Moderator: Jill Darling
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1:00 pm CT

Coordinator: Welcome and thank you for standing by. I would like to inform all participants that your lines have been placed on a listen-only mode until the question-and-answer session of today's call. Today's call is being recorded. If anyone has any objections, you may disconnect at this time. I would not would now like to turn the call over to Jill Darling. Thank you. You may begin.

Jill Darling: Hi, everyone. Thank you, (Amanda). This is Jill Darling in the CMS Office of Communications and welcome to today's Ambulance Open Door Forum. Before we get into today's agenda, I have one brief announcement. This open door forum is open to everyone. But if you are a member of the press you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And now I'd like to hand it off to our Chair, (Sarah Shirey-Losso).

(Sarah Shirey-Losso): Good afternoon, everyone. It's been quite a while since our last call which Jill just reminded me occurred last March. So a lot has happened since then as you can see from today's pretty packed agenda. Just quickly, just to go through the agenda. We he have two items today that are in the physician fee schedule proposed rule. One presentation from our colleagues in the Center for Program Integrity. And one from our hospital and ambulatory policy group. Just a reminder for those of you that may be new to the call is that when we're in proposed rulemaking. We also may not be able to respond to your comments directly. Because these items are in a proposed rule, but we

welcome your comments to these items during the formal comment period which closes on September the 27th and we'll have more information on that during some of the slide presentations.

We also have an item from our colleagues in the Innovation Center and the Center for Medicaid. And doing a quick overview of some of the changes and new things going on with the ET3 model. So because of our agenda I won't take too much longer and we'll go ahead and get started.

Jill Darling: All right, thanks (Sarah). First up we have (Tom Kessler) who will go over the changes to the ambulance physician certification statement requirement. (Tom)?

(Tom Kessler): Thanks, hi. So we are proposing to make two changes to the ambulance physician certification statement requirements located in 42CRF410.40 and 41. First we are making changes designed to clarify the requirements regarding the physician and non-physician certification statements. Second we're adding staff to consign certification statements when the ambulance provider or supplier is unable to obtain a signed statement from the attending physician.

Over the years, we have received feedback from ambulance providers, supplies and their industry representatives that various situations exist where the need for a physician certification or non-physician certification statement is excessive or at least redundant to similarly existing documentation requirement. Rather than attempt to add additional exceptions to the regulatory structure, we determined that changing the existing regulations would maximize flexibility for providers and suppliers, reduce burden and maintain focus on the medical necessity determination as opposed the precise for or format of the documentation used.

Although there has never been a precise form or format that's been required by the regs, this was somewhat misunderstood or lacked clarity based on the regulation. So the changes include the finding of two types of statements; physician certification and non-physician certification statements and then reorganizing as well as simplifying the regulatory structure. At this point, we do not anticipate that these clarifications of the regulatory structure will actually alter the frequency of claim denials.

In addition as I mentioned, we are also adding staff who are authorized to sing the non-physician certification statements. For some time, we've recognized that on occasion there could be difficulties in obtaining the physician certification statement within the 48-hour period. And have allowed these statements to be obtained from different staff members including physician assistants and nurse practitioners, clinical nurse specialists, et cetera.

But in the intervening years, we've received feedback from stakeholders that other staff such as LNs, social workers and case managers should be included on the list of those staff members that can sign the non-physician certification statement.

And so we are proposing to add these physicians to the list of staff that can actually sign when the attending physician is unavailable. Now as with the current staff listed, we would need to make sure that the beneficiary - the individual that's signing is actually is actually employed by the beneficiary's attending physician or hospital or facility. And the remaining of the requirements actually would still be replaced. But beyond that, most of the changes to the regs or to really just simplify, clarify the requirements and increase the flexibility that's been provided.

And with that, I'll turn it back over.

Jill Darling: Great, thank you (Tom). Next we have (Amy Gruber) who will give an overview of the proposed rule ground ambulance data collection system.

(Amy Gruber): Thank you, Jill. I work in the Center for Medicare, Hospital and Ambulatory policy group, Division of Ambulatory services. My division under (Sarah)'s leadership is responsible for the coverage and payment policy for the ambulance fee schedule. My colleague (Kim Campbell) and I will be providing an overview of the ground ambulance data collection system proposed rule. Our slide presentation is available on our ambulances services center Web site.

