Air Methods and Implementation of the No Surprises Act

Discussion Regarding No Surprises Act

AGENDA

- Background on Air Methods and Operations
- Current Landscape and Challenges
- No Surprises Act Execution and Experience To Date
- Real Life Examples
- Suggested Recommendations to Improve Process and Ensure Continued Access for Patients
- Questions

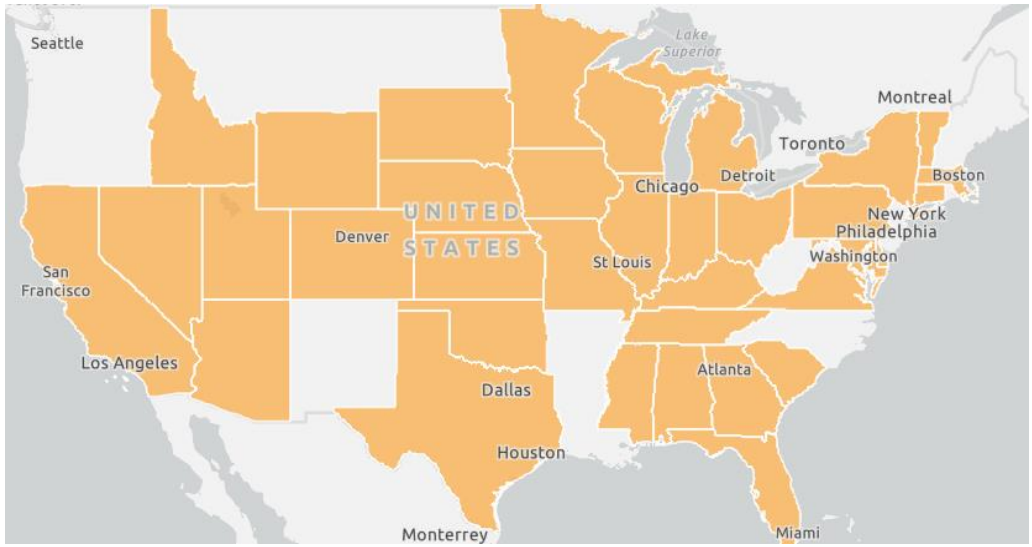
ATTENDEES

- Chris Myers, Executive Vice President, Customer Experience
- Carolyn Hicks Mayle, Vice President Government Affairs
- Kate Rose, Partner, Welsh Rose, LLC
- Congressman Joe Crowley, Senior Policy Director, Dentons
- Callan Smith, Associate, Dentons

Industry Leader in Negotiating In-Network Agreements

2017

2021



Air Methods has been committed to becoming a networked provider nationwide

- Through tireless negotiation, Air Methods' in-network status has grown substantially in the last four years
- In 2017, Air Methods was sitting at an in-network rate of 14%
- Today, Air Methods achieved an in-network rate of 75%
  - In network with National Payors: Anthem, United, and Humana, among others
  - Continued challenges with Aetna, Cigna, and Kaiser to go in network

Current Landscape and Challenges

- **COVID pandemic has brought, and continues to bring, challenges to operations beyond our control.**

- **Industry experiencing significant inflationary costs beyond normal market CPI.**
  - Due to shortages, labor costs have dramatically increased in 2021
    - Paramedic salaries increased 20.6 %
    - Nurse salaries increased 16.1%
    - Mechanics salaries increased 8.3%
    - 2021 pilot stipends increased 27.7% over 2020
    - Additional costs in overtime to ensure bases fully staffed
  - 2021 fuel costs have increased 51.3%

- **Continued under-reimbursement from over 70% of our transports**
  - Medicare (38% of transports) reimburses $5900 on average – which is less than half of actual costs
  - Medicaid (26% of transports) reimburses $2800 on average
  - Uninsured (8% of transports) reimburse $400 on average

- **Veterans Affairs Proposed Rule changes reimbursement by tying to the Medicare rate**

**** Bases cannot operate unless fully staffed with ICU trained nurse and paramedic, mechanic, and pilot.***

No Surprises Act 2022 Implementation Experience

Payor behavior and actions resulting in significant delays in claims process

- Insurers/plans delaying receipt of claim information, which delays 30 calendar day period to make a determination of payment or deny coverage. In addition, extended wait times and other delays.
- Payers incorrectly processing claims; which delays 30-day calendar period and Open Negotiation.
- Payors either do not send an Explanation of Benefits or do not provide required NSA language
- Lack of QPA information: Payors not providing QPA information verbally or in writing
- Significantly lower payments from remaining out of network health plans
    - 2022 reimbursement deviates materially from 2021 experience and in-network market rate

Interim Final Rulemaking on IDR is Unbalanced for Air Ambulance Providers

- Latest Guidance from CMS instructs the IDR entity to apply the QPA presumption in favor of the QPA for air ambulances, whereas other providers have QPA weighted equally with other factors outlined in the statute.
- This applies a different standard to air providers for no policy reason that was identified in the rule, and gives health plans the ability to under-reimburse with a depressed QPA
- In addition, it disincentivizes health plans from negotiating in good faith.

IDR Process Lacks Transparency and Clarity and Clear Directions and Standards for IDREs

- Backlog of IDR volume resulting in delayed determinations; little visibility or assistance from CMS/IDRE into reasons. Not enough IDREs to handle claims; 4 out of 11 IDRES not accepting new claims
- IDREs widely differ in knowledge of industry, process, and communications; lack of transparency, resulting in widely subjective decisions

Claims Processing Efficiencies and Accountability Needed

Burden falls on providers for claims resolution; Extremely Labor-Intensive Process

Initial payment timelines are unpredictable and delayed; lack of payor interaction and transparency, delays and inconsistent IDR process

Actual Performance (2022 YTD)
- Average 48-day response time (range of 20-120+)
- 25% initial payment after 30 days
- Top Offenders: Cigna, BCBS AZ

Actual Performance (2022 YTD)
- Claim volume impacting cashflow (262 claims open, from January)
- 38% on Hold Status (IDREs provide vague responses to inquiries requesting clarity)
- 15% pending IDRE response since CMS Entity Selection

