charge-private**	**Allowed Amount as % of Medicare-public**	**Allowed Amount as % of Medicare-private**
BLS nonemergency transport (A0428)	$1,370.87	$840.09 (34) **	$1,310.79 (712)	243%	406%	$943.96 (64)	$1,490.90 (1672)	347%	396%

BLS emergency transport (A0429)	$1,382.25	$802.92 (1,383)	$1,195.53 (1,308)	172%	229%	$781.62 (1,734)	$1,410.04 (2,262)	190%	327%
ALS nonemergency transport lvl 1 (A0426)	$1,559.06	$1,113.82 (33)	$2,399.96 (224)	258%	586%	$1,079.50 (50)	$2,276.97 (420)	311%	646%
ALS emergency transport lvl 1 (A0427)	$1,732.82	$1,039.89 (1,586)	$1,714.00 (777)	186%	293%	$991.13 (2,038)	$1,505.27 (1,095)	207%	340%
ALS emergency transport lvl 2 (A0433)	$1,923.59	$1,189.17 (112)	$1,575.12 (43)	152%	191%	$1,092.63 (156)	$1,590.50 (61)	157%	244%
Specialty care transport (A0434)	$2,246.61	<11 claims	$4,009.27 (235)	<11 claims	374%	<11 claims	$3,774.20 (582)	<11 claims	342%
Ambulance response and treatment, no transport (A0998)	NA	NA	NA	NA	NA	NA	NA	NA	NA

**Both commercial and Medicare claims are from 2021. Medicare allowed amounts are derived from the CMS Medicare Physician & Other Practitioners – by Provider and Service file. Medicare data was joined to commercial data on shared provider NPI in an attempt to account for variations by geography. Private providers include those categorized as independent, non-profit, private equity-owned, or publicly traded. The allowed amount for both commercial and Medicare data include the amount paid to the provider by the health plan and the total patient cost sharing component (sum of deductible and coinsurance amount that the beneficiary is responsible for paying).*

***Number of claims for each CPT code used to calculate average amount per CPT code.*

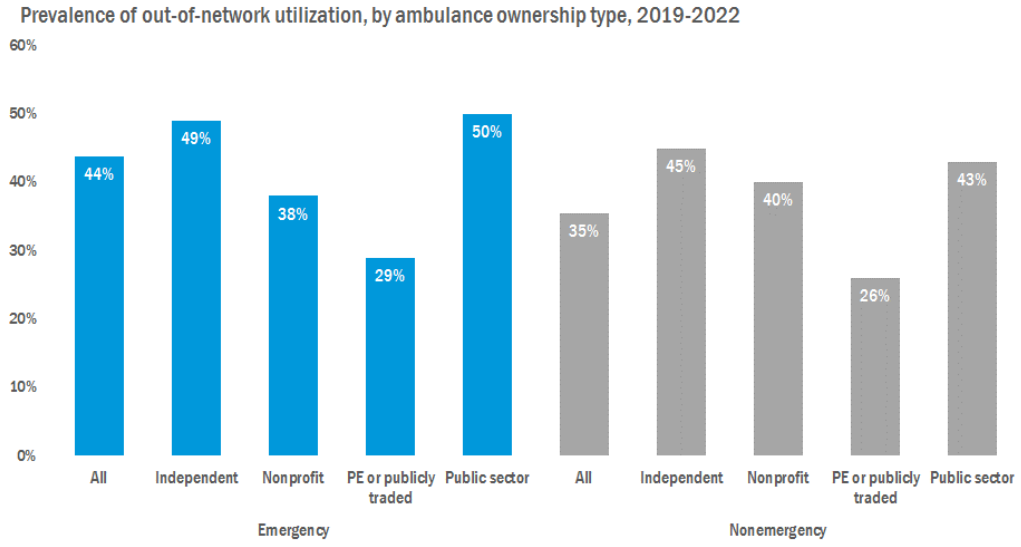
**** Cost calculated from provider survey. Total of responding providers was 65, with 58 public providers and 7 private providers. Thus, skewing results towards providers estimated costs.*

Exposure and Magnitude of Balance Billing on Consumers

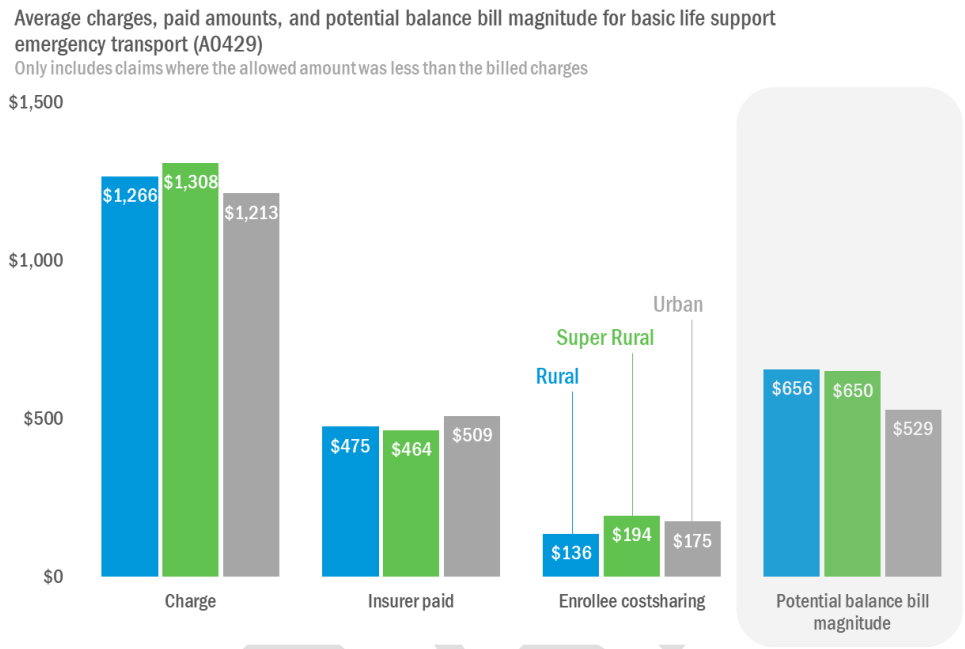
The increases in billed charges and allowed amounts reported by the 18 carriers surveyed for this report result in increased magnitude of potential balance bills.

The OIC reviewed its analysis of APCD claims data with the advisory group. The analysis assessed ground ambulance billed charges, payments, and cost-sharing from 2019-2022.

Due to the sheer volume of EMS services in Washington both providers and health carriers in the advisory group noted that the effort to contract as an in-network provider is a large administrative burden. This is particularly the case for smaller EMS services that simply do not have the administrative capacity to negotiate contracts with multiple insurance carriers. Carriers also struggle to contract with providers for various reasons, such as inability to reach an agreement or being unable to contact someone who handles contract negotiations. As a result, the prevalence of out-of-network ambulance utilization by consumers in emergent and non-emergent situations remains high across all ambulance ownership types.