On the agenda today Jill has provided a link to our Web site. The slides are available under spotlights, the fourth bullet if you were to click on the slide presentation. If you don't have a copy of the agenda, are ambulances services center Web site is https://www.cms.gov/center/provider-type/ambulances-services-center.html.

Moving onto slide Number 2, CMS has developed the proposed ground ambulance data collection system and has published our proposals to implement this legislation in the calendar year 2020 physician fee schedule, federal register, notice of proposed rulemaking which was published on August 14, 2019. Our proposed rule begins on Page 40682 of this document. We have made the federal register available on our ambulances services Web site. It is listed under Spotlights, proposal, second bullet where you can click on the proposed rule.

We would like to point out that the comment period ends on September 27, 2019. The public may submit their comments four ways; electronically

through www.regulations.gov or by regular mail or by express mail or overnight mail or by hand or currier. The address to submit written comments by regular mail or by express or overnight mail may be found on Page 40482 of the proposed rule. Each comment received timely will be received, excuse me, will be reviewed. The final determination for the proposals will be published in the final rule.

Moving onto Slide 4, so our proposals are in response to the statutory requirement under Section 50203B of the Bipartisan Budget Act, BBA for short, of 2018. Section 1834L of the Social Security Act established the fee schedule for ambulance services effective for dates of service on or after April 1, 2002. Section 50203B of the BBA of 2018 adds a new paragraph, 17, to Section 1834L of the Act. The first provision Section 1834L, 17A of the Act requires the Secretary to develop a data collection system which may include the use of a cost survey to collect cost, revenue, utilization and other information determined appropriate by the Secretary with respect to providers and suppliers of ground ambulance services.

Such a system must be designed to collect information needed to evaluate the extent to which report a cost related to payment rates under (unintelligible) fee schedule on the utilization of capital equipment and analyst capacity. And on different types of ground ambulance services furnished in different geographic locations including rural and super rural areas.

Moving onto Slide 5, the new Paragraph 17 at Section 1834L of the Act includes several provisions in addition to the development of the data collection systems that addresses such things as specification of the data collection system where this provision states that the Secretary must specify system by December 31, 2019. And identify the ground ambulance providers

and suppliers that would be required to submit information under data collection system including the representative sample.

This provision states that no individual provider or supplier should be included in the sample in two consecutive years to the extent practicable. The next provision reporting the cost information states that each year of ground ambulance provider/supplier identified in the representative sample as being required to submit information under data collection system for a period of the year must choose the Secretary information specified in the system in a formal manner and at the time specified by the Secretary.

Moving onto Slide 6, which includes two provisions which are the 10% payment reduction and the ongoing data collection provision. For the 10% payment reduction for failure to report the provision, this requires beginning January 1, 2022, a 10% pay reduction to the ambulance see schedule payment made to the provider/supplier that is required to submit information under the data collection system with respect to a period and does not sufficiently submit such information as determined by the Secretary.

The Secretary may exempt a provider/supplier from the payment reduction with respect to an applicable. In the event of a significant hardship such as natural disaster, bankruptcy, or other similar situations that the Secretary determines interfered with the ability of the provider or supplier to submit such information in a timely manner for the specified period.

The Secretary may establish a process under which a provider or supplier may seek and information review of a determination that the provide or supplier is subject to the 10% payment reduction. The other provision on this slide is the ongoing data collection. And that allows the Secretary to revise the system as

appropriate and to continue the data collection system for years after 2024 if deemed appropriate but in no less often than once every three years.

Moving onto Slide 7, this includes five other provisions under Section 1834L 17 of the Act. I would like to point out three provisions on the slide. First one is the report by the Medicare payment advisory commission. The acronym for them is (MedPAC). So no later than March 15, 2023 and as deemed necessary by (MedPAC). (MedPAC) must access and submit, much choose and must assess and submit to a report to Congress on information submitted by providers and suppliers through this data collection system. The adequacy of payments for ground ambulance services and the geographic variations in the cost of furnishing such services.

The contents that are required in this (MedPAC) report are listed on Slide 7. The next provision that I would like to mention is regarding the public availability. And this provision requires the Secretary to post information on the results of the data collection on the CMS Web site as determined appropriate by the Secretary.

And then finally I would like to point out that CMS is required to implement the provisions in Section 1837L17 of the Act through notice and comment rulemaking.

Moving onto Slide 8, this is regarding your ambulance. This proposal is for ground ambulance providers and suppliers only. However, some stakeholders have expressed interest to us in also making this type of information available for other providers or suppliers of ambulance services such as air ambulances. If you would like to comment on this, please submit your comments by September 27.

