REPORT OF THE DEPARTMENT OF HEALTH

House Bill 1728 of 2017 Workgroup Report (Chapter 172, 2017 Acts of Assembly)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 17

COMMONWEALTH OF VIRGINIA
RICHMOND
2017

House Bill 1728 of 2017

Workgroup Report

Virginia Department of Health
Office of Emergency Medical Services

Table of Contents

House Bill 1728 Language

In the 2017 session of the Virginia General Assembly, House Bill 1728 was submitted by Delegate Margaret Ransone. The language of House Bill 1728 is as follows:

"That the Department of Health (the Department) shall convene a work group composed of stakeholders, including representatives of law enforcement, emergency medical services providers, health insurance providers, and other interested stakeholders, to review the rules, regulations, and protocols governing use of air transportation services, also known as air ambulances, in emergency medical situations. The Department shall also review the rules, regulations, and protocols governing dispatch of air transportation services providers in response to emergency medical situations and develop recommendations for changes to such rules, regulations, and protocols that will address differences in procedures governing dispatch of air transportation services providers in emergency medical situations, differences in billing that may affect individuals involved in emergency medical situations during which air transportation services providers are dispatched for the provision of air transportation, and other issues related to the use of air transportation services in emergency medical situations. The Department shall report its findings and recommendations to the Governor and the General Assembly by December 1, 2017."

Dedication

The House Bill 1728 Workgroup humbly dedicates this report, as well as the efforts of the workgroup to produce its content, to the memory of Virginia State Police Lieutenant Henry Jay Cullen, III (1969-2017). Jay's dedication and contributions to the air medical system in Virginia, as well as his service to the citizens of the Commonwealth, will be remembered always.

Glossary of Terms and Acronyms

Note: In the context of this report, the terms "Air Ambulance," "Air Medical Services," and "Medevac" refer to the transportation of a sick or injured person in a rotary wing or fixed-wing aircraft or the aircraft itself.

ACA – Patient Protection and Affordable Care Act

Advisory Board – State EMS Advisory Board

ADA – Airline Deregulation Act of 1978

CAMTS – Commission on Accreditation of Medical Transport Systems

CMS – Centers for Medicare & Medicaid Services

DMAS – Virginia Department of Medical Assistance Services

EMS – Emergency Medical Services

EMTALA – Emergency Medical Treatment and Active Labor Act

ERISA – Employee Retirement Income Security Act

FAA – Federal Aviation Administration

FAR – Federal Aviation Regulation

GIS – Geographical Information System

HB1728 – Virginia House of Delegates Bill 1728

HMO – Healthcare Maintenance Organization

IRO – Independent Review Organization

MCO – Managed Care Organization

OEMS – Virginia Office of Emergency Medical Services

OLC – Virginia Office of Licensure and Certification

PPO – Preferred Provider Organization

PSAP – Public Safety Answering Point

VAHP – Virginia Association of Health Plans

VDH – Virginia Department of Health

VHHA – Virginia Hospital and Healthcare Association

VSP – Virginia State Police

Executive Summary

This report, provided by the House Bill 1728 (HB1728) work group, is the result of a thorough review of regulations, dispatch, and billing procedures that may affect individuals during situations where Medevac services are dispatched for the provision of emergent air medical transport. This is a complex issue rising from the challenges of several state and federal factors contributing to the issue of balance billing. These factors include: types of insurance, insurance carrier networks, Emergency Medical Treatment and Active Labor Act (EMTALA), Airline Deregulation Act (ADA), Centers for Medicare & Medicaid Services (CMS), and various other complex billing processes. There has been a national focus on provider reimbursement rates for air ambulance services, patient payment responsibility, prior authorization, and if health benefit contracts cover air ambulance services.

The work group report offers possible solutions, including the need for public education, transparency in billing practices, the use of new technology for dispatch, and continued expansion of training for healthcare providers. The report reviews the background on air medical services in Virginia, policy options, and the positions of stakeholders participating in the provision of air medical services. The report highlights recommendations from these stakeholders to include both consenting and divergent views.

Background

Over the course of 40 years, the Commonwealth of Virginia's air medical system has evolved to an integrated system, comprised of a mix of public and private providers. These providers have developed from different models including: municipal law enforcement programs, health systems (hospital based), or private corporations (community based). The number of aircraft and providers has increased over time to eventually cover the state of Virginia. As the industry evolves, these models have also evolved to hybrid structures, which may have health systems in partnership with a community-based operator.