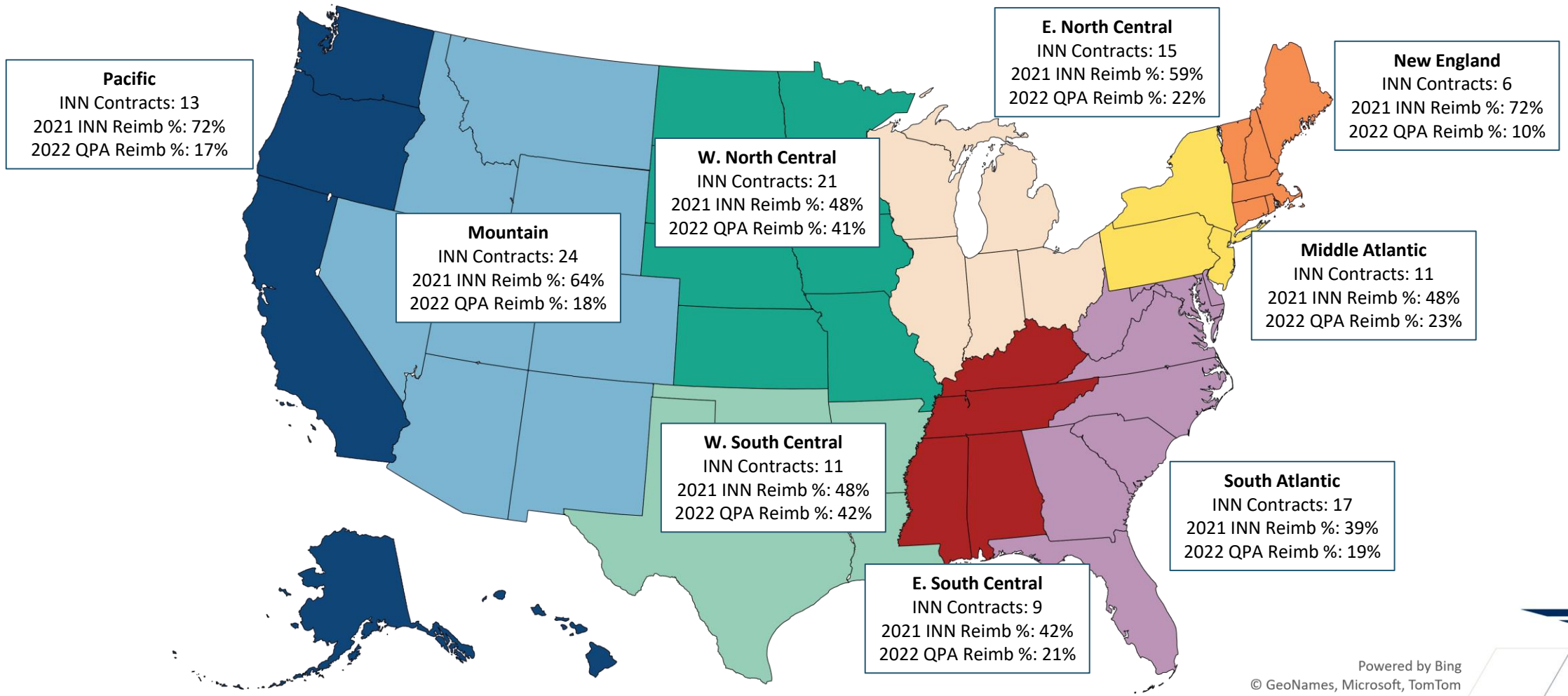
Actual Performance (2022 YTD)
- 40.6% reduction in amount of initial payment
- 0.6% of claims have yielded an additional payment
- Hold times 1.5+ hours
- 98% of payors not engaging in good faith negotiations (144 out of 147)

Actual Performance (2022 YTD)
- 30% of determinations not made within 30 days from IDRE Selection Date
- Select IDREs not responding to inquiries

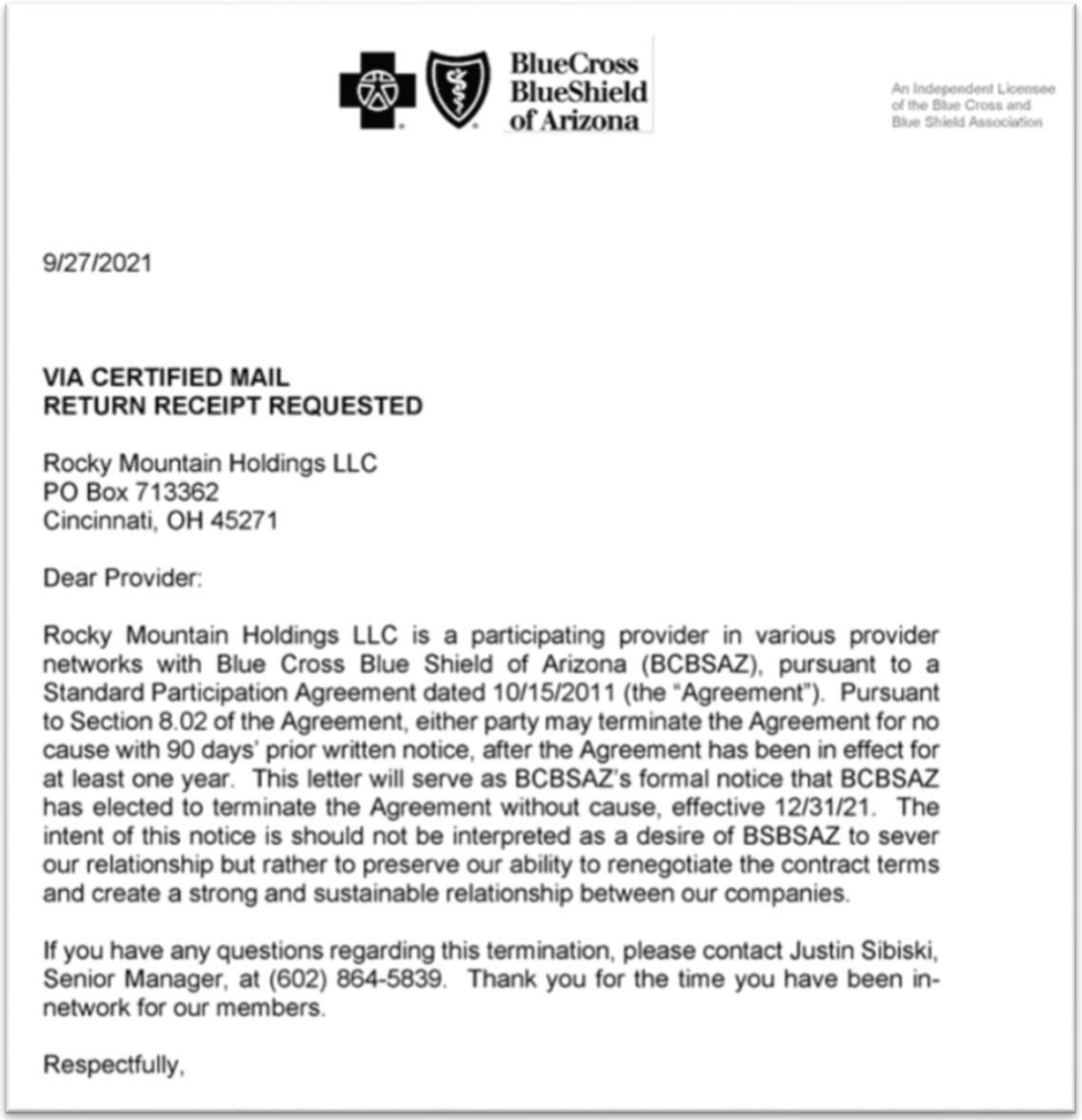
Providers need support in driving accountability for payors in the early stages of the claims resolution process for it work efficiently.