As this time I would like to turn our presentation over to (Kim Campbell) who will speak about the proposals for the data collection system and proposals for sampling. (Kim)?

(Kim Campbell): Thank you, (Amy). I will briefly discuss our proposals related to the data collection instrument and sampling plan as Amy mentioned. Another way to find the proposed rule data collection instrument, our contractors report as well as this presentation is to go to our Web site at cms.gov. Click on Medicare then provider type and then ambulance services. These documents are at the top of the page under spotlights. We have also provided links in this presentation.

Throughout the proposed rules we have discussed alternatives considered as well as the rationale for these proposals. Please refer to the proposed rule, the data collection instrument and our contractors report for all the details as this presentation will only provide an overview.

Section 3 of the proposed rule describes the research that informed the proposals for the data collection instrument and sampling plan.

Slide 10, the reincorporation, working with (Miter) and CMS conducted an environmental scan where we identified five previously fielded ambulance cost collection tools, conducted interviews with some of you and other stakeholders and analyzed Medicare claims and enrollment data. We want to thank everyone who took the time out of their busy schedule to talk with us. The information you provided was extremely helpful in developing our proposals in such a short time frame.

Slide 11, Rand report is located at the link on Slide 11 which describes the research in greater detail as well as the recommendations they made to CMS

regarding the data collection instrument and sampling plan. Our goals were to meet the statutory requirements to collect meaningful data when minimizing (unintelligible) to the extent possible. In Section 4 of the proposed rule, you will find our proposals for the data collection instrument.

Slide 13, we made several proposals related to the instruments, format, scope, domain and specific questions.

Slide 14, Section 4A of the proposed rule contains our proposals for the format of the instrument. Based on our analysis of the five previously fielded ambulance cost collection tools as well as our discussions with some of you, we do not believe any of the existing tools will be sufficient to collect the data required. Instead we are proposing an newly developed, secure, web-enabled, survey-based data collection instrument.

Our challenge was to develop an instrument that would minimize burdens but still be relevant for all land ambulance organizations. The proposed data collection instrument includes screening questions and skip patterns that allows one type of ground ambulance organization that may look vastly different from another organization to only view and respond to questions that are relevant to their specific organizations.

Slide 15, Section 4B contains our proposals regarding scope. We considered several proposals regarding the scope of cost, revenue, and utilization data. We are proposing to collect information on total ground ambulance cost, revenue and utilization form all providers and suppliers that fill Medicare for ground ambulance services for those ground ambulance services. For those ground ambulance organizations that have shared costs with other departments or operations, we are proposing that you report all costs and revenues entirely related to ground ambulance services. And report certain

information so that we can calculate an allocated share of costs that are partially related to the ground ambulance services. We are proposing that you do not report cost and revenues entirely unrelated to ground ambulance services.

Slide 16 provides a summary of the proposed data collection instrument section and their content. You will also find this chart in Section 4C of the proposed rule. I will highlight some of our proposals in each section.

Slide 17, in Section 4C one of the proposed rule, we're proposing to collect information on your organizations characteristics including information regarding the identify of your organization and those completing the instrument as well as service area, ownership, response time and some other characteristics as well as some broad questions about offered services to serve as screening questions.

As previously mentioned, responses to some of these questions will be used to tailor later questions to be more relevant to your organization.

Slide 18, in section 4C2 of the proposed rule, we are proposing to collect information on your organizations volume of ground ambulance services during the data collection year. And you can see what some of those are on Slide 18. We are also proposing to collect information on total utilization, not just Medicare utilization.

On Slide 19, in Section 4C2 of the proposed rule, we are also proposing to collect information on the shares of transport by level and only if applicable response that were emergency versus nonemergency, transports that were land versus water, and transports that were interfacility.

Slide 20, in Section 4C3 of the proposed rule we're proposing to collect information on ground ambulance organizations' total cost inclusive of costs unrelated to ground ambulance services in a single question. And the instructions here provide more information on how cost partially related to ground ambulance services should be reported throughout the rest of the instruments.

In order to make sure we're collecting all the costs associated with your organization, we are proposing that respondent's collect and report information on cost related to ground ambulance operations that are paid by other entities. And there are some examples on Slide 20.

