beneficiaries from the assignable beneficiary population used to calculate regional FFS expenditures and growth rates (described elsewhere in this section of this proposed rule), and policies addressing regional risk score growth.

K. Medicare Ground Ambulance Data Collection System

1. Background on Ambulance Services

Section 1861(s)(7) of the Act establishes an ambulance service as a Medicare Part B service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations. Since April 1, 2002, payment for ambulance services has been made under the ambulance fee schedule (AFS), which the Secretary established under section 1834(l) of the Act. Payment for an ambulance service is made at the lesser of the actual billed amount or the AFS amount, which consists of a base rate for the level of service, a separate payment for mileage to the nearest appropriate facility, a geographic adjustment factor (GAF), and other applicable adjustment factors as set forth at section 1834(l) of the Act and § 414.610 of the regulations. In accordance with section 1834(l)(3) of the Act and § 414.610(f), the AFS rates are adjusted annually based on an inflation factor. The AFS also incorporates two permanent add-on payments and three temporary add-on payments to the base rate and/or mileage rate. The two permanent add-on payments at § 414.610(c)(5)(i) are: (1) A 50 percent increase in the standard mileage rate for ground ambulance transports that originate in rural areas where the travel distance is between 1 and 17 miles; and (2) a 50 percent increase to both the base and mileage rate for rural air ambulance transports. The three temporary add-on payments at sections 1834(l)(12)(A) and (13)(A) of the Act and § 414.610 are: (1) A 3 percent increase to the base and mileage rate for ground ambulance transports that originate in rural areas; (2) a 2 percent increase to the base and mileage rate for ground ambulance transports that originate in urban areas; and (3) a 22.6 percent increase in the base rate for ground ambulance transports that originate in ''super rural'' areas. Section 50203(a)(1) and (2) of the Bipartisan Budget Act (BBA) of 2018 (Pub. L. 115–123, February 9, 2018) includes an extension of the temporary add-on payments through December 31, 2022.

Our regulations relating to coverage of and payment for ambulance services are set forth at 42 CFR part 410, subpart B, and 42 CFR part 414, subpart H.

2. Statutory Requirements for the Ground Ambulance Providers and Suppliers To Submit Cost and Other Information

Section 50203(b) of the BBA of 2018 added paragraph (17) to section 1834(l) of the Act, which requires ground ambulance providers of services and suppliers to submit cost and other information. Specifically, section 1834(l)(17)(A) of the Act requires the Secretary to develop a data collection system (which may include use of a cost survey) to collect cost, revenue, utilization, and other information determined appropriate by the Secretary for providers and suppliers of ground ambulance services. Section 1834(l)(17)(B)(i) of the Act requires the Secretary to specify the data collection system by December 31, 2019, and to identify the ground ambulance providers and suppliers that would be required to submit information under the data collection system. Section 1834(l)(17)(D) of the Act requires that beginning January 1, 2022, the Secretary apply a 10 percent payment reduction to payments made under section 1834(l) of the Act for the applicable period to a ground ambulance provider or supplier that is required to submit information under the data collection system and does not sufficiently submit such information. The term ''applicable period'' is defined under section 1834(l)(17)(D)(ii) of the Act to mean, for a ground ambulance provider or supplier, a year specified by the Secretary not more than 2 years after the end of the period for which the Secretary has made a determination that the ground ambulance provider or supplier has failed to sufficiently submit information under the data collection system. Section 1834(l)(17)(F) of the Act requires that no later than March 15, 2023 and as determined necessary by MedPAC, MedPAC must submit a report to Congress on the information submitted by the ground ambulance providers and suppliers through the data collection system on the adequacy of payments for ground ambulance services and geographic variations in the cost of furnishing such services.

In the CY 2020 PFS final rule (84 FR 62864 through 62897), we implemented section 1834(l)(17) of the Act and codified regulations governing data reporting by ground ambulance providers and suppliers (referred collectively as ''ground ambulance organizations'') at §§ 414.601, 414.605, 414.610(c)(9), and 414.626. In the CY 2020 PFS final rule (84 FR 62863 through 629897), we finalized a data collection system that collects detailed information on ground ambulance provider and supplier characteristics including service areas, service volume, costs, and revenue through a data collection instrument, commonly referred to as the Medicare Ground Ambulance Data Collection Instrument, via a web-based system. This instrument includes the specific questions that will be asked of ground ambulance organizations about the total service volume, costs, and revenue associated with a provider or supplier's entire ground ambulance organization in such a way that MedPAC could use to calculate an average cost per ground ambulance transport. We refer the reader to our CY 2020 PFS final rule (84 FR 62863 through 62897) for more specifics on the establishment of the Medicare Ground Ambulance Data Collection System.

3. Proposed Revisions to the Medicare Ground Ambulance Data Collection Instrument

As described in the CY 2020 PFS final rule (84 FR 62867), the Medicare Ground Ambulance Data Collection Instrument uses screening questions and skip patterns so that it is applicable to all ground ambulance organizations regardless of their size, scope of operations and services offered, and structure. We stated that we believe this approach is easier to navigate and less time consuming to complete than a cost report template or instrument and that it minimizes respondent burden by directing ground ambulance organizations to only view and respond to questions that apply to their specific type of organization, all while still collecting the information required in sections 1834(l)(17)(A) of the Act.

The CY 2020 PFS final rule provided a detailed overview of the elements of the data collection instrument, including questions to collect information on costs, revenues, utilization (which CMS defines for the purposes of the data collection instrument as service volume and service mix), as well as the characteristics of ground ambulance organizations. Table 27 includes a high-level summary of the 13 sections of the Medicare Ground Ambulance Data Collection Instrument.