QPA as Defined by Out-of-Network Health Plans Deviates Materially from In-Network Experience

In 2021, Air Methods' negotiated in-network reimbursement was 67% of charges. In 2022, health plan QPA for out of network claims is 23.5%. Geographic differences are as low as 6% in the central states and as high as 62% in New England. The health plan QPA calculation does not mirror the market rate.



Health Plan Actions



BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

9/27/2021

VIA CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Rocky Mountain Holdings LLC
PO Box 713362
Cincinnati, OH 45271

Dear Provider:

Rocky Mountain Holdings LLC is a participating provider in various provider networks with Blue Cross Blue Shield of Arizona (BCBSAZ), pursuant to a Standard Participation Agreement dated 10/15/2011 (the "Agreement"). Pursuant to Section 8.02 of the Agreement, either party may terminate the Agreement for no cause with 90 days' prior written notice, after the Agreement has been in effect for at least one year. This letter will serve as BCBSAZ's formal notice that BCBSAZ has elected to terminate the Agreement without cause, effective 12/31/21. The intent of this notice is should not be interpreted as a desire of BSBSAZ to sever our relationship but rather to preserve our ability to renegotiate the contract terms and create a strong and sustainable relationship between our companies.

If you have any questions regarding this termination, please contact Justin Sibiski, Senior Manager, at (602) 864-5839. Thank you for the time you have been in-network for our members.

Respectfully,

- Outside of the out of network health plans, some health plans now expressing interest in "renegotiating contracts to lower amount
- Recent example: BCBS of AZ terminating existing in-network agreement

Health Plan Actions

DCN# [redacted]

ROCKY MOUNTAIN HOLDINGS LLC
625 E CARNEGIE DR
SUITE 150
SAN BERNARDINO, CA 92408-3510

Transportation Provider Name: ROCKY MOUNTAIN HOLDINGS LLC
Date(s) of Service: 01/03/2022
Claim Number(s): [redacted]
Member Name(s): [redacted]
Member ID(s): [redacted]
Open Negotiation Received Date: 01/27/2022

Dear Transportation Provider:

Your request to initiate an Open Negotiation for the eligible claim(s) referenced above was received. Based on our review of available information, including your request for an Open Negotiation, we have made the following determination.

We are upholding the original benefit and allowed amount for the covered services and will not issue any additional amount. We benefitted the claim(s) as required by the Federal No Surprises Act using the Qualified Payment Amount (QPA) less the member's in-network cost share. Per the Act, we calculated the QPA as the median of our contracted rates for the same or similar service(s), supplied by a provider in the same or a similar specialty, and delivered in the Metropolitan Statistical Area (MSA) determined by the pick-up location provided on the claim(s).

Additionally, if applicable, the QPA was adjusted to account for billed modifier(s) that provided a more specific description of the furnished item(s) or service(s) and that affected the processing or allowance for the code(s) billed.

Thank you for giving us the opportunity to review your negotiation request.

Sincerely,

[redacted]

Remarks:

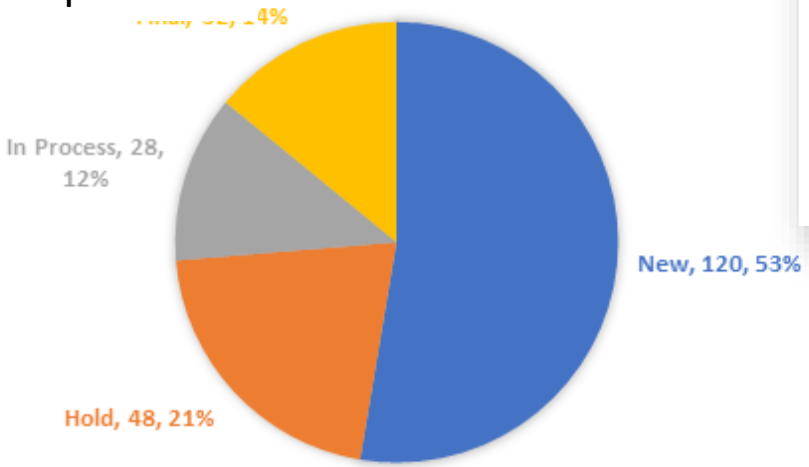
1 - *The Federal No Surprises Act (NSA) applies for this claim. We allowed covered services using the recognized Qualifying Payment Amount (QPA). The QPA complies with the NSA. We calculated the member's cost share using the QPA. The member only owes their cost share shown on this notice. You are prohibited from billing the member more than their cost share. Under NSA, if you don't accept the QPA and want to initiate an Open Negotiation, you have 30 business days from receipt of this notice to do so. You can submit a completed Open Negotiation request form to us via email at [redacted] or via fax at [redacted]. Our Provider Contact Center team can be reached at [redacted] if you need details on initiating an Open Negotiation. If no agreement is reached during the Open Negotiation, you may initiate the Federal Independent Dispute Resolution (IDR) process for eligible claims on business day 31. [FDZ]*

- National payors provide standard language on negotiations, referring to QPA, however do not provide QPA calculation details, even when requested
- Payers dictate the QPA; yet do not have to defend their calculations

CMS - IDR Process Challenges

- Backlog of IDR volume results in delayed determinations and where applicable, reimbursement
- Lack of responsiveness or vague explanations as to why disputes have been put “on hold” by CMS
- Boilerplate response from IDRE for different cases in same region where payor QPA is widely different
- IDRE misunderstanding about air medical industry being exempt from state processes (e.g., Alaska, Georgia, Maine, Michigan)
- Lack of portal visibility into which IDREs are not accepting new submissions, creating additional administrative burden for initiating parties

IDR Disputes



Thank you for your Independent Dispute Resolution (IDR) inquiry. Review your inquiry’s response below.

Inquiry: We do not agree with the selection of C2C as the IDR Entity. After reviewing the list, we select EdiPhy Advisors, L.L.C. as the IDR Entity.

Response: The certified Independent Dispute Resolution (IDR) entity **EdiPhy Advisors, LLC** is currently not accepting new assignments. Consequently, a new certified IDR entity needs to be selected for dispute reference number **DISP-21168** no later than **07/15/2022**.

