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ASSOCIATION OF AIR MEDICAL SERVICES

July 11, 2022

The Honorable Shalanda Young
Director
Office of Management and Budget
The White House
1600 Pennsylvania Ave NW
Washington, DC 20500t

Dear Director Young,

The Association of Air Medical Services (AAMS), representing over 1,000 helicopter and 200 fixed wing air ambulances across the United States, makes the following recommendations for the Final Rule(s) implementing the No Surprises Act (NSA). These recommendations address the consideration of statutory factors in the Independent Dispute Resolution process, and the enforcement of the laws and regulations governing out-of-network payment under the NSA and Interim Final Rule (IFR) Parts I and II. The adoption of these recommendations will allow for the implementation of the NSA in the fair and consistent manner as was intended and ensure all participants are behaving in accordance with the law as it was designed.

AAMS fully supports the patient protections in the NSA, as well as the fair and transparent process for resolving payment disputes set forth in the statute. However, the Administration's implementation and lax enforcement of the NSA has enabled plans and issuers to violate the law and cause significant financial hardships. It has also resulted in the unfair treatment of air ambulance providers in the IDR process.

Air ambulance services of every type: those affiliated with hospitals, those independent services, for-profit and non-profit, and in every part of the county are experiencing a host of issues that the NSA was designed to prevent. These services need to promptly recover fair payment to maintain cash flow adequate to sustain the delivery of services to patients. The failure of HHS to enforce the requirements of the NSA has enabled plan and issuer behavior that effectively limits an air medical provider's ability to receive prompt payment, or any payment, for emergent air ambulance transports already provided.

If the Departments do not enforce health plan accountability and create a level playing field for air ambulances, air ambulance providers will be unable to meet the cost of providing services to their communities, leading to limitations on the availability of air ambulances and further deepening healthcare access inequities.

End QPA "Weighting" for Air Ambulances, Address Flaws in QPA Calculation

The Departments' policy of giving special weight to the Qualifying Payment Amount (QPA) in the Independent Dispute Resolution (IDR) process, which is currently set forth in IFR Part II and sub-regulatory guidance, holds air medical providers to a different standard than all other providers in the IDR process and, in doing so, threatens patient access to critical air ambulance services.

The QPA is not a sound benchmark for payment for air ambulance services because the Departments defined numerous statutory terms in ways that skew the QPA in favor of plans and issuers, or otherwise yield unreliable results. For example, the Departments define "provider in the same or similar specialty" in terms of the plan's or issuer's usual business practice, and then arbitrarily carve out air ambulance providers from that general definition. Another problem is that plans and issuers have manipulated the QPA by pushing providers out of their networks and thereby reducing the number of rates that are available to calculate a median.

The Departments have compounded the flaws in the QPA methodology by continuing to require arbitrators to give special weight to the QPA in the IDR process. For all other providers, CMS guidance directs the arbitrator to consider all factors without giving any one factor special weight.

The Departments' arbitrary and capricious treatment of air ambulance providers relative to all other providers ensures that the IDR process for air ambulance providers – and only for air ambulance providers- favors insurers whose goal is to lower their payment at the expense of critical air ambulance services without regard for the cost of the services or the need to preserve access to care for critically ill patients. The policy encourages business practices by plans and issuers that effectively limit air ambulance providers' ability to obtain sufficient payment for emergency medical services already provided. When the QPA is the controlling statutory factor in IDR, plans and issuers make insufficient payments with the assurance that air ambulance providers have no meaningful recourse in the IDR process.

Payors Continue to Deny Claims for Medical Necessity, With No Relief from IDR

All helicopter air ambulance transports and most fixed-wing air ambulance transports are emergencies and must be requested by a physician or first-responder based on emergency medical criteria established by physicians. Despite the underlying clinical determinations, plans and issuers initially deny more than 50 percent of claims for nonparticipating air ambulance services on coverage grounds, without issuing a notice of denial of payment to the provider. In those cases, the provider may bill the entire charge to the patient, who must then file their own appeal with the plan or issuers. AAMS members tell us that approximately 90 percent of those denials are later overturned, which means that ***patients*** must appeal 45 – 55% percent of claims for nonparticipating air ambulance services to obtain the payments to which they were always entitled. The practice of systemically denying nonparticipating air ambulance claims and then providing coverage following appeal is a systemic policy problem that harms patients, disrupts the revenue cycle, threatens access to services, and defeats the goals of the NSA. We do not believe that Congress or the Departments intend for this result.

Payors are Ignoring NSA Requirements, Including Timelines and QPA Reports

The industry is aware of multiple violations of the NSA and the IFR by plans and issuers. These violations include, but are not limited to:

- failure to either make initial payments or send notices of denials of payments;
- failure to even acknowledge receipt of claims, resulting in weeks or months of delays in making an initial

payment or sending a notice of denial of payment, far beyond the 30 days required;
- failure by insurers and plans to report the Qualified Payment Amount (QPA) with initial payments to air ambulance providers and provide the rationale behind the amount they propose.

