Topher Spiro, Associate Director
Health Programs
Office of Management & Budget

RE: RIN 0938-AU63

Dear Mr. Spiro,

With enactment of the No Surprise Act (NSA), Congress rightly took positive and deliberate action to remove patients from payment disputes between healthcare providers and insurers. We fully support the intent and spirit of this action by Congress to encourage air ambulance services and insurers to work in good faith to find agreement on in-network participation. As you are aware, the effects of the proposed rule are difficult to quantify (especially for air ambulances) and the impact will be felt by all types of air ambulance services across the country.

Background:

PHI Health, LLC (PHI) is honored to serve those in need through our PHI Air Medical air ambulance services. Together with our fellow air ambulance services we provide high quality patient care and safe air ambulance transportation for both insured and uninsured patients throughout most of the United States. Our teams operate on a level of constant readiness, with 24 hour availability, each and every day. To meet this level, PHI employs over 1,800 employees, providing air ambulance services in fifteen states. Our teams not only serve their communities, they live in their communities. Our teams are an essential part of the local healthcare system and the local healthcare economy. In times of disaster, it is this local presence and uninterrupted readiness that allows air ambulances to “surge” and provide emergency air ambulance resources to disaster management efforts.

Our teams of flight paramedics, flight nurses, pilots, and mechanics deploy the latest in specialized transport medical equipment and advanced aviation technology in meeting the needs of our patients. The final rule should reflect the high bar of financial investment needed to support air ambulances in their dedication to the highest quality of patient care and operational safety. As an industry, air ambulances operate under a legal and moral Duty to Act, which

requires that that we respond to requests for service without any knowledge of the patient's ability to pay. But most commercial insurance patients discover after needing our services that we are not in their health insurer's provider network. This is not due to a lack of effort by the air ambulance industry. Commercial insurers have been unwilling to expand their networks and negotiate fair rates for services. This is not for lack of money; the combined net income of the oligopoly of the five largest commercial health insurers was $20,960,000,000 for 2018, $27,770,000,000 for 2019, and $33,610,000,000 for 2020. Nevertheless, PHI is undercompensated for these important emergency air ambulance services. This reimbursement deficiency is pervasive and its effects are felt throughout each level of state, local, and national economies. This amplifies health inequities in rural and underserved communities that rely heavily on government payors.

Medicare and Medicaid reimbursement results in inadequate reimbursement. Our level of reimbursement from Medicare is consistent with data demonstrating a median reimbursement of approximately $5,998 per patient transport, despite a median cost of approximately $10,199. Our reimbursement for transporting Medicaid patients is even less, and for uninsured payments, we are often unable to obtain any reimbursement. Thus, PHI is both undercompensated for Medicare and Medicaid services, and uncompensated for services to the uninsured. Between seven and eight out of every ten patients we transport are reimbursed by government payers at a rate that is below the cost of providing the service. This undercompensated care contributes to increased charges for our services to cover the costs of uncompensated care.

Also worth noting is the practice of routine and perfunctory denials of air ambulance claims by insurers for lack of medical necessity. As part of our Duty to Act, air ambulances respond to requests from first responders and physicians who determine that the patient's condition warrants air ambulance transport. Currently, insurance companies perform a retroactive review of the claim and deny emergency air ambulance claims for lack of medical necessity, yet on appeal, most of those denials are overturned. Today, this negotiation tactic by the insurance companies puts their patients squarely in the middle of payment disputes, requiring patients to navigate a complex insurer appeals process. These painstaking exercises forced upon patients by insurance companies can lead to financial distress and broader economic harm at the local level.