Rocky Mountain Holdings, LLC Next Steps:

1. Review the list of certified IDR entities and select an alternative certified IDR entity. You shouldn’t have a COI with the alternative certified IDR entity. **Note: The certified IDR entities EdiPhy Advisors, LLC., ProPeer Resources, LLC, Island Peer Review Organization, and Keystone Peer Review Organization, Inc. are not currently accepting new assignments.**
2. Reply all back to this email with the name of your selected alternate certified IDR entity as soon as possible, but no later than **07/15/2022**.

List of certified independent dispute resolution entities

The Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury have certified these organizations to serve as independent dispute resolution entities in the federal independent dispute resolution process between providers, facilities or providers of air ambulance services and group health plans, health insurance issuers and Federal Employees Health Benefits (FEHB) Program carriers.

Starting January 1, 2022, if a provider or facility and a health plan can't agree on the payment amount for an out-of-network service covered by No Surprises rules, these organizations can be selected to make a payment determination.

The application process opened September 30, 2021, and will remain open to accept applications on a rolling basis. The list will be updated as additional organizations become certified.

Legal Business Name	Application ID	Website	Flat Fee (single determinations)	Batched Fee (batched determinations)	Certified for the following states
C2C Innovative Solutions, Inc.	IDREApp-067	https://www.c2cinc.com	$299	$870	All states in which the federal process applies
EdiPhy Advisors, L.L.C.	IDREApp-115	https://www.medmanagementllc.com/	$500	$870	All states in which the federal process applies
Federal Hearings and Appeals Services, Inc.	IDREApp-107	https://www.fhas.com	$365	$450	All states in which the federal process applies
Island Peer Review Organization DBA: IPRO	IDREApp-066	https://ipro.org/	$500	$870	All states in which the federal process applies
Keystone Peer Review Organization, Inc.	IDREApp-113	https://www.kepro.com/	$398	$870	All states in which the federal process applies
					All states in which the federal process applies
					All states in which the federal process applies
					All states in which the federal process applies
Reviews DBA: National Medical Reviews, Inc.					All states in which the federal process applies
Network Medical Review Company DBA: Network Medical Review Company, Ltd.	IDREApp-071	https://www.nmrco.com	$397	$855	All states in which the federal process applies
ProPeer Resources, LLC	IDREApp-110	https://www.propeer.com/	$450	$800	All states in which the federal process applies

Real Life Patient Example

While the No Surprises Act appropriately protects patients, the plan's "payment offer" is not reflective of the value of emergency air ambulance services.

PATIENT SUFFERING FROM STROKE IN REMOTE RURAL COUNTY

- Patient came to the ER experiencing slurred speech and drooling; CAT scan that showed a blood clot in the middle cerebral artery confirming the diagnosis of stroke. Consulting with the neurologist, the patient's condition was critical and time-sensitive as rapid treatment from a stroke reduces permanent brain damage and long-term disability. The patient required the most rapid mode of transport to a Comprehensive Stroke Center in order to be evaluated and receive a thombectomy, which was not available at the referring hospital.

AIR METHODS HAS MADE GOOD FAITH ATTEMPTS TO OBTAIN A CONTRACT WITH AETNA

- In 2018, Air Methods initiated efforts to secure a contractual agreement with Aetna, offering competitive rates **consistent with national contracted rates**. Despite sixteen (16) written communications and eight (8) meetings throughout the years, Aetna has chosen not to contract with Air Methods, citing "business needs and strategies" as their deciding factor.
- Air Methods' most recent proposal provides Aetna with **$16.3 million in savings** and results in an overall loss on every Aetna transport. Air Methods' willingness to incur loss is driven by our desire to create a benefit for Aetna membership and an unwavering commitment to ensuring patient cost shares remain low.
- An independent commercial claims study found that Air Methods' clinical intervention reduces post-transport expenses incurred by insurers by $7,400 when measured against all other air medical providers. Based upon 2021 transport volumes for Aetna members, Aetna is expected to realize an **additional $25 million in downstream savings annually**.
- Aetna's refusal to contract with Air Methods has **disadvantaged its own members**, resulting in burden and stress to patients and caregivers at a time when they should be focused on healing and recovery after traumatic events.

AIR METHODS PROPOSES A DISCOUNTED PAYMENT OF $35,500 FOR SERVICES RENDERED

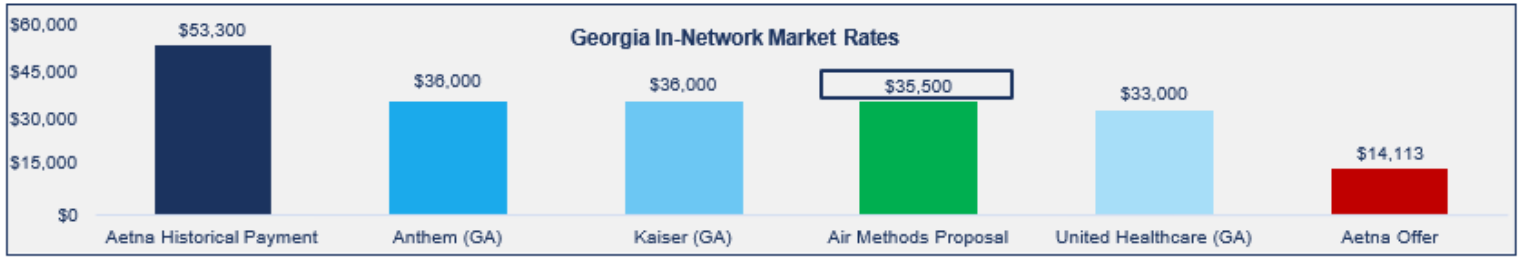
- Aetna's historical payment to Air Methods in GA is $53,300. Air Methods' median reimbursement for out-of-network plans in GA is $43,000.
- Aetna offered $14,138.38 for this transport, 43% lower than Air Methods' median rate of $33,000 for contracted partners in this geographic region.
- As an expression of our continued willingness to become an in-network provider and to ensure a low cost-share amount for Aetna members, **Air Methods is willing to accept a competitive in-network rate of $35,500** for this transport**.**

Current Out-of-Network Rates Significantly Lower than In-Network Rates

CURRENT OUT-OF-NETWORK REIMBURSEMENT SIGNIFICANTLY LOWER THAN IN-NETWORK RATES

- The chart above reprices the claim at issue comparing the payer's **historical payment** in the southern census region, Air Methods' **out-of-network payments**, **in-network rates**, **latest in-network proposal to Aetna**, and **Aetna's offer** in this dispute
- Aetna's offer is unreasonably low in comparison to Air Methods in-network contracts which are determined by the market. **Their offer not only has no relationship to market but is a departure from Aetna's own reimbursement before their policy change.**
- The appropriate comparison is to examine their offer in relation to the Out-of-Network agreements, and again their offer is clearly unreasonably low.