Slide 21, in Section 4C3 one of the proposed rule, we are proposing to collect information on staffing and labor costs related to staff with responsibilities that are entirely or partially related to ground ambulance services, including staffing in terms of hours during a typical week during the data collection year. And we define what we mean by a typical week in the proposed rule and the data collection instrument.

Total annual compensation for paid staff, volunteer staff, and hours during a typical week during the data collection year and cost associated with volunteer staff.

Slide 22, also in Section 4C3, one of the proposed rule we are proposing that staffing, labor costs and volunteer labor information be reported using specific categories. There are several response staff categories; a single, all administrator or facility staff category and a medical director category. Separate questions ask whether organizations have staff in more detailed administrative or facilities categories enrolled. The instrument collects

information necessary to allocate labor costs for staff with ground ambulance and other responsibility.

Slide 23, in Section 4C3, two and three, we're proposing to collect information on facilities and we're proposing to collect information on vehicles. And on Slide 23, you can see a little bit more detail about what we're proposing to (Coax).

In Section 4C3, four and five, we are proposing to collect information on equipment and supply costs. And we're also proposing to collect information on other costs including contracted services including billing, vehicle maintenance, IT support services and a wide range of other miscellaneous costs.

On Slide 25, in Section 4D of the proposed rule, we're proposing to collect information, revenue information. And we're proposing to collect total ground ambulance revenue for the organization from all sources. Revenue from healthcare payers and revenue from all other sources and you can see some of those other sources listed on Slide 25. In Section 5 of the proposed rule that's where we have proposals for sampling.

Slide 27, in terms of sampling requirements, the statute requires us to collect information from a sample that is representative of the different types of providers and suppliers of ground ambulance services, such as those providers and suppliers that are part of an emergency service or part of a government organization. Representative of the geographic location in which ground ambulance services are furnished such as urban, rural and low population density areas.

In terms of eligible organizations, we're proposing to sample from all national provider identifier that care for ground ambulance services in a prior year. And that would be 2017 we're proposing for the first data collection year. Please make sure your organizations NPI information is up to date and we provided a link on Slide 28.

We are also proposing to describe eligible organizations in terms of their volume of Medicare build transports, service area, population density, ownership and provider versus supplier status. Using the information we obtained from Medicare claims and enrollment data, so we please ask you that you make sure your information is up to date in the Medicare enrollment system which is the Medicare provider enrollment chain and ownership system, also known as PECO.

Slide 29, in terms of sample size, we are proposing to sample 25% of ground ambulance organizations in each year. As described in the proposed rule, we believe the sample of this size is guaranteed to cover all subgroups of ground ambulance organizations regardless of whether Medicare currently collects the data necessary to identify subgroups.

There are approximately 10,000 ambulance providers and suppliers that bill Medicare. So under CMS' proposed approach, the sample will include approximately 2500 organizations per year.

I will pass the mic back over to (Amy Gruver) to describe the rest of our proposals.

Amy Gruber: Thank you, (Kim). Moving onto Slide 31, we have (unintelligible) three proposals for collecting and reporting of information under the data collection system which can be found on Page 40698 of the proposed rule.

We are proposing Number 1, a continuous 12-month data collection period based on the ambulance provider or suppliers annual accounting period, either calendar or fiscal year. We are proposing this data collection period based on feedback from ground ambulance organizations that stated that they preferred to collect data based on annual accounting period either calendar year or fiscal year already used by the organization and that requiring all organizations to report on the same 12-month period, for example, calendar year could involve significant additional burden in terms of data collection and reporting. We believe that providing flexibility and collection information in the data collection system would reduce the burden on ground ambulance organizations.

Second proposal is that we are proposing that the first data collection period be January 1, 2020 through December 31, 2021 with organizations reporting on a calendar year basis collecting data from January 1, 2020 through December 31, 2021. And organizations reporting on a fiscal year basis collecting data over continuous 12-month period of time from the start of the fiscal year beginning in calendar year 2020.

Our third proposal is regarding the reporting period. We are proposing up to five months to report to CMS the data following the end of its 12-month data collection period. And the proposal rule, we have included several examples of data collecting and reporting period.

Moving onto Slide 33 which we have provided our proposals for payment reduction for failure to report. We are proposing to make a determination that the ground ambulance organization is subject to the 10% payment reduction no later than three months following the date that the data reporting period ends. We are also proposing that if we find the data reported is not sufficient,

we will notify the ground ambulance organization that it will be subject to the 10% payment reduction for ambulance services during the next calendar year. Calendar year is our proposed applicable period. We are also proposing a process to apply for hardship exemption and proposing a process to apply for internal review, excuse me, information review.