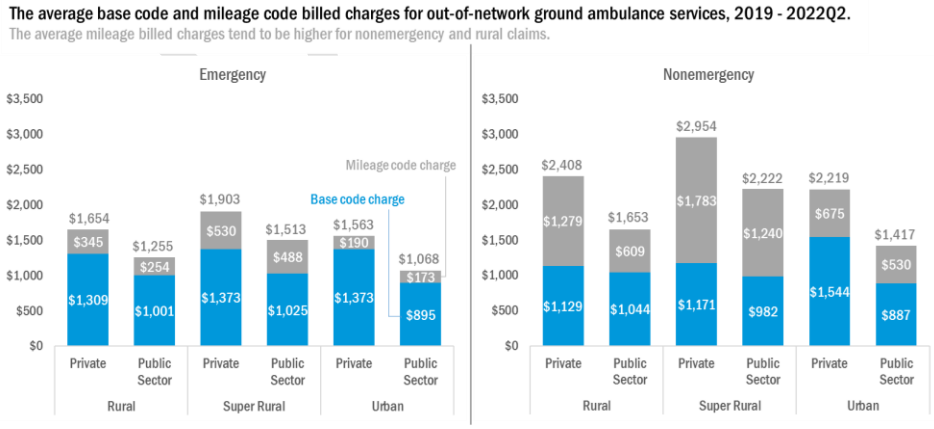


Currently, emergency transports are most likely to be covered by commercial health plans. For one of the most common types of services provided, BLS-emergency transport (CPT A0429) the difference between cost-sharing and billed charges for the service resulted in potential balance bills of over $500 in all geographic area designations.



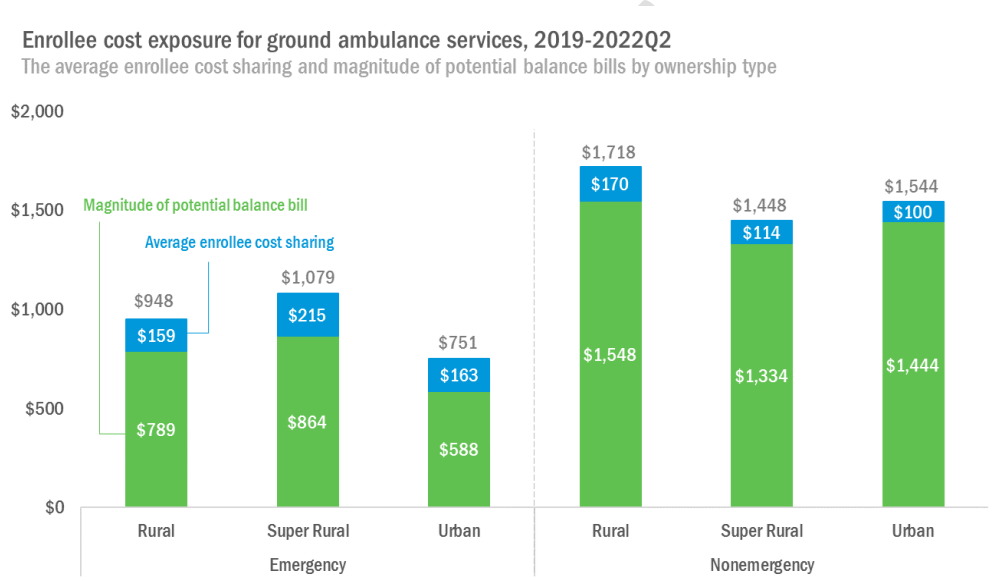
Provided from OIC APCD Analysis presented at Advisory Group on March 31st, 2023

Mileage is a separate component of ground ambulance services and is usually paid separately from the transport. The difference between the allowed amount and billed charges for mileage are another potential source of balance billing for consumers, with a greater burden falling on consumers in rural and super rural communities.



Provided from OIC APCD Analysis presented at Advisory Group on March 31st, 2023

Even with insurance, the high cost of ambulance services can be a surprise to consumers who have yet to meet their annual plan deductible or who have cost-sharing based on co-insurance rather than a fixed copayment. In the APCD analysis, even when appropriate cost-sharing was factored in, consumers still faced a potential balance bill in excess of $500, no matter their EMS provider or geographic location. A report completed in 2021 found that 1/3 of insured patients cannot afford a surprise medical bill of $1,000 or more, and 47% of insured patients cannot pay an emergency expense over $400 without borrowing money or selling assets.



Provided from OIC APCD Analysis presented at Advisory Group on March 31st, 2023

The burden of balance billing falls on insured consumers who are increasingly subjected to medical debt as a result of the high cost of covered services and balance billing. The consequences of medical debt are severe for consumers. They can face garnishment of wages, damage to their credit score, charges of 9% interest on the medical debt. They also can be sued by debt collectors for failure to pay, resulting in additional court fees. This entrenches consumers in a cycle of debt collection and poverty as a result of receiving life-saving care.

Commented [EB25]: 9% is the standard interest rate per RCW 19.52.010. But it may be worth noting that per RCW 19.16.500, debt collectors may charge 50% of the principal fee when collecting on behalf of **public entities,** like a public ambulance service.

While EMS providers often provide charity or hardship care to patients, it is an entirely voluntary program. In the Ground Ambulance Provider survey, 70% of respondents said they offered some sort of charity care or hardship program to consumers. In contrast to Washington state's hospital charity care law, there is no requirement in state law related to charity care for ambulance services.

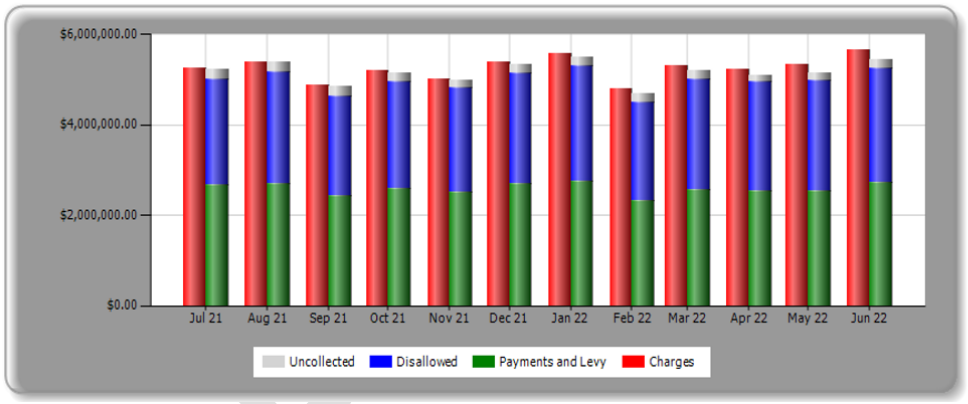
The public policy challenge is to balance the potential harm to consumers with the need to maintain access to EMS services. Systems Design West, LLC, an EMS and ambulance billing service, shared the chart below with the advisory group. It depicts annual collection statistics between July 2021 and June 2022, of a subset of public EMS providers in Washington. These EMS providers responded to and transported 62,653 patients. The total charges for those services were $62,999,208.88. Over half of the billed charges were either disallowed, uncollected, or still pending in collections from patients.

