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OFFICE OF
INSURANCE COMMISSIONER

October 1, 2025

Dear Chair Bronoske, Chair Cleveland, Chair Ormsby, Chair Robinson, and members of the House and Senate health care and fiscal committees;

Substitute Senate Bill (SSB) 5986 (2024) extended balance billing protections to ground ambulance services under our state's Balance Billing Protection Act (BBPA), effective January 1, 2025. Section 13 of the law directed OIC, in consultation with the Health Care Authority (HCA), to contract for an actuarial analysis "of the cost, potential cost savings, and total net costs or savings of covering services provided by ground ambulance services organizations when a ground ambulance services organization is dispatched to the scene of an emergency and the person is treated but is not transported to a hospital or behavioral health emergency services provider." This type of service is referred to as "treat no transport" (TNT).

OIC contracted with Lewis & Ellis (L&E) and Public Consulting Group (PCG) to complete this work. L&E and PCG surveyed ground ambulance services organizations (GASOs), reviewed claims data from the Washington All-Payers Claims Database (APCD), and utilized available Medicare Ground Ambulance Data Collection Survey (GADCS) responses to understand how TNT services are currently billed and reimbursed by commercial health plans in Washington State. They examined the approximate volume and cost of these services as compared to ground ambulance transports to hospitals or behavioral health emergency services providers. L&E and PCG met with OIC's Ground Ambulance Advisory Group several times during the course of the study to gather their input related to the data collected and potential recommendations.

The full report from L&E and PCG is attached for your review. For purposes of this report, TNT services are defined as follows:

> *"Treat but No Transport (TNT) refers to Emergency Medical Services (EMS) rendered at the scene of an incident in response to a 9-1-1 call when a Ground Ambulance Service Organization (GASO) dispatches an ambulance or aid unit, but the patient is not transported to a hospital or behavioral health emergency services provider." (Pg. 3)*

TNT services are not reimbursed by Medicare but are reimbursed by Medicaid in Washington State. Commercial health plan coverage varies by carrier and health plan. TNT services are primarily provided by public GASOs, i.e., local fire departments and fire districts, with possible assistance from private GASOs depending on location and contract type. Like ground ambulance transports, the majority of TNT services are provided to Medicare and Medicaid consumers. OIC Ground Ambulance Advisory Group members noted that in geographic areas that lack access to health care

services (i.e., primary care and long-term care services), TNT services are a stopgap option for residents who may call 911 for assistance.

Specific challenges faced by GASOs that provide TNT services include:

- TNT services are challenging to provide in rural and super rural areas, where a GASO can be expected to drive several hours to reach a patient.
- Basic life support (BLS) or advanced life support (ALS) services may be needed as a TNT service, with varying staffing requirements, medical services provided, and duration.
- TNT services are not frequently billed due to the lack of reimbursement. Thus, the number of TNT services currently being rendered is unclear and likely understated in commercial health plan claims data. The Ground Ambulance Advisory Group members noted that demand for TNT services is growing. As more rural health care services are lost and people lose health insurance coverage, they may increasingly rely on GASOs' TNT services.

L&E and PCG modeled two potential reimbursement options for TNT services in Washington State. One model assumes distinct reimbursement for basic life support (BLS) services and advanced life support (ALS) services. The second model is a blended rate for both BLS and ALS services. Both rate models have a super rural adjustment to account for the greater travel time associated with super rural services. The two-rate model options were developed to show the range in time spent, service classification, and staffing when providing TNT services.

Recommended Rate Option 1 – Distinct ALS & BLS Rates

Recommended Rate - OPTION 1	ALS	BLS	Source
Proposed Rate - Urban & Rural	$ 520.63	$ 465.68	Formula
Proposed Rate - Super-Rural	$ 638.29	$ 570.92	Medicare Basis

Recommended Rate Option 2 – Blended Rate

Recommended Rate - OPTION 2	ALS	BLS	Source
Number of TNT Dispatches	12,482	6,657	Survey Responses
Blended Rate - Urban & Rural	$501.51		Formula
Blended Rate - Super-Rural	$614.85		Medicare Basis

L&E and PCG also modeled the potential premium impacts to health insurance markets if TNT services were covered, as displayed in the table below.

Commercial Market Segment	Estimated Impact Range as a Percentage of Premium	Estimated Impact Range in Premium Per Member Per Month
Individual	0.08%-0.21%	$0.35-$0.92
Small Group	0.02%-0.06%	$0.12-$0.32
Large Group	0.03%-0.07%	$0.16-$0.42
PEBB[1]	0.00%-0.06%	$0.00-$0.34
SEBB[2]	0.00%-0.05%	$0.00-$0.27
Total Commercial Market	0.03%-0.09%	$0.17-$0.45

Recommendation regarding coverage of TNT services in Washington State

OIC recommends considering coverage of TNT services in concurrence with the Washington State Institute for Public Policy (WSIPP) EMS systems study, which will be completed on June 30, 2026. This study was commissioned in Section 14 of SSB 5986. It directed WSIPP to study and report to the legislature on the demand for EMS services, geographic disparities in access to EMS services, costs, and potential funding models for EMS services, including funding EMS systems substantially or completely with a blend of public funding, rather than under the current insurance model of payment for these services.

OIC's recommendation is based on the following considerations:

- Currently, a relatively small number of TNT services would be impacted by requiring coverage of these services by commercial health plans regulated by OIC. The majority of TNT services are provided to Medicare and Medicaid patients.
- Most importantly, the cost of TNT services may be partially or fully built into rates currently paid by carriers for ground ambulance transports. OIC would need to work with local governmental entities to ensure that duplicate payments for TNT services are not being collected.
- TNT services are considered non-emergency services. Based on OIC's Ground Ambulance Balance Billing report, about half of the health insurers in Washington cover some non-emergency ground ambulance services. Requiring coverage of TNT services could constitute a new mandate in the individual market, triggering the state cost defrayal provisions of the ACA. L&E estimated the following annual cost for coverage of TNT as a distinct service:
    - Individual Market (225,000 enrollees) ($0.35-$0.92)

[1] Public Employees Benefits Board Program
[2] School Employees Benefits Board Program

        - $945,000-$2,484,000 (ongoing defrayal)

- L&E also estimated a range of potential additional costs to the PEBB/SEBB Uniform Medical Plan:
    - PEBB/SEBB (700,000 enrollees) ($0.00-$0.34)
        - $0.00- $2,856,000

Utilization of TNT services is increasing and may continue to increase as people lose health insurance coverage due to the expiration of enhanced premium tax credits (ePTCs) on December 31, 2025, and Medicaid funding reductions. However, given the current fiscal challenges facing the state, upcoming premium impacts for individual market consumers of ePTCs expiring, and uncertainty related to federal law changes, in addition to H.R. 1, the OIC recommends considering this issue when WSIPP completes its report in June 2026.

We look forward to further discussion regarding this report. Please feel free to reach out with any questions.

Sincerely,

Patty Kuderer,
Insurance Commissioner

LEWIS & ELLIS
Actuaries and Consultants

Washington Office of Insurance Commissioner
Ground Ambulance Services Organizations
Treat but No Transport

CONTENTS

EXECUTIVE SUMMARY

The 2024 Legislature enacted Substitute Senate Bill 5986 (SSB 5986). Section 13 of this law directed the Washington Office of the Insurance Commissioner (OIC) to prepare a report related to the costs and potential savings of commercial health plan coverage of Treat but No Transport (TNT) services. This report was prepared by Lewis & Ellis LLC (L&E) and Public Consulting Group LLC (PCG) under contract with OIC in response to the legislative directive. This analysis specifically relates to the payment of TNT services as a distinct reimbursable service. It provides a comprehensive analysis of TNT service models in Washington state developed through data analysis, stakeholder engagement, and national policy review.

Treat but No Transport Definition

Treat but No Transport refers to Emergency Medical Services (EMS) rendered at the scene of an incident in response to a 9-1-1 call when a Ground Ambulance Service Organization (GASO) dispatches an ambulance or aid unit, but the patient is not transported to a hospital or behavioral health emergency services provider. This report assumes that TNT services would be billable only when medically necessary and rendered by GASOs that are licensed under Chap. 18.73 RCW. TNT services are billed under Procedure Code A0998.

The outline below summarizes the vehicles, personnel, and services that qualify as TNT, as well as one exception:

- **Vehicles**: Advanced Life Support (ALS) Ambulance, Basic Life Support (BLS) Ambulance, and Aid Units.
- **Personnel**: Paramedics, Emergency Medical Technicians (EMTs), Emergency Medical Responders (EMRs).
- **Services**: Medically necessary treatment including evaluation, stabilization, and medication administration.
- **Exception**: Instances where an individual is pronounced dead after the ambulance was dispatched but before the patient was transported are not included in the definition of TNT services and are separately reimbursable by health insurance utilizing modifier QL in conjunction with an appropriate transport code.

Appendix A: Glossary defines key terms relating to TNT and the scope of this report.

Data Sources

The data analysis within this report draws on multiple data sources, including surveys from GASOs, the Washington State All-Payers Claims Database (WA-APCD), and the Medicare Ground Ambulance Data Collection System (GADCS) to assess service delivery costs and reimbursement needs. The GADCS is an instrument developed by the Centers for Medicare and Medicaid Services (CMS) to collect cost, revenue, utilization, and other information from selected ground ambulance organizations.[1] The data collected encompassed ambulance responses by type, response durations, staffing, volunteer hours, direct ambulance costs, and other organizational expenses.

[1] https://www.cms.gov/files/document/gadcs-user-guide.pdf

Community Partner Engagement

The TNT review team held three engagement sessions with the OIC Ground Ambulance Advisory Group, which includes representatives from public and private providers, firefighters, insurers, billing vendors, local governments, and consumers. These sessions provided valuable input at key stages of the study, including survey design, preliminary findings, and the draft rate model and recommendations. Key takeaways informed TNT Review Team on items such as a clearer definition of TNT services, a better understanding of administrative components, and the acuity and geographic challenges experienced on TNT service calls.

Peer State Research

An evaluation of current reimbursement practices for TNT responses provided insight into the definitions and reimbursement practices associated with TNT across the nation. Fifty percent of all state Medicaid programs currently reimburse for TNT under procedure code A0998 but, reimbursement rates vary widely. Medicare currently does not reimburse for TNT services. Limited data was available regarding TNT reimbursement by commercial carriers; however, Anthem Blue Cross Blue Shield was identified as one commercial carrier currently reimbursing for TNT.

Reimbursement Recommendations

In partnership with WA OIC and key interested parties, rate recommendations were developed based on the estimated cost to deliver TNT responses throughout the Washington. The report presents two key rate model options for the OIC. Reimbursement methodologies were developed using a combination of survey data and industry standards to arrive at the estimated cost of a TNT response.

The proposed reimbursement methodologies include two options:

- The first option creates distinct reimbursement rates for ALS and BLS services.
- The second option presents a unified blended rate for TNT services, applicable irrespective of their classification as ALS or BLS services.

Both recommended options include a super-rural adjustment that uses the Medicare method, applying a 122.6% factor to the rural reimbursement rate. The super-rural adjustment recognizes the expected increase in cost of care in certain geographical areas.

The recommended reimbursement rate options are provided in *Figure 0.1 and Figure 0.2* below.

Recommended Rate Option 1 – Distinct ALS & BLS Rates

Recommended Rate - OPTION 1	ALS	BLS	Source
Proposed Rate - Urban & Rural	$ 520.63	$ 465.68	Formula
Proposed Rate - Super-Rural	$ 638.29	$ 570.92	Medicare Basis

Figure 0.1 Recommended Rate Option 1

Recommended Rate Option 2 – Blended Rate

Recommended Rate - OPTION 2	ALS	BLS	Source
Number of TNT Dispatches	12,482	6,657	Survey Responses
Blended Rate - Urban & Rural	$501.51		Formula
Blended Rate - Super-Rural	$614.85		Medicare Basis

Figure 0.2 Recommended Rate Option 2

These recommended rates focused only on direct reimbursement mechanisms and did not include indirect reimbursement models or scenarios in which TNT costs are embedded within broader ambulance service rates, such as those for ALS or BLS transports. To the extent that TNT costs are currently embedded within locally set GASO rates, if the legislature were to require coverage of TNT services, local government entities would likely need to revise and update these rates.

It is further recommended that rates be reviewed and/or updated on a regular basis using inflation-based metrics or periodic rate studies.

Estimated Financial Impact

Claims data from the WA-APCD was used to estimate the financial impact of the proposed TNT rates on commercial premiums. *Section 6: Evaluating Actuarial Soundness* details the underlying assumptions used to calculate the estimate. Figure 0.3 shows a summary of the resulting estimated premium impact by market and overall.

Commercial Market Segment	Estimated Impact Range as a Percentage of Premium	Estimated Impact Range in Premium Per Member Per Month
Individual	0.08%-0.21%	$0.35-$0.92
Small Group	0.02%-0.06%	$0.12-$0.32
Large Group	0.03%-0.07%	$0.16-$0.42
PEBB[2]	0.00%-0.06%	$0.00-$0.34
SEBB[3]	0.00%-0.05%	$0.00-$0.27
Total Commercial Market	0.03%-0.09%	$0.17-$0.45

Figure 0.3 Estimated Premium Impact of TNT Reimbursement

Implementation Considerations

The analysis highlights several considerations for implementing TNT reimbursement including:

- **Payment Duplication**: It is recommended that transport rates be reviewed to ensure the exclusion of TNT costs to avoid double-counting costs within collective ambulance reimbursement rates (i.e. transport rates and TNT rates).
- **Documentation**: Preliminary discussions suggest that current Electronic Patient Care Reporting (EPCR) data tracking can show medically necessary care was provided while also confirming that no transport occurred. However, it is recommended that WA OIC provide clear, finalized guidance on required documentation.
- **Provider Communication & Training**: It is recommended that the implementation process include education to help providers, health insurers, and billing vendors understand the definition of qualifying TNT responses and documentation requirements.
- **Consumer Impact**: Potential benefits to consumers include reduced unnecessary transports and improved system efficiency. Risks include confusion about TNT charges that could discourage 9-1-1 use. A follow-up study after one year of implementation is recommended to assess consumer impacts. Clear consumer communication and billing transparency will be essential to maintain trust.

[2] Public Employees Benefits Board Program
[3] School Employees Benefits Board Program

- **Regulatory Implications**:
  - If implemented, WA OIC will need to determine if Washington will be responsible for defraying any costs under Affordable Care Act (ACA) mandate requirements.
  - If implemented, TNT would fall under the Balance Billing Protection Act, extending protections to certain health plans.

SECTION 1: INTRODUCTION

BACKGROUND

Emergency Medical Services (EMS) are a critical component of the health care system, providing rapid response and care in emergent and urgent situations. Traditionally, EMS reimbursement has been tied to patient transport to a hospital or other facility, creating a financial disincentive for treating patients at the scene when transport is not clinically necessary. Further, individuals have the option to refuse transport, resulting in uncompensated care that impacts the financial sustainability of Ground Ambulance Services Organizations (GASOs). GASOs are defined in RCW 48.43.005(28) as public or private organizations licensed by the Department of Health under Chapter 18.73 RCW to provide ground ambulance services. *Appendix A: Glossary* provides more detailed definitions of the types of ground ambulance services including Advanced Life Support (ALS), Basic Life Support (BLS) and Treat but No Transport (TNT) responses.

A TNT payment model could potentially address this gap by allowing EMS providers to deliver care on-site without requiring transport to a hospital or behavioral health facility.