In addition to our proposals, there's a regulatory impact analysis section beginning on Page 40888 of the proposed rule that provides estimated costs for ground ambulance providers and suppliers that are selected to submit their data as well as to apply for hardship exemption and informal review.

In closing, please send us your comments. Thank you.

Jill Darling: Thank you (Amy) and (Kim). And next we have (Sarah Goldman) who will give a refresher of the ET3.

(Sarah Goldman): Thank you very much. Good afternoon, everybody. Currently, Medicare pays for EMS services only when beneficiaries are transported to a limited number of covered destinations such as the emergency department. This creates a perverse incentive to bring Medicare beneficiaries to high acuity, high cost settings even when their healthcare needs could be more appropriately addressed in the lower acuity, lower cost setting such as a federally qualified healthcare center.

The emergency triage treat and transport model also known as the ET3 model aims to address this misaligned incentives by providing EMS payment for delivering new services that will provide beneficiaries more care options and encourage appropriate utilization of services. Specifically, these new services include payment for unscheduled emergency ambulance transport of Medicare fee for service beneficiaries to alternative destinations such as behavioral

health centers, sober centers, and urgent care centers. And second, payment for treatment in place where appropriate and rendered in conjunction with a Medicare enrolled, healthcare practitioner either on the scene or via telehealth.

Starting January 2020, ET3 will be implemented in the Medicare fee for service beneficiary population. But the Innovation Center recognizes the importance of achieving multi-payer alignment in securing ET3 success. Multi-payer alignment is crucial for a multitude of reasons, including improving EMS ability to implement ET3 interventions. We understand that EMS providers already face numerous challenges when rendering care in the field. And that having to discern a patient insurance provider to determine ET3 service eligibility would introduce another layer of complexity.

As part of the application process, we are asking applicants to describe their multi-payer strategy. However, to be clear, while multiplayer involvement is highly encouraged, it is not mandatory. For those applicants who plan on engaging with other payers, the Innovation Center does not expect formal arrangements to be secured at the time of application. The innovation center is committed to helping applicants achieve a robust multi-payer collaboration. To this end, we recognize that a crucial player in this space are state Medicaid agencies. We have released guidance to state Medicaid agencies outlining potential steps to developing ET3 aligned interventions. We appreciate that for many EMS suppliers, the opportunity to work with their state and Medicaid office to implement interventions may be new.

I, therefore turn to my colleague (Cherie) to further provide to you guidance and explain any important background information and next steps in working with your specific state's Medicaid office.

(Sheri Gaskins): Good afternoon, everyone. My name is (Sheri Gaskins) and I work in the Division of Benefits and Coverage within the Centers for Medicaid (unintelligible) Services. As you are aware, CSM issued the informational bulletin or (CIB) on August 8, 2019. The purpose of the letter was to provide an overview of how a state Medicaid program could achieve the aims of the ET3 model.

Before I discuss the (CIB), we would like to start by giving a brief background on the Medicaid program to ensure that everyone on the call today understand at a high level the process and information that states will need to consider. First, Medicaid is a health insurance program for individual with limited resources. It is jointly funded by the federal government and state governments. Each state is responsible for administrating the Medicaid program within broad federal guidelines. This means that every state will have a different method of administering the Medicaid program.

The Center for Medicare and Medicaid services if the federal agency tasked with oversight responsibilities for each state's Medicaid program. Each state provides a plan to operate the Medicaid program in what is known as the state plan. And you often hear folks mentioning the state plan. Changes to the state plan are submitted to CMS is called estate plan amendment or SPA for short. Because each state is different steps states will need to take to implement this model will also be different. The federal rules governing how a state operates their Medicaid program for transportation is flexible enough to implement the ET3 model intervention.

The (CIB) offers states pathways to achieve the ET3 intervention such as how to reimburse for treatment interventions provided on the scene. We also provide a series of state assessment questions to determine whether they are

ready for implementation. This includes assessment of their operational environment as well as the need to make changes to their state plan.

While the (CIB) is targeted to state Medicaid programs, you may find value in reviewing the federal flexibilities outlined in the (CIB). Of particular interest maybe the state assessment questions to understand the type of information states will need to consider to participate in the ET3 model. Understanding this information will be helpful as you frame conversations with your state Medicaid agency.

That concludes this discussion on Medicaid and ET3.