TABLE 27: Components for the Data Collection Instrument

Component (Data Collection Instrument Section)	Broad Description
General survey instructions (1)	Information on background and motivation for data collection, instructions for navigating the instrument, and links for questions and other resources.
Ground ambulance organization characteristics (2-4)	Information regarding the identity of the organization and respondent(s), service area, ownership, response time, and other characteristics; broad questions about offered services to serve as screening questions.
Utilization: Ground ambulance service volume and service mix (5 and 6)	Number of responses and transports, level of services reported by HCPCS code.
Costs (7-12)	Information on all costs partially or entirely related to ground ambulance services.
• Staffing and Labor Costs (7)	Hours and costs associated with EMTs, administrative staff, and facilities staff; separate reporting of volunteer staff and associated costs.
• Facilities Costs (8)	Number of facilities; annual cost of ownership, insurance, maintenance, and utilities.
• Vehicle Costs (9)	Number of ground ambulances; number of other vehicles used in ground ambulance responses; annual cost of ownership; total fuel, maintenance, and insurance costs.
• Equipment & Supply Costs (10)	Capital medical and non-medical equipment; medical and non-medical supplies and other equipment.
• Other Costs (11)	All other costs not reported elsewhere.
• Total Cost (12)	Total costs for the ground ambulance organization included as a way to cross-check costs reported in the data collection instrument.
Revenue (13)	Revenue from health insurers (including Medicare); revenue from all other sources including communities served.

We continue to receive ad hoc questions and feedback related to the Medicare Ground Ambulance Data Collection System and the Medicare Ground Ambulance Data Collection Instrument via three primary channels. First, we receive email and other communication from ground ambulance organizations via the CMS Ambulance Data Collection email inbox (*AmbulanceDataCollection@cms.hhs.gov*) and through other channels (for example, inquiries sent by organizations to Medicare Administrative Contractors (MACs) and then forwarded to CMS). These emails and other communications often include questions seeking clarification of instrument questions and their applicability to specific ground ambulance organization scenarios and context. We continue to update a Medicare Ground Ambulance Data Collection System Frequently Asked Questions (FAQ) document with answers to commonly asked questions. This document is available on the CMS website at *https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html*. Through review of questions and feedback, we have identified some instances where a clarification to the instrument language itself will likely be more useful and less burdensome to respondents than having to respond with reference to the FAQ document. Second, our contractor also asked a small number of ground ambulance organizations to complete and provide feedback on a paper version of the Medicare Ground Ambulance Data Collection Instrument. This feedback was helpful to identify some additional opportunities for clarification. Third, we continue to identify opportunities to clarify instructions and correct a small number of typos as we work to develop the web-based, programmed version of the Medicare Ground Ambulance Data Collection Instrument.

Based on information that we received via the three sources described above, we are proposing the following changes and clarifications to the Medicare Ground Ambulance Data Collection Instrument. The proposed changes and clarifications aim to reduce burden on respondents, improve data quality, or both.

a. Proposed Change to the Shared Services Questions in Section 2 (Organizational Characteristics)

One component of the data collection instrument is ground ambulance organization characteristics, which is information regarding the identity of the organization and respondent(s) service area, ownership, response time, and other characteristics (84 FR 62871 through 62875). One characteristic on which we sought information is organization type, including whether costs are shared with fire or police response or health care delivery operations (84 FR 62871). The instrument contains a number of questions that are relevant to the issue of shared costs.

Section 2, Question 7 asks ''Which category best describes your ground ambulance operation?'' and allows respondents to select one of the following options:

(a) Fire department-based; (b) Police or other public safety department-based (including all-hazards public safety organizations); (c) Government stand-alone emergency medical services (EMS) agency; (d) Hospital or other Medicare provider of services (such as skilled nursing facility); (e) Independent/proprietary organization primarily providing EMS services; (f) Independent/proprietary organization primarily providing non-emergency services; or (g) Other (please specify).

Section 2, Question 8 subsequently asks respondents answering a, b, or d to Question 7 to ''confirm that your ground ambulance operation shares operational costs, such as building space or personnel, with these other operations.''

Section 2, Question 9 asks ''Does your ground ambulance operation share any operational costs, such as building space or personnel, with one of the following,'' offering respondents the following options: (a) A fire department (not presented if the response to Section 2, Question 7 is ''a''); (b) A police or other public safety department (not presented if the response to Section 2, Question 7 is ''b''); (c) A hospital or other Medicare provider of services (such as a skilled nursing facility) (not presented if the response to Section 2, Question 7 is ''d''); (d) Another healthcare organization (excluding hospitals, skilled nursing facilities, or other Medicare provider of services); (e) Another healthcare organization (excluding hospitals, skilled nursing facilities, or other Medicare provider of services); (f) Other (specify).

Collectively, the purpose of these three questions is to collect information on whether a portion of organizations' costs and revenues may be related to services or operations other than providing ground ambulance services. When this occurs, ground ambulance organizations are presented with additional instructions specifying how they should report costs and revenues associated with providing ground ambulance services rather than these other services or operations.

Based on feedback from ground ambulance organizations, we believe the specific wording of Section 2, Question 9 may be confusing. The question asks respondents whether they share operational costs with ''one of the following,'' implying respondents are limited to a single response, even though in some cases respondents may wish to select multiple responses. Furthermore, ground ambulance organizations may have difficulty interpreting the phrase ''share any operational costs.'' We received questions from some ground ambulance organizations asking whether renting space from a fire department qualified as a ''shared operational cost.'' The intent of the question was to ask about shared ownership and accounting, not renting facility space, sharing a physical space with a separate organization, or similar business and logistical arrangements.

We propose to revise Section 2, Question 9, to read, ''Does your organization provide any of the following services or operations (select all that apply)?'' retaining the current response options. This change clarifies that the intent of Section 2, Question 9 is to collect information on services or operations provided by the sampled organization. We invite comments on our proposal regarding reporting shared services.

b. Proposed Change to Average Trip Time Question

We stated that the area served by ambulance organizations is an important characteristic and finalized a policy to collect information on the geographic area served by each ambulance organization in Section 3 of the data collection instrument (84 FR 62875). We included questions related to average trip time in primary and secondary service areas (questions 3 and 6 of Section 3) that were important to understand how geographic distance between the ground ambulance organization's facilities and patients affects costs (84 FR 62873).

