OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

Ground Ambulance Balance Billing Study Report

Legislative study report
July 10th, 2023

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

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

Table of contents

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 of 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.

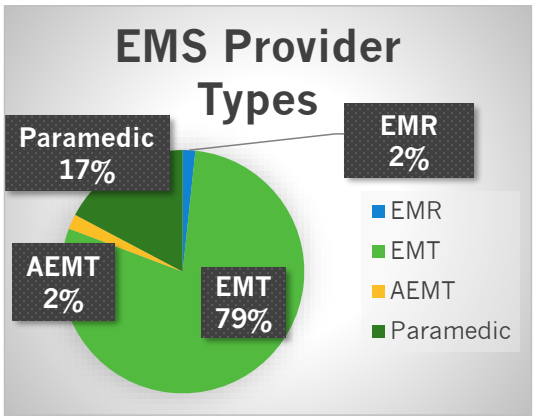
Who Staffs EMS Systems

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.

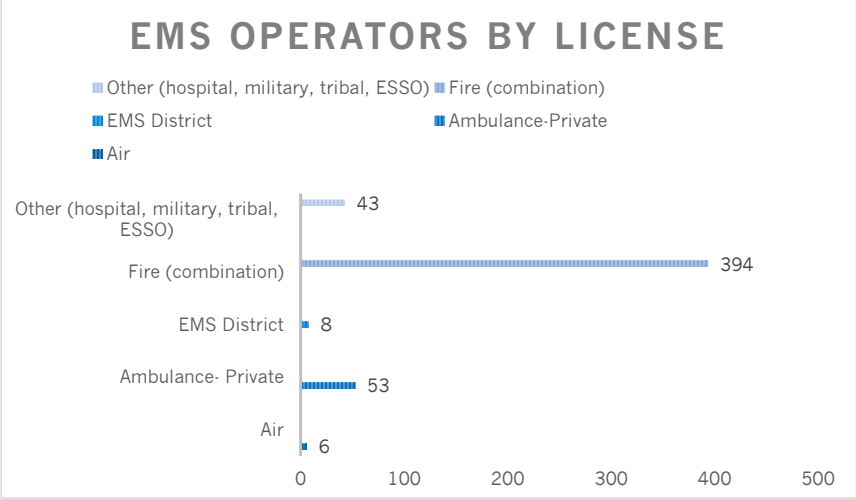
Operation of EMS Systems

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 operate~~s~~ 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~~To provide scale, the same number of people would fill 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~~. T~~, 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%)

Commented [PAL(1]: Is this an average across all respondents, or a composite estimate, or something else? What size of EMS system are we talking about? E.g., how many square miles is their service area, how many vehicles, what level of provider, rural or urban, etc. It would seem like there would be massive variation here and these numbers have to be theoretical, so what is the basis for them?

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

Commented [PAL(2]: These numbers are given entirely without context, so the reader has no idea how to interpret them. Does "eight trauma care regions" mean there are eight EMS systems in Washington? If so, are they all the same size? How many staff of what level are included in the first number? What kind of facilities are included in the second? How many ambulances are included in the third and fourth numbers - one? The report mentions that there is great variation in services so these numbers are basically smoke without any context.

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

Commented [PAL(3]: Instead of "Yes" and "No", recommend using "covered" or "not covered" because the table itself does not include the information about what "yes" and "no" mean.

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.

Commented [PAL(4]: Would it be relevant to briefly explain why these items are not billable? Is it statute? Tradition? Negotiated payment amounts/types? It seems as though we should advise the legislature whether they can do anything about this, since this information begs those questions.

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

Commented [PAL(5]: Do these utilities exist? Can we identify examples? If not, can we explain why?

Commented [PAL(6]: Existing examples?

Commented [PAL(7]: Is it weird that this list is not in the same order as the description of these entities?