Aetna and Cigna are the only large, national payors that have refused to contract with AirMethods.

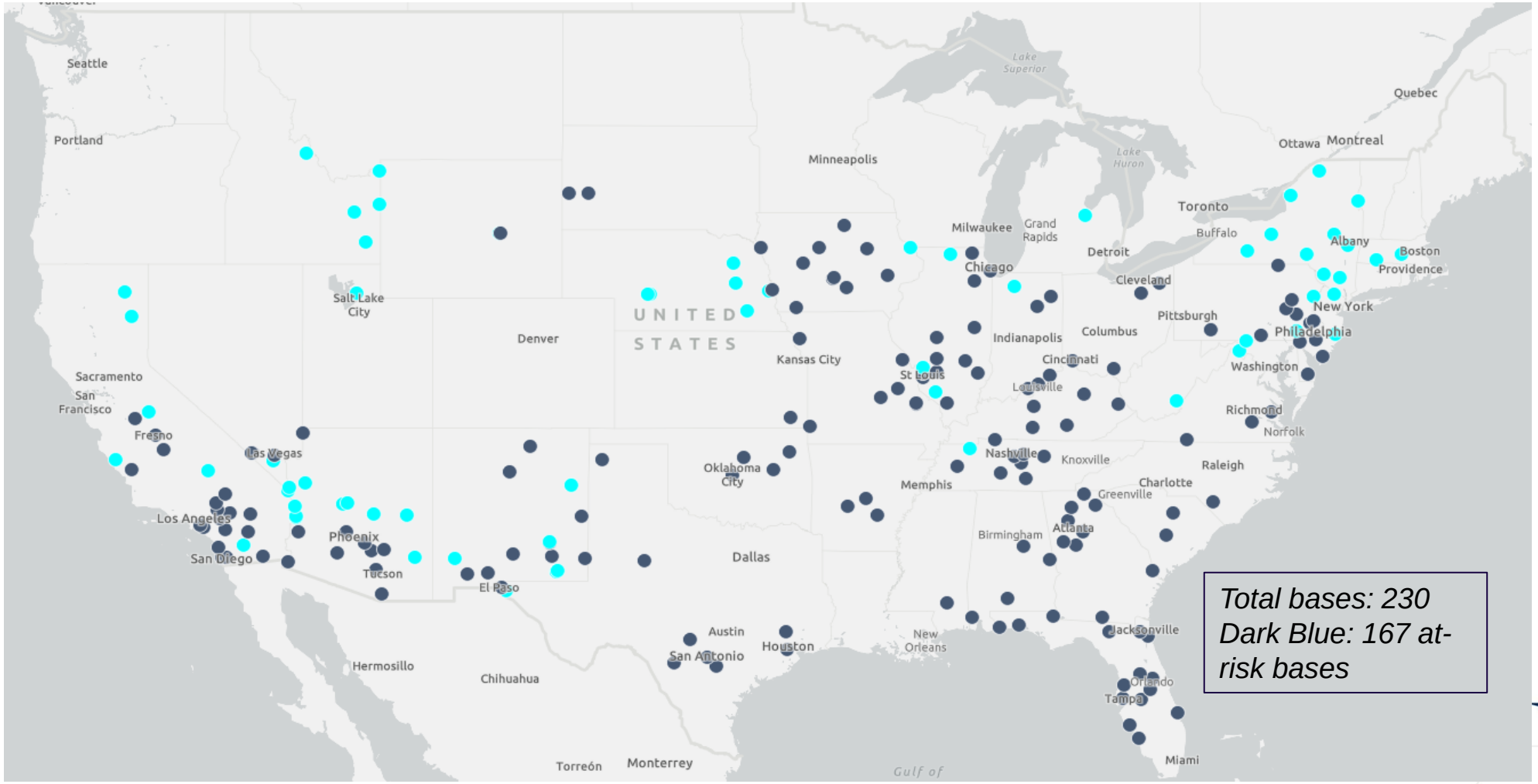


- Given the number of in-network contracts in Georgia, one should consider the entire sample when contemplating the appropriate payment amount.

Understanding the need for compromise, Air Methods is wiling to accept $35,500 – which represents the market share weighted average for in network contracts.

Air Methods Bases at Risk of Closure

Assuming a 30% reduction in commercial reimbursement, 73% of bases are at risk of closure without enforcing health plan accountability.



Total bases: 230
Dark Blue: 167 at-risk bases

Proposed Changes and Enhancements

Air Methods has a history of being a leader in the industry, leading in-network engagement, supporting the need to protect against balance billing, and advocating for cost data collection to promote industry transparency. With the NSA in full effect, we see a few opportunities to improve the process greatly for providers to ensure continued access to critical health services.

Issue #1: Need for Meaningful Payor Engagement and Accountability

- The provider bears all risk in the current claims resolution process whereas health plans face little to any accountability or oversight..

Air Methods Recommendation(s):

- Define a clean claim with timelines to set expectations and promote complete transparency
  - Within 10 calendar days from receipt of claim, the insurer/plan must respond to acknowledge sufficient information or to demand specific additional information necessary to process the claim
  - Within 10 calendar days of receipt of any additional information demanded, the insurer must respond to acknowledge receipt of sufficient information to process the claim
  - Consistent with the NSA Act and the regulations, the insurer then has 30 calendar days to make payment or deny payment.
  - If plans continue to be nonresponsive or hold up timelines, initiating should be rewarded with the offer they submitted as the final determination.
- Require plans to provide explanation and data for calculation of the QPA to both providers and IDREs
- If health plans are not going to engage in meaningful negotiations during the 30 day period, this timeline should be shortened.
- Additional unbiased IDREs needed to handle volume delays and meet timelines
- Additional CMS transparency and clarity on IDRE process and/or guidance to IDREs on review process for air ambulance claims
- Enforcement of timelines or incur penalties