In 2024, the Washington State Legislature enacted Substitute Senate Bill 5986 (SSB 5986), which includes a directive in Section 13 for the Office of the Insurance Commissioner (OIC) to contract for an actuarial analysis of the costs, potential savings, and net financial impact of covering TNT services. Specifically, the legislation focuses on services provided by GASOs: when a GASO is dispatched to the scene of an emergency, treatment is provided, but the patient is not transported to a hospital or behavioral health emergency services provider.

This report responds to the legislative directive by examining peer-state policies and reimbursement models for TNT services, as well as presenting a data-driven reimbursement model specific to Washington's TNT services.

SCOPE OF WORK AND DELIVERABLES

To fulfill the requirements of SSB 5986, the OIC engaged Lewis & Ellis LLC (L&E) and Public Consulting Group LLC (PCG), collectively referenced as the TNT review team, to conduct a comprehensive analysis of TNT reimbursement models. The scope of work included:

1. **Data Collection and Analysis**: Gathering data related to ground ambulance dispatches to emergency scenes from 2019 through 2024. This included analyzing the proportion of dispatches that result in transport to hospitals, emergency behavioral health facilities, secondary locations, and those that do not result in transport.

2. **Reimbursement Rates Analysis**: Gathering and analyzing data on current reimbursement rates for ground ambulance transports, including TNT services. This involved collecting data from the Washington State All-Payer Claims Database (WA-APCD), Medicare Ground Ambulance Data Collection System (GADCS), and other relevant sources. The GADCS is an instrument developed by the Centers for Medicare and Medicaid Services (CMS) to collect cost, revenue, utilization, and other information from selected ground ambulance organizations.

3. **Actuarial Analysis**: Conducting an actuarial analysis of the cost, potential cost savings, and total net costs or savings of covering TNT services. This analysis considered various factors, appropriate and sufficient payment rates, financial risk and uncertainty, potential savings resulting from not transporting patients unnecessarily, and the impact on health care pricing and utilization.

4. **Policy Analysis**: Analyzing coverage of TNT models in other states or localities. This includes reviewing policies and models in use or under consideration and contemplating their relevance to the potential implementation of the TNT reimbursement in Washington state.

5. **Recommendations and Reporting**: Developing recommendations on coverage and payment rates for TNT services based on the findings from the data collection, analysis, and actuarial work.

This analysis focused on direct reimbursement mechanisms and did not include indirect reimbursement models or scenarios in which TNT costs are embedded within broader ambulance service rates, such as those for ALS or BLS transports. Under RCW 18.73.030, ALS is defined as invasive emergency medical services requiring advanced medical treatment skills, and BLS is noninvasive emergency medical services requiring basic medical treatment skills.

Under RCW 48.49.200, local governments establish "locally set rates" which, at least until December 31, 2027, govern how much health insurers pay GASOs for ground ambulance transports. To the extent that TNT costs are currently embedded within locally set GASO rates, if the legislature were to require coverage of TNT services, local government entities would likely need to revise and update these rates.

This report summarizes the work completed, as well as a final potential reimbursement model.

SECTION 2: DATA SOURCES & COLLECTION

This section details the data review process, including the information collected and how it was gathered. This section also addresses key considerations, including the context of data collection and limitations or challenges encountered, such as gaps in data availability, potential biases, or constraints related to time, resources, or access.

DATA OVERVIEW

To develop an appropriate commercial rate setting model for TNT responses for GASOs, the TNT review team gathered data related to recent ground ambulance responses in the state. There were four primary data sources:

1. **GASO Data Collection Survey**: Surveys designed by the TNT review team were distributed to various GASOs in the state to capture response and cost information related to their ambulance operations. The survey tools can be found in *Appendix B: Distributed Surveys*.

2. **Ground Ambulance Data Collection System (GADCS)**: These are reports submitted to the federal Centers for Medicare and Medicaid Services (CMS) for a Medicare ground ambulance data collection study. CMS selected a sample of ambulance service organizations to provide transport and cost data for use in a Medicare analytical report. GASOs that had completed these surveys were contacted by the TNT review team to request their approval to use their GADCS data submissions for this analysis. As this data was not Medicare-specific, its use was appropriate for this analysis as well.

3. **Washington State All-Payers Claims Database (WA-APCD)**: The WA-APCD includes claims data for commercial health plans, the public employee benefits program (PEBB), school employee benefits program (SEBB), Medicaid, and limited Medicare data. The WA-APCD data was used to identify payment levels and claim frequencies for various transport categories and to benchmark these against the survey data and rate setting model.

4. **OIC Ground Ambulance Advisory Group**: Interested parties, including representatives of EMS billers, health insurers, consumers, firefighters, and public and private GASOs were engaged to gain an understanding of current ambulance service practices related to TNT and to review and comment on the data, proposed rate setting, and administrative procedures related to commercial carrier payment for TNT costs. These advisory group meetings are discussed further in *Section 3: Collaboration with Interested Parties* of this report.

DATA LIMITATIONS

The data collected through the GASO surveys was primarily self-reported. Our initial data analysis identified several respondents whose responses were either not appropriate for this analysis or incomplete. In partnership with survey respondents, the TNT review team also made minor revisions to the data to correct distribution or rounding errors. The data, as reported, was used to build out a financial model of the operational costs of TNT services. This included an assessment of service costs for ALS vs. BLS responses, as well as an assessment by regional designation: urban, rural, and super-rural. An analysis was performed to ensure that the respondents were an appropriate representation of the GASO population, including an analysis to identify outlier data to ensure that extreme responses did not unduly impact the results. These analyses and further data results and considerations are discussed throughout the remainder of this report.

GASO DATA COLLECTION SURVEY

The TNT review team developed two surveys as the primary tools to collect data related to GASO operations and costs.

The first survey was distributed to GASOs throughout Washington state. The survey requested detailed information on personnel costs by role, staffing, and response times, and other expenses tied to both ambulance and facility operations. Respondents were also asked whether they had completed the GADCS survey, and if so, to share a copy of their submission.

Data elements collected and analyzed included:

1. Ambulance response by type, including ALS, BLS, transports to hospitals, treatment without transport, aid transports, and responses with no treatment provided.
2. Average duration of response by transport type.
3. Typical personnel staffing the various transport types by personnel role (ALS, BLS, paramedic, Emergency Medical Technician (EMT), Emergency Medical Response (EMR), administrative/driver).
4. Annual volunteer hours by role.
5. Direct ambulance costs (vehicles, supplies, depreciation, leasing costs).
6. Additional organizational costs (facility, training, overhead, call center costs, professional fees).

In addition to the surveys, the TNT review team leveraged a previous PCG project involving Washington GASOs, in which PCG assisted GASOs in preparation of their GADCS submissions. These organizations received a shorter version of the survey focused specifically on TNT services. Permission was also requested to use the GADCS data previously submitted on their behalf for this study.

The survey instruments can be found in *Appendix B: Distributed Survey*s.

Forty-one GASOs operating in Washington state submitted responses to the survey. Of these respondents, eight indicated that no TNT response service was provided, and an additional seven respondents did not provide complete data. Of the twenty-six respondents with usable data, GADCS responses were acquired from 15 of the GASOs to supplement the survey data. The remaining eleven GASO responses were analyzed based solely on their survey responses. The representativeness of the survey responses is discussed below.

GROUND AMBULANCE DATA COLLECTION SYSTEM

The GADCS collection, coordinated by CMS, was designed to capture detailed financial data associated with GASO operating costs. These surveys offer more granular insights into personnel expenses and hours worked, as well as direct ambulance-related and broader organizational costs. Because of the depth of information included in the GADCS, survey respondents who had completed it were able to skip several questions in our data collection survey, particularly those related to operating costs.

In addition to the fifteen organizations that submitted both a GADCS response and a survey response, PCG included data from seven former clients who authorized the use of their previously submitted GADCS surveys for this analysis.

While these additional GADCS responses aided the overall data profile, they lacked certain details necessary for specific components of the analysis. For example, data such as TNT response counts broken down by ALS and BLS, time spent per response, and personnel roles by response type were not captured in the GADCS. To address these gaps, the following methods were used to appropriately allocate and estimate the missing data for analysis:

- TNT response counts were split between ALS and BLS based upon the ALS/BLS personnel costs by organization.

- Mean time on response (in minutes) was estimated from other responder data.
- Roles by response type were analyzed to estimate the number of personnel per response. The GADCS-only responses did not provide sufficient detail on this component, and so were not factored into this analysis.

WASHINGTON STATE ALL-PAYERS CLAIMS DATABASE

The WA-APCD was the primary source for claims data from commercial health insurers. Calendar year 2023 claims data were used to estimate the premium impact of implementing reimbursement rates for TNT services. The calculation of the estimated impact is discussed further in *Section 6: Evaluating Actuarial Soundness* of this report.

Calendar year 2023 claims data was analyzed to calculate the average allowed amount for the various response types– —ALS and BLS —by emergency and non-emergency designations. In this context, "allowed amount" refers to the maximum payment a GASO will receive for a claim, including both the insured member's cost sharing and payment from the health insurer. *Figure 2.1* shows the average allowed amount for the various response types in 2023.

Procedure Code	Avg. Allowed Amount per Claim
A0426 - Advanced Life Support, Level 1 (ALS1), Non-emergency	$1,089
A0427 - Advanced Life Support, Level 1 (ALS1), Emergency	$1,230
A0428 - Basic Life Support (BLS), Non-emergency	$768
A0429 - Basic Life Support (BLS), Emergency	$1,032
A0432 - Paramedic Intercept, Volunteer Ambulance Co	$276
A0433 - Advanced Life Support, Level 2 (ALS2)	$1,259
A0434 - Specialty Care Transport (SCT)	$2,214
A0998 - Ambulance Response and Treatment, no transport	$301

Figure 2.1 CY2023 Average Allowed Amount per Claim by Procedure Code

EVALUATING SAMPLE REPRESENTATIVENESS

Using the WA-APCD dataset, the TNT review team identified 342 GASOs in Washington State that received at least $5,000 in annual payments for transport and response service codes in 2023. Collectively, these organizations were paid $35.3 million by commercial insurers for these services (excluding mileage reimbursements).

The 33 GASOs included in this analysis represent approximately 9.6% of all GASOs and account for approximately 5.7% of the total 2023 transport/TNT payment volume. Of the top 15 organizations by payment volume, this analysis includes one of these organizations, representing about 35% of the total payment volume among the 33 included organizations. The respondents were predominantly public entities, representing either a fire district or municipality. Only one private GASO provided response detail in the analysis.

Despite these limitations, our analysis and discussions with various interested parties indicated that the rate model inputs gleaned from the data were in line with expectations and provided an appropriate array of cost and response data for the state. As such, the rate model development from this sample data did not warrant significant adjustments for bias or excluded organizations.

SECTION 3: COLLABORATION WITH INTERESTED PARTIES

Throughout the course of this study, several engagement sessions were conducted with the OIC Ground Ambulance Advisory Group and representatives from public GASOs.

The Advisory Group is composed of representatives from public and private ground ambulance providers, firefighters, health insurers, billing vendors, local governments, and consumers. The group offered valuable insights and recommendations based on their collective experience and perspectives.

The TNT review team met with the Advisory Group three times during the study period to gather feedback at key stages. The first meeting, held in early January 2025, focused on reviewing the proposed survey instruments and data collection approach. The group provided constructive input, including suggestions to:

- Incorporate ALS/BLS service distinctions,
- Reflect the typical staffing structures of ground ambulance providers, and
- Emphasize the value and benefits of survey participation for providers.

Preliminary findings from the survey responses and WA-APCD data analysis were shared in the second Advisory Group meeting in May 2025. The discussion focused on whether the data were reflective of advisory group members' experiences and if any cost or operational components were underrepresented or mischaracterized in the survey analysis or WA-APCD data.

Participants also shared their perspectives on the most common types of TNT services and discussed what policies, procedures, or safeguards could help ensure appropriate use of TNT. The session concluded with a conversation about locally established rates.

Key takeaways included:

- ***Clearer definitions of TNT are needed*** – Inconsistent terminology and classification are leading to variation in how services are reported and reimbursed.

- ***Multi-agency responses may be underrepresented*** – Claims data may not fully capture the complexity of responses involving multiple agencies (e.g., EMS and fire).
    - This could understate the true cost and operational effort of TNT services.

- ***High-acuity calls often involve TNT*** – Common TNT scenarios include cardiac arrests and overdose responses.
    - Cases can involve multiple units and extended time spent on scene.

- ***Need for guardrails around TNT billing*** – Interested parties emphasized the importance of establishing guardrails, including:
    - Clear definitions of what qualifies as a billable TNT service and what does not
    - Standardized coding and documentation requirements for accurate claims processing

Before the final meeting with the Advisory Group, OIC hosted a dedicated session with public GASOs to inform the development of the rate model and provide additional context for the study's conclusions. This session focused on how public jurisdictions currently set rates for TNT services and the administrative challenges associated with billing for these services. The discussion was highly informative, offering deeper insight into the most common categories of TNT responses as well as emerging standards and expectations for TNT service delivery.

In July 2025, a final meeting with the Advisory Group was held to present the draft proposed rate model and accompanying recommendations. During this session, the group was guided through the proposed definition of TNT services, shared examples of TNT documentation requirements from other states, and explained the methodology used to develop the rate model.

Based on the group's feedback, the TNT service definition was refined to be more specific. The group also noted that additional documentation requirements would likely be unnecessary, as most providers already complete a patient assessment within their Electronic Patient Care Reporting (EPCR) systems. Additionally, following the discussion, a super-rural adjustment was incorporated into the rate model in response to concerns that providers serving super-rural areas incur additional costs.

SECTION 4: NATIONAL AND PEER-STATE POLICY ANALYSIS

This section provides an overview of publicly available information relating to TNT reimbursement practices across the country. This research provided important information on trends, challenges, and opportunities related to TNT reimbursement practices currently in place within and outside of Washington.

Several challenges were encountered in identifying and comparing models across states and payer types. These include limited publicly available data, particularly for commercial health plan reimbursement, inconsistent terminology used to describe TNT or similar models, and a lack of standardized reporting on policy implementation or outcomes. Despite these limitations, the findings offer valuable insights. This research supported the development of a TNT reimbursement model tailored to Washington State's healthcare landscape, with the goal of improving access, efficiency, and sustainability in EMS delivery.

NATIONAL TNT REIMBURSEMENT

Overview

As a starting point for the analysis, the TNT review team focused on national findings related to TNT reimbursement. TNT reimbursement policies vary significantly across states and insurers.

Based on preliminary analysis, TNT reimbursement is increasingly prevalent across multiple payers. According to the GADCS Year 1 and Year 2 Cohort Analysis published by CMS in December 2024, 11.5% of respondents reported payments for "non-transport EMS/medical

services" with a median annual revenue amount of $18,169 and a mean of $405,613[4]. Revenue reported spanned all payers, including commercial insurers, Medicare, and Medicaid.

Billing practices for TNT services vary significantly across providers. The Academy of International Mobile Healthcare Integration (AIMHI) 2024 Benchmarking Survey indicated that provider charges for TNT services ranged from $0.00 to $1,785.00 per incident for EMS systems defined by AIMHI as High-Performance/High Value, reflecting significant variability in approach and pricing structures.[5]

Several challenges were identified in relation to TNT reimbursement. Chief among these is the administrative complexity involved in securing payment. Payers frequently require detailed documentation to substantiate medical necessity, with requirements varying across insurers and individual health plan policies. As a result, providers often face claim denials, contributing to the significant administrative burden associated with billing for TNT services. In some instances, providers do not collect insurance information unless a transport occurs, limiting their ability to pursue reimbursement for TNT services. Additional challenges include a lack of industry-wide knowledge, inconsistent coverage across health insurers and plan types, and a changing regulatory landscape surrounding TNT.