ANNUAL COLLECTION STATISTICS

Date Of Service	7/1/2021
Date Of Service	6/30/2022

Month	Tickets	Charges	Payments	%	Levy	%	Disallowed	%	Uncollected	%	Pending	%
Jul 21	5279	5,259,176.81	-2,352,910.18	45 %	-329,160.20	6 %	-2,339,169.23	44 %	-208,727.01	4 %	29,210.19	1 %
Aug 21	5394	5,392,777.94	-2,388,974.41	44 %	-312,822.19	6 %	-2,476,232.06	46 %	-193,071.06	4 %	21,678.22	0 %
Sep 21	4904	4,876,383.62	-2,133,740.70	44 %	-297,681.73	6 %	-2,190,789.83	45 %	-217,510.11	4 %	36,661.25	1 %
Oct 21	5207	5,196,225.63	-2,298,658.62	44 %	-297,279.69	6 %	-2,370,742.80	46 %	-189,018.54	4 %	40,525.98	1 %
Nov 21	5086	5,020,101.03	-2,215,046.76	44 %	-301,062.16	6 %	-2,290,987.87	46 %	-162,038.41	3 %	50,965.83	1 %
Dec 21	5403	5,391,933.20	-2,364,624.83	44 %	-339,163.90	6 %	-2,435,030.22	45 %	-201,229.97	4 %	51,884.28	1 %
Jan 22	5470	5,577,297.21	-2,376,705.20	43 %	-369,689.46	7 %	-2,552,321.07	46 %	-187,285.30	3 %	91,296.18	2 %
Feb 22	4705	4,791,782.29	-2,044,513.11	43 %	-289,960.74	6 %	-2,174,198.02	45 %	-187,978.21	4 %	95,132.21	2 %
Mar 22	5250	5,301,529.93	-2,258,288.33	43 %	-319,522.69	6 %	-2,429,075.46	46 %	-181,206.15	3 %	113,437.30	2 %
Apr 22	5131	5,211,898.92	-2,251,684.78	43 %	-294,330.40	6 %	-2,407,668.98	46 %	-133,108.89	3 %	125,105.87	2 %
May 22	5310	5,319,254.22	-2,233,247.80	42 %	-292,397.40	5 %	-2,445,780.10	46 %	-162,912.71	3 %	184,916.21	3 %
Jun 22	5514	5,660,842.08	-2,413,474.30	43 %	-321,483.11	6 %	-2,523,779.25	45 %	-186,484.24	3 %	215,621.18	4 %
	62,653	**62,999,202.88**	**-27,331,869.02**		**-3,764,553.67**		**-28,635,774.89**		**-2,210,570.60**		**1,056,434.70**	

All amounts shown relate directly to each month's charges.



The burden of payment is falling primarily on commercially insured patients and health plans who despite only accounting for 19% of transports between July 1, 2021, and June 39, 2022, accounted for 33% of the payments received by the EMS Systems.

Current Ground Ambulance Balance Billing Protections

The data shared above illustrates the financial burden that balance billing for ground ambulance services can have on consumers who have experienced an unanticipated emergency. Steps have been taken or are being considered to address this problem at both the federal and state level.

Ground Ambulance Balance Billing Protections-Federal

Advisory Committee on Ground Ambulance and Patient Billing (GAPB)

As directed by Congress in the No Surprises Act, CMS has assembled the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) to assess ground ambulance balance billing. They are reviewing options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing. Their report to Congress, with any findings and recommendations, is due in November 2023. To date, the committee has held public meetings in May and August, and has meetings scheduled in October and November. The committee also established two subcommittees.

At the time of this report, no formal recommendations have been made by GAPB. OIC will share any final recommendations with the appropriate policy and fiscal committees of the Washington legislature when the report is released.

Medicare Ground Ambulance Data Collection System (GADCS)

To assess the appropriateness of Medicare reimbursement for ground ambulance services, Congress directed CMS to create the Medicare Ground Ambulance Data Collection System (GADCS). GADCS requires a four cohorts of ground ambulance providers to report one year's worth of data to GADCS. This data includes the organization's costs, revenue, and utilization of ground ambulance services. The data collection began on January 1, 2020, and will go through January 1, 2024. This data will be reported to MedPAC who will analyze the data and make recommendations to Congress about appropriate reimbursement for ground ambulance services. As data collection is still underway, there are no recommendations or data available at the time of this report.

Ground Ambulance Balance Billing Protections-Other States

Thirteen states have enacted ground ambulance balance billing laws. Legislation also is pending in the California legislature where it has passed the Assembly and is currently being considered in the Senate. The laws vary with respect to the route chosen to protect consumers. Some set rates for out-of-network ground ambulance provider payments and some use a negotiated rate approach. All but Arkansas expressly prohibits ground ambulance balance billing.

State (Year of Enactment)	Protects Consumers from Surprise Bills	Regulates Reimbursement Rates for Out-of-Network Providers	Rate of Reimbursement Guidance	Protections Apply to Public/Private Providers?	Notes
Arkansas (2023)	Yes	Yes	Minimum allowable reimbursement at: (1) Rate set by local government entity or; (2) the lesser of; (i) Rate established by the Worker's Compensation Commission or; (ii) the provider's billed charge.	Both	Requires payment be regarded as payment in full, with exception of applicable enrollee cost-sharing. Does not explicitly ban balance billing or limit applicable cost-sharing to in-network amount.
Colorado (2019)	Yes	Yes	(1)325% of Medicare; or (2) a negotiated independent reimbursement rate	Private only	
Delaware (2001)	Yes	No	N/A	Both	Does not apply to volunteer fire departments
Florida (2016)	Yes	Yes	Lesser of: (1) The provider's billed charges; (2) The usual and customary provider charges for similar services in the community where services were provided*; or (3) The charge mutually agreed to by the insurer and provider within 60 days of claim submittal	Both	Applies only to HMO Plans
Illinois (2011)	Yes	No	N/A	Both	
Louisiana (2023)	Yes	Yes	Minimum allowable reimbursement rate to out-of-network provider at: (1)a rate set or approved by local government entity or; (2) If no rate set or approved, the lesser of	Both	Cost-sharing must be based on applicable in-network amount

			325% of Medicare or the provider's billed charge.		
Maine (2020)	Yes	Yes	Out-of-network provider's rate	Both	Through Dec. 2023 carriers are required to reimburse out-of-pocket network providers at the lower of the provider's rare or 180% of Medicare, plus any adjustments for transfer of Medicaid recipients by providers in rural or super-rural areas.
Maryland (2015)	Yes	No	Sets minimum payment at amount paid to an ambulance service provider under contract with the carrier for the same service in the same geographic region.	Public only	Balance billing protections only apply if the ambulance service provider obtains an assignment of benefits from the insured.
New York (2015)	Yes	Yes	Usual and customary rate, which cannot be excessive or unreasonable*	Both	-Does not apply to interfacility transportation -Usual and customary rate is not defined in law or regulation and is set forth in insurance contract.
Ohio (2020)	Yes, for emergency services	Yes; reimbursement at the greatest of three rates and provides for negotiation/arbitration process.	Insurer must reimburse at based on greatest of: (1) median in-network rate (2) Usual, customary, and reasonable amount; * (3) Medicare rate; or (4) Provider may negotiate reimbursement. If not successful in 30 days, may proceed to arbitration.	Both	
Texas (2023)	Yes	Yes	(1) an amount set by a political subdivision and filed with the state or; (2) the lesser of; (i) 325% of Medicare or; (ii)the provider's billed charge	Public	Law expires on Sept. 1, 2025. Separate statutes apply to HMOs, health benefit plans, and insurers.

Vermont (1994)	Yes, for emergency services	No	N/A	Both	
West Virginia (1997)	Yes	Yes	Provider's normal charges	Both	Does not apply to PPO plans

Amended from Center on Health Insurance Reforms (CHIR) Commonwealth CHIR blog post on November 15th, 2021. Please visit CHIR blog for more detailed information and interactive map.