Issue #2: Need for Fair Guidance to Ensure Fair and Balanced Arbitration

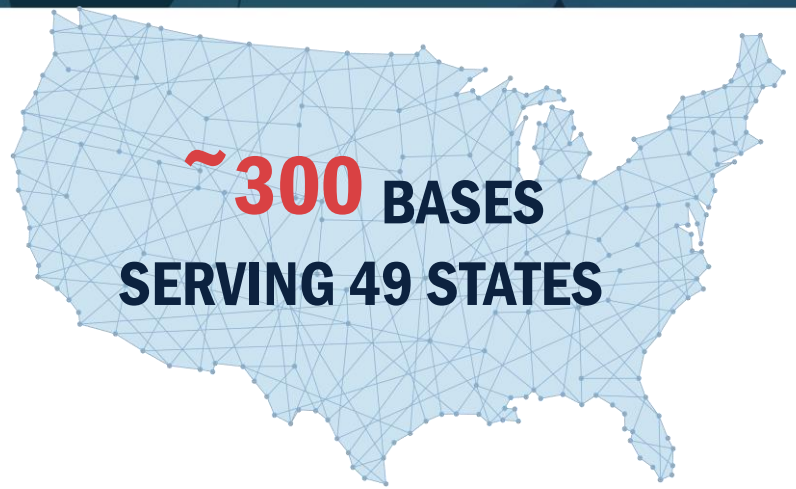
- Latest guidance treats air ambulance to different standard for IDR Process; which will allow health plans to limit payments to air medical providers

- **Air Methods Recommendation(s):**
  - CMS should amend its regulatory guidance to treat air ambulance providers like all other providers in which the QPA is not weighted more heavily than other considerations under IFR Part II
  - CMS should amend is regulatory guidance to revise the definition of “same or similar specialty” to distinguish between independent and non-independent providers of air ambulance services

Thank you for your valuable time.

APPENDIX

Air Methods at a Glance



130,000+/year
FLIGHT HOURS

400+
HELICOPTERS
& FIXED WING
AIRCRAFT

100,000+/year
PATIENT TRANSPORTS

5,000+
TEAMMATES

PATIENT ADVOCACY IS IN OUR DNA

IT'S PART OF OUR CORE VALUES TO GIVE
OUR PATIENTS THE BEST EXPERIENCE POSSIBLE FROM BEGINNING TO END.

WE'RE AN AIRBORNE ICU,

AND WE RESPOND ONLY WHEN A PHYSICIAN OR A FIRST RESPONDER CALLS US.

The Cost of Lifesaving Air Medical Transport

- Aircraft are flying intensive care units ready 24/7 and its service is comparable to complex and high-cost clinical care
- Significant Resources and Expertise is Required to Care for High Acuity Patients

Startup Costs vs. Ongoing Costs

SUMMARY OF COSTS

Aircraft

- Rotor Wing: $8.2M - $11.1M
- Fixed Wing: $5.4M

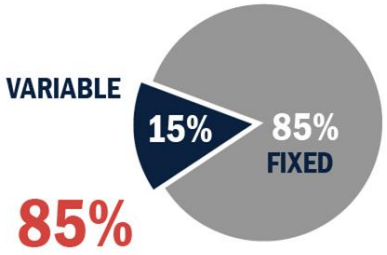
Equipment $200K +

Sample of Equipment on Every Flight:

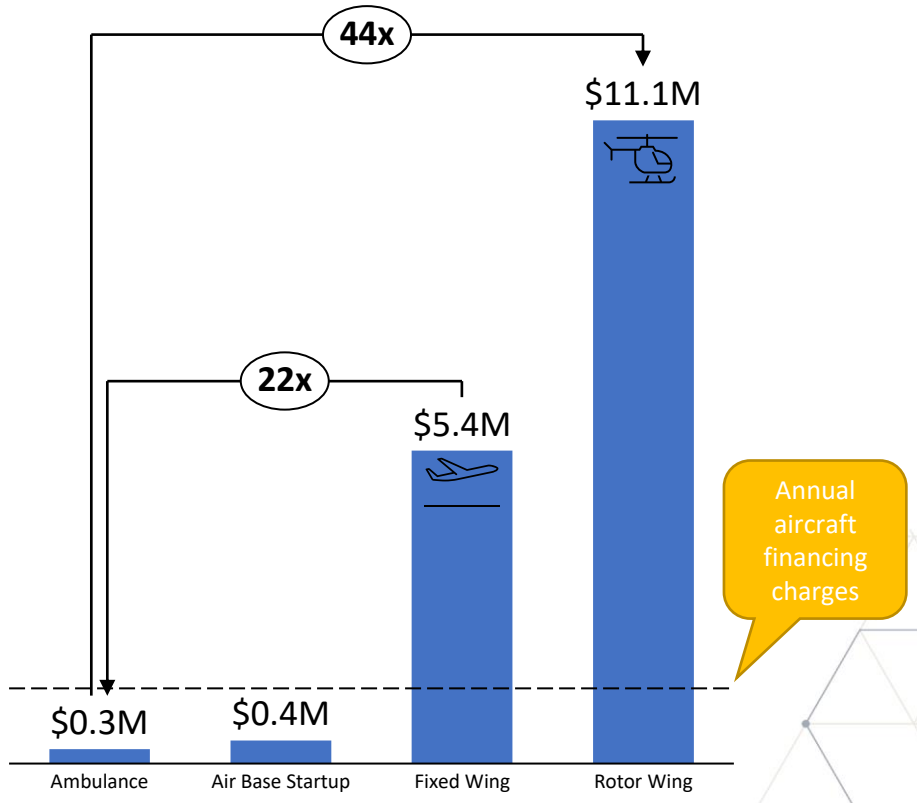
- Advanced Ventilators
- Fetal Heart Monitors
- Intra-aortic balloon pumps
- Night Vision Goggles
- Bilevel positive airway pressure device
- Video Laryngoscope
- Surgical Airway Equipment
- Needle Cricothyroidotomy
- Cardiac Monitoring
- Obstetric Delivery Kit
- Formulary with 50+ Drugs

TOTAL COST $5.6M – $11.3M

IT COSTS AN AVERAGE OF
$3 MILLION ANNUALLY
TO OPERATE ONE AIR MEDICAL BASE



85%
OF COSTS ARE INCURRED
WHETHER WE FLY OR NOT



The capital cost of an air ambulance can be
44x GREATER
than a ground ambulance.

Industry Leader in Clinical Investments and Patient Outcomes

Air Methods has invested $100M+ over the past five years in training and quality programs with documented outcomes that result in excellent patient care, most recently being named as the only approved air medical provider by the American Nurses Credentialing Center (ANCC).

CLINICAL EXCELLENCE AT AIR METHODS

CLINICAL QUALIFICATIONS & TRAINING

Our highly-trained critical care transport crewmembers are the best in the air medical industry. Their knowledge, expertise and kindness help give patients a real chance at another tomorrow. As the leader in the air medical industry. **Air Methods hiring requirements and education delivery are unmatched.**

HIRING TOP TALENT

Flight Nurses

- Minimum 3+ years in an ICU or ED
- Current RN license(s) for states of practice
- EMS or MICN certification/licensure*
- Current certifications in Healthcare Provider BLS/CPR: ACLS; PALS or equivalent and TNCC/ITLS-advanced provider*
  If required by state and/or county

Flight Paramedics

- Minimum 3+ years at advanced life support/ambulance service
- EMT-P certification in state(s)
- Current certifications in Healthcare Provider BLS/CPR; ACLS; PALS or equivalent and TNCC/ITLS-advanced provider*
- *If required by state and/or county*

TRAINING PROGRAM

Air Methods provides our newly-hired clinicians with a comprehensive training program. All clinicians receive ongoing training. Air Methods utilizes both simulation and didactic education in development of its medical teams.