Air ambulances are most often reimbursed based on a combination of base rate plus mileage for loaded (i.e., patient on board) miles. Our experience supports industry data (https://cdn.ymaws.com/aams.org/resource/resmgr/air-medical-services-cost-st.pdf), which demonstrates that the majority of our air ambulance transports are not covered by commercial insurance (again, 70-80% are government payer or self-pay reimbursement). Indeed, for the 20-30% that are reimbursed by commercial insurance, most of these remain out-of-network despite our efforts to increase in-network participation (PHI Health now has nearly 35% of our commercially insured transports reimbursed at agreed-upon in-network rates). The consideration of only contracted amounts in determining the Qualified Payment Amount places an inordinate weight on the minority of air ambulance transports, and does not give a full picture of the offset necessary to ensure financial support of an air ambulance base. Further, it is our experience that insurers look to a multiple of the Medicare rate, as a means of reducing the financial obligations of the insurer. For hospital-based air ambulance services, network agreements historically trade a lower reimbursement for the air ambulance services for a higher overall reimbursement for in-hospital services. Rarely is the hospital negotiation for their air ambulance services negotiated separately from the larger hospital contract with insurers. While some hospitals may be moving towards less subsidization, this cannot be taken as representative of all hospital-based models.

Section 102: QPA methodology

Section 102 requires rulemaking to establish an appropriate methodology for the Qualifying Payment Amount (QPA). Section 105, which specifically addresses air ambulances references Section 102. However, it must be understood that air ambulances provide both aviation and healthcare, which brings in cost factors and regulations that make air ambulances unique among healthcare providers. Further, variation does exist within the air ambulance industry and comparisons must be made between similar services. In the air ambulance industry, as it exists today, there are both for-profit and not-for-profit entities providing air ambulance services, as well as governmental (or quasi-governmental) entities. Within each category, there are those that are subsidized (e.g., hospital-funded, foundation-supported, or tax-supported) and those that are unsubsidized (i.e., relying primarily on reimbursement for services provided). It would be an erroneous comparison to consider the financial structures of an air ambulance

service that enjoys significant financial support (i.e., hospital funding, foundation support, or tax support) as having similar financial structures to an air ambulance service that has no support beyond reimbursement. The former is able to offset costs (resulting in a lower cost per transport), while the latter has no support (resulting in a higher cost per transport). The support received by these subsidized air ambulance services must be considered as part of the cost, and thus is a factor too in any consideration of an appropriate payment amount determination. Failure to address this cost disparity will put at risk the substantial amount of capital that independent air ambulance companies have invested to provide an essential service to the American public, and thus put at risk the very service this rulemaking is designed to preserve.

1. In determining the methodology for the QPA for air ambulances, we respectfully ask that the methodology include the consideration of the median of both in-network payments and historical out-of-network payments. We also ask that the Tri-Departments acknowledge the silent, but powerful effects of the use of Medicare rates by health insurers as a benchmark for in-network contracts. The continued use of Medicare rates as a reference for insurers in network negotiations contributes to a devaluation of air ambulance services. By including historical out-of-network payments to air ambulances, the methodology will provide a more sufficient level of payment that more accurately reflects the costs of providing the services, thereby reducing the likelihood of the need for the parties to utilize the IDR process.

2. Utilizing a median of in-network rates uses a limited data set that reflects a very small subset of patients, primarily from a very small number of mostly subsidized, loss-leader hospital-based programs. Thus, the considerations in determining the QPA need to be expanded to include the extent to which subsidies have influenced the median in-network rate. Consideration of only in-network agreements will likely result in a substantial underpayment that threatens the financial sustainability of the service for the far larger number of air ambulance services that do not receive a financial subsidy. This skews the QPA downward, to the detriment of most air ambulances services, and to the benefit of the insurers, resulting in a regulation that provides a net benefit to insurers.

We urge the Tri-Departments to be cautious in consideration of existing databases in areas where insufficient data exists for air ambulances. It is our experience that the dominant databases (e.g., HCCI and FairHealth) rely primarily on hospitals and health systems, which may skew the QPA towards a level that is sufficient for a subsidized service, but not for a rural, non-subsidized provider in a determined geographical area. To avoid exacerbating healthcare inequities that currently exist for rural and underserved populations, we respectfully ask that the QPA methodology be crafted in a manner that ensures a sufficient payment that supports uninterrupted access to emergency air ambulance services in these geographic areas.