Section 3 (Service Area), Questions 3 and 6 in the instrument ask ground ambulance organizations to report their ''average trip time'' using a set of categorical time ranges (for example, 30–60 minutes). These questions define average trip time as ''the time the ambulance leaves the station to when that ambulance is available to take another call.'' Based on feedback from ground ambulance organizations, we believe this definition may be confusing in cases where an ambulance responds to a call from a location other than the station (for example, while en route to another call, from a standby event, or from a hospital). Based on the literal wording of the question, it is not clear whether and if so, how ground ambulance organizations should report trip times for responses not originating at a station when responding to this question, leading to potentially missing or biased data.

We are proposing that this question be revised to ask for ''average time on task'' defined as ''from the time an ambulance begins its response to the time when the ambulance is available to respond to another call (that is, time on task)'' to better capture interfacility transfers and situations when an ambulance is already out and responds from a site other than the central station. We believe this change in the wording of the question would be clearer to respondents and would result in higher-quality reported data. We invite comments on our proposal to change the definition of the average trip time.

c. Proposed Change to Secondary Service Area Instructions

In Section 3, Question 4 instructions define the secondary service area for an organization as ''outside [its] primary service area, but one where [it] regularly provide[s] services through mutual or auto-aid arrangements. The instruction directs organizations to ''not include areas where [they] provide services only under exceptional circumstances.'' We were notified that some ground ambulance organizations are unsure how to report areas where they (a) did have mutual or auto-aid arrangements in place, which aligns with the definition of secondary service area in the instructions, but where (b) they responded to calls only very rarely, for example once a year, which could be considered an ''exceptional circumstance'' and ignored for reporting per the instruction.

Although the instructions leave the determination of whether an organization has a secondary service area at the discretion of the sampled ground ambulance organization, we believe that some organizations may benefit from a rule of thumb or example to help assess whether they should or should not report a ZIP code as being part of their secondary service area. We propose to add the following text to the Section 3, Question 4 instructions: ''Some, but not all, ground ambulance organizations regularly provide service outside of their primary service area, for example through mutual or auto-aid agreements with nearby municipalities. If this applies to your organization, please report areas that are outside your primary service area but where you regularly provide services as part of your secondary service area. You do not need to report areas where you provide services very rarely or only under exceptional circumstances (for example, when participating in coordinated national or state responses to disasters or mass casualty events). Use your judgment as to whether your organization regularly serves a secondary service area. For example, you may choose to consider ZIP codes outside your primary service area but where you had 5 or more responses during the data collection period as part of your secondary service area if you believe these transports have a significant impact on your organization's costs.'' Even with this added text, ground ambulance organizations could still determine whether they do or do not have a secondary service area for the purposes of reporting in the Medicare Ground Ambulance Data Collection System. We invite comments on our proposal to revise the secondary service area instructions.

d. Proposed Change to the 90th Percentile Emergency Response Time

Section 4 (Emergency Response Time), Question 3 asks ground ambulance organizations to report the

90th percentile emergency response time, which the question defines as the time separating the quickest 90 percent of responses from the longest 10 percent of responses. The intent of the question was to collect information to help CMS understand the difference between average response times and atypical ''outlier'' response time. In the CY 2020 PFS proposed rule (84 FR 40688), we proposed to include a question on average response time. As we noted in the CY 2020 PFS final rule (84 FR 62873), several commenters to the CY 2020 PFS proposed rule recommended asking ground ambulance organizations to provide 90th percentile response time rather than or in addition to the average response time. They believed 90th percentile response time is a more accurate indicator of ambulance services capabilities and quality. They stated that the average time has too wide a range for error, since roughly half of responses are quicker/slower than average. They further stated that using average response time also tends to flatten the data, which means the fastest and slowest organizations did not stand out as much. In response to these comments (84 FR 62874), we finalized an additional question to the instrument asking ground ambulance organizations responding to emergency calls for service to report their 90th percentile response time.

Based on feedback from ground ambulance organizations that we have received on this question since we finalized the instrument, we believe most ground ambulance organizations will find it challenging to interpret this question and report the requested information. Several ground ambulance organizations have indicated that they would misinterpret this question, describing a shorter 90th percentile emergency response time compared to average response time, which, while mathematically possible, is not the intent as we were interested in characterizing outlier emergency responses with unusually long response times.

Thus, we propose to revise the question to ask: ''what is your best estimate of the share of responses (enter percentage) that take more than twice as long as the average response time as reported in the prior question?'' We believe this would be an easier question for ground ambulance organizations to understand. The goal of this question is to help CMS understand whether the organization has some response times that are much longer than its typical response time. Although the question language would be different, the reported information would still help CMS understand the extent to which a small number of emergency responses may be substantially longer than the average response for each organization. We invite comments on our proposal to revise the question to ask respondents to report the share of responses with more than twice the average response time instead of their 90th percentile emergency response time.

e. Proposed Change to Reporting Paid Ambulance Transports

In the CY 2020 PFS final rule (84 FR 62876 through 62877), we established a series of questions in the data collection instrument to collect data on the volume and the mix of services, including paid ground ambulance transports, that is, ground ambulance transports where the ambulance provider or supplier was paid for a billed amount in part or in full. The general instructions for Section 5 (Ground Ambulance Service Volume) note: ''A paid ground ambulance transport refers to a ground ambulance transport for which your organization has been paid in full or in part by a payer and/or patient only. Depending on how your organization collects data, you may report (a) the number of transports furnished during the data collection period that were also paid during the data collection period, or (b) the number of transports paid during the data collection period even if some transports occurred prior to the data collection period.'' Furthermore, Section 5, Question 7 asks respondents, ''what was the total number of paid ground ambulance transports in calendar year 202X [or fill fiscal year as appropriate], across all payer types and regardless of the level of service or geography? (Enter number).''