Policy Recommendations and Key Findings

Advisory Group Process for Development of Policy Recommendations and Key Findings

In the course of the advisory group discussions, several policy options to end balance billing for consumers were reviewed. While there was broad consensus that balance billing for consumers should be prohibited, the focus of discussion was avoiding unintended consequences impacting availability of and access to ground ambulance services.

In the July and August meetings of the advisory group, 22 options were compiled. Advisory group members were asked to rank these options from 1-22 with 1 being the option they fully supported and 22 being the option they least supported. The members also were asked whether the option to apply to public providers, private providers, or both and whether they should apply to emergency services, non-emergency services, or both.

Note: In the original ranking there were 23 options. This was due to the option Cost-based reimbursement (similar to Critical Access Hospital [CAH]) being listed twice on the spreadsheet.

The policy options were ranked as either a policy recommendation or a finding. This distinction was made given the scope of the Legislature's direction, i.e., how ground ambulance balance billing for commercially insured consumers can be prevented. A policy recommendation is something that an advisory group member would support as a recommendation to the legislature. A finding is considered important and should either be studied further or at least brought to the attention of the legislature, if not addressed directly through a policy recommendation.

The following options were discussed and presented to the advisory group for ranking:

Policy/Findings Options	
End Balance Billing for Consumers	Develop reimbursement model that manages prices appropriately
No distinction between in-network and OON status for ground ambulance	Coverage for transport to alternative sites
Ground Ambulance services not subject to deductible (except high-deductible health plans (HDHP) with qualifying health savings accounts (HAS))	Coverage of non-covered services such treat, but no transport
Cost-based reimbursement (similar to Critical Access Hospital [CAH])	Coverage for unloaded miles
Cap OON ground ambulance rate at 150% of Medicare for providers that refuse to contract at a market rate	Increase Medicare reimbursement

Reimburse at full billed charges	Increase Medicaid Reimbursement
Reimbursements at 350% of Medicare	Maintain GEMT program with current scope of allowable costs
Reimburse at applicable local government/jurisdiction approved rate	Continue QAF beyond current expiration date (07/01/2028)
Reimburse at applicable local jurisdiction fixed rate, or if no local rate, at lesser of fixed percentage of Medicare (e.g., 325%) or billed charges	Enhance QAF funding (subject to federal 6% cap on provider tax/donations programs)
Ensure mechanism is set up for providers to dispute improper payment	EMS local levy authority increase
Allow self-insured groups to opt into any protections	Make EMS an essential health service that is provided by states and funded by federal, state and/or local funds

Advisory group members were given the option to respond individually or to submit a single ranking sheet for their organization. A total of nine ranking sheets were submitted by the deadline. As two were identical, only seven ranking spreadsheets with comments were presented. Three of the seven respondents were ground ambulance providers, one was a consumer advocate, two were health carriers, and one was a division of HCA.

The following recommendations and findings are presented after careful review and consideration. A full summary of comments and rankings are included in Appendix G of this report.

Policy Recommendations

Prohibit Balance Billing of Consumers

- Apply to emergency and non-emergency transports
- Apply to public and private providers

This was agreed upon by all interested parties, but also linked by several to the recommendation below related to ground ambulance rates. The burden of ground ambulance costs should not be placed on commercial health plan consumers. The comments that accompanied this focused mostly on finding alternative revenue sources for ground ambulance providers to maintain the viability of their operations. There was also concern that by banning balance billing, the cost of services could be shifted elsewhere, such as an increased premiums or cost-sharing.

Reimburse at applicable local jurisdiction fixed rate, or if no local rate exists, at the lesser of a fixed percentage of Medicare or billed charges

- Apply to emergency and non-emergency transports
- Apply to public and private providers

Adopted by Arkansas, Louisiana, and Texas by three other states, this is one of the most prevalent approaches to setting ground ambulance service rates. Reimbursement is set at the applicable local jurisdiction's fixed rate, or if no local rate has been set, then at the lesser of a fixed percentage of Medicare or billed charges.

Commented [EB26]: Duplicative

This specific solution achieved moderate support from the advisory group but was directly tied to two other closely related policy options that received high rankings. The APCD claims data analysis (see p. XX) showed substantial disparity between billed charges and allowed amounts of public versus private ground ambulance providers. A likely explanation for this is that public providers base their billed charges on locally set rates and have access to public funding to support their services. Given the complexity of this policy recommendation some important considerations include the following:

- Allowed amounts as a percentage of Medicare for BLS emergency transports (A0429), the most commonly billed CPT code, ranged from 172% -327% of Medicare. For the second most common code, ALS emergency transport level 1 (A0427), the range was 186% - 340%. It is recommended that that the fixed percentage of Medicare fall between the ranges for these codes and be set in statue by the legislature, alongside a review mechanism as noted below.
- The fixed percentage of Medicare should be applied only to claims for emergency services. Given the variability in billed charges and the allowed amounts as a percentage of Medicare for non-emergency services (from 350% to over 600% of Medicare., due in part to a smaller number of paid claims.), setting a fixed percentage may be premature.
- A review mechanism should be established to assess the appropriateness of the percentage of Medicare rate at regular intervals. This feature was strongly supported. The review would be conducted by the OIC and would take place in 2027 for the 2028 Legislature's consideration, or if Medicare makes a substantial update to their ground ambulance reimbursement rates, whichever occurs earlier.

Mandate Coverage for Emergency Transportation to Alternative Sites

- Apply to emergency transports
- Apply to both public and private providers
- Alternative sites include: behavioral health emergency services providers, including crisis stabilization facilities, evaluation and treatment facilities, medical withdrawal management and other crisis providers as defined in RCW 48.43.005.

In 2022, the Legislature expanded required coverage of emergency services by commercial health plans to include behavioral health crisis services. This expansion reflected the understanding that a hospital emergency room is not the most appropriate place for someone experiencing a behavioral health crisis. More appropriate care could be provided by a dedicated behavioral health crisis service provider. To fully effectuate the intent of the law, commercial health plans also should cover emergency ground ambulance transport to these facilities.

Key Findings

The following key findings were identified as important issues by various advisory group members as policy options that should be shared with legislators for further review and study.

Commented [EB27]: This bullet does not answer the question of what should happen to reimbursement for non-emergency services. If balance billing is also prohibited for non-emergency services (as it should be), how can we ensure that prices won't escalate?

It would be helpful to suggest a next step. I'm not certain of the best approach here - but brainstorming: how about something like a freeze in rates until further study due by X date and a phased-in reimbursement recommendation due to the Legislature by Y date.

Commented [EB28]: For consideration: Loren Adler has raised the suggestion that there should *also* be a review mechanism for the applicable local jurisdiction rate to ensure it is reasonable. Loren's concern is that cash-starved municipalities could increase their ground ambulance rates to pay for other services. I'm not certain if this is a concern in WA given restrictions on municipal rates, but wanted to raise the flag.

Ground Ambulance Services that Go Uncompensated

- Treat, but no transport: emergency responses that do not result in a patient being transported to a hospital.

As repeatedly stated by all interested parties, when someone calls 911 it should be a *free call.* If treat by no transport services are covered by commercial health plans, there is a question as to whether the service should be subject to a consumer's deductible or other cost-sharing. Coverage of treat but no transport services could potentially result in fewer transports to emergency rooms, saving health carriers the expense of an emergency department visit. Given these uncertain impacts, OIC should contract for an actuarial analysis of the cost and cost offsets of covering treat but no transport services and submit its findings to the 2025 or 2026 legislature.