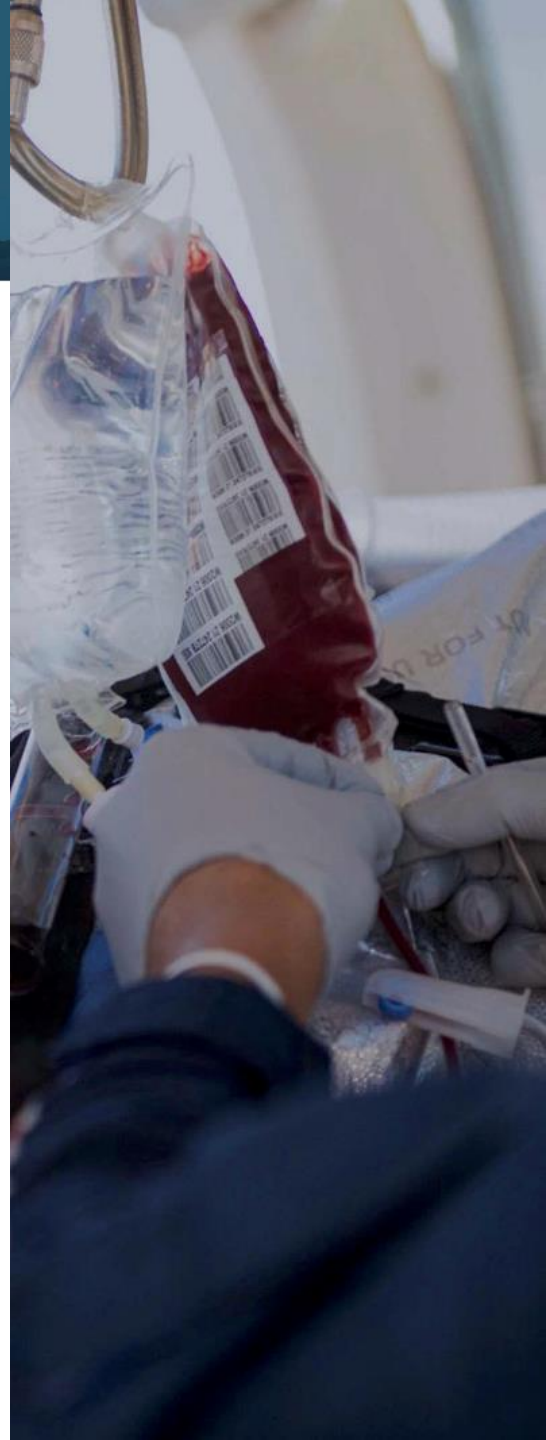
New Hire – All Clinicians

- All newly-hired clinicians attend a seven-day orientation and local preceptorship.
- Attend 100 hours of didactic lectures
- Utilize dynamic METI critical care human patient simulators
- Validate 24 competencies including cadaver laboratory

Ongoing – All Clinicians

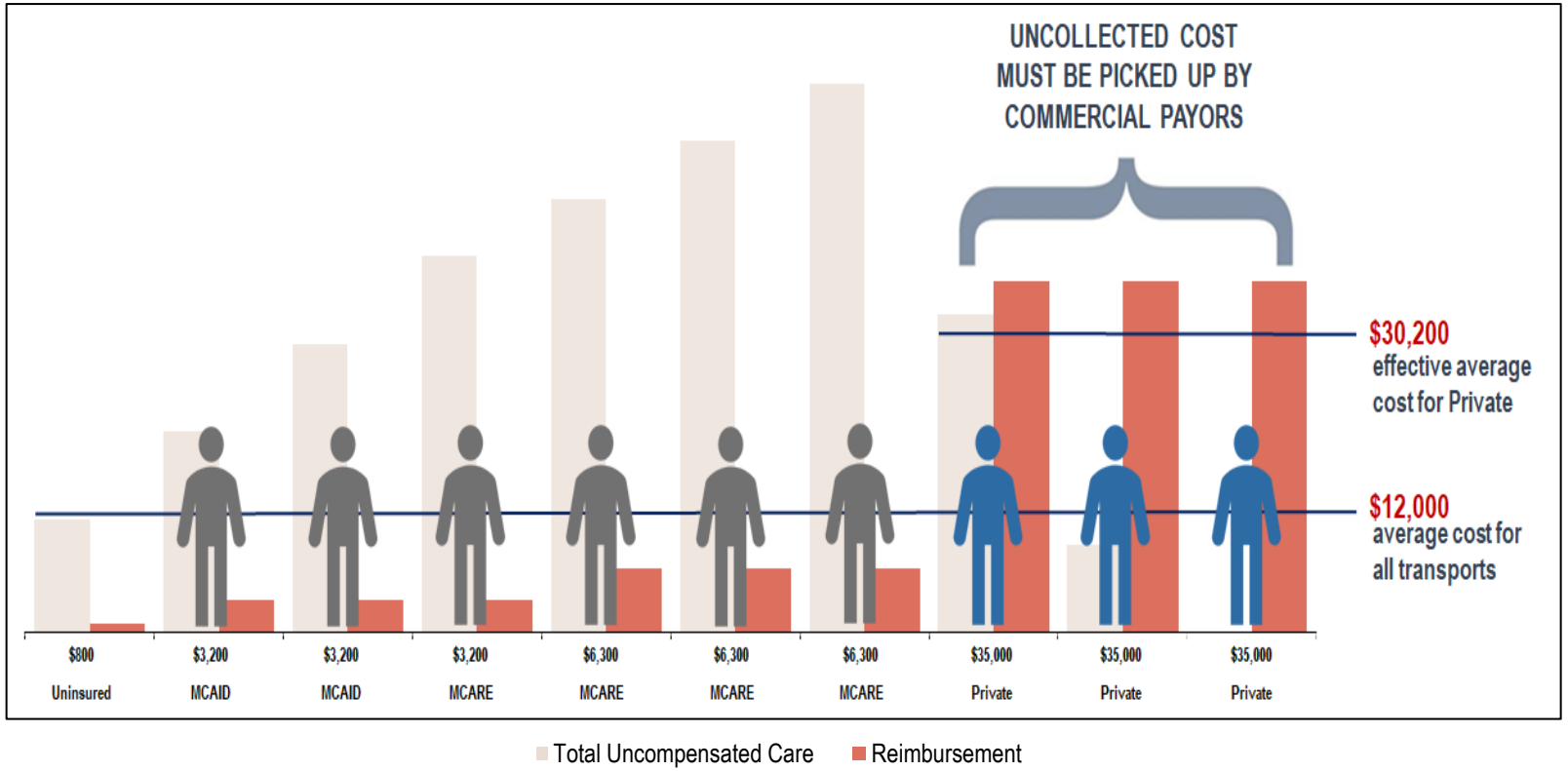
All clinicians receive ongoing training at six dedicated training centers across the country.