Further, many AAMS members report that some plans and issuers are declining to pay or send them a notice of denial of payment—and then declining to engage in open negotiations—while the judicial challenges to IFR Parts I and II are ongoing. Such plans and issuers have made the decision to thwart the NSA by refusing to acknowledge receipt of "clean claims". Without recognition of the claim there is no initial payment, no identification of the QPA or how the QPA was calculated, and no opportunity for open negotiation or IDR. Further, the lack of QPA information also prevents the successful initiation of the IDR process, as the initiating party must provide the QPA information. Such an approach is untenable.

AAMS Recommendations for the Final Rule

End the Special Weighting of the QPA in the IDR Process, Address QPA Calculation

The Final Rule should eliminate the regulatory text that requires the air ambulance provider to show that the QPA is materially different from the appropriate out-of-network rate. [i] The Final Rule should treat air ambulance providers the same as all other providers in the IDR process.

Removing this regulatory requirement will ensure patient access to critical air ambulance services, ensure parity across all providers, and align with the intent of Congress and the ruling of the *TMA* court. It also will ultimately lead to improved health plan practices, transparency, and a willingness to negotiate with air providers.

The Final Rule should also address flaws in the QPA calculation methodology. The Final Rule should (1) apply the general definition for "provider in the same or similar specialty" to air ambulance providers, (2) include SCAs in the definition of "contracted rate" and consider historical payment information, and (3) remove Census divisions from the geographic region definition.

Allow the IDR Process to Apply to Payment Disputes Arising from Medical Necessity Denials

The Departments should align the Final Rule with the text and structure of the Act and interpret the term "notice of denial of payment" to include coverage denials (including medical necessity denials). Alternatively, the Departments should use the rulemaking to require payers to cover all emergency air ambulance services as essential health benefits whenever they qualify as emergency services rendered in connection with an emergency medical condition under the "prudent layperson" standard. The application of the "prudent layperson" standard during the initial claims adjudication would greatly reduce the number of coverage denials.

Require Plans to Acknowledge Receipt of Claims

The Final Rule should address the lack of payment or denial by requiring that plans and issuers have 10 days to request any additional information necessary to determine payment or denial, and then an additional 10 days to verify receipt and make payment or denial for air ambulance services. An initial payment or notice of denial payment must be sent by the plan or issuer no later than 30 calendar days after a claim is received. When a dispute arises, a party must initiate open negotiations within 30 business days after the provider receives a payment denial or initial payment.[ii]

Clearly Identify Federal Authority in NSA Enforcement

We recommend that the Final Rule clarify how the Departments will enforce the NSA against plans and issuers and make it clearer that the Departments may assess monetary penalties against plans and issuers for violations of the NSA, including specific penalties for specific violations. The Final Rule should address when and how HHS will exercise enforcement jurisdiction in lieu of the States. We firmly believe that a lack of clarity on the federal and state responsibilities and processes for enforcing the NSA are producing uneven enforcement and a lack of willingness among plans and issuers to abide by the law.

We thank you for your consideration of these requests.

Sincerely,

Christopher Eastlee
Vice President of Public Affairs
Association of Air Medical Services

Rene Borghese, MSN, RN, CMTE
Chair
Director-At-Large
Administrative Director
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[i] 45 C.F.R. 149.520(b)(2) (requiring, for air ambulance providers only, that "additional information" submitted by a party in the IDR process "must … clearly demonstrate that the qualifying payment amount is materially different from the appropriate out-of-network rate"). The same QPA presumption for all other providers in 45 C.F.R. 149.510 has been vacated by a federal court. *See Texas Medical Ass'n v. Dep't of Health & Human Servs.*, 2022 WL 542879 (E.D. Tex. Feb. 23, 2022). Nonetheless, because that decision did not vacate Section 149.520(b)(2), the Departments have maintained that the QPA still applies to air ambulance providers. AAMS is challenging that arbitrary treatment in litigation, seeking vacatur of the QPA presumption as applied to air ambulance providers. *See Ass'n of Air Medical Servs. v. Dep't of Health & Human Servs.*, 1:21-cv-30310-RJL (D.D.C.), ECF No. 1, at 39 (seeking vacatur of the QPA presumption in IFR Part II, Section 54.9816-8T(c)(4)(B)(ii)); *id.* at ECF Nos. 59, 61-62 (challenging arbitrary distinction made in Departments' interpretation of *Texas Medical Association*).

[ii] 45 C.F.R. § 149.510(b)(1)(i).