National TNT Reimbursement – Commercial Health Plans

Some health insurers have begun reimbursing TNT services for their commercial health plans in select states; however, these policies are not widespread and are often limited to specific regions or pilot programs. Commercial health insurance reimbursement and coverage information is typically not publicly available, which makes it difficult to identify which health insurers are currently reimbursing for TNT services nationwide. The information contained within this report is based on publicly available data sources and may not provide a complete picture of current commercial health plan reimbursement practices.

The TNT review team also evaluated data maintained by FAIR Health, an organization that collects data on claims paid by private insurers. According to a FAIR Health analysis, commercial health plan and Medicare Advantage claim volume for TNT Services increased by 36% between 2018 and 2022. TNT claims increased from 1.4% of all ground ambulance claim lines in 2018 to 1.9% in 2022.[6] TNT claims peaked at 2% in 2020, possibly impacted by increased reluctance to visit a hospital ED during the COVID-19 pandemic.

According to FAIR Health data, the most common diagnoses associated with TNT claims were "General Signs and Symptoms," at 24.9% of claims. The next most common diagnoses were "General signs and symptoms involving circulatory and respiratory" and "injury to body," which collectively made up an additional 15.4% of TNT claims.

[4] https://www.cms.gov/files/document/medicare-ground-ambulance-data-collection-system-gadcs-report-year-1-and-year-2-cohort-analysis.pdf
[5] https://aimhi.mobi/page-18073
[6] https://s3.amazonaws.com/media2.fairhealth.org/brief/asset/A%20Window%20into%20Utilization%20and%20Cost%20of%20Ground%20Ambulance%20Services%20-%20A%20FAIR%20Health%20Brief.pdf

ANTHEM BLUE CROSS BLUE SHIELD

Anthem Blue Cross Blue Shield, a major commercial health insurer, is reimbursing TNT under procedure code A0998. In the 14 states where Anthem Blue Cross Blue Shield operates and reimburses for TNT, services are reimbursed at approximately 70% of the average ambulance transport rate specific to each state. TNT is reimbursable when ambulance providers respond to a call and treat the member, but transport is not necessary. The following criteria must be met:

- Member consents to evaluation and treatment.
- After evaluation, medic and member agree there is not a medical emergency.
- Member does not desire transport to an emergency department for evaluation.
- Member is stable for referral to the member's physician or other community resource.
- Member has the ability (mental capacity, transportation resources) to obtain assistance and medically indicated follow-up.[7]

While other commercial health insurers have begun reimbursing for TNT, Anthem Blue Cross Blue Shield was the largest insurer identified as covering TNT claims under procedure code A0998 across multiple states. Additional information on state-specific commercial health insurance coverage of TNT is discussed below.

National TNT Reimbursement – Department of Defense

TRICARE is the United States Department of Defense (DOD) insurance program that provides coverage to current and former military members and their families. According to the TRICARE website, TRICARE reimburses for TNT responses described as "treat and release." No information was found regarding reimbursement rates or eligibility criteria for TNT claims paid by TRICARE.[8]

National TNT Reimbursement – Medicare Part B

MEDICARE AMBULANCE PUBLIC USE FILES

Medicare Part B does not pay for TNT services under procedure code A0998. Medicare reimbursement rates are publicly available on the CMS website. Medicare rates for ground ambulance services are defined in Ambulance Public Use files, which are updated annually. Medicare coverage and reimbursement methodologies are aligned across all 50 states with state-specific adjustments applied to account for geographic differences in cost.

MEDICARE PROGRAMS SPECIFIC TO TNT COVERAGE

Medicare has a history of pilot programs and short-term reimbursement initiatives enabling TNT reimbursement. These include:

- **Temporary reimbursement during the COVID-19 Public Health Emergency (PHE)**: In Sec. 9832 of the American Rescue Plan Act of 2021, CMS was authorized to pay for treatment in place under Medicare waiver authority.[9] During the PHE, Medicare reimbursed CPT codes A0429, BLS ambulance transport, and A0427, ALS ambulance transport, under the following circumstances:

[7] https://www.anthembluecross.com/content/dam/digital/docs/provider/commercial/policy/reimb/C-1900_ABCBS_2.pdf
[8] https://tricare.mil/CoveredServices/IsItCovered/AmbulanceServices
[9] https://www.cms.gov/files/document/covid-waiver-medicare-ground-ambulance-services-treatment-place.pdf

- The ground ambulance service was furnished in response to a 9-1-1 call (or the equivalent in areas without a 9-1-1 call system), and
- The patient would have been transported to a destination permitted under Medicare regulations, but such transport didn't occur because of community-wide emergency medical service (EMS) protocols due to the COVID-19 PHE.

Under this waiver authority, claims for services provided between March 1, 2020, and May 5, 2021, during the PHE, were eligible for submission. The deadline to file these claims was May 5, 2022.

- **Emergency Triage, Treat, and Transport (ET3) Model**: CMS released a Request for Application (RFA) in 2019 to invite Medicare-enrolled ambulance providers to participate in a five-year ET3 pilot program that reimbursed at the Emergency BLS rates for TNT and alternate destination transports. For context, the 2025 Medicare rate for BLS Emergency is $446 (without factoring in geographic adjustments specific to states and regions). There were 72 active ET3 participants who provided services to 2,964 unique beneficiaries.[10] Due to limited participation and lower than projected interventions, CMS ended the model on December 31, 2023, two years ahead of the anticipated end date.

ADDITIONAL MEDICARE CONSIDERATIONS

Medicare has recently completed a multi-year GADCS data collection initiative. Preliminary findings are available in the Year 1 and Year 2 Cohort Analysis, referenced above. A Year 3 and Year 4 Cohort Analysis is expected to be released in the future. Although the impact of the GADCS data on future Medicare reimbursement methodologies is unknown at this time, GADCS data may be used to rebase Medicare reimbursement methodologies in the future.

There are currently no federal regulations mandating Medicare reimbursement for TNT. The Comprehensive Alternative Response for Emergencies (CARE) Act, introduced in Congress, aims to establish Medicare reimbursement for TNT services. As of May 15, 2025, the CARE Act of 2025 has been referred to the Committee on Energy and Commerce and the Committee on Ways and Means. The outcome of this legislation and other similar legislative initiatives could significantly impact the adoption and reimbursement of TNT models nationwide. The CARE Act does not prescribe a specific reimbursement rate for TNT services billed under procedure code A0998.

National TNT Reimbursement – Medicaid

Medicaid allows states to include TNT reimbursement as a covered service in their Medicaid State Plans. Consequently, Medicaid reimbursement for TNT services varies considerably by state, with some states covering TNT services under procedure code A0998, and others excluding TNT services from reimbursement altogether.

In September 2023, CMS published a Medicaid Transportation Coverage Guide in the form of a State Medicaid Director Letter (SMDL).[11] The guide noted that states cannot receive federal Medicaid funding for the treatment "as a transportation service"; however, CMS offered possible paths to include TNT services as a Medicaid-reimbursable service. Options for obtaining federal

[10] https://www.cms.gov/priorities/innovation/innovation-models/et3
[11] https://www.medicaid.gov/federal-policy-guidance/downloads/smd23006.pdf

approval for TNT coverage under Medicaid State Plans include the other licensed practitioner (OLP) benefit described in Sec. 1905(a)(6) of the Social Security Act.

In August 2019, CMS also published an informational bulletin, "Medicaid Opportunities in the Emergency Triage, Treat, and Transport (ET3) Model," which directly addressed ways to attain federal Medicaid reimbursement for TNT services.

STATE COVERAGE

The following section provides additional insights into state-specific TNT reimbursement practices across Medicaid and commercial health insurance.

Medicaid

Twenty-five states currently have Medicaid Fee-For-Service (FFS) rates published under procedure code A0998. *Figure 4.1* below demonstrates the variable reimbursement levels for TNT across state Medicaid programs.

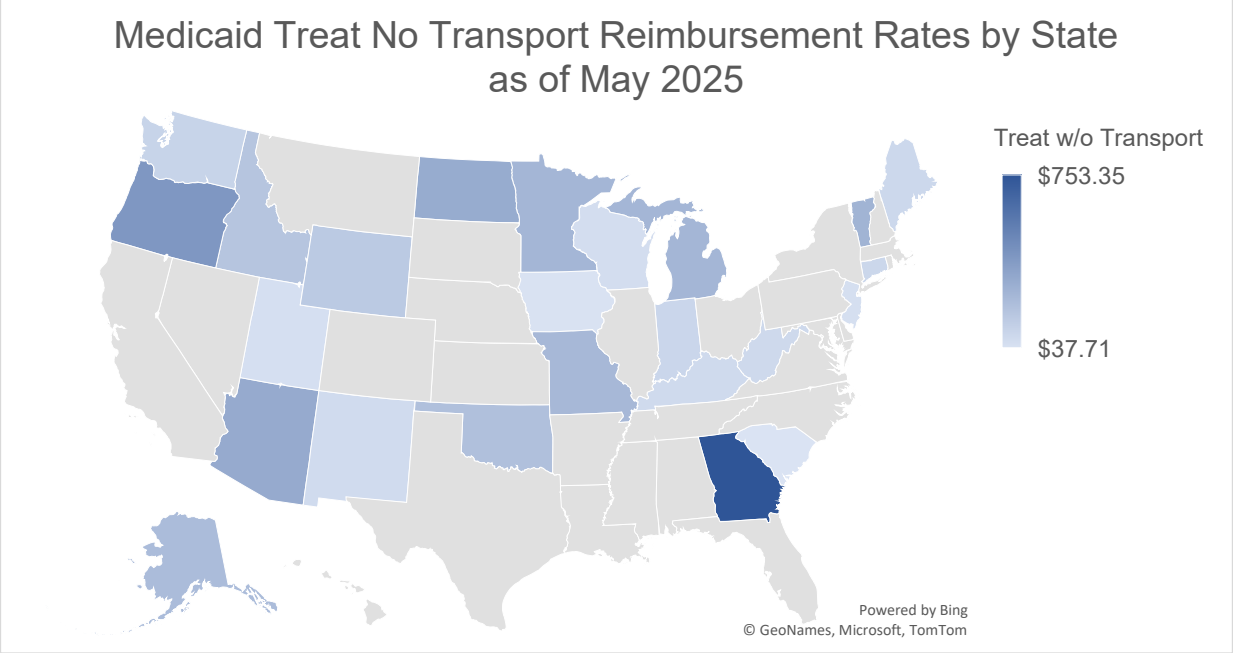

Figure 4.1: Medicaid FFS Reimbursement Rates by State

*Rates for AZ and NM reflect the lowest reimbursement level under procedure code A0998, representing rates applicable to Urban responses and BLS responses, respectively.

In addition to direct FFS Medicaid reimbursement, many states participate in Medicaid Ground Emergency Medical Transportation (GEMT) supplemental payment programs. GEMT programs typically allow for cost-based reimbursement for publicly owned GASOs serving Medicaid beneficiaries. There is no universal approach to integrating TNT costs and/or TNT transports into GEMT programs.

The subsequent paragraphs provide additional state-specific insights relating to Medicaid reimbursement for TNT services.

WASHINGTON – MEDICAID

Washington State Medicaid reimburses for TNT under the Treat and Refer Program. The current rate of reimbursement is the same as the BLS rate of $115.34.[12] The Treat and Refer Program is voluntary and allows publicly owned providers to receive payment under the community assistance referral program (RCW35.21.930). The program was designed to reduce emergency department visits in the state.

Fire/EMS agencies must meet the criteria below to receive payment:

- Publicly owned and operated fire department under Title 52 RCW, Chapter 52.26 RCW or RCW 84.52.069.
- Enrolled Medicaid provider with an active Core Provider Agreement (CPA) for the service period.
- Have an established community assistance referral and education service program under RCW 35.21.930.

Claims must be billed using procedure code A0998 under FFS. Additionally, certain modifiers are required when billing the code as reflected in *Figure 4.2*, below. These modifiers do not impact reimbursement levels. The reimbursement rate is $115.34 for both A0998 claims and claims that include an additional modifier.

Modifier	Description
Modifier U1	Treat on scene, refer to a licensed health care provider.
Modifier U2	Treat on scene, refer to crisis response (i.e., Designated Crisis Responder (DCR) called to the scene).
Modifier U3	Treat on scene, refer to a behavioral health (BH) provider.
Modifier U4	Treat on scene, refer to chemical dependency.
Modifier U5	Treat on scene, refer to urgent care.
Modifier U6	Treat on scene, refer to community assistance referral and educational services team.

Figure 4.2: WA Medicaid Required TNT Modifiers

Payments are subject to review and audit through this program under Chapter 182-502A WAC.

The Washington Ground Emergency Medicaid Transportation (GEMT) Program was established by HB 2007 in 2015. The Medicaid state plan amendment to implement the program was approved in July 2017. The program began operating in SFY16. The program was created to provide supplemental payments to publicly owned and operated emergency medical transportation providers to cover the gap between actual transport costs and Medicaid reimbursement. The program reimburses based on the Federal Medical Assistance Percentage (FMAP), and the federal share is paid back to the provider. The GEMT program does not reimburse TNT.

Departments are eligible to participate in both the GEMT and Treat and Refer programs. However, few choose to participate in both, as doing so results in a slight reduction in GEMT funding.

[12] https://www.hca.wa.gov/assets/billers-and-providers/Ambulance-Trans-bg-20210101.pdf

Another feature of Washington's reimbursement to GASOs is the "locally-set" rates for the fully insured health plan market and PEBB/SEBB programs, which are established based on cost report data submitted by public ambulance providers. Washington's locally set rates were last updated in July 2025 and are publicly available.[13] Twenty percent of all records included a locally set rate for procedure code A0998, ranging from $75 to $1,850. A review of commercial claims from the WA-APCD data showed very limited reimbursement under procedure code A0998, and it is unclear the extent to which locally set rates for A0998 are paid today.

Many other states have adopted balance billing protection regulations specific to ground ambulance services, some of which include a "locally-set" rate component or option like Washington's. Examples include Arkansas, California, Louisiana and Texas, as outlined in *Figure 4.3* below.

State	Rate of Reimbursement Guidance	Non-emergency transport included?
Arkansas	Minimum allowable reimbursement rate set by local government.	Yes
California	Payment based on a rate established or approved by the local government with jurisdiction for the area, if no local rate is set.	Yes
Louisiana	Minimum allowable reimbursement rate set at a rate set or approved by local government or if no rate set the lesser of 325% of Medicare or the providers billed charge.	No
Texas	The payment rate is based on an amount set by a political subdivision and filed with the state or the lesser of 325% of Medicare or the providers billed charge.	No

Figure 4.3 Examples of Locally-Set Rates in Other States

ARIZONA – MEDICAID

Under Arizona's FFS Medicaid program administered by Arizona Health Care Cost Containment System (AHCCCS), ground ambulance providers are eligible for reimbursement when medically necessary treatment is provided at the scene of an emergency without transport. These services are billed using procedure code A0998 (Response No Transport).[14] Under the Ground Transportation fee schedule, Arizona uses the TN modifier to identify rural transports (outside of Phoenix and Tucson) and provide enhanced reimbursement according to the fee schedule in *Figure 4.4*, below:[15]

Procedure Code	Mod	Procedure Description	FFS Rate
A0998		Ambulance Response and Treatment, No Transport, urban	$322.78
A0998	TN	Ambulance Response and Treatment, No Transport, rural	$355.06

Figure 4.4: AZ TNT FFS Fee Schedule

[13] https://data.wa.gov/dataset/WA-Ground-Ambulance-Locally-Set-Rates/r9b2-b8ff/about_data
[14] https://www.azahcccs.gov/PlansProviders/Downloads/IHSChap11Transport.pdf
[15] https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/transportationground.html?id=AETR

In addition to establishing TNT rates, Arizona also has Treat and Refer reimbursement rates under procedure code A0998, according to the fee schedule in *Figure 4.5*, below.