Jill Darling: Thank you (Sheri) and thank you (Sarah). (Amanda) will go into our Q&A, please.

Coordinator: Thank you. If you'd like to ask a question, please press Star 1. Please unmute your phone and record your name clearly when prompted. Your name is required to introduce your question. Again, that's Star 1 if you'd like to ask a question. One moment please.

One moment for our first question. Our first question comes from (Mark Epstein). Your line is open.

(Mark Epstein): Yes, good afternoon. I wanted some clarification on the reimbursement model. If you have two separate entities; one providing the ambulance response for a BLS or ALS 1E level and another entity providing telemedicine. Are there two separate bills submitted?

Sarah Goldman: So this is for us. Thank you for your question. If I understand you correctly, you are asking does the ambulance provider receive two separate payments?

One payment for the treatment in place for you and then a second payment for rendering treatment on the scene, is that correct?

(Mark Epstein): No, the question is if the ambulance provider does treatment in place via telemedicine as I understand it the payment scenario would be the ambulance provider would bill for the BLSE or the ALS 1E rate based upon their level of assessment. And then there would be a separate bill submitted for telemedicine services. Is that correct?

Sarah Goldman: So thank you for that clarification. That is not correct. There are two separate payments that will be made. The first payment will got to the ambulance provider and you are correct that it either may be BLS or ALS depending on the service required. The second payment will be to the telehealth provider, the qualified provider, i.e. the physician, PA or NP who renders the service.

(Mark Epstein): And those are the standard rates now that have a minimum 30 minute evaluation time for the telemedicine provider?

Sarah Goldman: We will be providing more guidance on telehealth, but there is a wide range of telehealth codes that will be available depending on what the provider actually renders on scene.

(Mark Epstein): Okay, so it will be a new schedule that will be forthcoming to better delineate the telemedicine reimbursement. Is that correct?

Sarah Goldman: We are going to be providing some guidance, but just be aware that we will not be making any changes to the current telehealth rules. All payments will be provided based on the level of service that the rendering provider, provides.

(Mark Epstein): Okay, and then the last part of that, but as I understand it currently, the telehealth services predicate on a minimum of 30 minute evaluation. Is that, I'm trying to understand how that might fit into this program?

Sarah Goldman: That's a good question. It is my understanding that there are actually a wide range of codes and it is not just limited to 30 minutes. But I can certainly circle back and we will be able to provide people with more technical guidance. It becomes a little bit tricky given that our application is currently opened and while we can provide technical assistance, we are limited in the types of answers that we can appropriately provide.

(Mark Epstein): Thank you.

Coordinator: Thank you. Our next question comes from (Cory Aults). You line is open.

(Cory Aults): Hi, so the Medicare prior authorization model for repetitive scheduled nonemergency ambulance transport is scheduled to expire at the end of November and I'm wondering if CMS has any plans to extend that further or extend it nationwide.

(Angela Gaston): Hi, this is (Angela Gaston). We do not have a final decision yet on the model in the current states. Be looking for an announcement on that sometime this fall and that will be on our ambulance (unintelligible) Web site.

(Cory Aults): All right, I'll keep my eyes peeled. Thank you.

Coordinator: Thank you. Our next question comes from (Patty Teslin). Your line is open.

(Patty Teslin): Yes, I'm confused on this collection system. Does every ground ambulance have to supply this by 2023? Or will they let - or they pick and choose and let them know that they have to supply all this information?

(Sarah Shirey-Losso): Hi, this is (Sarah Shirey-Losso). I encourage you to use the links and review the proposed rule. At this point is it proposals, but we are required to take a representative sample of ambulance providers and suppliers. And if you are selected in that sample, you are required to report.

(Patty Teslin): Okay, so you have to go onto the Web site there to find out if you're - if they're requiring that you send us a sample.

(Sarah Shirey-Losso): Yes. No one has been sampled at this time. We're still in a proposed period where we're discussing the options.

(Patty Teslin): Okay, well that's a lot of information to get together.

(Sarah Shirey-Losso): Yes, at this point we're in a proposed period so nothing has been finalized at this time.

(Patty Teslin): When will it be finalized, do you know?

(Sarah Shirey-Losso): It'll - any decisions made as part of the comments that we will receive on these proposals would be finalized in November of this year.

(Patty Teslin): November, okay. Thank you.

Coordinator: Thank you. Our next question comes from (Donna Navarro). Your line is open.