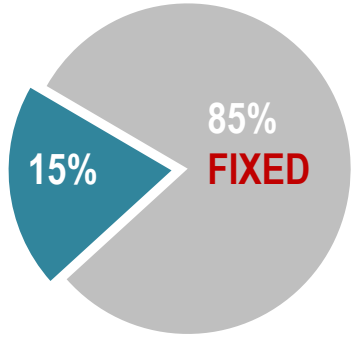
- Complete 100 hours of online education
- Use dynamic METI critical care human patient simulation centers two times annually.



70% of Transports Reimburse at 30-50% of Cost

- Over 70% of transports are either Medicare, Medicaid, or uninsured.
- Unlike vast majority of providers where Medicare and Medicaid reimburse 70-80% of costs, air ambulance is reimbursed at 30-50% of actual cost.
- The role of commercial coverage INCREDIBLY important to maintaining access.





85%

OF COSTS ARE INCURRED
WHETHER WE FLY OR NOT

IDREs Provide Verbatim Language for Different Cases in Same Region

- 100% of determinations received from C2C are unfavorable and are accompanied with verbatim language containing no detail regardless of offer amount
- Health plan QPA amounts differ despite same services provided by same provider within same geographic region – no explanation on these calculations
- Case submissions are not being reviewed by individual arbiters and merits of case are not being explored

Written Payment Determination Notice DISP-01098

IDRInquiries <IDRInquiries@c2cinc.com>
To

You forwarded this message on 6/17/2022 2:39 PM.

In determining which offer to select, the IDRE must consider:

A. The qualifying payment amount (QPA) for the applicable year for the same or similar item or service.
B. Additional related and credible information relating to the offer submitted by the parties. This information must demonstrate that the QPA amount is materially different from the appropriate OON rate.

Parties may submit additional information regarding any of the six circumstances, which include:

1. The quality and outcomes measurements of the provider of air ambulance services that furnished the services.
2. The acuity of the condition of the participant, beneficiary, or enrollee receiving the service, or the complexity of furnishing the service to the participant, beneficiary, or enrollee.
3. The level of training, experience, and quality of medical personnel that furnished the air ambulance services.
4. The air ambulance vehicle type, including the clinical capability level of such vehicle.
5. The population density of the point of pick-up for the air ambulance (such as urban, suburban, rural, or frontier).
6. Demonstration of good faith efforts (or lack thereof) made by the OON provider of air ambulance services or the plan to enter into network agreements, as well as contracted rates between the provider and the plan during the previous four plan years.

The IDRE has received offers from both parties. The QPA in this instance for code A0436 was $853.40 and for code A0431 the QPA was $3,759.84. The final offer submitted by the initiating party for code A0436 was $11,714.00, which is 1373 percentage of the QPA and the offer was $23,286.00 for code A0431, which is 619 percentage of the QPA. The final offer submitted by the non-initiating party for code A0436 was $853.40 and the final offer for code A0431 was $3,759.84, which are equal to the respective QPAs.

As noted above, the IDRE must consider related and credible information submitted by the parties to determine the appropriate ONN rate. The information submitted by the initiating party includes: patient summary; accreditations, training, and clinical qualifications; good faith efforts to enter a network arrangement, and negotiation. In addition, the documentation includes the air ambulance vehicle type including the clinical capability and level population density of the point of pickup. The information submitted by the non-initiating party includes the offer and the QPA. The QPA takes into consideration the reimbursement for geographical regions, ambulance type, and conventional air services. The information does not clearly demonstrate that the experience, training, patient clinical status, and complexity of services made an impact on the care that was provided. Furthermore, the clinical information lacked sufficient detail including the quality of the medical personnel, description of services, and acuity of the condition of the patient.

Written Payment Determination Notice DISP-01111

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In determining which offer to select, the IDRE must consider:

A. The qualifying payment amount (QPA) for the applicable year for the same or similar item or service.
B. Additional related and credible information relating to the offer submitted by the parties. This information must demonstrate that the QPA amount is materially different from the appropriate OON rate.

Parties may submit additional information regarding any of the six circumstances, which include:

1. The quality and outcomes measurements of the provider of air ambulance services that furnished the services.
2. The acuity of the condition of the participant, beneficiary, or enrollee receiving the service, or the complexity of furnishing the service to the participant, beneficiary, or enrollee.
3. The level of training, experience, and quality of medical personnel that furnished the air ambulance services.
4. The air ambulance vehicle type, including the clinical capability level of such vehicle.
5. The population density of the point of pick-up for the air ambulance (such as urban, suburban, rural, or frontier).
6. Demonstration of good faith efforts (or lack thereof) made by the OON provider of air ambulance services or the plan to enter into network agreements, as well as contracted rates between the provider and the plan during the previous four plan years.

The IDRE has received offers from both parties. The QPA in this instance for code A0436 was $18,336.84 and for code A0431 the QPA was $11,579.20. The final offer submitted by the initiating party was $18,002.00 for code A0436, which is 98 percentage of the QPA and the offer was $16,998.00 for code A0431, which is 147 percentage of the QPA. The final offer by the non-initiating party was $18,336.84 for code A0436 and $11,579.20 for code A0431, which are equal to the respective QPAs.

As noted above, the IDRE must consider related and credible information submitted by the parties to determine the appropriate OON rate. The information submitted by the initiating party includes: patient summary; accreditations, training, and clinical qualifications; good faith efforts to enter a network arrangement, and negotiation. In addition, the documentation includes the air ambulance vehicle type including the clinical capability and level population density of the point of pickup. The information submitted by the non-initiating party includes the offer and the QPA. The QPA takes into consideration the reimbursement for geographical regions, ambulance type, and conventional air services. The information does not clearly demonstrate that the experience, training, patient clinical status, and complexity of services made an impact on the care that was provided. Furthermore, the clinical information lacked sufficient detail including the quality of the medical personnel, description of services, and acuity of the condition of the patient.

Based upon review of the submitted information, the IDRE has selected the non-initiating party's offer of $18,336.84 for code A0436 and $11,579.20 for code A0431. The IDRE finds that this offer best represents the value of the services at issue. Therefore, the IDRE has determined the non-initiating party prevailed.