Based on questions and feedback from ground ambulance organizations that we have received since we finalized the instrument, we believe respondents may have different interpretations of this question, which could lead to inconsistent reported data, including the reported total ground ambulance transports during the data collection period (Section 5, Question 6). The intent of this question was to capture the reported number of ground ambulance transports during the data collection period, provided such transports were paid by the time the information was prepared for reporting to CMS. We did not intend for organizations to report the total number of ground ambulance transports for which they received the payment itself during the data collection period.

We recognize that there is a temporal disconnect between when services are provided and when initial and final payment may be received. In order to standardize the information that is reported by all ground ambulance organizations, and to align the reported information on the number of responses and transports during the data collection period with information reported on the number of paid transports, we propose to clarify Section 5, Question 7 to ask ''Of the ground ambulance transports your organization provided in calendar year 202X [or fill fiscal year as appropriate], how many were paid (either in part or in full) across all payer types and regardless of the level of service or geography by the time you are reporting data to CMS?''

We recognize that the ''runout period,'' that is, the time from when services are provided to the time when data is being analyzed, will be short and variable across organizations, particularly for transports towards the end of organizations' data collection periods. Despite this limitation, we believe this approach is preferable to alternatives where (a) respondents have variable interpretations of Section 5, Question 7 and (b) where respondents are asked to report the number of transports for which payment was received during the data collection period, even if the transports for which payment was received happened prior to the data collection period. In the latter case, the number of paid ground ambulance transports could not be directly compared to the number of total ground ambulance transports reported in Section 5, Question 6.

We also are proposing to revise the general instructions in Section 5 to delete the following text as it will no longer be relevant: ''Depending on how your organization collects data, you may report (a) the number of transports furnished during the data collection period that were also paid during the data collection period, or (b) the number of transports paid during the data collection period even if some transports occurred prior to the data collection period.''

We invite comments on our proposal to revise reporting paid ground ambulance transports.

f. Proposed Change to Questions Related to Labor Hours

Section 7 (Labor Costs) of the data collection instrument asks respondents to report compensation and hours worked for ground ambulance staff. The instrument currently asks respondents to report, separately for each staff category: Total compensation, total hours worked inclusive of all responsibilities, and total hours worked unrelated to either ground ambulance or

public safety responsibilities. The rationale for asking for total compensation and hours, even if these include compensation and hours for activities other than those related to ground ambulance services, was to preserve the ability to compare compensation between organizations and to external benchmarks such as Bureau of Labor Statistics data. The last item, total hours worked unrelated to either ground ambulance or public safety responsibilities, can be subtracted from overall total hours worked related to ground ambulance and public safety responsibilities combined, and further allocation could separate ground ambulance time and compensation from public safety time and compensation for fire and other public safety-based ground ambulance organizations.

Based on questions received by ground ambulance organizations since we finalized the instrument and feedback through testing on Section 7 questions, we learned that some ground ambulance organizations may misinterpret the Section 7 questions. Specifically, we believe some organizations may assume the question is asking for hours ''related'' rather than ''unrelated'' to ground ambulance or public safety responsibilities given the focus of the data collection effort, despite instructions to the contrary. Relatedly, we were notified that some organizations were confused that the Section 7 questions did not provide an opportunity to report total hours worked related to ground ambulance responsibilities, which they assumed was an unintentional omission from the instrument.

We propose to change the instructions in Section 7 to ask respondents to report hours worked on different activities in such a way that the sum of hours worked across different activities equals total hours worked annually. We believe this approach would be easier for respondents to understand and estimate, resulting in less burden for respondents and higher quality reported information.

For stand-alone ground ambulance organizations, we propose to ask respondents to report each of the following per staff category: (a.) Total annual compensation; (b.) Total hours worked annually; (c.) Total hours worked annually related to ground ambulance operations; and (d.) Total hours worked annually related to all other responsibilities. With this change, the instructions in Section 7 would note that ''total hours worked annually related to ground ambulance operations'' plus ''total hours worked annually related to all other responsibilities'' should equal ''total hours worked annually.''

For fire department or other public safety-based ground ambulance organizations, we propose to ask respondents to report each of the following per staff category: (a.) Total annual compensation; (b.) Total hours worked annually; (c.) Total hours worked annually related to ground ambulance operations; (d.) Total hours worked annually related to fire, police, or other public safety operations; and (e.) Total hours worked annually related to all other responsibilities. The Section 7 instructions would note that the sum of total hours worked related to ground ambulance operations; fire, police, or other public safety operations; and all other responsibilities should equal total hours worked annually. We invite comments on our proposal to revise the labor hours.

g. Proposed Change to Instructions Related to Facility, Vehicle, and Equipment Certain Expenses

In the CY 2020 PFS final rule (84 FR 62882 through 62886), we finalized policies to collect cost information related to facilities, vehicles, and other equipment, consumables and supplies. The purpose of Sections 8 (Facilities Costs), 9 (Vehicles Costs), and 10 (Equipment, Consumable, and Supply Costs) in the instrument is to collect total expenses during the data collection period related to facilities, vehicles, and equipment and supplies, respectively. Based on feedback from ground ambulance organizations that we have received since we finalized the instrument, we are concerned that some respondents, particularly those that do not currently depreciate facilities, vehicles, and/or equipment for accounting purposes, may not be sure where to report some components of total expenses in these categories. Although we believe most ground ambulance organizations depreciate facilities, vehicles, and capital medical equipment, we were notified that some ground ambulance organizations do not depreciate these items in their regular accounting practices. Upon a review of the instrument, we found that the instructions and opportunities to report costs for organizations using a cash basis for accounting were inconsistent across Sections 8, 9, and 10 of the instrument. In some instances, ground ambulance organizations are asked to report annual depreciation expenses only, without a clear question related to expenses should the organization not regularly depreciate a certain category of asset. In other cases, there are questions asking respondents to report annual expenses other than annual depreciation expenses, but the instructions provide incomplete guidance on what expenses are in scope.