The Virginia State Medevac Committee, a standing committee of the State EMS Advisory Board (Advisory Board), has been well established in coordinating air medical services and ensures regulatory, quality, safety, and general operations air medical services expertise is extended to the Virginia Office of Emergency Medical Services (OEMS). The OEMS coordinates with this committee to ensure that appropriate rules and regulations are in place for the provision of care in the EMS environment. While there is not one uniform sole provider across the Commonwealth, the provision of air medical services is a network of various providers usually based in a specific region(s) of Virginia.

Current Medevac System in Virginia

In 2016, there were 7,815 air medical transports in Virginia. Approximately 66% of those transports were interfacility flights, while the remaining flights were from a scene.[1] The Federal Aviation Administration (FAA) regulates Medevac flights within Virginia with Federal Aviation Regulations Part 91 and Part 135. Part 91 defines and regulates general aviation where Part 135 further regulates commercial aviation operations. Part 91 within the Federal Aviation Regulation (FAR) define operation of small non-commercial aircraft within the United States. For example, these regulations set forth Flight Rules (Subpart B) and Equipment, Instrument and Certificate Requirements (Subpart E).[2] Part 135 within FAR defines operations of commercial aircraft such as non-scheduled charter and air taxi operations within the United States. For example, these regulations set forth Aircraft and Equipment (Subpart C) and VFR/IFR Operating Limitation and Weather Requirements (Subpart B).[3] Pilot licensing regulations are defined in FAR Part 61. For example, these regulations set forth the requirements and privileges for a Commercial Pilots (Subpart F) and Airline Transport Pilots (Subpart F). All of the Medevac pilots in Virginia have either a Commercial or Airline Transport Pilot license.[4]

The Virginia State Police (VSP) and Fairfax County Police are the only two Medevac operation agencies within Virginia operating under Part 91. The United States Park Police and Maryland State Police represent public safety agencies based outside but provide service within Virginia. The remaining Medevac operations within the state are Part 135 commercial entities, five of which are based outside of Virginia.

A historical timeline of Air Medical Services in Virginia is included in this report as Appendix A. A map of the Medevac system in Virginia (with labels based on Regional EMS Council service areas) is included in this report as Appendix B.

The Airline Deregulation Act (ADA), enacted in 1978, is a federal law that deregulated the airline industry in the United States, removing U.S. Federal Government control over such things as fares, routes and market entry of new airlines, introducing a free market in the commercial airline industry and leading to a great increase in the number of flights, a decrease in fares, and an increase in the number of passengers and miles flown. The Civil Aeronautics Board's powers of regulation were phased out, but the Act did not diminish the regulatory powers of the FAA over all aspects of aviation safety.[5]

The ADA prohibits states from regulating the price, route or service of an air carrier for the purposes of keeping national commercial air travel competitive. Air carriers that provide air ambulance services operate under the rules and regulations of the ADA, and are not subject to state regulation of their price, route and service.

States have no jurisdiction over the federally-issued, certificate holder's right to operate an airline. The certificate is issued by the FAA, and it is therefore the responsibility of the FAA to regulate the operation, not the states that they operate from. This is the position that the federal courts have taken in related litigation.

Additionally, the OEMS does not have the authority to regulate routes or fees for air medical service. The OEMS does receive inquiries from the public related to air medical services billing practices, but has no regulatory authority to govern it. These inquiries are typically referred to the Virginia Department of Medical Assistance Services (DMAS), and/or the Virginia Department of Health, Office of Licensure and Certification (OLC). Typically, there are one to two public inquiries per year.

Since 1984, the OEMS has transferred funds to the VSP to supplement Med Flight operations, and as the Virginia General Assembly has approved increases in the "For Life"

funding, funds earmarked to VSP for Med Flight has also increased. Virginia Code § 32.1-111.3 (D) states "Whenever any state-owned aircraft, vehicle, or other form of conveyance is utilized under the provisions of this section, an appropriate amount not to exceed the actual costs of operation may be charged by the agency having administrative control of such aircraft, vehicle, or other form of conveyance." Currently, the VSP receives $3.1 million dollars annually from the OEMS specifically for Med-Flight operations. No other air medical services operator in Virginia receives direct operating funds from the OEMS.