Procedure Code	Mod	Procedure Description	FFS Rate
A0998	UA	Treat at home, refer to PCP/specialist	$268.64
A0998	UB	Treat at home, refer to Crisis Response	$268.64
A0998	UC	Treat at home, refer to BH Provider	$268.64
A0998	UD	Treat at home, refer to Urgent Care	$268.64

Figure 4.5: AZ Treat and Refer FFS Fee Schedule

To ensure appropriate use of TNT and Treat and Refer services, Arizona has implemented several oversight mechanisms:

- **Documentation Requirements:** EMS agencies must record clinical evaluations, treatment plans, and follow-up efforts, including patient satisfaction.
- **Follow-Up Verification:** Agencies must attempt follow-up with 100% of Treat and Refer patients quarterly, with a minimum 30% success rate.
- **Standing Orders and Protocols:** Agencies must maintain evidence-based standing orders for each condition treated, including behavioral health protocols.
- **Performance Monitoring:** Agencies are required to conduct regular administrative reviews and use performance measurement tools to monitor quality.
- **Education and Oversight:** EMS personnel must complete specialized training, and medical directors must oversee clinical documentation and protocol adherence.
- **Data Reporting:** Participation in the Treat and Refer data registry is mandatory to ensure transparency and compliance.

These guardrails help ensure that services billed under TNT and Treat and Refer codes are clinically appropriate, well-documented, and followed through with patient engagement.

NEW MEXICO – MEDICAID

New Mexico Medicaid reimburses providers for TNT services using procedure code A0998, with payment rates and modifiers based on the level of care provided and the outcome of the emergency response, as outlined below in *Figure 4.6*.[16]

Procedure Code	Mod	Description	Rate
A0998	QL	Patient declared dead upon ambulance arrival; or basic life support assessment only.	$47.11 per unit
A0998	UA	Advanced life support provided per medical protocol; patient not transported.	$100.49 per unit
A0998	UB	Basic life support provided per medical protocol; patient not transported.	$78.51 per unit
A0998	UD	ALS – Patient expired at scene despite treatment by ambulance team.	$327.27 per unit

[16] https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd2/6f3f17b7-8c4e-461b-93cf-e1f4035e4312/Medicaid%20Transportation%20Fee%20Schedule

Procedure Code	Mod	Description	Rate
A0998	U8	BLS – Patient expired at scene despite treatment by ambulance team.	$315.41 per unit

Figure 4.6: New Mexico Medicaid Reimbursement for TNT

GEORGIA – MEDICAID

Georgia Medicaid reimburses for TNT at a rate of up to $753.35, the highest in the country.[17] For Medicaid to reimburse TNT, specific criteria must be met. The assessment and treatment provided on scene to patients must be compliant with approved protocols. Additionally, a signed and witnessed S-SV EMS Refusal of Care Form must be submitted to be paid for the service. This form outlines the criteria that must be met for the patient to be released at the scene and includes acknowledgment and signatures from both the patient and the EMS provider. Georgia Medicaid has a higher reimbursement ceiling for TNT services billed under procedure code A0998 than any other Non-Emergency Medical Transportation (NEMT) or Ground Emergency Medical Transportation (GEMT) transport code.

OREGON – MEDICAID

Under the FFS component of their Medicaid program, Oregon updated its reimbursement rates for TNT in December 2024 to align reimbursement with the ALS 1 Emergency reimbursement rate ($420.62).[18]

Oregon administers Medicaid primarily through Coordinated Care Organizations (CCOs), which manage physical, behavioral, and oral health services for defined populations. This flexible structure has allowed several CCOs to pilot TNT reimbursement arrangements through negotiated contracts with EMS agencies. One of the most prominent examples is CareOregon, a CCO that has implemented TNT payments within capitated or value-based care models, particularly in urban areas like Portland. These programs require that treatment be medically necessary and that EMS providers follow established clinical protocols. Participating agencies must meet documentation and data reporting requirements.

TEXAS – MEDICAID

Texas administers Medicaid through a network of Managed Care Organizations (MCOs), which have increasingly supported TNT and similar models through innovative payment arrangements. In cities such as Houston, San Antonio, and Austin, local EMS agencies have launched programs to provide treatment-in-place and non-transport services, often supported by Medicaid MCOs. Superior HealthPlan, Molina Healthcare, and Blue Cross Blue Shield of Texas have implemented pilot programs that reimburse TNT services within broader value-based payment frameworks. These models generally require EMS providers to use online medical oversight, adhere to approved triage algorithms, and meet rigorous documentation standards. Legislative action, such as Senate Bill 8 (2021), has also provided state-level grant funding to encourage EMS innovation, particularly in the use of alternative transport and community paramedicine programs.

[17] https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Emergency%20Ambulance%20Q2-April%202025%20250325215242.pdf

[18] https://www.google.com/url?client=internal-element-cse&cx=017270664345420165392:hlpaoij-wts&q=https://www.oregon.gov/oha/HSD/OHP/Announcements/Rate-Increases0724.pdf&sa=U&ved=2ahUKEwjU4-a7lbOOAxWXQzABHeILMYsQFnoECAoQAg&usg=AOvVaw1M_IKeTLFW9N-j3J1vO9x1&fexp=72986053,72986052

WEST VIRGINIA – MEDICAID

West Virginia has not yet implemented formal TNT reimbursement policies under its Medicaid program. Under current rules, EMS agencies are generally required to transport patients to qualify for payment. A limited number of grant-funded initiatives have tested aspects of TNT and community paramedicine, especially in rural counties where long transport times and high response costs challenge traditional EMS operations. The state has shown some interest in exploring TNT models through potential federal innovation waivers, but no proposals have been formally submitted. Meanwhile, the West Virginia Office of Emergency Medical Services has encouraged EMS agencies to collect and report data on non-transport encounters, suggesting a potential foundation for future reimbursement policy development.

CALIFORNIA – MEDICAID

California does not include TNT reimbursement in the current Medicaid fee schedule; however, there are various Medicaid reimbursement policies regarding procedure code A0998. Some Med-Cal Managed Care Plans may cover A0998 if the services provided are medically necessary and align with the specific plan's approved protocols. This is subject to change based on the specific plan and EMS contract agreement. In the context of Medi-Cal, FFS reimbursement for TNT services is uncommon and typically only occurs under specific pilot initiatives, such as the ET3 Program or Assembly Bill 1554 (described further below).

Commercial Health Insurance

Commercial health insurance payment policies for TNT and rates paid were more difficult to identify because commercial health insurers are not subject to the same rate disclosure requirements as state Medicaid agencies. The information below was identified through publicly available data sources.

WASHINGTON – COMMERCIAL

There is limited coverage of TNT services by commercial health insurers in Washington state, based upon data from the WA-APCD. Based on a preliminary analysis of commercial data obtained from WA-APCD in 2023:

- There were 136 commercial claims paid for TNT services under procedure code A0998 in 2023.
- Average per unit reimbursement from commercial payers under the procedure code A0998 was $301 (including cost sharing).
- TNT claims payments made up less than 1% of commercial ground ambulance service claims paid in 2023.

The Uniform Medical Plan (UMP) is a self-insured health plan offered under the Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) programs, and administered by the Washington State Health Care Authority (HCA). HCA informed the TNT review team that UMP currently offers reimbursement for TNT services.

Other than UMP, there are no known policies or pilot programs supporting TNT reimbursement in the state's commercial health insurance market.

NEW HAMPSHIRE – COMMERCIAL

On July 31, 2025, New Hampshire recently enacted S.B. 245, establishing a reimbursement floor for out-of-network ground ambulance services under commercial insurers. The law requires ambulance providers to accept legislatively mandated reimbursement rates as payment in full and bar providers from balance billing.

In early 2025, the New Hampshire Insurance Department (NHID) published a preliminary report highlighting reimbursement methodology recommendations developed by PCG and Lewis & Ellis (L&E) in collaboration with NHID and other key interested parties. The recommendations included a tiered reimbursement structure for TNT services based on the level of acuity of care.[19]

Ultimately, S.B. 245 did not include reimbursement rates for TNT services.[20] However, it called for an ongoing study to develop new reimbursement rates effective January 2028, which will include a reimbursement methodology for TNT services.

PENNSYLVANIA – COMMERCIAL

Pennsylvania Act 103 of 2018 (EMS Treat but No Transport Bill) bans commercial health insurers and managed care plans from denying a claim because an enrollee did not require transport or refused transport. As a result, commercial insurers in PA are currently reimbursing TNT services under procedure code A0998.

The Commonwealth Act 103 of 2018 states that services are covered if they meet the criteria for medical necessity listed below.

- The services provided are medically necessary to stabilize the individual's medical condition.
- The responding EMS ambulance is Pennsylvania-licensed and rendering EMS services in the Commonwealth of Pennsylvania.
- The responding EMS ambulance, in accordance with state regulations, is a specially designed and equipped vehicle used to transport the sick or injured.
- The responding EMS ambulance, in accordance with state regulations, is staffed by state-certified or qualified staff who are able to provide BLS or ALS services, as appropriate, at the treatment location during the time of the emergency.
- The responding EMS staff provides on-scene emergency evaluation and, if necessary, treatment to stabilize the individual's medical condition, and it is subsequently determined that transportation to an acute care hospital or other emergency care facility for additional care is not required, or the individual declines transportation.

AmeriHealth

AmeriHealth provides reimbursement for TNT services exclusively in the Commonwealth of Pennsylvania, despite operating in more than thirteen states.

19 https://cms3.revize.com/revize/brooklinenh/Documents/Government/Departments/Ambulance%20Service/NH%20Ground%20Amb%20Cost%20Study%20Final%20Report%20Jan%202025.pdf

20 https://legiscan.com/NH/text/SB245/id/3075859

Independence Blue Cross
Similarly, Independence Blue Cross, which operates solely within the Commonwealth of Pennsylvania, also reimburses for TNT services in accordance with the provisions of Act 103 of 2018.

Highmark
Highmark began covering TNT services in January 2020 at a reimbursement rate of $200 per response. It is unknown whether reimbursement rates have been updated since that time.[21]

SECTION 5: RECOMMENDED RATE METHODOLOGY & MODEL

DATA OVERVIEW

As discussed in *Section 2: Data Sources & Collection* above, the TNT review team used personnel and financial data from 33 GASOs operating in Washington state as sample data for a rate development model. The purpose of this model is to produce a representative reimbursement level for TNT responses that is intended to cover the average cost of a TNT response within the state.

Of the 33 responses received, the breakdown between types of response data was as follows:

- 11 organizations provided data collection survey responses only.
- 7 organizations provided their GADCS responses only.
- 15 organizations provided both responses to the data collection survey and their GADCS survey.

The *Section 2: Data Sources & Collection* section above discusses the data contained in these different surveys and the additional limitations and considerations relating to these survey results.

The data collected was intended to provide an overall financial profile of each responding GASO, with the operating finances broken down into transport types (emergency transport, non-emergency transport, treat but no transport, and responses where no treatment was delivered). ALS and BLS distinctions were included in the data collection survey to further break down the transport types and to assess any cost distinctions between ALS and BLS TNT responses. The number of responders and the type of responders, such as Paramedics, Emergency Medical Technicians (EMTs), Emergency Medical Responders (EMRs), typically assigned to ALS and BLS units were requested to assess the personnel costs associated with each response type. Additionally, average minutes on call for each of the response types were requested to best estimate the costs associated with GASO operations by response type.

[21] https://providers.highmark.com/content/dam/highmark/en/providerresourcecenter/pdfs/all/documents/pdfs/claims-and-authorization/reimbursement-resources/amb-treat-no-transport-faqs.pdf

Data Elements – GADCS with the Data Collection Survey

The GADCS survey was coordinated by CMS to capture detailed financial data associated with GASO operations for a historical financial period, focusing on ambulance services. These costs included personnel costs by role and detail on various direct and indirect operating costs for each GASO. Response volumes by type of response also were included in the GADCS.

Since this study and report are focused solely on TNT responses, the GADCS was supplemented by an additional data collection survey that included details on response volumes and duration of response, including distinguishing between ALS and BLS responses and estimating response volumes by CMS regional distinction (urban, rural, and super-rural). When both surveys were available, the organization was asked to use a similar time period for its survey responses to provide a consistent financial profile of the organization.

Data Elements – Data Collection Survey Only

For those organizations that did not have the GADCS responses available, the data collection survey requested additional information on the personnel costs by role (paramedic, EMT, advanced EMT, EMR, and administrative) and operating costs by type (facility, equipment, vehicle, and other expenses). Response counts by type (emergency transport, non-emergency transport, treat but no transport, and no treat responses) were also captured in this extended survey.

Data Elements – GADCS Only

For organizations that did not respond to the survey but had completed a GADCS survey, the TNT review team reached out to request the usage of their GADCS results. For these seven organizations, the overall financial profile was of most use, as these surveys did not capture details associated with minutes on response or personnel responders by response type.

For those organizations that did not have the GADCS responses available, the data collection survey requested additional information on the personnel costs by role (paramedic, EMT, advanced EMT, EMR, and administrative) and operating costs by type (facility, equipment, vehicle, and other expenses). Ground ambulance response types (emergency transport, non-emergency transport, treat but no transport, and no treat responses) were also captured in this extended survey.

Data Summaries

Through meetings and interviews with the OIC and other interested entities, various data summaries and statistics were presented to ensure that the sample survey response data were in line with expectations. These summaries are reproduced below based on the responses from the 33 organizations that provided survey data.

OVERALL RESPONSE TYPE

Our survey data indicated that 22% of responses included treatment without transport to a hospital or behavioral health emergency facility. These responses represented 18% of the total response time. Other non-transport events include situations where the patient could not be located or refused treatment and transport. These figures, reflected in *Figure 5.*1 and *Figure 5.*2, were in line with the interested party's expectations.