We considered several factors when developing our proposals to address these inconsistencies. Overall, the purpose of the questions in Sections 8, 9, and 10 is to collect comprehensive information on total expenses related to facilities, vehicles, and equipment and supplies during the organizations' data collection periods. We believe the primary purpose of changes and clarifications to questions in this section should be to ensure all expenses are reported from both organizations that do and do not depreciate facilities, vehicles, and equipment for accounting purposes. We understand that allowing organizations flexibility to report cost information using their current accounting approach will reduce burden. The instructions to the instrument currently state: ''In general, you will be able to report information collected under your organization's current accounting practices. We understand that some ground ambulance organizations use accrual-basis accounting while others use cash-basis accounting.'' We continue to believe this is the correct approach, and that alternatives would impose considerable additional burden on ground ambulance organizations.

We considered several broad alternatives on how to report facility, vehicle, and equipment expenses in Sections 8, 9, and 10. One option is to require all organizations to calculate and report depreciation for facilities, vehicles, and equipment using a standardized approach. Although this would increase burden for respondents, potentially significantly for organizations that do not currently calculate depreciation, it would result in the most standardized information being submitted to CMS and the fewest changes to the layout of the instrument. Another option would be to retain the current structure of the instrument but provide more detailed instructions on how organizations that do and do not depreciate facilities, vehicles, and equipment should report information. A third option is to add new screening questions to the instrument asking individually whether the organization depreciates facilities, vehicles, and equipment. The responses to these screening questions could be used to tailor the instructions, table headings, and question text later in the instrument to avoid confusion.

After considering these options, we propose to add screening questions to the instrument asking individually

whether the organization depreciates facilities, vehicles, and equipment. We believe this would not substantively affect response burden for organizations and may in some cases reduce burden by clarifying what and how information on expenses must be reported in Sections 8, 9, and 10.

There are two specific places in Sections 8 and 9 in the instrument where we believe the instructions on how to report annual expenses may not be clear. First, Section 8.2, Question 1 asks respondents to report annual expenses for each facility that they report as being related to their ground ambulance operation in Section 8.1, Question 3. Section 8.2, Question 1 is a table with columns for ''annual lease or rental costs,'' ''annual depreciation expenses,'' and ''annual mortgage, bond interest, and other costs of ownership.'' Although the instructions note ''do not report depreciation if your organization does not capitalize facilities for accounting purposes,'' it is not immediately clear where organizations that do not capitalize facilities should report expenses if the facility is owned outright (for example, in cases where a facility is acquired during the data collection period).

Second, Section 9.1, Question 5 and Section 9.2, Question 5 are tables where respondents report costs associated with individual vehicles. Both tables currently ask, ''What was the annual depreciation expense for this vehicle?'' Although the instructions note ''for owned vehicles, do not report depreciation if your organization accounts for vehicles on a cash basis,'' the instructions do not indicate where expenses for vehicles purchased during the data collection period should be reported by organizations that do not capitalize vehicles for accounting purposes.

We considered several options to clarify the instructions in Sections 8 and 9 specifically. One option is to preserve current table structures and item numbers in both sections while providing additional written instructions. We believe that although this will minimize disruption to the layout of the instrument, it will also do the least to address potential confusion around these questions. Another option is to add new columns in Sections 8 and 9 for facilities and vehicles purchased outright during the data collection period for organizations that do not depreciate these expenses. We propose to add an additional column for clarity, but note that if the screening questions are added as described above not all columns would appear for all respondents, particularly given our proposal to add screening questions related to reporting expenses in Sections 8 and 9.

We also believe there are specific instructions in Section 10 that may not be clear. Section 10.1, Question 1 and Section 10.2, Question 1 asks respondents to report ''annual depreciation expenses'' for medical and non-medical capital equipment, respectively. The Section 10 instructions note ''do not report depreciation if your organization uses a cash basis for accounting'' and that ''for capital expenditures, medical and non-medical equipment, most organizations will amortize costs over the life of the good'' but do not specify that organizations that do not depreciate medical or non-medical equipment should skip these questions and report expenses for equipment acquired during the data collection period in Section 10.1, Question 3, and Section 10.2, Question 3 instead.

We considered several options to clarify the instructions in Section 10 specifically. One option is to clarify in the instructions that organizations that do not depreciate medical or non-medical equipment should skip Section 10.1, Question 1 and Section 10.2, Question 1 and report expenses for equipment acquired during the data collection period in Section 10.1, Question 3, and Section 10.2, Question 3 instead. Although this would involve the least change to the instrument, we would lose the ability to distinguish between expenses for the kinds of equipment that most ground ambulance organizations depreciate for organizations reporting in this way. Another option is to change the instructions for Section 10.1, Question 1 and Section 10.2, Question 1 to refer to broad types of equipment that are typically considered capital medical and non-medical equipment, and then ask respondents to report relevant annual expenses for qualifying equipment in these questions, regardless of whether the expenses are annual depreciation expenses or purchase costs (for organizations not calculating depreciation). We propose to ask organizations that do not depreciate equipment to report expenses associated with purchasing equipment in Section 10.1, Question 1 and Section 10.2, Question 1. This option would preserve our and MedPAC's ability to separately analyze these expenses. We invite comment on these alternatives to address instructions related to facility, vehicle, and equipment expenses.

h. Proposed Changes to Questions Related to National Provider Identifier's (NPIs) Under Broader Parent Organizations

Some ground ambulance NPIs are part of broader parent organization companies that own and/or operate multiple ground ambulance NPIs. Section 2, Question 2 asks, ''Did your organization use more than one NPI to bill Medicare for ground ambulance services during the data collection period?'' Based on feedback from ground ambulance organizations that we have received since we finalized the instrument, we were notified that the use of ''organization'' in this question is potentially confusing because it is not clear whether the term applies to the organization sampled to report information to the Medicare Ground Ambulance Data Collection System (which, by definition, is an individual NPI) or to a broader ''parent organization.'' We propose clarifying the question to ask ''Is this NPI part of a larger 'parent organization' that owns or operates multiple NPIs billing for ground ambulance services?'' We are also proposing to clarify the wording of the follow-up instruction for organizations that answer ''yes'' to this question. The follow-up instruction currently reads, ''You are being asked to complete this instrument and enter data only for the following NPI: [pre-populate number].'' Because very large parent organizations may have several NPIs sampled and a single or small number of staff collecting and reporting data for multiple NPIs, we are proposing to revise the text to read, ''You are being asked to complete this instrument and enter data separately for each sampled NPI. The following questions refer only to the following NPI: [pre-populate number].''