Maintain Public Funding for Public and Private Providers for Medicaid/Apple Health Ground Ambulance Services

- Maintain Medicaid/Apple Health GEMT program funding
- Maintain Medicaid/Apple Health QAF program funding

These programs were identified as essential funding that helps cover the cost of care and transportation for Medicaid/Apple Health patients. Ground ambulance providers rely on this funding to reduce or alleviate the cost disparity between Medicaid/Apple Health amounts and the cost of services. Both programs have recently been extended or renewed and there was support for their continuation.

Future study of EMS an as essential health service that is provided by local and state governments and funded by federal, state, and/or local funds

- Strongly supported by advisory group members, including DOH who administers the EMS System in Washington
- Outside the scope of this study

Advisory group members agreed that given the number and complexity of EMS systems in Washington state, and the critical role that they play, a comprehensive study of the entire EMS System needs to be performed. The last such review was completed in 2010 when the Statewide Trauma Care System (Chapter 70.168) was updated to include the Center for Disease Control (CDC) recommendations for cardiac and stroke care. It is strongly recommended that this study be conducted with the specific goal of assessing if the EMS Systems in Washington should be considered and funded as an essential public health service similar to fire and police responses.

Conclusion

Advisory group members confronted the public policy challenge of balancing the harm experienced by consumers who are balance billed with the need to sustain critical EMS systems and the services they provide. There are 478 licensed EMS Systems in Washington state, 299 of which provide emergency transportation for Washington residents in need. However, the burden of funding this care should not fall disproportionately on commercially insured consumers. To this end, this reports recommendations and findings are intended to strike a reasonable, balanced approach to addressing this challenge. The EMS System is complex and critical to the health of all Washington residents; it should be appropriately funded and equitably accessible for all consumers.

Appendices

Appendix A: Advisory Group Members

Members

First Name	Last Name	Organization
Cathy	MacCaul	AARP
Curtis	Steinhauer	Assn. Of WA Counties
Emily	Brice	NoHLA
Shawn	Baird, CEO	Olympic Ambulance
Alex	Hamasaski	Patient Coalition of WA
Jeff	Faucett, Fire Chief	South Kitsap Fire Rescue
Jenn	Braus	Systems Designs West, Billing Agency
Shaun	Ford	WA Fire Chiefs
Dylan	Doty	WA Fire Chiefs
AJ	Johnson	WA State Council of Firefighters
Bud	Sizemore	WA State Council of Firefighters
Mike	Battis	Washington Ambulance Association
Paul	Priest	Washington Ambulance Association
Dennis	Lawson	WA State Council of Firefighters
Mike	Westland	WA State Council of Firefighters
Rhonda	Holden	WS Hospital Association
Pat	Songer	WS Hospital Association
Samuel	Wilcoxson	AWHP (Premera)
Christine	Dolly	AWHP (Aetna)
Eric	Koreis	Association of Washington Cities
Tom	Huntington	Association of Washington Cities

Observers

First Name	Last Name	Organization
Paul	Berendt	American Medical Response
Catie	Holstein	DOH
Michelle	Corral	HCA
Stefanee	Hale	HCA
Abby	Cole	HCA/Medicaid
Shawna	Lang	HCA/ERB
Mark	Streuli	Olympia Ambulance
Aya	Samman	Washington Ambulance Association
Jacob	Ewing	Association of Washington Cities

Lisa	Gaulin	Mass AGO
Elyssa	Penner-champlin	HCA
Desiree	Comfort	CVS Health
Lucy	Crow	HCA
Cade	Walker	HCA
Andrea	Philhower	HCA

Project Team

First Name	Last Name	Organization
Simon	Casson	OIC
Sydney	Rogalla	OIC
Joseph	Joo	UW Health systems collective
Ashok	Reddy	UW Health systems collective
Anh	Le	UW Health systems collective
Joy	Lee	UW Health systems collective
Wendy	Choy	WA State Auditor

Appendix B: Emergency Medical Services (EMS) Licensing Applications VSSL Report

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Appendix C: All Payer Claims Database (APCD) Ground Ambulance Services Analysis

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Appendix D: Health Carrier Survey

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Appendix E: Ground Ambulance Provider Survey

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Appendix F: Glossary of Terms

Glossary is in alphabetical order

- ***Advanced Life Support (ALS)-*** The most advanced level of care that can be provided by first responders or paramedics. It is provided in the event of a life-threatening illness or injury until full medical care can be provided. Can perform all BLS and ILS services as well as intubate patients in the field and perform chest decompression. This care can only be provided by certified paramedics.
- ***Aid Service-*** An EMS service that operates one or more aid vehicles to respond to calls and provide initial care on an emergency scene. These vehicles respond to 911 calls but are not able to transport patients as most are not designed to carry stretchers.
- ***Air Ambulance-*** EMS service that operates one or more air ambulance vehicles that respond to calls, provide patient care and transport patients to facilities. These can carry stretchers. Air ambulances can either be helicopters or fixed-wing aircraft.
- ***All Payer Claims Database (APCD)-*** Washington states database that includes medical, pharmacy, and dental claims, as well as eligibility and provider files reported directly to the state by insures.
- ***Allowed Amount-*** this is the maximum amount the plan will pay for a specific covered health care service (i.e., x-ray, flu shot, office visit).
- ***Balance Billing Protection Act (BBPA)-*** Act passed by Washington legislature in 2019 and amended by E2SHB 1688 in March 2022 than bans balance billing in a variety of settings.
- ***Balance Billing-*** The practice of a provider billing a patient for the difference between the provider's charges for services and the allowed amount. Also known as surprise billing.
- ***Basic Life Support (BLS)-*** The basic level of care provided by first responders in the event of a life-threatening illness or injury until full medical care can be provided. Can perform CPR, take vitals, control bleeding, provide certain medications, etc.
- ***Billed Charges-*** The total amount charged and submitted by the provider to the health carrier for reimbursement.
- ***Charity Care/ Hardship Care (Financial Aid)-*** Health care provided at free or reduced rates for patients and families with low-income.
- ***Co-insurance-*** The percentage of a healthcare bill that patients pay for health care services that are not fully covered by health insurance. Co-insurance can vary by type of service.
- ***Copayments (Copays)-*** A fixed dollar amount that a patient pays to a medical provider for services in addition to what is paid by the insurance provider. This amount varies by service.