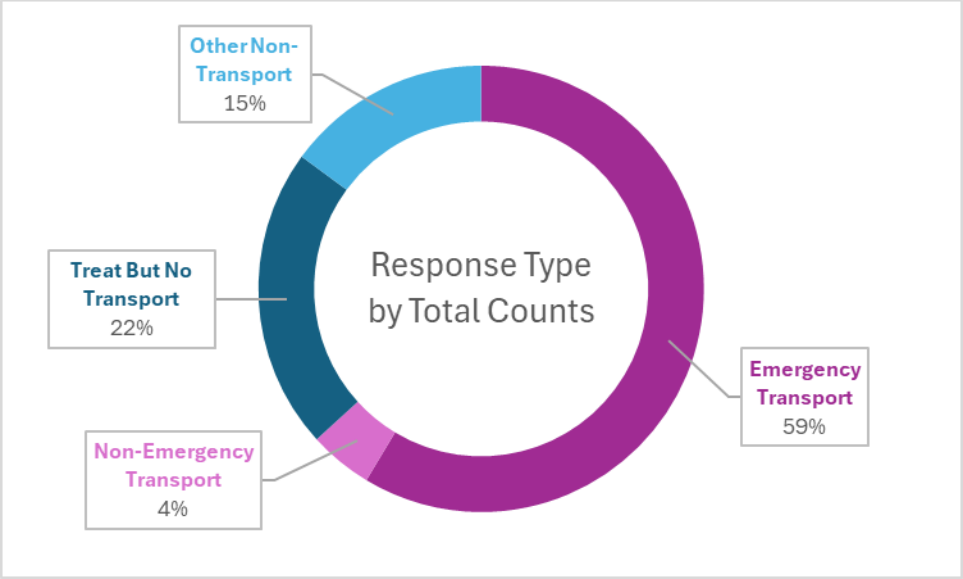

Figure 5.1 Response Type by Total Counts

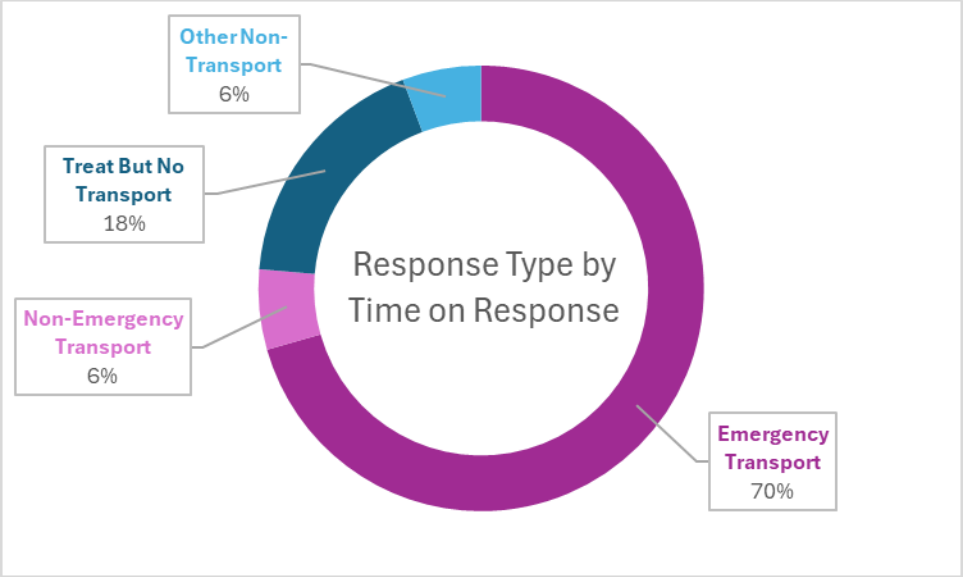

Figure 5.2 Response Type by Time on Response

The above charts indicate that the time spent responding to calls is longer for emergency and non-emergency transports than for TNT and the other non-transports. These statistics are borne out in *Figure 5.3*:

Response Type	Average Duration (Minutes)
Emergency Transport	56
Non-Emergency Transport	59
Treat but No Transport	38
Other Non-Transport	18

Figure 5.3 Average Duration by Response Type

RESPONSES BY REGION

Survey data indicated the following distribution by CMS region distinction: 63% urban, 19% rural, 18% super-rural.

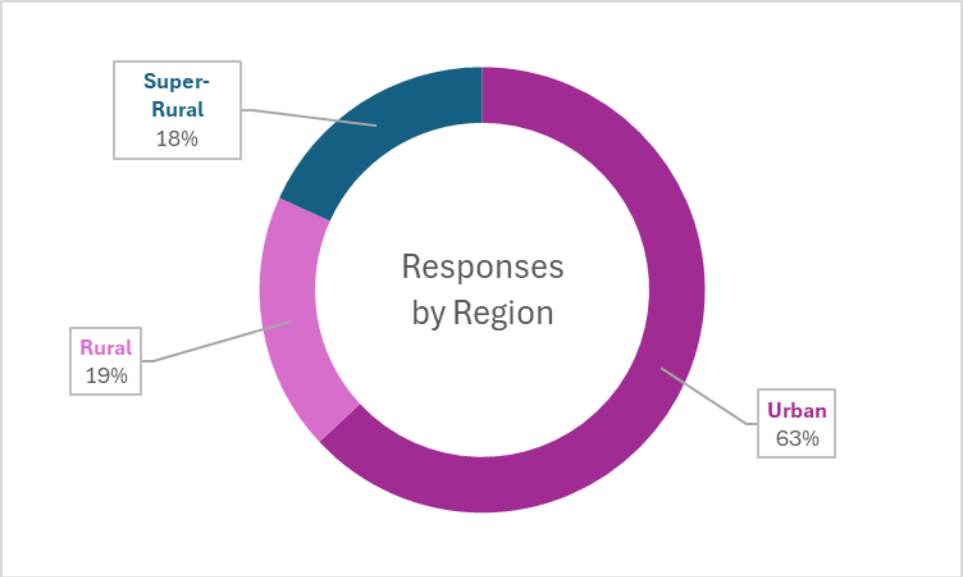

Figure 5.4 Responses by Region

RESPONSES BY ACUITY LEVEL

The survey data broke down the response types by acuity level. ALS transports refer to emergency medical services provided by healthcare professionals with advanced training. These transports include interventions such as cardiac monitoring, administration of medications, intravenous therapy, airway management, and other procedures intended for patients with life-threatening conditions or those requiring more complex medical attention.

BLS transports, on the other hand, involve fundamental emergency medical care performed by providers trained in basic procedures. These typically include patient assessment, CPR, oxygen administration, splinting, and wound care, but do not encompass advanced interventions or invasive procedures.

The primary difference lies in the level of care administered: ALS is equipped for higher acuity cases and can deliver advanced interventions, while BLS focuses on essential support and stabilization without advanced medical techniques.

The GADCS survey captured the frequency of these two designations for responses resulting in transport, but did not do so when no transport occurred. The data collection survey attempted to fill in these gaps for the non-transport data, but in instances where the designation was not made, the splits between ALS and BLS responses were based on the personnel employed by the GASO.

The data indicated that most transports involve BLS services, while most non-transports involve ALS services. In our discussions, the interested parties validated these differences. They noted that advanced life support could be required in cases of cardiac arrest or diabetic shock to stabilize the patient, but additional treatment at a facility may not be required.

The distribution of ALS and BLS responses by transport type is reflected in Figure 5.5.

Response Type	ALS %	BLS %
Emergency Transport	45%	55%
Non-Emergency Transport	37%	63%
Treat but No Transport	73%	27%
Other Non-Transport	53%	47%

Figure 5.5 Responses by Acuity Level

PERSONNEL DATA

The GASO Data Collection Survey and GADCS data provided details on personnel costs by role and level of life support provided. This data was provided for the organization's operations in total and was allocated back to the response types based on the time on response. In the context of this report, "time on response" refers to the percentage of time personnel spend on "active responses," which is the time from when a vehicle is dispatched to a scene to the time it returns to a station or posted location.

As expected, the data showed that ALS units are most frequently staffed with paramedics, with EMTs as secondary personnel. BLS units are most commonly staffed with EMTs but use other role types (drivers, other administrative personnel) as secondary personnel.

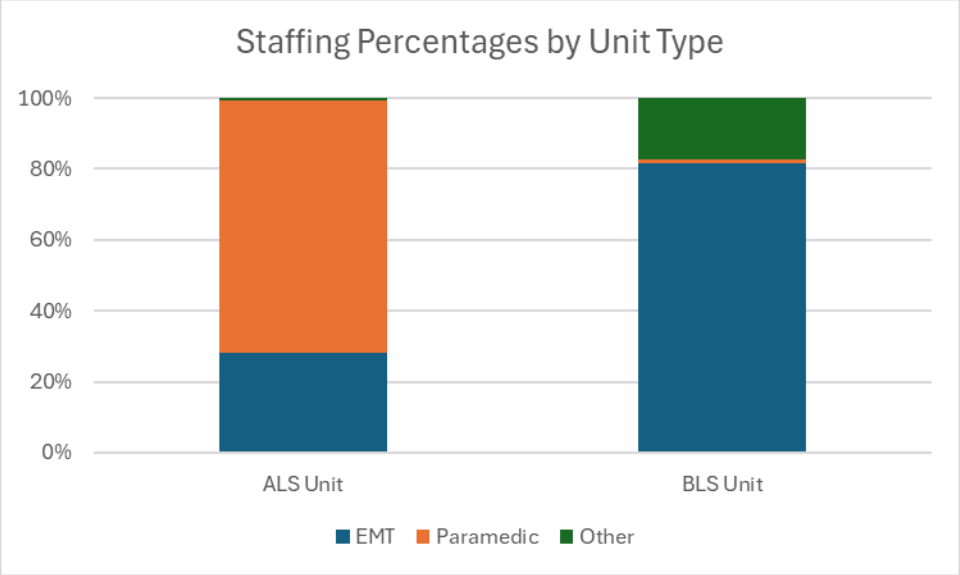

Figure 5.6 Staffing Percentages by Unit Type

Reviewing personnel costs by role resulted in the following hourly rates (weighted by total time on responses):

Role	Average Hourly Cost
EMT	$64.37
Paramedic	$72.29
Admin/Other	$73.12

Figure 5.7 Average Hourly Cost by Role

To assess the appropriateness of the results, the TNT review team held several meetings with the OIC and other interested parties to present the findings. While a higher hourly wage for paramedics compared to EMTs was anticipated, additional feedback was sought to ensure the disparity was reasonable and appropriate. Comparisons also were made to Washington State wage benchmarks from the Bureau of Labor Statistics. The interested parties noted that rising EMT wages are being driven by workforce shortages, while others pointed out that EMTs often perform multiple roles, which further contributes to higher compensation. Admin/other personnel often similarly had these dual roles or were in senior or managerial roles with higher average wages.

The survey results also indicated that personnel are the primary driver of overall costs. The other cost centers are discussed below.

% of Spending by Cost Center	ALS	BLS	Source
Response Personnel Cost %	71.83%	71.83%	Survey Responses
Admin Cost %	7.98%	7.98%	Survey Responses
Non-Personnel Cost %	20.19%	20.19%	Survey Responses

Figure 5.8 Percent of Spending by Cost Center

NON-PERSONNEL COSTS

The GADCS responses provided details on additional operational costs incurred by GASOs, broken down by category of expenses. The GASO Data Collection Survey asked for only four categories of additional expenses: facility, equipment, vehicle, and other. The GADCS responses were rolled up into these four categories. These responses represent only the costs associated with the ambulance response services, so no further calculations were needed to allocate costs to response services. The GADCS survey also included expenses associated with capital expenditures, which were included in a separate category.

The distribution of costs by expense type was as follows:

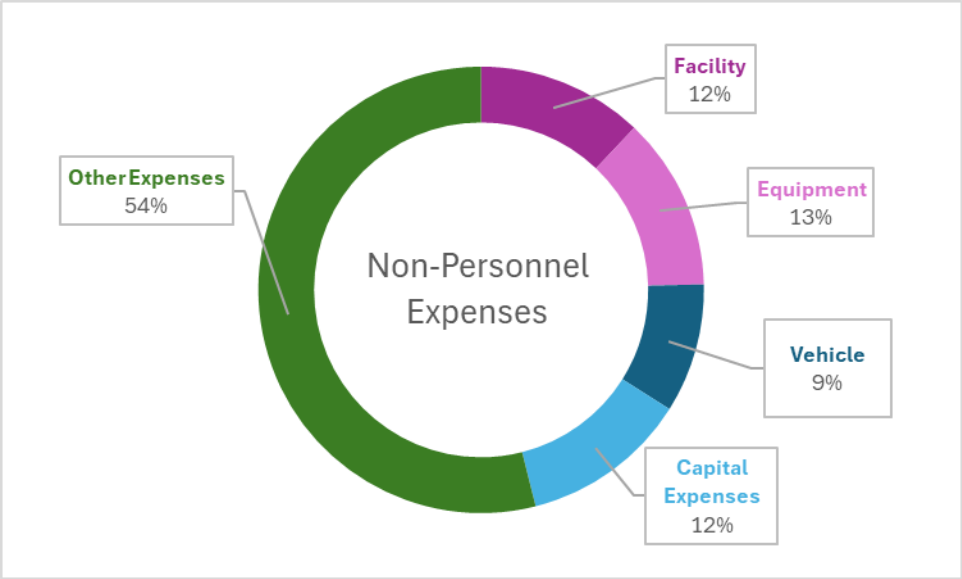

Figure 5.9 Breakdown of Non-Personnel Expenses

In total, the non-personnel costs represented 20% of the total cost of operations when combined with the personnel costs. This percentage was in line with expectations for GASO operational costs.

DATA VALIDATION AND ANALYSIS

REPRESENTATIVE SAMPLE ANALYSIS

As discussed above in the *Evaluating Sample Representativeness* subsection of this report within *Section 2: Data Sources & Collection*, the TNT review team found the overall results from the responses that were used for rate model inputs were in line with expectations and appropriately representative of the population of GASOs providing TNT response services in the state. The rate model data were not further adjusted for potential biases or exclusions except as indicated below.

INFLATION ADJUSTMENT

Each survey reported the time period of the data presented. To ensure a consistent representative time period, all financial data was adjusted to midyear 2025 (June 2025). By changing to the midpoint of the year, this adjustment resulted in an appropriate full-year 2025 financial profile. The inflation adjustment was determined from the Bureau of Labor Statistics inflation data for medical care in the Western United States.

OUTLIER ANALYSIS

A critical component of our analysis included a review of the data for potential outliers. Organizational statistics related to compensation, personnel, response counts and duration, and expenses were reviewed to identify potential outliers impacting results. Since many of these statistics were developed from self-reported data, the TNT review team assessed all responses to ensure alignment amongst the various organizations. Our analysis resulted in the following observations and adjustments:

Personnel Costs

The average hourly rate for personnel assigned to response services ranged from a low of $18.71 per hour to a high of $93.82 per hour. A review of this data with the OIC indicated that these results were in line with expectations and provided clarity in the wide variety of organizations providing these services. To better reflect expected averages, the top two and bottom two organizations (below the 5th percentile and above the 95th percentile) were excluded from the overall results, providing a more balanced cost profile for the rate study.

Dispatch Statistics

While the dispatch results were heavily weighted by several larger organizations, no adjustments for outliers were deemed appropriate. Given that much of the data was self-reported, variance among organizations was anticipated. The average time on response for TNT responses ranged from a high of ninety minutes to a low of five minutes. Rather than adjusting for outliers, the reported results were used as-is, and a Provision for Adverse Deviation (PAD) was applied and is discussed further below.

Expense Outliers

One organization reported expense statistics on the GASO Data Collection Survey that were significantly higher than those of the other organizations. Discussions with interested parties suggested that such an outlier may reflect a capital cost expenditure occurring periodically, such as the replacement of outdated equipment and vehicles. As this was self-reported data and represents a typical periodic expense for such organizations, no further adjustment was made.

RATE MODEL APPROACH

The following factors influenced estimated TNT costs:

1. ***Time on Response*** – No data was available regarding the percentage of time response personnel spend on "active responses," defined as the time from when a vehicle is dispatched to a scene to the time it returns to a station or posted location or the time it is rerouted to a new call. Given the unplanned nature of emergency services, it is expected that personnel spend additional "readiness time" when they are available to respond to the next emergency call. Readiness time is factored into the cost of TNT responses, calculated to ensure the availability of responders.

2. ***Representative Analysis*** – As discussed above, survey responders represented approximately 10% of the total GASOs operating in the state. Although a larger sample size would have been preferable, the data covered a broad range of geographic and cost profiles and was deemed acceptable. Rather than adjusting for sample size, the factor for adverse deviation was applied to account for variability across the entire GASO population.

3. ***Additional Outliers*** – While results from several organizations with extreme personnel cost data were removed, no further adjustments for outliers were made. The variety of results was considered acceptable, and variability was taken into account when determining the PAD.

4. ***Regional Approach*** – The survey response data did not provide strong evidence for utilizing regional rate distinctions. Results showed rural responses as the costliest, followed by urban, with super-rural responses appearing least costly. However, given the expected longer response times for super-rural calls, the region-specific data was not considered reliable. Further review revealed that urban results were heavily influenced by a single responder, accounting for over 80% of the volume. In comparison, super-rural results were similarly dominated by one responder with over 70% of the responses. Removing these responders would have significantly reduced the data volume, so a standardized adjustment for super-rural call responses was applied instead.