The instrument asks these organizations to report an allocated share of parent organization expenses at the end of most sections of the instrument. For example, Question 3 in Section 7.2 on paid administration, facilities, and medical director staff costs asks, ''Please report the allocated portion of administrative labor costs incurred at the level of the parent organization/central office of this NPI based on your organization's approach for allocating costs to specific NPIs. (Enter dollar amount.)''

There are four sections in the instrument that lack similar questions: Section 7.1 (Paid EMT/Response Staff Compensation and Hours Worked), Section 7.3 (Volunteer Labor), Section 9.1 (Ground Ambulance Vehicle Costs), and Section 10.1 (Medical Equipment/

Supplies). Without these questions, total reported costs may be biased downward for NPIs that are part of broader parent organizations. We propose to add questions like the one reproduced above to the end of these four sections for completeness. The text would be the same as the above except for replacing ''EMT/response staff labor costs,'' ''costs associated with volunteer labor,'' ''ground ambulance vehicle costs,'' and ''medical equipment and supply costs'' for ''administrative labor costs'' in the respective sections.

Relatedly, for completeness, we propose to clarify in the instructions for Section 12 (Total Cost), Question 1, that organizations part of broader parent organizations should include an allocated portion of parent organization (or ''central office'') costs when reporting their total costs in this question. We invite comments on our proposal to address questions related to NPIs under broader parent organizations.

i. Other Clarifications to the Medicare Ground Ambulance Data Collection Instrument

We propose the following 11 additional clarifications and updates to the instrument:

i. Replacing all first-person language (for example, ''we'') with third-person language (for example, ''CMS'') throughout the instrument for editorial consistency.

ii. Section 2, Question 17: There is a typo where this question referred to itself rather than, as is implied by the ordering and framing of the question, the prior item. The question currently asks, ''other than what was reported in item 17 . . .,'' when it should read, ''other than what was reported in item 16 . . .''.

iii. Section 3, Question 2: This question currently asks, ''are you the primary emergency ambulance provider . . .,'' using ''provider'' more colloquially than elsewhere in the instrument where the same word is sometimes used to differentiate between Medicare providers of service and Medicare suppliers. We propose to reword this question to read, ''are you the primary emergency ambulance organization . . .''

iv. Section 4, Questions 1 and 2 Clarification: The question currently defines response time as ''the time from when the call comes in to when the ambulance or another EMS response vehicle arrives on the scene.'' We propose clarifying this definition to say ''the time from when the call comes in to dispatch to when the ambulance or another EMS response vehicle arrives on the scene.'' Relatedly, for Section 4, Question 2, we propose adding a second answer option for this question that reads, ''From the time our organization receives a call from dispatch to the time the ambulance or other EMS vehicle is at the scene.'' Respondents would still have the option to write-in their own response in Section 4, Question 2, if neither of the pre-programmed options apply to their organization.

v. Section 5, Question 3a. Clarification: This question asks respondents to report the percentage of ground ambulance responses that involve a non-transporting agency and the percentage of ground ambulance transports in which the non-transporting agency continues to provide medical care in the ambulance during a transport. Based on feedback from ground ambulance organizations that we have received since we finalized the instrument, we believe many organizations do not currently track this data and will not easily be able to begin tracking it. We propose clarifying this question to note that estimated percentages are acceptable, as they are in response to certain other questions in the instrument (where noted). We specifically propose to edit Section 5 question 3a. to read: ''What is your best estimate of the percentage of total ground ambulance responses that involved a non-transporting agency? (Enter percentage)''

vi. Section 7.1 Instruction Clarification: We propose clarifying ''You will report on these staff in a different section'' to ''You will report on these staff in a later section'' to make it clear that the opportunity to report on these staff follows the current instruction.

vii. Sections 7.1 and 7.2 Instruction Clarification: We propose to add ''employer payroll taxes'' as an additional example of a component contributing to total compensation, without altering any of the definitions or other instructions in these sections.

viii. Section 7.2, Question 3 Clarification: We propose adding a clarification warning for respondents not to consider labor that was reported elsewhere when responding to this question.

ix. Section 7.3, Question 4 Clarification: We propose adding a clarification that medical director volunteer hours do not contribute to this response and a reminder that they are reported separately below (Section 7.3, Question 5).

x. Section 10 Instructions: We propose to correct a typo in the instructions where the instrument describes ''operation expenses'' rather than ''operating expenses'' as intended.

xi. Section 13, Question 3 Clarification: Based on the instructions for this question, organizations may report revenue from specific payers that include patient cost-sharing amounts. To ensure patient cost-sharing is not reported twice, we recommend clarifying the item in the chart that currently reads, ''Patient self-pay (amount patients pay for deductibles, coinsurance, etc.) to read, ''Patient self-pay (cash payment and the amount patients paid for deductibles, coinsurance, and other cost-sharing only if not reported in a row above.)'' We invite comments on these proposed clarifications and updates to the instrument.