- ***Cost-*** Most commonly used by providers and refers to the calculation of total cost of their service based on supplies used, mileage traveled, hourly rate of response team, etc.
- ***Cost-Sharing-*** The amount patients pay for health care services that aren't fully covered by insurance, including copayments and co-insurance.
- **Current Procedural Terminology (CPT)-** The language used by health care professional and health carriers for uniform coding of medical services and procedures. Used to streamline reporting and increase accuracy and efficiency.
- ***Deductible-*** The amount paid by the individual or family before insurance covers a part of the services. Deductibles vary for individuals and families.
- ***Emergency Medical Services (EMS)-*** Services that provide emergent pre-hospital services for life-threatening illnesses or injuries. Including transportation to the nearest emergency department.
- **Emergency Medical Treatment and Active Labor Act (EMTALA)-** A law passed in 1986 by Congress requiring hospitals with emergency departments to provide emergency medical services and examinations (including active labor) regardless of a person's ability to pay. They are also required to stabilize the patient. This also means that no emergency department visit can be considered out-of-network and consumer cost-sharing must be billed at the in-network cost-sharing rate.
- ***Emergency Medical Treatment and Active Labor Act (EMTALA)-*** federal law requiring emergency medical services be provided for emergency medical conditions regardless of a patient's ability to pay for those services. Also, prohibited any emergency department from being considered out-of-network and that all services must be billed at an in-network cost-sharing rate.
- ***Emergency Services-*** Also known as emergency care or emergent care, these are services given in an emergency room to prevent death or serious damage to the patient. This includes mental health crisis stabilization services.
- ***Emergency Services Supervisory Organization (ESSO)-*** An organization such as law enforcement agencies, search and rescue operations, and businesses with industrial organized safety teams provide initial medical treatment for on-site medical care prior to dispatch of EMS services. The organizations do not respond to 911 calls and do not provide transport to patients.
    - *Example: A coinsurance of 20% means a patient is responsible for 20% of the allowed amount while the health insurance provider is responsible for the remaining 80%.*
    - *Example: Copayment of $25.00 to visit a primary care provider and $50.00 copayment to see a specialist care provider.*
- ***Fee For Service-*** The most common type of health care payment method based on a fee schedule established by a health care provider for each service and procedure that they provide.
- ***Ground Ambulance-*** An ambulance used to transport patients with a traumatic illness or injury that require emergency medical services, or an ambulance used to transport patients in non-emergent situations who require extra assistance for interfacility and specialty care transport.
- ***Ground Ambulance-*** EMS service that operates one or more ground ambulance vehicles that respond to calls, provide patient care and transport patients to facilities. These can carry stretchers.

- ***In-Network (participating) (IN)-*** A provider or facility who is contracted with your health insurance plan.
- ***Interfacility Transport-*** Transport of a patient between two healthcare facilities via ground ambulance. Examples include transport between hospitals and hospice care centers, transportation to dialysis centers, etc.
- ***Intermediate Life Support (ILS)-*** More advanced than BLS, it is mid-level care provided to a person with a life-threatening illness or injury until full medical care can be provided. Can provide all basic life support and start IV, administer a wider array of medications, etc.
- ***Loaded Miles-*** Miles driven by a ground ambulance with a patient in the vehicle being transported to a hospital or alternative destination.
- ***No Suprises Act (NSA)-*** Act passed by Congress and took effect in January 2022, overlapped with Washington state BBPA. Bans balance billing in a variety of settings.
- ***Non-Emergent Services:*** Care or services provided in any setting that are not an emergency or medically necessary to prevent death or serious damage to the patient. This includes planned surgeries and scheduled appointments in a provider's office.
- ***Out-of- Network (non-participating) (OON)-*** A provider or facility who does not have a contract with your health insurance provider.
- ***Rate-*** *Fixed amount established by the health insurance carrier.*
- ***Specialty Care Transport-*** Interfacility transport for critically injured or ill patients that requires care beyond EMT-Paramedic level care, such as a critical care nurse.
- ***Surprise Billing-*** When a patient unknowingly or unavoidably receives health care services from a provider outside of their health insurance provider's network. Then they are billed the difference between the provider's charged amount for the care and the allowed amount.
- **Trauma Verified (verification)-** the process by which an aid or ambulance service are endorsed by DOH to respond to 911 calls and treat and/or transport trauma patients to hospitals designated to provide trauma care.
- ***Unloaded Miles-*** Miles driven by a ground ambulance without a patient being transported in the vehicle**.**

Appendix G: Advisory Group Policy and Finding Rankings with Comments

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Section 1

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- Text

	Policy/Findings Options	Include as finding? (Ranked 1-23 with "1" as most important)	Include as recommendation? (Ranked 1-23 with "1" as most important)	Apply to emergency services only or apply to emergency and non-emergency services?	Should this apply to public or private providers? Or Both?	Comments:
	End Balance Billing for Consumers		1 - most important	Both	Both	It is critical that OIC's report include a recommendation to end balance billing for consumers, as broadly as possible. As we noted in our 7/31/23 written comments, Washington consumers continue to suffer serious harm because of the gap in balance billing protections for ground ambulance services. It is time to take consumers out of the middle of reimbursement disputes between insurers and ground ambulance providers and manage those issues in a different way.
	No distinction between in-network and OON status for ground ambulance		1 - see comments	Both	Both	From a consumer perspective, it is essential to ensure that protections from balance billing include a requirement that insured enrollees will only face cost-sharing related to the in-network negotiated rate. On the front end, there should be no longer be a distinction between in-network and out-of-network ground ambulance providers. On the back end, there may be some differences, depending on the reimbursement mechanism selected.
	Ground Ambulance services not subject to deductible (except high-deductible health plans (HDHP) with qualifying health savings accounts (HAS))	2 - see comments				We recommend flagging the problem of high deductibles and other cost-sharing in the report as finding or area that needs further study. Even if we end balance billing, consumers may face high cost-sharing for ground ambulance services - this was clear in the Workgroup discussiom about how Medicare enrollees are struggling with high cost-sharing in Medicare Advantage plans, even though balace billing has been eliminated in Medicare. However, we are not certain that requiring all health plans to place ground abulances prior to the deductible is warranted at this time. Actuarial value limitations mean that removing the deductible from one service can have a substantial impact on cost-sharing for other services. This needs more analysis. We recommend asking the carriers in the Workgroup to model the likely cost-sharing impact of potential reimbursement models and further discussion of this point - perhaps at a mid-fall re-convening?
ment Rate Options	Cost-based reimbursement (similar to Critical Access Hospital [CAH])					Any consideration of a costs-based approach needs a mechanism to examine whether costs are warranted and appropriately managed.
	Cap OON ground ambulance rate at 150% of Medicare for providers that refuse to contract at a market rate					We are open to this general approach, but recommend further examination of whether consumer access could be maintained at this lower percentage of Medicare.
	Reimburse at full billed charges					This suggestion is inappropriate because it could result in billed charges that spiral ever higher for consumers, without any mechanism to manage that trend.
	Reimbursements at 350% of Medicare					We are open to this general approach, but recommend further examination of the consumer cost impact of pursuing this higher percentage of Medicare.
	Reimburse at applicable local government/jurisdiction approved rate					We are open to this general approach, but there should be a mechanism to address jurisdictions that don't have a default rate. There should also be a state-wide mechanism to ensure that local jurisdiction rates are appropriate/cost-based, to prevent the possibility that local jurisdictions could use the set rate as a way to generate additional revenue from carriers that is not related to the costs of ground ambulance services.