3. In determining geographical regions, as part of the QPA methodology, we urge the Tri-Departments to recognize that over 1/3 of air ambulance transports cross state lines. In most states, there are neither sufficient services nor an adequate number of in-network contracts to serve as credible data to derive a proper median. We ask that geographic regions should capture services and in-network contracts sufficient to derive a proper median and align with the areas where air ambulance providers operate. These regions should not be limited by state boundaries and should still account for disparities in rurality and organization type, given the unique role those factors play in the context of air ambulances. We recognize that the Tri-Departments may rely on states or regions for geographical considerations. If so, we acknowledge that the Tri-Departments may have to take into account that very large western states may need further consideration for variances between regions internal to a particular state. Further, the Tri-Departments may also need to consider a regional approach, where appropriate, for geographically smaller eastern states, as a means of deriving geographical regions that align with air ambulance service areas for similar air ambulance service models. Most importantly, the QPA should be written in a manner that recognizes that air ambulances cross state lines every day to provide emergency and critical care transport to definitive care.

Similar to our industry colleagues, PHI Health has worked with diligence to increase our in-network participation. We are committed to improving this further,

yet our experience is similar to other industry colleagues in overcoming challenges to finding network agreements. We have identified similar issues:

- low volume of patients (when compared to hospitals and healthcare systems)
- unpredictability of call volume

While our industry colleagues from smaller, niche air ambulance services in unique or closed markets report satisfying outcomes in insurer negotiations, we believe this is an exception to the experiences of the majority of air ambulance services, relative to insurer network agreements.

QPA methodology considerations:

PHI Health appreciates the ability of air ambulance services to offer specialized services (e.g., ECMO, Intra-aortic balloon pumps, etc.), which does create some variation in provider capability. As a partner in each community we serve, PHI understands the importance of offering these specialized services, so that we can ensure the highest quality of care for the patients and maintain ICU level care from hospital to hospital. Indeed, our own experience has demonstrated that when we offer that service, we do so with the acknowledgment that we carry the full cost of that specialized equipment, so our investment in that specialty service follows community need and likelihood of deployment of that service. This is in sharp contrast to a subsidized model, which can offset the high cost of specialty services and provide this specialty service at a loss that is overcome through in-patient hospital revenue, foundation support, or a tax base.

We respectfully ask for thoughtful consideration of any comments that singularly emphasize the effects of volume on costs. While volume may affect cost per transport, it would be an oversight to not consider the effects of payer mix on cost per transport. Volume and payer mix both factor into the average cost per transport and both must be considered equally, Air ambulances serve our communities when the community determines it has a need and invites the air ambulance to serve the area. The community may anticipate a relative number of patients who will need air ambulance services. However, in contrast to comments that emphasize volume, the cost per transport to provide air ambulance services does not rely solely on volume. When the payer mix is composed of primarily government payers this low level of reimbursement also affects cost. Indeed,

Congress recognized this disparity when they instructed the IDR entity to not consider reimbursement from government payors, in order to prevent an artificial deflation of any determined amount. In considering the cost per transport and the effects of volume and payer mix, it is likely that an air ambulance service that is subsidized by a foundation, tax base, or health system will be able to overcome low overall government reimbursement, whereas a nonsubsidized air ambulance service will have to account for these variations in order to provide ongoing service to a patient transport volume that has a high percentage of government payer reimbursement.

Conclusion:

As the rulemaking proceeds, PHI Health urges the Tri-Departments to craft the rulemaking in the same manner as the NSA is crafted, recognizing the unique nature of air ambulances when compared to other healthcare providers. Further we ask that the methodology for the QPA for air ambulances recognize this difference and that the QPA be based on the totality of in- and out-of-network payments made by insurers to air ambulance services. In doing so, both air ambulance services and insurers can rely on a greater likelihood of the sufficiency of the QPA, with less likelihood of payment dispute that would generate requests for IDR.

Sincerely,

Christopher Hall
Director, Government Affairs & Industry Relations