4. Collection and Reporting of Information Under the Data Collection System

In the CY 2020 PFS final rule (84 FR 62893), we finalized our sampling proposals to implement a 25 percent stratified sample in each of the first four years of data collection and codified the representative sample approach at § 414.626(c). CMS' sampling approach is designed to result in representative samples of ground ambulance organizations in terms of key characteristics including provider versus supplier status, service area population density, volume of transports, and ownership category. The selected ground ambulance organizations for year 1 and year 2 have already been listed on the CMS website at *https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html.*

In the CY 2020 PFS final rule (84 FR 62894), we finalized the data collection period as a continuous 12-month period of time, which is either the calendar year aligning with the data collection year, or the organization's annual accounting period that begins during the data collection year when an organization has an annual accounting period (such as a fiscal year) that differs from the calendar year and the organization elects to collect and report data over this period rather than the calendar year. We also finalized our proposal to require organizations to report data during a 5-month data reporting period starting immediately following the end of the data collection period. The data collection and reporting requirements for selected ground ambulance organizations were codified at § 414.626(b).

As part of the Medicare Ground Ambulance Data Collection System, sampled ground ambulance

organizations will report information to CMS using a web-based version of a data collection instrument that is posted on the CMS website at *https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html*. We are currently developing the Medicare Ground Ambulance Data Collection System and stated in the CY 2020 PFS final rule (84 FR 62867) that the web-based survey would be available before the start of the first data reporting period to allow time for users to register, receive their secure login information, and receive training from CMS on how to use the system.

Due to the COVID–19 public health emergency (PHE), we issued two blanket waivers (May 5, 2020 and November 25, 2020) to delay the data collection and data reporting periods under the Medicare Ground Ambulance Data Collection System. The first waiver delayed the data collection period and data reporting period for selected year 1 ground ambulance organizations and the second waiver delayed the data collection periods and data reporting periods for selected year 1 and year 2 ground ambulance organizations.

This revised modification has been issued on page 32 in the following document: *https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf*. Specifically, we modified the data collection period and data reporting period, as defined at § 414.626(a), for ground ambulance organizations (as defined at § 414.605) that were selected by CMS under § 414.626(c) to collect data beginning between January 1, 2020 and December 31, 2020 (year 1) and for ground ambulance organizations that were selected to collect data beginning between January 1, 2021 and December 31, 2021 (year 2) for purposes of complying with the data reporting requirements described at § 414.626.

Under this modification, these ground ambulance organizations would select a new continuous 12-month data collection period (organizations may choose a collection period aligning with the calendar year or the organization's fiscal year) that begins between January 1, 2022 and December 31, 2022, to collect data necessary to complete the Medicare Ground Ambulance Data Collection Instrument during their selected data collection period, and submit a completed Medicare Ground Ambulance Data Collection Instrument during the data reporting period that corresponds to their selected data collection period. We modified this data collection and reporting period to increase flexibilities for ground ambulance organizations that would otherwise be required to collect data in 2020–2021 so that they can focus on their operations and patient care during the COVID–19 public health emergency (PHE). We stated, when the blanket waiver was granted, in the COVID–19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing document (page 63 of this document: *https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf*) that CMS will not allow an option to continue with their current data collection period because the data collected in 2020 and 2021 during the PHE may not be reflective of typical costs and revenues associated with providing ground ambulance services.

As a result of the COVID–19 delay, ground ambulance organizations selected in year 1, 2, and 3 will have the same data collection periods beginning between January 1, 2022 and December 31, 2022 and will have the same data reporting periods beginning between January 1, 2023 and December 31, 2023. In the CY 2020 PFS final rule (84 FR 62893), we finalized our sampling proposals to implement a 25 percent stratified sample in each of the 4 years of data collection. Prior to the delay, we anticipated approximately equal shares of ground ambulance organizations would collect and report data in four consecutive periods. However, as a result of the delays, there will now be approximately 75 percent of the ground ambulance organizations that will have data collection periods that start in the same year and subsequently will have data reporting periods starting in the same year. Later, a final 25 percent sample of ground ambulance organizations in year 4 will collect and report data.

When finalizing our policies in regard to ground ambulance collection and reporting of data, we did not intend to have approximately 75 percent of ground ambulance organizations collect and report data at the same time. To provide MedPAC with the data needed for analysis, acknowledging that due to the COVID–19 delay there will be a delay in CMS providing that data, we believe that we should revise the data collection period and data reporting period for selected ground ambulance organizations in year 3.

Accordingly, we are proposing to revise the data collection period beginning between January 1, 2022 and December 31, 2022 and data reporting period beginning between January 1, 2023 and December 31, 2023 for selected ground ambulance organizations in year 3. Under this proposal, there will be a new data collection period beginning between January 1, 2023 and December 31, 2023 and a new reporting period beginning between January 1, 2024 and December 31, 2024 for selected ground ambulance organizations in year 3. With this proposal, we plan to do the sample in 2022 for selected ground ambulance organizations in year 3 rather than the current plan in 2021. The main advantage of delaying the year 3 sample is that the selected organizations would be more representative of the organizations actually collecting beginning in 2023 and reporting beginning in 2024. The longer the delay between sampling and the data collection and data reporting, the more changes in the industry (for example, NPIs ceasing ground ambulance or all operations). This timeline would align with the data collection period and data reporting period requirements for selected ground ambulance organizations in year 4. As a result, there would be approximately 50 percent of ground ambulance organizations selected in year 1 and 2 with data reporting periods beginning between January 1, 2023 and December 31, 2023 and approximately 50 percent of ground ambulance organizations selected in year 3 and 4 with data reporting periods beginning between January 1, 2024 and December 31, 2024.

Due to the delay caused by the COVID–19 PHE, we examined the possibility of extending the data reporting to encompass 4 years as planned instead of 2 years. We concluded that it would not be feasible to extend the data reporting period over 4 years. Extending the data reporting to encompass four years would further delay MedPAC receiving the data required to analyze for its report to Congress, which is required to be submitted by March 15, 2023. The sampling for year 1 and year 2 selected ground ambulance organizations has already been completed and the lists for the selected ground ambulance organizations in year 1 and year 2 are posted on the CMS website.