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).*

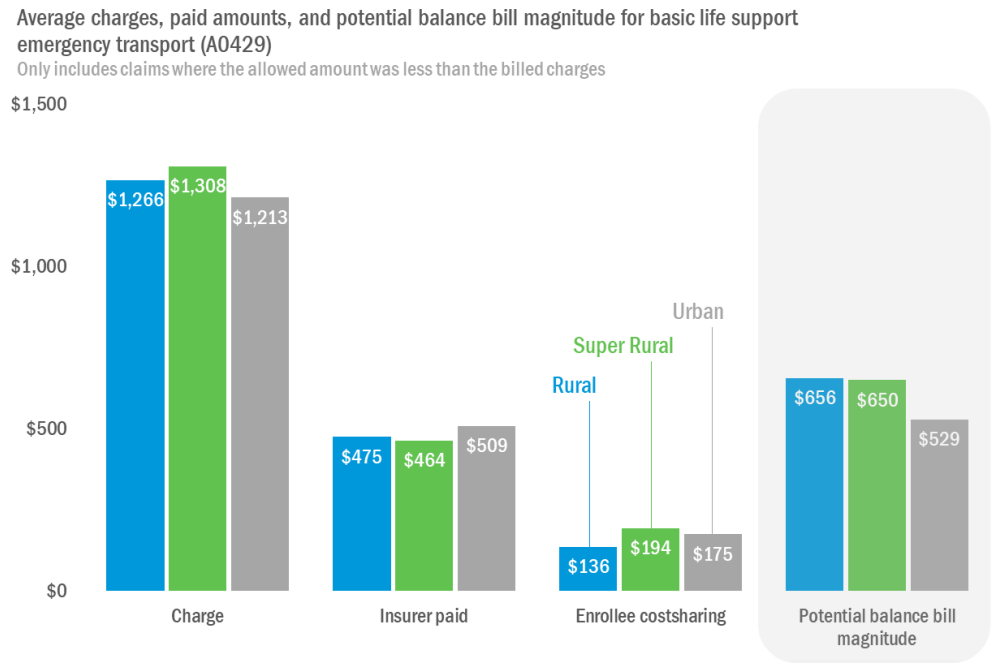
***Number of claims for each CPT code used to calculate average amount per CPT code.*

**** 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.*

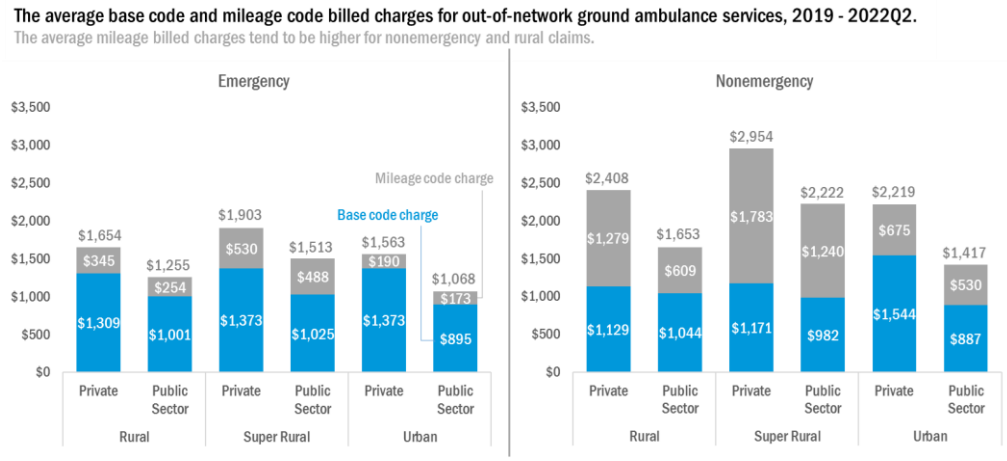
The increases in billed charges and allowed amounts reported by the 18 carriers surveyed for this report results in increased magnitude of balance bills that patients can receive.

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.