MODEL DATA – PERSONNEL COSTS

Results from the GASO Data Collection Survey and GADCS provided the base model staffing costs. Staffing by role and response type provided the following assumption table for costs and staffing by response type:

Staffing Breakdown by Unit Type		ALS	BLS	Source
EMT	$63.12	21%	83%	Survey Responses
Paramedic	$74.51	77%	2%	Survey Responses
Other	$70.36	2%	15%	Survey Responses

Figure 5.10 Staffing Breakdown by Unit Type

MODEL DATA – OTHER EXPENSES

In addition to personnel, GASOs have additional operating expenses associated with administrative overhead and vehicle and facility costs. Using the data from the GASO Data Collection Survey and GADCS, these operating costs are included in addition to the personnel costs, based on the total costs associated with TNT response calls.

% of Spending by Cost Center	ALS	BLS	Source
Response Personnel Cost %	71.83%	71.83%	Survey Responses
Admin Cost %	7.98%	7.98%	Survey Responses
Non-Personnel Cost %	20.19%	20.19%	Survey Responses

Figure 5.11 Percent of Spending by Cost Center

AVERAGE HOURLY COSTS

Combining the personnel and other expenses results in the following base hourly costs for rate modeling:

Average Hourly Cost	ALS	BLS	Source
Average Hourly Cost Per FTE	$ 72.04	$ 64.43	Costs above
Admin Hourly Cost $	$ 8.00	$ 7.16	Costs above
Non-Personnel Hourly Cost $	$ 20.25	$ 18.11	Costs above
Total Cost Per FTE Hour	**$ 100.29**	**$ 89.70**	

Figure 5.12 Average Hourly Cost by Unit Type

The above table represents the average hourly costs associated with a single responder based upon the response service level (advanced or basic). The average hourly cost per FTE is the weighted average calculated from the "Staffing Breakdown by Unit Type" table, while the additional hourly costs are determined from this FTE cost adjusted by the percentages in the "% of Spending by Cost Center" table.

ADDITIONAL ASSUMPTIONS

The above hourly cost assumptions were used to build up to the appropriate reimbursement level for TNT responses. The additional assumptions used in rate development include:

1. ***FTE Per Vehicle*** – Most responders indicated that their vehicles are staffed with two responders. However, a small percentage of respondents reported more than two responders per vehicle. About 5% of total responses reported more than two personnel on responses, resulting in an additional 0.1 FTE unit on average. Thus, our assumption of responders per vehicle is assumed to be 2.1 to account for instances when more than two responders participate in a response.

2. ***TNT Average Duration*** – From the survey responses, the average duration of TNT responses was 38.69 minutes. Although this self-reported data ranged from five to ninety minutes, the average was used in the rate calculation. Variability in response times was addressed through the PAD, discussed below.

3. ***Active Response Percent*** – While the data did not provide a clear estimate of active response time, an estimate was developed based on public studies and through discussions with interested parties. An active response rate of 30% was applied in the rate model to reflect the potential disparity of responding times among providers.

4. ***Provision for Adverse Deviation (PAD)*** – This factor accounts for variability in rates and costs among providers and addresses the uncertainty of using sample data to represent the broader population. The considerations that informed the selection of the PAD are discussed further in *Section 6: Evaluating Actuarial Soundness* section of this report.

These additional adjustments are summarized in *Figure 5.13*:

Adjustment Factors	ALS	BLS	Source
Total Cost Per FTE Hour	$ 100.29	$ 89.70	
FTE Per Vehicle	2.1	2.1	Industry Std / Survey
TNT Average Duration (minutes)	38.69	38.69	Survey Responses
Active Response %	30%	30%	Variable Input
Provision for Adverse Deviation	15%	15%	Variable Input

Figure 5.13 Recommended Adjustment Factors

RATE SETTING FORMULA

The following formula establishes the initial rate by service level:

Proposed Rate = Total Cost Per FTE Hour
x FTE Per Vehicle
x TNT Average Duration / 60
/ (1 – Active Response %)
x (1 + Provision for Adverse Deviation)

RATE PROPOSAL – OPTION 1

The above formula with the factors above produces the following initial rate proposal:

Recommended Rate - OPTION 1	ALS	BLS	Source
Proposed Rate - Urban & Rural	$ 520.63	$ 465.68	Formula
Proposed Rate - Super-Rural	$ 638.29	$ 570.92	Medicare Basis

Figure 5.14 Recommended Rate Option 1

To address the concerns regarding additional time and expenses associated with super-rural response calls, the ground ambulance add-on payment factor for super-rural regions, as promulgated by CMS for Medicare payments, was applied.[22]

[22] Ambulance Fee Schedule Public Use Files | CMS

RATE PROPOSAL – OPTION 2

Option 1 assumes that the distinction between ALS and BLS response types is identifiable through administrative efforts and would not be likely to create cost shifting or service shifting by GASOs. As a secondary option to remove cost shifting or service shifting concerns, a blended approach may be preferable. Using survey responses to weight the rates by support level produces the following blended rate option:

Recommended Rate - OPTION 2	ALS	BLS	Source
Number of TNT Dispatches	12,482	6,657	Survey Responses
Blended Rate - Urban & Rural	$501.51		Formula
Blended Rate - Super-Rural	$614.85		Medicare Basis

Figure 5.15 Recommended Rate Option 2

SECTION 6: EVALUATING ACTUARIAL SOUNDNESS

The following definition of actuarial soundness was curated for this project based on the Actuarial Standards of Practice (ASOPs)[23]:

> Actuarially sound rates are:
>
> 1. Developed based on appropriate data sources that are derived from a comparable population and/or services to those anticipated, or if not, are adjusted to make them comparable.
> 2. Developed using adjustments to smooth data and account for expected changes from the base data period to the rate contract period, such as incomplete data adjustments, trend/inflation, population changes, changes in contracted services, etc.
> 3. Expected to be sufficient to cover the contracted services, not only under expected conditions, but under moderately adverse conditions, where moderately adverse conditions are defined as conditions that include one or more unfavorable, but not extreme, events that have a reasonable probability of occurring during the contract period.
> 4. Developed in accordance with generally accepted actuarial principles and standards of practice.

Throughout the rate development process, including data collection and analysis, the TNT review team consistently monitored progress to ensure requirements #1 and #2 were appropriately followed. To fully address requirement #4, a Provision for Adverse Deviation (PAD) was established in accordance with requirement #3. PAD, also known as a risk margin or margin for uncertainty, represents an additional amount, typically expressed as a percentage increase, designed to account for the following:

[23] Particularly, ASOPs 1, 22, 23, 26, 31, and 49. These can be found at the following link: https://www.actuarialstandardsboard.org/standards-of-practice/

- **Uncertainty in Rate Development:** This includes variability inherent in the data sample used for rate development compared to the true value, as well as uncertainties in adjustments and assumptions made during the process. Examples include the selection of methodologies for smoothing data and excluding outliers, as well as setting assumptions for factors like inflation.
- **Increased Confidence in Rate Sufficiency**: PAD helps ensure that the rates remain adequate even if actual future (i.e., rating period) results turn out to be moderately adverse compared to the reporting period used as a basis for rate development.

Based on the factors outlined above, a PAD of 15% was selected. Other than satisfying #3 of the requirements for an actuarially sound rate outlined above, this selection was informed by the following considerations:

- **Data Confidence**: From a statistical standpoint, the final data sample size used for rate model inputs, as deemed reasonable and appropriate, provided over 90% confidence that the results fall within +/-15% of the true value.
- **Support Readiness and Provider Risk**: The proposed rates are designed to ensure that providers remain prepared to deliver TNT emergency services at all times, while incorporating a reasonable operating and risk margin. This margin is essential to account for the inherent uncertainty in both the frequency and severity of emergency service needs. Since demand may fluctuate unpredictably and occasionally exceed expectations during any given period, the risk margin provides necessary financial resilience for providers.

FINANCIAL IMPACT ASSESSMENT

To estimate the impact of the proposed TNT rates, claims data from the WA-APCD was utilized. The analysis focused on commercial ambulance claims incurred during the 2023 calendar year and paid through September 2024. The following underlying assumptions were used to produce the subsequent table (*Figure 6.1)*, which delineates the calculation of the estimated premium impact range for the total commercial market:

- TNT services are estimated to make up 15%-25% of total ambulance dispatches. This assumption range is based on the Washington survey response data.
- ALS services account for 65% of total ambulance dispatches, and 15% of total ambulance dispatches are estimated to be super rural. This assumption range is based on the Washington survey response data.
- All ambulance dispatches, including those for TNT, are assumed to be submitted to payors for claim payment (i.e., number of dispatches = number of claims).
- The low-range reflects an outcome where insurer non-benefit expenses (i.e., administrative costs, taxes/fees, etc.) remain flat on a dollar amount basis, decreasing the non-benefit expenses as a *percentage of premium* when claims are increased due to TNT reimbursement. The high-range impact estimate assumes that insurer non-benefit expenses will remain constant as a percentage of premium, and therefore, increase as a *dollar amount* when claims are increased due to TNT reimbursement.

Total Commercial Market Premium Impact Estimate	Low Impact	High Impact
Estimated TNT Claims (a)[24]	7,096	13,978
Average TNT Rate (b)	$518.51	$518.51
Estimated 2023 TNT Commercial Allowed Costs[25] (c)=(a)*(b)	$3,679,575	$7,247,647
% of Commercial TNT Allowed Cost Paid by Insurer[26] (d)	80%	90%
Estimated 2023 TNT Commercial Claim Cost Impact (e)=(c)*(d)	$2,943,660	$6,522,883
Total 2023 Commercial Paid Claim Cost[27] (f)	$7,647,739,293	$7,647,739,293
Estimated Average Commercial Pricing Loss Ratio[28] (g)	80%	85%
Estimated 2023Total Commercial Premium (h)=(f)*(g)	$9,559,674,116	$8,997,340,345
Estimated Impact of Recommended TNT Rates as a Percentage of Premium For Low Range: (i)=(e)/(h) For High Range: (i) = [(e)/(g)]/(h)	**0.03%**	**0.09%**
Estimated 2025 Total Commercial Premium[29] (j)	$11,566,249,714	$10,885,882,083
Estimated 2025 TNT Paid Claims Impact (k)=(i)*(j)	$3,561,534	$9,284,748
Estimated 2025 Member Months[30] (l)	20,526,555	20,526,555
Estimated 2025 TNT Premium Impact Per Member Per Month (PMPM) (m)=(k)/(l)	**$0.17**	**$0.45**

Figure 6.1 Total Commercial Market Premium Impact Estimate

[24] Represents 15-25% of total ambulance dispatches, where total ambulance dispatches were estimated using the number of emergency transport claims (i.e. claims for A0427, A0429, A0432, A0433, and A0434) and assuming those represent 55-65% to total dispatches, based on Washington survey response data. This method was used for estimating total ambulance dispatches because non-emergency ambulance dispatches, especially TNT since it is largely not reimbursed, are not always claimed for reimbursement.

[25] Allowed costs are claim costs paid to the provider, inclusive of costs paid by the insurer **and** costs paid by the insured member.

[26] Based portion of ambulance allowed claims paid by the insurer within 2023 Washington APCD data.

[27] i.e., for all Commercial claims, inclusive of both non-ambulance and ambulance claims.

[28] Based on L&E's knowledge of typical pricing loss ratios in the Commercial market.
Pricing Loss Ratio = Paid Claims/Premium

[29] Reflects an estimated 10% average annual premium rate increase in the Commercial market from 2023 to 2025 based on publicly available press releases from www.insurance.wa.gov.

[30] Assumed to be equal to 2023 member months.

A similar table for the following separate segments of the Commercial Market is provided in *Appendix C: Premium Impact Estimate by Commercial Market Segment.*[31] *Figure 6.2* provides a summary of the resulting estimated premium impact by market.

Commercial Market Segment	Estimated Impact Range as a Percentage of Premium	Estimated Impact Range in Premium Per Member Per Month
Individual	0.08%-0.21%	$0.35-$0.92
Small Group	0.02%-0.06%	$0.12-$0.32
Large Group	0.03%-0.07%	$0.16-$0.42
PEBB[32]	0.00%-0.06%	$0.00-$0.34
SEBB[33]	0.00%-0.05%	$0.00-$0.27
Total Commercial Market	0.03%-0.09%	$0.17-$0.45

Figure 6.2 Commercial Market Premium Impact Estimate by Market Segment

The impact for each insurer will depend on the characteristics of their specific covered population, which could result in higher or lower cost effects compared to the overall market average or market segment average.

The following information provides background regarding the estimated impact range for PEBB/SEBB:

- A large portion (>50%) of the PEBB/SEBB population is self-insured through UMP. As previously mentioned, HCA—the plan's administrator—informed the TNT review team that UMP provides coverage and reimbursement for TNT services.
- Despite this, the APCD data included only 136 TNT claims in total, with just 17 attributed to the PEBB/SEBB population. These TNT claims represent less than 0.2% of all ambulance claims, both overall and for the PEBB/SEBB segment alone. According to the OIC Ground Ambulance Advisory Group, TNT services are often not claimed because the likelihood of non-reimbursement outweighs the administrative costs of documenting and submitting claims.
- If TNT coverage is mandated, there could be a fiscal impact from increased claiming activity. Therefore, the high-end estimate is reflective of current TNT claiming practices that are immaterial to none. However, if the UMP population truly uses TNT services at a significantly lower rate than other groups—or if TNT claims are not being accurately captured in the APCD—then no fiscal impact would occur. To account for this possibility, the low-end estimate for PEBB/SEBB assumes no impact.
- Employer contributions for fully insured PEBB/SEBB members are based on UMP coverage, claims experience, and budget. Therefore, if fully insured members do not currently have TNT coverage, they could face slightly higher employee contributions in the event their insurer increases premiums to add the TNT benefit and UMP TNT claims remain unchanged.

[31] Note that the sum of these segments will not reconcile to the total Commercial market amounts presented in the body of the report. There is also an "Other" Commercial market segment present in the WA APCD data, which accounted for approximately 8% of paid claims data in 2023.
[32] Public Employees Benefits Board Program
[33] School Employees Benefits Board Program

There is potential for cost savings associated with reimbursed TNT services, particularly through reduced emergency department and hospital claims due to fewer transports. Data from CMS' ET3 pilot program indicated a per beneficiary average savings of over $500 when a patient received TNT services in place of a transport to a hospital emergency department.[34] Additionally, if current reimbursement levels and/or locally set rates for other ambulance services are influenced by providers' inability to receive payment for TNT services, introducing reimbursement for TNT services could indirectly reduce reimbursement for non-TNT services. However, the financial impact estimate does not explicitly incorporate such potential savings, as there was insufficient reliable data to substantiate such assumptions within the Commercial market. Nonetheless, the estimated financial impact range implicitly reflects scenarios where some cost savings may occur, even though these savings were not directly assumed in the analysis.

SECTION 7: IMPLEMENTATION CONSIDERATIONS

PAYMENT DUPLICATION

This analysis specifically relates to the payment of TNT services as a distinct reimbursable service. Given that there is very little direct reimbursement for TNT responses currently, it is expected that providers may establish contracted and/or locally set rates for transport responses that are inflated to include the cost of currently unbillable activities, including TNT.

As part of the implementation of TNT reimbursement rates, the TNT review team recommends ensuring that there is no double-counting of TNT costs by requiring that commercial rates for transport responses be set without integrating the cost of TNT.

DOCUMENTATION REQUIREMENTS

WA OIC should provide clear guidance on the data to be collected and retained to support TNT billing. Preliminary discussions suggest that current Electronic Patient Care Reporting (EPCR) data tracking can show medically necessary care was provided while also confirming that no transport occurred.