Ground Ambulance Pay	Reimburse at applicable local jurisdiction fixed rate, or if no local rate, at lesser of fixed percentage of Medicare (e.g. 325%) or billed charges		1 - most important (with caveats, see notes)	Both	Both	This "hybrid" approach seems to meet the practical needs of most stakeholders while offering consumers protection from balance billing. However, we have concerns about the percentage of Medicare selected as an example, given that it is over 3 times the reimbursement level the federal government has deemed to be fair/appropriate. We are concerned that a rate of 325% of Medicare could "bake in" excessive pricing and profit incentives we see in the market today. At the last Workgroup meeting, we saw data that compared ground ambulance commercial claims to Medicare, and the results spanned a wide range (from 152% of Medicare to a whopping 646% of Medicare). At the July Workgroup meeting, we saw data indicating that commercial billed charges and allowed amounts have risen substantially over the last 5 years, often by about 50% or greater. This suggests that there may be excesses occurring in some parts of the ground ambulance market. We recommend starting discussion with a lower percentage of Medicare (for example, a percentage that is closer to the average allowed amount by the public ground ambulances), and regardless of which percentage is selected, including: (1) authority at OIC or another regulatory body to modify the percentage based on analysis of costs and consumer impact, (2) a regularly-scheduled look-back analysis that would trigger such review, and (3) an off-cycle review scheduled whenever Medicare modifies their rates. As noted above, we also suggest: (1) Asking health plan participants in the Workgroup to model the likely premium and cost-sharing impacts associated with the percentage of Medicare that is selected; and (2) identifying a mechanism by which local jurisdiction rates can also be subject to a reasonableness review to ensure they are tethered to appropriately-managed costs. Finally, we flag the question of how this approach would handle services that aren't covered by Medicare but billed charges may be excessive - could there be another default rate in that instance, such as the carrier's usual/customary in-network rate?
	Ensure mechanism is set up for providers to dispute improper payment					
	Allow self-insured groups to opt into any protections		1 - most important	Both	Both	Our experience with the BBPA suggests that allowing a self-insured opt-in would be appropriate and valuable to ensure balance billing protections reach as many WA consumers as possible. Alternatively, could the state directly regulate the issue for self-insured enrollees by placing the protections in DOH statute and regulating the ground ambulance services themselves?
	Develop reimbursement model that manages prices appropriately		1 - most important	Both	Both	As noted above, this is a key consideration for consumers. Any reimbursement mechanism needs to recognize that ambulance costs are already untenable for consumers and cannot be allowed to grow without review.
	Coverage for transport to alternative sites	3 - open to including				Though this is not integral to the issue of balance billing, it may be apprropriate to discusss as a finding, given the need to address behavioral health crises and other public health issues that do not require transport to a hospital facility.
	Coverage of non-covered services such treat, but no transport	3 - open to including				Though this is not integral to the issue of balance billing, it may be apprropriate to discusss as a finding, given the need to address behavioral health crises and other public health issues that do not require transport to a hospital facility.
	Coverage for unloaded miles	3 - open to including				Though this is not integral to the issue of balance billing, it may be apprropriate to discusss as a finding, given the need to address rural access.
	Increase Medicare reimbursement					May be appropriate to discuss the likelihood of changes to Medicare rates in the near future so that state policymakers understand that the federal environment is likely to change.
Ambulance Medicaid Payment Ra	Increase Medicaid Reimbursement					Seems reasonable to discuss stakeholder concerns as part of the background section of the report.
	Maintain GEMT program with current scope of allowable costs					Seems reasonable to discuss stakeholder concerns as part of the background section of the report.
	Continue QAF beyond current expiration date (07/01/2028)					Seems reasonable to discuss stakeholder concerns as part of the background section of the report.
	Enhance QAF funding (subject to federal 6% cap on provider tax/donations programs)					Seems reasonable to discuss stakeholder concerns as part of the background section of the report.

Ground						
	Cost-based reimbursement (similar to Critical Access Hospital [CAH])					Any consideration of a costs-based approach needs a mechanism to examine whether costs are warranted and appropriately managed.
	EMS local levy authority increase	3 - open to including				It is clear that public authorities are struggling to manage within current levy limits. It seems appropriate to suggest greater flexibility, given that any increases would need to be approved by voters so there is a "check" against excesses.
	Make EMS an essential health service that is provided by states and funded by federal, state and/or local funds		2 - medium important (but may take transition time - see comments)			This is an appropriate recommendation that would meet the needs of many stakeholders, including consumers. The Workgroup has discussed the fact that EMS is an essential service that is integrated into fire services and other municipal services in many jurisdictions. Many local public services do not contract with carriers. Instead of moving to a system that emphasizes carrier reimbursement, it would be appropriate for the Legislature to consider the possibility of a public utility model for ground ambulance services. There may be lessons learned here from the struggle for mental health parity implementation - in retrospect, would it have been better to build on the public BH infrastructure we had, instead of attempting to build up a carrier-based reimbursement system that has been challenging to achieve? We suggest including the notion of a purely public system in the discusson of recommendations, but since this is less likely to be adopted by the Legislature in short order, we recommend suggesting it as an alternative to the reimbursement model we selected as our primary recommendation. Perhaps the Legislature could include a study of what it would cost to transition to a public utility model? If this approach is selected, it would be important to tax health insurers or other industry stakeholders who would benefit from the enhanced public infrastructure. It would also be important to establish a fair public reimbursement system that accounts for current shortfalls while managing costs. And it would be important to consider whether such a public system should continue to contract with private providers and whether it would serve non-emergency services.
					OTHER COMMENTS	We suggest including a finding or recommendation in the report related to: (1) the need for consumer education and notices, particularly if there are any gaps in the regulatory approach that consumers need to understand; and (2) the need for ongoing study of the problems in the ground ambulance sector. Our Workgroup has done a relatively shallow examination of a number of issues that are important to consumers, such as the best way to ensure that EMS personnel can be available for "treat in place" type scenarios that are important for public health and behavioral health. The Legislature may wish to continue the Workgroup at OIC or elsewhere for ongoing examination of these issues and to help implement any balance billing protections and related reimbursement approaches.