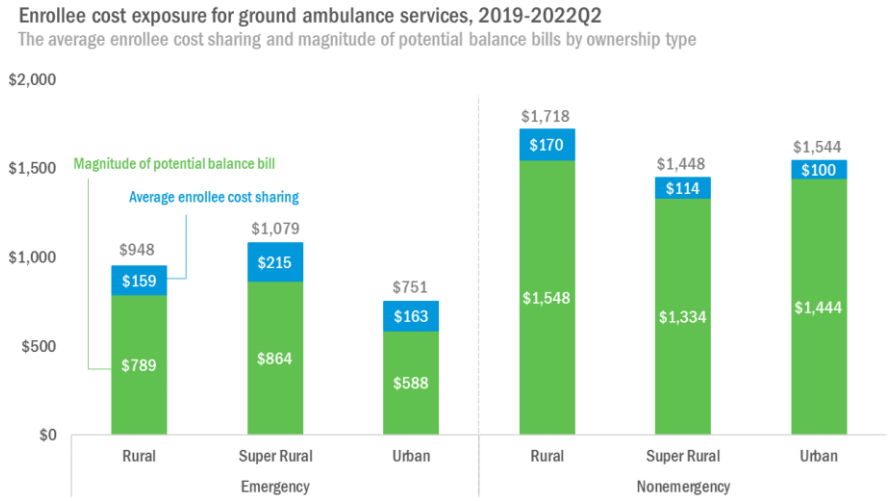
Currently, emergency transports are most likely to be covered by commercial health plans. For one of the most common types of services provided, BLS-emergency transport (CPT A0429) the difference between cost-sharing and billed charges for the service resulted in potential balance bills of over $500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



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.

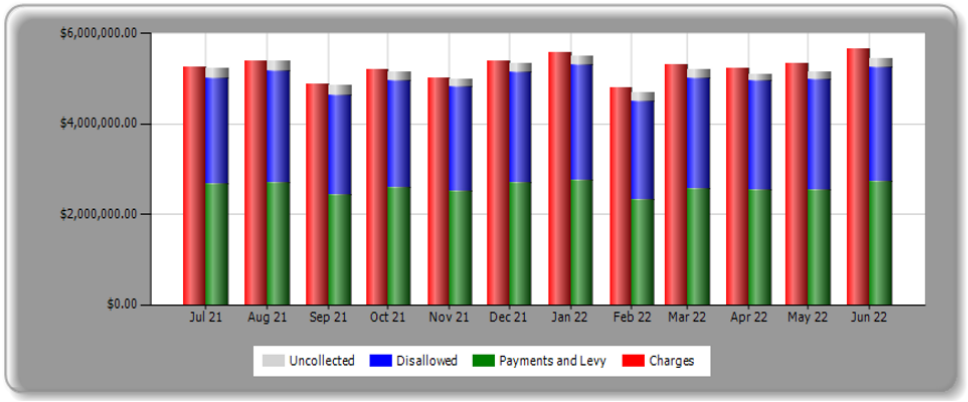
Provided by Systems Design West, LLC, an EMS and ambulance billing service, the chart below depicts annual collection statistics between July 2021 and June 2022, of a subset of public EMS providers in Washington. These EMS providers responded to and transported 62,653 patients. The total charges for 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

Commented [PAL(8]: This chart is a great idea but, as it currently exists, really doesn't say anything. Many of the lines don't make sense, e.g. the line for Delaware. It would be better to try to group the laws into categories and just list the states that fall into those categories. E.g., "The following states cap reimbursement at the lesser of a percentage of Medicare or an agreed rate, and ban balance billing for public or private providers: X, Y, Z."

			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~~ rate 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