PROVIDER COMMUNICATION & TRAINING

To support changing reimbursement rates, it will be important to prepare targeted communication and training to help providers, health insurers, and billing vendors understand new requirements. This includes a clear definition of qualifying TNT responses, documentation requirements, and reimbursement rates.

CONSUMER IMPACT

While the reimbursement of TNT services as a distinct benefit may carry important implications for consumers, available data is currently limited, and definitive conclusions about its impact cannot yet be drawn. Known considerations include the potential for improved system efficiency by reducing unnecessary transports to emergency departments.

[34] https://www.naemt.org/WhatsNewALLNEWS/2024/04/25/et3-savings-data-supports-ems-treatment-in-place-legislation?

An unintended consequence of TNT reimbursement may be consumer uncertainty about TNT service charges. This uncertainty could discourage consumers from calling 9-1-1 during emergencies, potentially delaying care and worsening health outcomes.

Given these uncertainties, the TNT review team recommends conducting a follow-up study after at least one year of implementation to assess the actual impact on consumer behavior, access to care, and overall system utilization.

In the meantime, clear communication to consumers will be essential. Ensuring transparency around billing practices and educating consumers on when and how TNT services are used can help preserve trust in the EMS system while promoting appropriate use of services.

ESSENTIAL HEALTH BENEFITS BENCHMARK PLAN

If TNT services are deemed a required benefit or considered a new mandate under the Affordable Care Act (ACA), the State of Washington may be obligated to defray the associated costs. The TNT review team defers to the WA OIC to determine whether TNT would qualify as an essential health benefit under the ACA framework.

BALANCED BILLING PROTECTION ACT

TNT responses are covered in the definition of ground ambulance services in RCW 48.43.005(27)(a). If TNT responses were required to be a covered service in Washington, per RCW 48.49.200, they would be subject to the Balance Billing Protection Act (BBPA). These protections would only apply to fully-insured health plans and self-funded group health plans that have opted into the BBPA.

SECTION 8: CONCLUSION

In partnership with WA OIC and its interested parties, rate recommendations were developed based on the estimated cost to deliver Treat but No Transport (TNT) responses throughout the State of Washington.

Key Findings:

- There is currently little direct reimbursement for TNT responses in Washington. It is unknown whether current locally set transport rates may be inflated to recover these costs unless clear policies are set.
- Nationally, 25 Medicaid programs reimburse for TNT under Procedure Code A0998; however, little data is available regarding commercial TNT reimbursement.
- Accurate data tracking is essential. Existing Electronic Patient Care Reporting (EPCR) systems and standard procedure codes should provide adequate documentation for TNT scenarios.
- TNT responses are a common occurrence today, and many Ground Ambulance Service Organizations (GASOs) are rendering TNT responses without receiving reimbursement specific to TNT services.

Recommendations:

- When implementing TNT reimbursement, it will be important to ensure that transport rates do not include TNT costs to avoid double payments.
- Given the geographical makeup of the state, a "super-rural adjustment" is recommended to ensure access to care in the most rural areas. A super-rural adjustment was adopted to reflect the expected higher costs and longer response times in the most remote areas of the state. Interested parties raised concerns about super rural areas.
    - Conversely, survey data and interested party feedback did not demonstrate material differences in transport costs in urban areas compared to rural areas not designated as super-rural. Consequently, no additional adjustment was recommended for rural transports not meeting the super-rural designation.
- Rates should be updated on a regular basis using inflation-based metrics or periodic rate studies.
- If the legislature determines that TNT services should be a covered service in commercial health plans, potential reimbursement methodologies include a single blended TNT rate and a discrete rate for Advanced Life Support (ALS) versus Basic Life Support (BLS) TNT responses. The recommended reimbursement rate options are provided below.

Recommended Rate - OPTION 1	ALS	BLS	Source
Proposed Rate - Urban & Rural	$ 520.63	$ 465.68	Formula
Proposed Rate - Super-Rural	$ 638.29	$ 570.92	Medicare Basis

Figure 8.1 Recommended Rate Option 1

Recommended Rate - OPTION 2	ALS	BLS	Source
Number of TNT Dispatches	12,482	6,657	Survey Responses
Blended Rate - Urban & Rural	$501.51		Formula
Blended Rate - Super-Rural	$614.85		Medicare Basis

Figure 8.2 Recommended Rate Option 1

Adopting these recommendations will help ensure a fair, transparent, and sustainable reimbursement process that reflects the anticipated cost of care delivered.

APPENDIX A: GLOSSARY

Below is a list of key terms used throughout this report as well as definitions.

- **Actuarial Standards of Practice (ASOPs)**: Actuarial standards of practice are professional guidelines that set forth the responsibilities and requirements for actuaries when performing their work. These standards promote consistency, transparency, and credibility in actuarial analysis and reporting.
- **Advanced Life Support (ALS)**: A level of emergency medical care provided by paramedics or specially trained personnel, including advanced airway management, medication administration, and other invasive procedures.
- **Aid Units:** A vehicle used to carry aid equipment and individuals trained in first aid or emergency medical procedures. An aid unit is a broad term that can refer to several different types of vehicles, including fire apparatus, and multi-purpose support vehicles.
- **ALS Ambulance**: An ALS ambulance is a specialized emergency vehicle equipped with advanced medical technology and staffed by paramedics capable of performing complex interventions. The presence of advanced equipment and trained personnel enables ALS ambulances to deliver life-saving treatments in the field before and during transport.
- **Basic Life Support (BLS)**: A basic level of emergency medical care, usually provided by EMTs, focusing on non-invasive techniques such as CPR, basic airway management, and patient transport.
- **Blended Rate**: A reimbursement rate structure that combines multiple service levels, such as ALS and BLS, into a single payment rate for TNT services.
- **BLS Ambulance**: A BLS ambulance is staffed by emergency medical technicians trained to provide BLS services. BLS ambulances play a vital role in responding to less critical emergencies and ensuring patients receive timely care while traveling to medical facilities.
- **Centers for Medicare & Medicaid Services (CMS):** The federal agency within the United States Department of Health and Human Services responsible for administering the nation's major healthcare programs, including Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). CMS sets standards, policies, and reimbursement rates for these programs, playing a central role in healthcare quality and cost regulation.
- **Emergency Medical Services (EMS):** EMS is the delivery of care by trained emergency response personnel to individuals experiencing acute illness or injury. EMS includes both ALS and BLS interventions delivered in the field, rapid response to emergencies, and may include the safe transport of patients to appropriate healthcare destinations. These services are typically mobilized through emergency calls and are integral in stabilizing and treating patients during critical moments including before and during hospital transfer.
- **Emergency Transport:** This refers to the rapid response and transfer of patients experiencing a medical emergency, such as severe injury, cardiac arrest, or other critical conditions requiring immediate advanced medical care. Emergency transport is typically initiated by a 911 call and involves prompt dispatch of aid units or ambulances equipped to deliver Advanced Life Support (ALS) or Basic Life Support (BLS) services.
- **Ground Ambulance Data Collection System (GADCS)**: The GADCS is an instrument developed by the Centers for Medicare and Medicaid Services (CMS) to collect cost, revenue, utilization, and other information from selected ground ambulance organizations. All Medicare-enrolled GASOs were selected to participate in the GADCS survey. Those

that opted not to participate received a reduction in per-transport Medicare reimbursement.

- **Ground Ambulance Services Organization (GASO)**: An organization providing emergency and non-emergency medical transport via ground ambulance. For the purpose of this study, Washington State GASOs must be licensed under Chap. 18.73 RCW.
- **Medicaid Ground Emergency Medical Transportation (GEMT):** programs offer supplemental payments to eligible publicly owned GASOs in states with CMS-approved GEMT programs. These GASOs submit annual Medicaid cost reports to determine the cost of transporting Medicaid beneficiaries and receive additional funding for certain costs not covered by interim Medicaid claims.
- **Non-Emergency Transport**: This type of transport involves the scheduled or routine transfer of patients who do not require immediate or life-saving medical intervention. Non-emergency transport is often used for individuals needing assistance getting to or from medical appointments, hospital discharges, or transfers between healthcare facilities, where the patient's condition is stable and does not necessitate urgent medical attention.
- **Periodic Rate Studies:** Regular assessments conducted to evaluate and adjust reimbursement rates based on current costs, service needs, and economic conditions.
- **Premium Impact Estimate:** An estimate of how a change (such as updated reimbursement rates) will affect insurance premium costs within different market segments.
- **Public Employees Benefits Board (PEBB) Program:** The PEBB Program is administered by the Washington State Health Care Authority and provides health insurance and other benefits to eligible state employees, higher-education employees, retirees, and their dependents. It offers medical, dental, vision, life, and disability insurance, along with other wellness programs.
- **School Employees Benefits Board (SEBB) Program:** The SEBB Program, also administered by the Washington State Health Care Authority and provides benefits to eligible K–12 school district and charter school employees, and their dependents. It offers medical, dental, vision, life, and disability insurance.
- **Super-Rural**: Super-rural refers to a ZIP code located in a county among the lowest 25% of all rural counties by population density.
- **Super-Rural Adjustment:** An additional reimbursement adjustment for ambulance services in remote, sparsely populated areas to account for higher costs and longer response times. CMS applies a 22.6% super-rural bonus to transports originating in super-rural ZIP codes.
- **Treat but No Transport (TNT):** TNT refers to Emergency Medical Services (EMS) rendered at the scene of an incident in response to a 9-1-1 call when a Ground Ambulance Service Organization (GASO) dispatches an ambulance or aid unit, but the patient is not transported to a hospital or behavioral health emergency services provider. This report assumes that TNT services would be billable only when medically necessary and rendered by GASOs that are licensed under Chap. 18.73 RCW. TNT services are billed under Procedure Code A0998. What Qualifies as TNT:
    - **Vehicles**: ALS Ambulances, BLS ambulances and Aid Units.
    - **Personnel**: Paramedics, Emergency Medical Technicians (EMTs), Emergency Medical Responders (EMRs);
    - **Services**: Medically necessary treatment including evaluation, stabilization, and medication administration.

- **Exceptions**: Instances where an individual is pronounced dead after the ambulance was dispatched but before the patient was transported are not included in the definition of TNT services and are separately reimbursable utilizing modifier QL in conjunction with an appropriate transport code.

- **TNT review team**: the TNT review team included representatives from actuarial firm Lewis & Ellis LLC (L&E) as well as consulting firm Public Consulting Group LLC (PCG) with experience in GASO rate setting and actuarial analysis.

APPENDIX B: DISTRIBUTED SURVEYS

Below, please find the surveys distributed to the Ground Ambulance Services Organizations (GASOs) as part of the data collection methodology.

GASO DATA COLLECTION SURVEY

Please see below for the survey distributed to Ground Ambulance Services Organizations in Washington as part of our data collection.

In order to submit this form, you should open it with Adobe Acrobat Reader.

Licensed EMS Unit Data Collection Survey

Ground Ambulance Services Organizations Treat no Transport Study

This data request is part of the actuarial analysis of the cost, potential cost savings, and total net cost or savings of covering services provided by a Ground Ambulance Services Organization when a ground ambulance is dispatched to the scene of an emergency and medical treatment is rendered on site, but no transport to a hospital or behavioral health emergency facility is provided.
Information collected will be analyzed and presented in a final report, using aggregate data only.
Please submit this form no later than **February 4, 2025.**

Contact PCG at WATNT@pcgus.com for technical assistance to complete this survey.

Organization Information

Organization Name *

Organization NPI *

10-digit National Provider Identification Number

1. Does your department provide treat no transport services? A treat no transport has occurred when a ground ambulance is dispatched to the scene of an emergency and medical treatment is rendered on site, but no transport to a hospital or behavioral health emergency facility is provided *

- ○ Yes
- ○ No

Contact Information for Submitter

Please answer YES if you are rendering treat-no-transport services, regardless of whether or not your are billing for those services.

1

1a. If you answered no, please briefly explain why you don't provide treat no transport services: *

Your Name *

First Name Last Name

Your Title *

Your Phone Number *

Please enter a valid phone number.

Your Email *

example@example.com

Treat No Transport Services

2. What is the estimated average duration (in minutes) for the following ground ambulance response types. Duration includes all time on task beginning with ambulance dispatch and ending with return to readiness (i.e.,when an ambulance is available to respond to a subsequent incident):

	Estimated Average Response Duration (in minutes)
Emergency Transport (including ALS Emergency, BLS Emergency and Specialty Care Transports)	
Non-Emergency Transport (including ALS Non-Emergency and BLS Non-Emergency responses)	

2

Treat no Transport (responses where treatment is rendered on-scene and no transport occurs)	
Other no Transport (all other responses including canceled calls, patient not located and patient refusals)	

3. Does your department have ALS and/or BLS units? (Intermediate Life Support (ILS) units should be grouped with ALS units) *

- ○ Advanced Life Support (ALS) only
- ○ Basic Life Support (BLS) only
- ○ Both ALS and BLS

4. What is the percentage of responses completed by ALS Units and BLS Units for each of the following ground ambulance response types?

	ALS Estimated % of Responses	BLS Estimated % of Responses
Emergency Transport (including ALS Emergency, BLS Emergency and Specialty Care Transports)		
Non-Emergency Transport (including ALS Non-Emergency and BLS Non-Emergency responses)		
Treat no Transport (responses where treatment is rendered on-scene and no transport occurs)		
Other no Transport (all other responses including canceled calls, patient not located and patient refusals)		

5. Enter the number of responders by type that are typically assigned to a single ALS and/or BLS unit below:

	Typical ALS Unit Staffing	Typical BLS Unit Staffing
EMT		
Advanced EMT		
EMR		
Paramedic		
Other		

6. Is there any additional information you'd like to provide regarding treat no transport responses?

Regional Response Services

8. What is the estimated percentage of responses for each Licensed EMS Unit within the following CMS zip code classifications: Urban, Rural, Super Rural? Information about CMS zip code classifications can be found here: https://www.cms.gov/files/zip/zip-code-carrier-locality-file-revised-08/20/2024.zip

	Estimated % of Responses
Urban	
Rural	
Super Rural	

9. What percentage of all ambulance responses conducted during the reporting year took place in the State of Washington? *

7. Does your department provide treat no transport services with an aid unit, or non-ambulance vehicle? *

- Yes
- No

Participation in the Medicare Ground Ambulance Data Collection System (GADCS)

Aid Unit Responses

The following questions ask about your department's aid unit responses, specific to treat no transport services.

7a. Please report the count of responses where an aid vehicle was the only vehicle on scene and

medical care was rendered: *

7b. Please report the average response duration (in minutes) where an aid unit was the only vehicle on scene and medical care was rendered: *

This section asks if you were selected for the Medicare GADCS and if you already submitted your GADCS Instrument to CMS. Information about the GADCS is available on the CMS website found at this link.

10. Has your department submitted the Medicare Ground Ambulance Data Collection (GADCS) Instrument to CMS? *

- ○ Yes
- ○ Not yet, we are currently in the GADCS data collection/reporting period
- ○ No, my department was selected but we have been unable to comply thus far
- ○ Not Applicable: our department was not selected by CMS to participate in GADCS

11. Document the start and end dates of the GADCS data collection period your department selected in the spaces provided below. For example: January 1, 2022 – December 31, 2022; July 1, 2022 – June 30, 2023.