(Donna Navarro): Hi, my question is, is the PCS required if we use a GY modifier? Hello?

Sarah Shirey-Losso: (Tom), I'm not sure if you're still on the line.

(Tom Kessler): Hi, I am still on the line. And I can tell you that is something I don't know the answer to. I think it's outside the scope of what we were doing. So I apologize for that.

(Donna Navarro): So where can I find out that information or who can I find that out?

(Tom Kessler): If there's someone else on line, hopefully they could weigh in.

Jill Darling: And if you don't mind, sending in your question to the ambulance ODF email, it's ambulanceodf@cms.hhs.gov.

(Donna Navarro): Okay, thank you.

Jill Darling: Thank you.

Coordinator: Thank you. Our next questions comes from Mr. (Larkins). Your line is open.

Mr. (Larkins): Yes, this is a quick question. For the application process, you have two. You have an RFA, NOFO. We're a local government so we'll be applying the NOFO and where do we secure that application?

Sarah Goldman: The NOFO is scheduled to be released later this fall. And is not currently opened yet. Keep in mind that our RFA for our alternative destination and telemedicine, sorry telehealth treatment in place programs are currently opened.

Mr. (Larkins): Will that work for a municipality?

Sarah Goldman: Eligible applicants for the RFA are EMS suppliers. So local governments are not eligible to apply for the RFA.

Mr. (Larkins): Understood. So a September deadline won't apply. We'll hear something more closer to November?

Sarah Goldman: Yes.

Mr. (Larkins): Okay, thank you.

Coordinator: Thank you. Your next questions comes from (Isaac Sovil). Your line is open.

(Isaac Sovil): Yes, in the proposed cost data collection rule, will the providers and suppliers from the representative sample be selected specifically from the 855B enrollment or will 855A providers or suppliers be selected as well?

Sarah Shirey-Losso: Thank you for your question. It would be 855A and B.

(Isaac Sovil): And just a quick follow-up on the cost data collection. It's - if a provider wishes to change their fiscal year, you know, in order to give them some extra leeway. Is that allowed under the proposed rule their, let's say their 2019 fiscal year would have to apply for 2020 as well?

Sarah Shirey-Losso: I think that is a comment you should probably make to the proposed rule.

(Isaac Sovil): Okay, and just one final question switching gears. There were (unintelligible) medicine reduced by some of the max including MGS that went into effect 4/1 for (SNIF) consolidated billing. The edits are overly inclusive because in the

absence of a corresponding unbundled hospital claims, the claim gets denied. It could just be a simple delay on the hospital level. Is there anything in the works at the CMS level because CMS has been driving the edit requirement? It's my understanding anyway. Is there anything underway to have those edits adjusted to be fair so that there's no, you know, undue cash delay to providers and suppliers?

(Sarah Shirey-Losso): I just wanted to check, this is (Sarah Shari), if anyone from the provider billing group was able to join this call that may be able to respond? Otherwise, sorry, I think we have to take your information and you can send your question to ambulance open door forum mailbox.

Jill Darling: It's ambulanceodf@cms.hhs.gov.

(Isaac Sovil): Thank you.

Coordinator: Thank you. Our next questions comes from (Taylor Cowee). Your line is open.

(Taylor Cowee): Hi, thank you. My question is somewhat technical regarding submission of an ET3 application via the portal. My question is can multiple ambulance suppliers apply with separate applications but through a shared log in credential through the portal? For example if they are applying separately through their own MPIs bur proposed a regional approach together.

Woman: Thank you for your question. I will have to circle back with our group to provide you the appropriate guidance. If you don't mind sending your question through and we will provide you with an answer shortly.

Jill Darling: And that's ambulanceodf@cms.hhs.gov.

(Taylor Cowee): Thank you.

Jill Darling: (Amanda), do we have any more questions?

Coordinator: I apologize. (Jeff Spencer). Your line is open.

(Jeff Spencer): Yes, hi. Thank you for taking my question. It may be premature. The thing is still in the comment phase. Regarding the cost data collection, a lot of really small services that have no internal, like administrative staff. They don't have bookkeepers, accountants. They account on a cash basis. A lot of people think that you're going to require them to change their accounting to accrual. If I read the notice of proposed rulemaking, revenues are reported as they're received. Is that the same case with cost? Hello?

(Sarah Shirey-Losso): This is (Sarah Shirey-Losso). I think you would have - you should send that as a comment to the proposed rule.