Text

Heading 4

Text

- Text
- Text
- 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	1	Emergency Only	Both	Whatever else we do, this needs to happen in connection with it. Where consumers in emergency situations have no choice of providers, the Balance Billing Protection Act has clearly shown Washington's policy that balance billing is unconscionable. The No Surprises Act is the federal government's expression of this same policy. While it is certainly understandable that medical transport companies of all types cannot lose money on these transports, their financial survival cannot be put on the backs of covered consumers. At least with non-emergent transport, the patient has a fighting chance to shop providers to avoid incurring massive bills. When they have a choice in non-emergency situations, cost transparency could be expected to create a market situation where ambulance providers can charge fees that cover their costs, but won't be able to succeed if they engage in price-gouging.
No distinction between in-network and OON status for ground ambulance	2	2	Emergency Only	Both	This is a minimum and should happen with whatever else we do. Where consumers in emergency situations have no choice of providers, the Balance Billing Protection Act has clearly shown Washington's policy that consumers should be protected from shocking surprise bills. The No Surprises Act is the federal government's expression of this same policy.
Ground Ambulance services not subject to deductible (except high-deductible health plans (HDHP) with qualifying health savings accounts (HAS))	22	22	Both	Both	As long as we're doing #1 and #2, this won't be necessary. Consumers are aware of their deductibles when they choose their plans, so at least have the option of making an informed choice about their deductible before they're helpless in an emergency.
Cost-based reimbursement (similar to Critical Access Hospital [CAH])	6	6	At least emergency-only, preferably Both	At least emergency-only, preferably Both	
Cap OON ground ambulance rate at 150% of Medicare for providers that refuse to contract at a market rate	9	9	Both	Both	This is a stopgap.
Reimburse at full billed charges	23	23	Both	Both	This is a non-starter. Payers do not do this in any area. Nor should they. Allowed amounts must always be negotiated to prevent abuses, especially where out-of-pocket expenses from patients are involved.

Ground Ambulance Payment Rate Options	Reimbursements at 350% of Medicare	17	17	Emergency Only	Both	Where consumers in emergency situations have no choice of providers, the Balance Billing Protection Act has clearly shown Washington's policy that balance billing is unconscionable. The No Surprises Act is the federal government's expression of this same policy. While it is certainly understandable that medical transport companies of all types cannot lose money on these transports, their financial survival cannot be put on the backs of covered consumers. At least with non-emergent transport, the patient has a fighting chance to shop providers to avoid incurring massive bills. When they have a choice in non-emergency situations, cost transparency could be expected to create a market situation where ambulance providers can charge fees that cover their costs, but won't be able to succeed if they engage in price-gouging.
	Reimburse at applicable local government/jurisdiction approved rate	4	4	Both	Both	Although this would be a lot of work and have to be done by legislation, it's an excellent solution.
	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	5	5	Both	Both	Although this would be a lot of work and have to be done by legislation, it's an excellent solution.
	Ensure mechanism is set up for providers to dispute improper payment	21	21	Both	Both	This is a stopgap for the current, broken process. If we only prohibit balance billing for emergency transport, then it would remain necessary. But we should instead try to fix the current broken process by establishing reimbursement amounts industry-wide.
	Allow self-insured groups to opt into any protections	3	3	both	both	Whatever else we do, this needs to happen in connection with it.
	Develop reimbursement model that manages prices appropriately	18	18	Both	Both	What does this even mean? Isn't this the big-picture problem we're trying to solve?
	Coverage for transport to alternative sites	12	12	Emergency Only	Both	This could certainly be implemented along with other measures, such as creating an applicable government/jurisdiction approved rate.
	Coverage of non-covered services such treat, but no transport	11	11	Emergency Only	Both	This could certainly be implemented along with other measures, such as creating an applicable government/jurisdiction approved rate.
	Coverage for unloaded miles	8	8	Both	Both	This would require some oversight to prevent abuse, but is reasonable.
	Increase Medicare reimbursement	16	16	Both	Both	This is unrealistic so not much time should be spent on considering this.
Medicaid Payment Rate ptions	Increase Medicaid Reimbursement	15	15	Both	Both	This is unrealistic so not much time should be spent on considering this.
	Maintain GEMT program with current scope of allowable costs	10	10	Only applies to emergency	Both	
	Continue QAF beyond current expiration date (07/01/2028)	13	13	Both	Private	

Ground Ambulance O	Enhance QAF funding (subject to federal 6% cap on provider tax/donations programs)	14	14	Both	Private	
	Cost-based reimbursement (similar to Critical Access Hospital [CAH])	7	7			
	EMS local levy authority increase	19	19	Both	Both	We do not need to increase taxes, especially where there is coverage for these services from non-tax sources.
	Make EMS an essential health service that is provided by states and funded by federal, state and/or local funds	20	20	Both	Both	We do not need to increase taxes, especially where there is coverage for these services from non-tax sources.

	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	
	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.	