Start Date *

Month Day Year

End Date *

Month Day Year

12. Do you have your completed GADCS instrument or know where to find it? *

- ○ Yes
- ○ No

13. Are the backup or raw data reports used to determine your Instrument's answers accessible? *

- ○ Yes
- ○ No
- ○ I don't know

Data Collection: Medicare GADCS Submitters

Ground Ambulance Services Organizations Treat no Transport Study

REQUESTING THE GADCS INSTRUMENT FROM CMS
If you do not have a copy of your GADCS instrument, request a copy from CMS by sending an email to ambulancedatacollection@cms.hhs.gov:
Subject Line: | Request for GADCS
Email Body Text: I am with [Licensed EMS Unit Name], and I am requesting a copy of our GADCS Instrument. Our NPI number is [insert NPI number]. We kindly request to obtain a copy of our GADCS Instrument by February 4th.
Detailed instructions for requesting the completed GADCS from CMS are available at this link.
For questions regarding this study or technical support, contact WATNT@pcgus.com

Medicare Ground Ambulance Data Collection (GADCS) Instrument Upload

This section collects information about your organization and provides a field for you to upload the completed GADCS instrument PDF. You have been identified as the individual responsible for completing this data request, PCG staff may contact you to obtain clarification or additional data to inform our analysis.

Data Collection: Non-Medicare GADCS Submitters

Ground Ambulance Services Organizations Treat no Transport Study

The survey asks for the following information:
Expenditure
Staffing
Transport Data
Thank you for your prompt attention to this request and for your continued participation in this important study.

Part I: Data Collection Survey

We ask that you use the same reporting time period corresponding to your fiscal year for all the data elements being requested and that you provide the most recent data available. This will be your "selected reporting year." For example: July 1 2023 – June 30, 2024; October 1, 2022 – September 30, 2023, January 1, 2022 - December 31, 2023.
ENTER YOUR SELECTED REPORTING YEAR START AND END DATES IN THE FIELDS BELOW.

Reporting Year Start Date *

Month Day Year

Reporting Year End Date *

Month Day Year

Non-personnel Expenditures

Non-personnel expenditures include annual depreciation costs for large assets, in addition to all other non-personnel costs incurred throughout the year associated with providing ground ambulance services. Examples of included non-personnel costs include: facilities costs, insurance costs, and equipment costs.

14. Total annual non-personnel expenditures associated with ground ambulance services by category (Facility Costs, Equipment Consumable and Supply Costs, Vehicle Costs, and Other Costs)

	Annual Non-Personnel Expenditures
Facility Costs	
Equipment, Consumable, and Supply Costs	
Vehicle Costs	
Other Costs	

Personnel Data & Labor Costs

This section collects information about your department's staffing numbers and related personnel costs. For each data element requested, enter total numbers for your selected reporting year. This includes the total hours worked as well as hours worked on ground ambulance services for each labor category. If a labor category is 100% dedicated to ground ambulance services, the total hours worked should equal the total hours worked on ground ambulance services. If you do not have staff in a specific labor category, enter 0 in each required field.

PERSONNEL HOURS:

This includes total number of staff employed in the following labor categories: Paramedics, Emergency Medical Technicians (EMTs), Advanced EMTs, Emergency Medical Responders (EMRs), and support/administrative staff.

COMPENSATION COSTS:

The survey also asks about total compensation (salaries and benefits) for each labor category. **Total compensation includes all salary and fringe costs paid by the Licensed EMS Unit**. Enter the total

compensation numbers per labor category.

15. For the following section, please report the total hours, total hours worked on ground ambulance services, and total compensation for all PAID staff members. If you do not employ PAID staff under a particular professional level, enter 0:

	Total Hours Worked	Total Hours Worked on Ground Ambulance Services	Total Compensation
Paramedic Staff			
EMTs			
Advanced EMTs			
EMRs			
Support / Admin			

16. For the following section, please report the total hours worked on ground ambulance services for all VOLUNTEER staff members. If you do not employ VOLUNTEER staff under a particular professional level, enter 0:

	Total Hours Worked on Ground Ambulance Services
Paramedic Staff	
EMTs	
Advanced EMTs	
EMRs	
Support / Admin	

Response Data

This section collects information about call response data and volume of ground ambulance calls your department responded to. For each data element requested, enter total numbers for your selected reporting year.

17. What is the total count of distinct ground ambulance responses completed during the one-year reporting period under each of the following response types:

	Estimated number of Ground Ambulance Responses by Transport Type

Emergency Transport (including ALS Emergency, BLS Emergency and Specialty Care Transports)	
Non-Emergency Transport (including ALS Non-Emergency and BLS Non-Emergency responses)	
Treat no Transport (responses where treatment is rendered on-scene and no transport occurs)	
Other no Transport (all other responses including canceled calls, patient not located and patient refusals)	

Survey Submission

Please click the "Submit" button to complete your response. Thank you for your time!

Submit

SHORTENED GASO DATA COLLECTION SURVEY

Please see below for the shortened survey sent to PCG's GADCS clients.

In order to submit this form, you should open it with Adobe Acrobat Reader.

Licensed EMS Unit Data Collection Survey

Ground Ambulance Services Organizations Treat no Transport Study

This data request is part of the actuarial analysis of the cost, potential cost savings, and total net cost or savings of covering services provided by a Ground Ambulance Services Organization when a ground ambulance is dispatched to the scene of an emergency and medical treatment is rendered on site, but no transport to a hospital or behavioral health emergency facility is provided.
Information collected will be analyzed and presented in a final report, using aggregate data only.
Please submit this form no later than **February 18, 2025.**

Contact PCG at WATNT@pcgus.com for technical assistance to complete this survey.

Organization Information

Organization Name *

Organization NPI *

10-digit National Provider Identification Number

1. Does your department provide treat no transport services? A treat no transport has occurred when a ground ambulance is dispatched to the scene of an emergency and medical treatment is rendered on site, but no transport to a hospital or behavioral health emergency facility is provided *

- ○ Yes
- ○ No

Contact Information for Submitter

Please answer YES if you are rendering treat-no-transport services, regardless of whether or not your are billing for those services.

1a. If you answered no, please briefly explain why you don't provide treat no transport services: *

Your Name *

First Name Last Name

Your Title *

Your Phone Number *

Please enter a valid phone number.

Your Email *

example@example.com

Treat No Transport Services

2. What is the estimated average duration (in minutes) for the following ground ambulance response types. Duration includes all time on task beginning with ambulance dispatch and ending with return to readiness (i.e.,when an ambulance is available to respond to a subsequent incident):

	Estimated Average Response Duration (in minutes)
Emergency Transport (including ALS Emergency, BLS Emergency and Specialty Care Transports)	
Non-Emergency Transport (including ALS Non-Emergency and BLS Non-Emergency responses)	

2

Treat no Transport (responses where treatment is rendered on-scene and no transport occurs)	
Other no Transport (all other responses including canceled calls, patient not located and patient refusals)	

3. Does your department have ALS and/or BLS units? (Intermediate Life Support (ILS) units should be grouped with ALS units) *

- ○ Advanced Life Support (ALS) only
- ○ Basic Life Support (BLS) only
- ○ Both ALS and BLS

4. What is the percentage of responses completed by ALS Units and BLS Units for each of the following ground ambulance response types?

	ALS Estimated % of Responses	BLS Estimated % of Responses
Emergency Transport (including ALS Emergency, BLS Emergency and Specialty Care Transports)		
Non-Emergency Transport (including ALS Non-Emergency and BLS Non-Emergency responses)		
Treat no Transport (responses where treatment is rendered on-scene and no transport occurs)		
Other no Transport (all other responses including canceled calls, patient not located and patient refusals)		

5. Enter the number of responders by type that are typically assigned to a single ALS and/or BLS unit below:

	Typical ALS Unit Staffing	Typical BLS Unit Staffing
EMT		
Advanced EMT		
EMR		
Paramedic		
Other		

6. Is there any additional information you'd like to provide regarding treat no transport responses?

Data Collection: Medicare Ground Ambulance Data Collection System (GADCS)

8. I authorize the use of my organization's GADCS survey in the Washington Treat No Transport Rate Study. *

- ○ Yes
- ○ No

7. Does your department provide treat no transport services with an aid unit, or non-ambulance vehicle? *

- ○ Yes
- ○ No

7a. Please report the count of responses where an aid vehicle was the only vehicle on scene and medical care was rendered: *

Aid Unit Responses

The following questions ask about your department's aid unit responses, specific to treat no transport services.

7b. Please report the average response duration (in minutes) where an aid unit was the only vehicle on scene and medical care was rendered: *

Submit

Public Consulting Group (PCG) has supported multiple providers in collecting and reporting the required data to complete the Ground Ambulance Data Collection System (GADCS) instrument. As part of the ongoing Treat No Transport Rate Study conducted by the Washington State Office of the Insurance Commissioner, we are requesting your permission to use the GADCS survey that PCG submitted on your

behalf.

Survey Submission

Please click the "Submit" button to complete your response. Thank you for your time!

5

APPENDIX C: PREMIUM IMPACT ESTIMATE BY COMMERCIAL MARKET SEGMENT

Individual Commercial Market Premium Impact Estimate	Low Impact	High Impact
Estimated TNT Claims (a)	2,067	4,071
Average TNT Rate (b)	$518.51	$518.51
Estimated 2023 TNT Commercial Allowed Costs (c)=(a)*(b)	$1,071,649	$2,110,823
% of Commercial TNT Allowed Cost Paid by Insurer (d)	80%	90%
Estimated 2023 TNT Commercial Claim Cost Impact (e)=(c)*(d)	$857,319	$1,899,741
Total 2023 Commercial Paid Claim Cost (f)	$885,677,620	$885,677,620
Estimated Average Commercial Pricing Loss Ratio (g)	80%	85%
Estimated 2023Total Commercial Premium (h)=(f)*(g)	$1,107,097,025	$1,041,973,671
Estimated Impact of Recommended TNT Rates as a Percentage of Premium For Low Range: (i)=(e)/(h) For High Range: (i) = [(e)/(g)]/(h)	**0.08%**	**0.21%**
Estimated 2025 Total Commercial Premium (j)	$1,339,476,691	$1,260,683,944
Estimated 2025 TNT Paid Claims Impact (k)=(i)*(j)	$1,037,270	$2,704,114
Estimated 2025 Member Months (l)	2,923,656	2,923,656
Estimated 2025 TNT Premium Impact Per Member Per Month (PMPM) (m)=(k)/(l)	**$0.35**	**$0.92**

Small Group Commercial Market Premium Impact Estimate	Low Impact	High Impact
Estimated TNT Claims (a)	796	1,568
Average TNT Rate (b)	$518.51	$518.51
Estimated 2023 TNT Commercial Allowed Costs (c)=(a)*(b)	$412,817	$813,124
% of Commercial TNT Allowed Cost Paid by Insurer (d)	80%	90%
Estimated 2023 TNT Commercial Claim Cost Impact (e)=(c)*(d)	$330,254	$731,812
Total 2023 Commercial Paid Claim Cost (f)	$1,137,498,861	$1,137,498,861
Estimated Average Commercial Pricing Loss Ratio (g)	85%	80%
Estimated 2023Total Commercial Premium (h)=(f)*(g)	$1,338,233,954	$1,421,873,576
Estimated Impact of Recommended TNT Rates as a Percentage of Premium For Low Range: (i)=(e)/(h) For High Range: (i) = [(e)/(g)]/(h)	**0.02%**	**0.06%**
Estimated 2025 Total Commercial Premium (j)	$1,619,129,261	$1,720,324,840
Estimated 2025 TNT Paid Claims Impact (k)=(i)*(j)	$399,574	$1,106,774
Estimated 2025 Member Months (l)	3,416,220	3,416,220
Estimated 2025 TNT Premium Impact Per Member Per Month (PMPM) (m)=(k)/(l)	**$0.12**	**$0.32**

Large Group Commercial Market Premium Impact Estimate	Low Impact	High Impact
Estimated TNT Claims (a)	2,196	4,325
Average TNT Rate (b)	$518.51	$518.51
Estimated 2023 TNT Commercial Allowed Costs (c)=(a)*(b)	$1,138,537	$2,242,573
% of Commercial TNT Allowed Cost Paid by Insurer (d)	80%	90%
Estimated 2023 TNT Commercial Claim Cost Impact (e)=(c)*(d)	$910,830	$2,018,316
Total 2023 Commercial Paid Claim Cost (f)	$2,814,023,901	$2,814,023,901
Estimated Average Commercial Pricing Loss Ratio (g)	80%	85%
Estimated 2023Total Commercial Premium (h)=(f)*(g)	$3,517,529,876	$3,310,616,354
Estimated Impact of Recommended TNT Rates as a Percentage of Premium For Low Range: (i)=(e)/(h) For High Range: (i) = [(e)/(g)]/(h)	**0.03%**	**0.07%**
Estimated 2025 Total Commercial Premium (j)	$4,255,859,397	$4,005,514,727
Estimated 2025 TNT Paid Claims Impact (k)=(i)*(j)	$1,102,013	$2,872,894
Estimated 2025 Member Months (l)	6,844,674	6,844,674
Estimated 2025 TNT Premium Impact Per Member Per Month (PMPM) (m)=(k)/(l)	**$0.16**	**$0.42**

PEBB Commercial Market Premium Impact Estimate	Low Impact[35]	High Impact
Estimated TNT Claims (a)		1,600
Average TNT Rate (b)		$518.51
Estimated 2023 TNT Commercial Allowed Costs (c)=(a)*(b)		$829,858
% of Commercial TNT Allowed Cost Paid by Insurer (d)		90%
Estimated 2023 TNT Commercial Claim Cost Impact (e)=(c)*(d)		$746,872
Total 2023 Commercial Paid Claim Cost (f)		$1,304,101,430
Estimated Average Commercial Pricing Loss Ratio (g)		85%
Estimated 2023Total Commercial Premium (h)=(f)*(g)		$1,534,236,976
Estimated Impact of Recommended TNT Rates as a Percentage of Premium For Low Range: (i)=(e)/(h) For High Range: (i) = [(e)/(g)]/(h)	**0.00%**	**0.06%**
Estimated 2025 Total Commercial Premium (j)		$1,856,273,318
Estimated 2025 TNT Paid Claims Impact (k)=(i)*(j)		$1,063,107
Estimated 2025 Member Months (l)		3,170,152
Estimated 2025 TNT Premium Impact Per Member Per Month (PMPM) (m)=(k)/(l)	**$0.00**	**$0.34**

[35] Assumed no impact to account for the possibility that TNT is already covered for this population and claiming practices are true to the utilization of services. See page 37 of this report for further information.

SEBB Commercial Market Premium Impact Estimate	Low Impact[36]	High Impact
Estimated TNT Claims (a)		1,224
Average TNT Rate (b)		$518.51
Estimated 2023 TNT Commercial Allowed Costs (c)=(a)*(b)		$634,708
% of Commercial TNT Allowed Cost Paid by Insurer (d)		90%
Estimated 2023 TNT Commercial Claim Cost Impact (e)=(c)*(d)		$571,237
Total 2023 Commercial Paid Claim Cost (f)		$1,074,666,388
Estimated Average Commercial Pricing Loss Ratio (g)		85%
Estimated 2023Total Commercial Premium (h)=(f)*(g)		$1,264,313,398
Estimated Impact of Recommended TNT Rates as a Percentage of Premium For Low Range: (i)=(e)/(h) For High Range: (i) = [(e)/(g)]/(h)	**0.00%**	**0.05%**
Estimated 2025 Total Commercial Premium (j)		$1,529,692,780
Estimated 2025 TNT Paid Claims Impact (k)=(i)*(j)		$813,106
Estimated 2025 Member Months (l)		2,971,642
Estimated 2025 TNT Premium Impact Per Member Per Month (PMPM) (m)=(k)/(l)	**$0.00**	**$0.27**

[36] Assumed no impact to account for the possibility that TNT is already covered for this population and claiming practices are true to the utilization of services. See page 37 of this report for further information.