With this proposal, more data would be collected in 2023 as there would hopefully be more distance from the peak of the COVID–19 pandemic. Thus, it is our hope that 2023 will be even more reflective of a typical year of costs for ground ambulance organizations than 2022. As the course of the pandemic continues to evolve, we believe that our proposal provides a potential for more even distribution of data over two years for comparison by MedPAC. We invite comments on our proposal to revise the data collection period and data reporting period for

ground ambulance organizations selected in year 3.

5. Proposed Change to the Notification Process for Selected Ground Ambulance Organizations Required To Report

In the CY 2020 PFS final rule, we codified our notification process at § 414.626(c)(3) and (b)(1). We stated at § 414.626(c)(3) that CMS will notify an eligible ground ambulance organization that it has been selected to report data for a year at least 30 days prior to the beginning of the calendar year in which the ground ambulance organization must begin to collect data by posting a list of selected organizations on the CMS web page and providing written notification to each selected ground ambulance organization via email or U.S. mail.

The Medicare Administrative Contractor (MAC) is responsible for providing written notifications to the selected ground ambulance organizations in their service area. We codified their role at § 414.626(b)(1) which states that within 30 days of the date we notify a ground ambulance organization that it has been selected to report data under this section, the ground ambulance must select a data collection period that corresponds with its annual accounting period and provide the start date of that data collection period to the ground ambulance organization's Medicare Administrative Contractor.

We propose to make a technical revision to § 414.626(b)(1) to state that the selected ground ambulance organization provide the start date of the data collection period to CMS or its contractor instead of the Medicare Administrator Contractor. This change will provide CMS with flexibility to have the MACs or other contracted entities provide written notifications and collect information from the selected ground ambulance organizations. If we find the response rate is low, having the flexibility to contract with other entities that could employ additional outreach resources may be useful. This revision would not preclude CMS from including the MACs in the notification process. We also propose to correct a typographical error at § 414.626(b)(1), which currently states ''a ground ambulance must select a data collection period'' to read ''a ground ambulance organization must select a data collection period.'' We invite comments on our technical revisions to the citation at § 414.626(b)(1).

6. Payment Reduction for Failure To Report

Section 1834(l)(17)(D)(i) of the Act requires that beginning January 1, 2022, subject to clause (ii), the Secretary reduce the payments made to a ground ambulance organizations under section 1834(l)(17) of the Act for the applicable period by 10 percent if the ground ambulance organization is required to submit data under the data collection system with respect to a data collection period under the data collection period and does not sufficiently submit such data.

We stated in the CY 2020 PFS final rule (84 FR 62895) that we would make a determination that the ground ambulance organization is subject to the 10 percent payment reduction no later than the date that is 3 months following the date that the ground ambulance organization's data reporting period ends. In this final rule, we provided examples of when the determination will be made based on calendar year and fiscal year data collection period beginning in 2020. Due to the delay caused by the COVID–19 PHE, we did not receive data collected in 2020. We will begin to follow this timeline to make a determination that the ground ambulance organization is subject to the 10 percent payment reduction when data collected in 2022 is required to be reported in 2023 for selected ground ambulance organizations in year 1 and year 2.

For example, if a selected ground ambulance organization's data collection period is based on a calendar year, that is, January 1, 2022 through December 31, 2022, we will allow a ground ambulance organization 5 months to report the data collected during the data collection period. For this example, the data reporting period for this organization is January 1, 2023–May 31, 2023. We would make a determination that the ground ambulance organization is subject to the 10 percent payment reduction no later than August 31, 2023. With this timeframe, we would apply the 10 percent reduction in payments, if applicable (no hardship exemption or informal review is granted), for ambulance services provided between January 1, 2024 and December 31, 2024.

As another example, if a selected ground ambulance organization's data collection period is based on a fiscal year, that is, October 1, 2022 through September 30, 2023, we will allow a ground ambulance organization 5 months to report the data collected during the data collection period. For this example, the data reporting period for this organization is October 1, 2023 –February 28, 2024, we would make a determination that the ground ambulance organization is subject to the 10 percent payment reduction no later than June 1, 2024. With this timeframe, we would apply the 10 percent reduction in payments, if applicable (no hardship exemption or informal review is granted), for ambulance services provided between January 1, 2025 and December 31, 2025.

7. Public Availability of Data

We stated in the CY 2020 PFS final rule (84 FR 62897), the data will be made available to the public through posting on our website at least every 2 years and we will post the summary results by the last quarter of 2022. We codified the public availability at § 414.626(f), which states: (f) Public availability of data. Beginning in 2022, and at least once every 2 years thereafter, CMS will post on its website data that it collected under this section, including but not limited to summary statistics and ground ambulance organization characteristics.

Due to the COVID–19 delay, we are proposing to revise § 414.626(f) to state that we will make the data collected under § 414.626 publicly available beginning in 2024. We invite comments on our proposal to revise the timeline when the public availability of data will begin.

L. Medicare Diabetes Prevention Program (MDPP)

The Medicare Diabetes Prevention Program (MDPP) expanded model is a structured intervention that aims to prevent or delay onset of type 2 diabetes among eligible Medicare beneficiaries diagnosed with pre-diabetes. The MDPP expanded model is an expansion of duration and scope of the Diabetes Prevention Program (DPP) model test, which was initially tested through a Round One Health Care Innovation Award. MDPP services are furnished in community and health care settings by organizations that enroll in Medicare as MDPP suppliers, a new supplier type, even if they have an existing Medicare enrollment as another supplier type. MDPP services furnished under the MDPP expanded model are covered as an additional preventive service with no cost-sharing under Medicare. Eligible organizations seeking to furnish MDPP services began enrolling in Medicare as MDPP suppliers on January 1, 2018, and began furnishing MDPP services on April 1, 2018.

We propose to amend our regulation at § 410.79 to preclude the provision of ongoing maintenance sessions unless