(Jeff Spencer): I will do that. Thank you.

Coordinator: Thank you. Our next question comes from (Virginia Chapman). Your line is open.

(Virginia Chapman): Hi, this is in reference to the PCF form. Mr. (Kepler), (Tom Kepler) stated LPN caseworker and their one other credentialing for signature requirements.

(Tom Kessler): Yes, LPN, social workers and case managers.

(Virginia Chapman): Is there any literature on CMS Web site regarding this? Or when does this go into effect?

(Tom Kessler): Well it's not in effect. It's been proposed. And it's, right.

(Virginia Chapman): Oh.

(Tom Kessler): It's the comment period closes at the end of September.

(Virginia Chapman): Okay. Thank you.

Coordinator: Thank you. Our next question comes from (Marian Munce). Your line is open.

(Marian Munce): I have a question about hospital to hospital transport. Because the patients are stable under impala, are there letters of criteria in order to be able to bill it as an emergency transport between two hospitals?

Woman: If you don't mind, would you please submit that into the ambulance ODF email, please?

(Marian Munce); Okay.

Sarah Shirey-Losso: If you could let us know what it's in reference to? If it's just general ambulance policy or related to a model, that would be helpful.

(Marian Munce): Just general ambulance policy. I think there's word on the street that hospital to hospital transports can never be billed at an emergency level. Because under impala, the patient is stable and therefore there can't be an emergency. So I think there's a little guidance needed.

Sarah Shirey-Losso: Thank you.

Coordinator: Thank you. Our next question comes from (Keith Heart). Your line is open.

(Keith Heart): Hi, in regards to the ET3 application process, if we have some supporting documentation but it doesn't have a clear area to upload it, can you make some recommendations as to where we can upload it or would it be possible to add like a miscellaneous section or something like that?

Sarah Goldman: Thank you. That's a great question. We have been hearing that. If you also submit this comment to the email server, we'll be able to get back to you on more specific guidance.

(Keith Heart): Okay.

Sarah Goldman: Thank you.

Coordinator: Thank you. Our next question comes from (Lisa Mason). Your line is open.

(Lisa Mason): Thank you. Can you make available that guidance that was given to the state Medicaid departments that offers pathways and assessment questions that would be helpful for other health plans?

Sheri Gaskins: Sure it's actually available on our Web site which is www.medicaid.gov. And it's actually hyperlinked on that landing page under new and notable. I believe it's the last hyperlinked document on the landing page.

(Lisa Mason): Thank you.

Jill Darling: We'll take one more question, please.

Coordinator: Thank you. Our last question comes from (Judy Zinc). Your line is open.

(Judy Zinc): This is actually a comment. In regard to that GY modifier question that they had earlier. Our understanding is that the PCS is not required if you are using a GY modifier. Also in regards to the ET3, if you are a municipality, and you are enrolled with Medicare, you would be an ambulance supplier. And our understanding is that you are eligible to apply under the RFA. Is that correct?

Woman: I'm sorry. Can you repeat that? I didn't quite hear you.

(Judy Zinc): So in regard to the public provider who is eligible to apply for the ET3, our understanding is that if you are a Medicare enrolled provider you would be in there as, in the system as an ambulance supplier. So you would be able to apply via the RFA as a municipality. Is that correct?

Woman: Do you mean if you are a hospital-owned ambulance supplier? Can you give me an example?

(Judy Zinc): No, so for instance if you are a fire department and you are a municipality.

Woman: Sure absolutely, for example like you're talking about the fire department of New York.

(Judy Zinc): Correct, yes.

Woman: So if you are a municipality that has ownership over the EMS services, you are eligible to apply, but only if you have the ownership and you operate the actual EMS.

(Judy Zinc): Right, we are just seeking clarification for the question earlier.

Woman: Okay, yes. Lots of counties do not actually operate. So just to be clear, you actually have to operate the system in order to be eligible to apply.

(Judy Zinc): Thank you.

(Sarah Shirey-Losso): Sure, well that was our last question. This is (Sarah Shirey-Losso) again. I just wanted to - we sent a lot of information you way today. And if you refer back to you agenda, we have links to the presentations and other information as well. If you want to have - when you have more time to go back and digest some of that information. Again any questions we didn't get to, you can feel free to send that to our mailbox, ambulanceodf@cms.hhs.gov.

And we look forward to any comments you have on the proposed rules as well. Thank you so much.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

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