	Recommendation/Finding	Suggester Organization	Primary Benefit	Primary Concern	1. Protects Consumers	2. Enhanced EMS funding	4. Policy legislation needed	5. Regulatory Oversight Responsibility	6. Potential Medicaid MCO or commercial health plan rate Impact	7. General Fund-State fiscal impact	Notes
	Prohibit Balance Billing										
1	End Balance Billing for Consumers	OIC, NoHLA	Protects Consumers	Eliminates a currrent funding source for EMS providers	Yes	No	Yes	Yes-OIC	Yes	No	Directly related to legislative directive to submit report and any recommendations "as to how balance billing can be prevented and whether ground ambulance services should be subject to the BBPA. Also would require consumer cost-sharing calculation at in-network rates and application of consumer cost-sharing to their deductible and maximum out-of-pocket (MOOP) limits
	Commercial Health Plan Contracting										
2	No distinction between in-network and OON status for ground ambulance	WS Hospital Association	Protects consumers in emergency situations	Does not address non-emergent services	Potential	Potentially, depends upon rate established by payer	Yes	Yes-OIC	Yes	No	Addresse emergency situations, but balance billing more likely with respect nonemergency services. Applying balance billing protection means that the service is calculated at the in-network cost-sharing rates. GA should not be considered OON – consumer has no choice of which EMS provider responds. GA providers don't have the bandwidth to negotiate or contract with carriers. Challenging to have "take it or leave it" contracting situations.
3	Ground Ambulance services not subject to deductible (except high-deductible health plans (HDHP) with qualifying health savings accounts (HAS))	Provider/Carrier Survey	Protects consumers from higher charges	Would still require contracting between carriers and providers if not applied to OON providers as well	Yes	Yes	Yes	Yes-OIC	Yes	No	Concern for HDHP enrollees who would be exempt from this. Contracting requirement could still be necessary depending upon scope of this policy.
4	**Ground Ambulance Payment Rate Options**										
A	Cost-based reimbursement (similar to Critical Access Hospital [CAH])	Provider/Carrier Survey	Additional revenue for GA providers	Doesn't provide full revenue alternative	Potential	Yes	Yes	Yes-OIC for commercial; HCA for Medicaid	No	Yes, if applied to Medicaid	Legislation and oversight required. Plan to provide to only rural and super rural ambulances in certain designations
B	Cap OON ground ambulance rate at 150% of Medicare for providers that refuse to contract at a market rate	Provider/Carrier Survey	Sets rate for reimbursement	Does not provide alternative revenue source and concern about meeting costs	Potential	No	Yes	Yes-OIC	Yes	No	Limiting for providers without fully addressing their concerns.
C	Reimburse at full billed charges	Provider/Carrier Survey	Additional revenue for GA providers	Contracting requirement if limited to in-network provider	Potential	Yes	Yes	Yes-OIC	Yes	No	Contracting requirement would still be necessary for OON providers.
D	Reimbursements at 350% of Medicare	WA Fire Chiefs	Additional revenue for GA providers	Higher than any other state	Potential	Yes	Yes	Yes-OIC	Yes	No, if only applied to commercial plans	Current rates are 325% of Medicare in several other states that have recently enacted GA balance billing prohibitions
E	Reimburse at applicable local government/jurisdiction approved rate	WA Fire Chiefs	Sets clear reimbursement rate for providers	Legislative oversight and variations per county and jurisdiction	Potential	Yes	Yes	Yes-OIC	Yes	No, if only applied to commercial plans	Provides clear rate in statues.
F	Reimburse at applicable local jurisdiction fixed rate, or if no local rate, at lesser of fixed percentage of Medicare (e.g. 325%) or billed charges	OIC	Sets clear reimbursement rate for providers with back up option if none exists	Legislative oversight and variations per county and jurisdiction	Potential	Yes	Yes	Yes-OIC	Yes	No, if only applied to commercial plans	Provides clear rate in statues. Consistent with approach taken in several states that have recently enacted GA balance billing prohibitions
G	Ensure mechanism is set up for providers to dispute improper payment	Washington Ambulance Association. WA Fire Chiefs	Protects consumers and providers	Requires regulatory oversight	No	Impact TBD	Yes	Yes-OIC	n/a	No, if only applied to commercial plans	Less about new options and more about oversight that is important for providers and consumers. Could be folded into existing BBPA IDR process.
5	Allow self-insured groups to opt into any protections	NoHLA	Provides protections for consumers	Not a guarantee for all consumers in WA	Yes	Impact TBD	No, current SFGHP opt-in statute would accommodate BBPA amdmt.	Yes-OIC	n/a	n/a	Additional consumer protection that should be considered following original BBPA guidelines
6	Develop reimbursement model that manages prices appropriately	NoHLA	Provides mechanism for evolving price changes	Requires constant regulatory oversight	Potential	Yes	Yes	Yes-OIC	Yes	No	Would require legislation and regular oversight but could help manage prices more appropriately. Could set rate to be reviewed on a regular basis through APCD claims analysis to assess rates.
	Coverage of Services Not Currently/Generally Billable										
7	Coverage for transport to alternative sites, consistent with recent BBPA amendment including behavioral health crisis services as emergency services	OIC	Coverage for additional services leading to alternative revenue	Ability of alternative sites to accept patients	Potential	Yes	Yes	Yes-OIC	Yes	No, if only applied to commercial plans	Provides alternative revenue. Important to consider implications for emergency and non-emergency transports and if this would impact people's willingness to call 911.
8	Coverage of non-covered services such treat, but no transport	Washington Ambulance Association. WA Fire Chiefs, Systems Design West	Coverage for additional services leading to alternative revenue	Ensuring appropriate reimbursement rate	Potential	Yes	Yes	Yes-OIC	Yes	No, if only applied to commercial plans	Would increase revenue through coverage of different services. Would require legislation and consider impacts on emergency and non-emergent situations. Also if it would limit or impact the willingness of some to call 911 at all.
9	Coverage for unloaded miles	OIC	Coverage of a service thus providing an additional funding source	Ensuring appropriate reimbursement rate	Potential	Yes	Yes	Yes-OIC	Yes	No, if only applied to commercial plans	Provides alternative revenue source, but important to consider if it would make up the difference and the impact for rural and super rural communities.
	Public Program Funding										
10	Increase Medicare reimbursement	Provider/Carrier Survey	Additional funding for providers	The federal gov't (CMS) sets Medicare rates	Potential	Yes	Yes	Yes- CMS	Yes	Yes	This would require significant legislation and is inadequate to fully address the needs of consumers being balanced billed, we also have no control over Medicare rates and therefore could not feasibly enforce that portion of it

11	**Ground Ambulance Medicaid Payment Rate Options**										
A	Increase Medicaid Reimbursement	Provider/Carrier Survey	Additional funding for providers	Rates not set by OIC	Potential	Yes	Yes	Yes- HCA for Medicaid	Yes	Yes	This would require significant legislation and is inadequate to fully address the needs of consumers being balanced billed, we also have no control over Medicare rates and therefore could not feasibly enforce that portion of it
B	Maintain GEMT program with current scope of allowable costs	Provider/Carrier Survey	Continues an essential funding source for public providers	Doesn't address private ambulances or provide enough revenue to cover that lost from balance billing	No cost-sharing for Medicaid clients	No	No	Yes- HCA	No	No	This is likely to happen and does not address private providers or fully provide alternative revenue source for balance billing
C	Continue QAF beyond current expiration date (07/01/2028)	Provider/Carrier Survey	Continues an essential funding source for private providers	Doesn't address public ambulances or provide enough revenue to cover that lost from balance billing	Potential	No	Yes	Yes- HCA	No	No	While this is likely to happen currently it is not guaranteed in 5 years and still does not fully provide alternative revenue source for balance billing.
D	Enhance QAF funding (subject to federal 6% cap on provider tax/donations programs)	Provider/Carrier Survey	Provides additional revenue	We are very close to the cap already	Potential	Yes	Yes	Yes- HCA	No	No	Currently QAF is capped at 6%. We are very close to the cap, but not there yet. Chapter 74.70
E	Cost-based reimbursement (similar to Critical Access Hospital [CAH])	Provider/Carrier Survey	Provides additional revenue to GA providers	Doesn't provide full revenue alternative	Potential	Yes	Yes	Yes- OIC for commercial; HCA for Medicaid	No	Yes, if applied to Medicaid	Legislation and oversight required. Plan to provide to only rural and super rural ambulances in certain designations
12	EMS local levy authority increase	Provider/Carrier Survey	Additional funding for public GA providers	Subject to local determination	Yes	Yes-if passed	Yes	Yes-Local gov'ts	No	No	Would require legislation and voter approval in every county on 6- and 10- year basis to increase unless permanent levy is in place. Would have to be county specific, unless a state-wide levy was created which would require additional legislation.
13	Make EMS an essential health service that is provided by states and funded by federal, state and/or local funds	WS Hospital Association	Provides protection and additional revenue source	Requires legislation	Yes	Yes	Yes	Yes- DOH & local gov'ts	No	Yes	This would protect consumers and apply public health logic to EMS services, however it would require legislative buy in and would completely shift how EMS has previously been viewed.