The OEMS is the agent that grants the authority for an air medical service to provide medical service in Virginia, as well as inspects the equipment that service uses to provide care, the certifications and training records of providers, and EMS training and performance improvement records of the agency. The OEMS does not have the authority to inspect the mechanical capability of an air ambulance (rotor wing or fixed wing), nor the authority to inspect the licenses of pilots or flight mechanics. Additionally, the OEMS does not currently have the authority to regulate where Air Medical Service is to be provided. 12VAC5-31-420(C.) of the *Virginia EMS Regulations* states that "An ordinance or resolution from the governing body of each locality where an agency maintains an office, stations an EMS vehicle for response within a locality, or is a Designated Emergency Response Agency as required by Virginia Code § 15.2-955 confirming approval. This ordinance or resolution must specify the geographic boundaries of the agency's primary service area within the locality." This governmental approval process is often completed without question by local governmental officials.

Representatives of the air medical service stakeholders in Virginia participate in the regular meetings of the State Medevac Committee. The Advisory Board purpose is outlined in Virginia Code § 32.1-111.4:1.[6] The State Medevac Committee meets quarterly, and is charged

with providing expert guidance to the OEMS and the Advisory Board regarding appropriate standards and recommendations to promote a safe, high quality Medevac system for Virginia.

In the 2017 session of the Virginia General Assembly, House Bill 1728 was submitted by Delegate Margaret Ransone. The language of House Bill 1728 is as follows:

"That the Department of Health (the Department) shall convene a work group composed of stakeholders, including representatives of law enforcement, emergency medical services providers, health insurance providers, and other interested stakeholders, to review the rules, regulations, and protocols governing use of air transportation services, also known as air ambulances, in emergency medical situations. The Department shall also review the rules, regulations, and protocols governing dispatch of air transportation services providers in response to emergency medical situations and develop recommendations for changes to such rules, regulations, and protocols that will address differences in procedures governing dispatch of air transportation services providers in emergency medical situations, differences in billing that may affect individuals involved in emergency medical situations during which air transportation services providers are dispatched for the provision of air transportation, and other issues related to the use of air transportation services in emergency medical situations. The Department shall report its findings and recommendations to the Governor and the General Assembly by December 1, 2017."

Delegate Ransone introduced House Bill 1728 because of a constituent who was transported from Warsaw, Virginia to Richmond, Virginia due to a cerebrovascular accident (CVA), commonly known as a "stroke". The patient was later charged with a bill for service of over $35,000. Upon further research and discussions, Delegate Ransone's office found that the

constituent's situation was not unique. Legislation concerning this topic has been enacted in Montana and North Dakota, and introduced in other states.[7]

On March 2, 2017, the OEMS staff met with State Health Commissioner Marissa Levine, MD, MPH, and Chief Deputy Commissioner Hughes Melton, MD, MBA, FAAFP, FABAM, and were directed to contact specific agencies for their suggestions for representation, including the Virginia State Corporation Commission Bureau of Insurance, DMAS, OLC, and Virginia Hospital and Healthcare Association (VHHA), to request a representative. All of those agencies, and other related stakeholder agencies did provide a representative to the workgroup. Both Drs. Levine and Melton agreed and approved the representation for the HB1728 workgroup as follows:

HB1728 Workgroup Representatives:

- Law Enforcement:
  - Lieutenant. H. Jay Cullen - Unit Commander – VSP Aviation
- EMS Providers:
  - Deputy Chief Eddie Ferguson - Goochland County Department of Fire-Rescue & Emergency Services, Past President – Virginia Association of Governmental EMS Administrators
  - Derrick S. Ruble – Director of 911 & Emergency Communications, Tazewell County, Virginia
- Health Insurance:
  - Jim Young, Insurance Policy Advisor – Virginia State Corporation Commission, Bureau of Insurance - Policy, Compliance and Administration Division
  - Bill Zieser, Transportation Unit Supervisor - Virginia DMAS

  - Kyle Shreve, Director of Policy - Virginia Association of Health Plans (VAHP)
- Medevac Committee:
  - Anita Perry – Virginia State Medevac Committee Chair
  - Julia Marsden – Virginia State Medevac Committee Vice Chair (Workgroup Facilitator)
  - George Lindbeck, MD, FACEP, FAEMS - Virginia State EMS and Trauma Systems Medical Director
- Interested Stakeholders:
  - Rob Hamilton, President, Med-Trans Air Medical Transport (representing air medical operators)
  - Paul Davenport, Vice President – Emergency Services, Carilion Clinic (representing VHHA)
  - Paul Sharpe, Director of Trauma Services, Henrico Doctors' Hospital (representing VHHA)
  - Ed Rhodes – Rhodes Consulting Group (Recommended by Delegate Ransone)
- Virginia Department of Health (VDH)
  - T.C. Jones, Managed Care Health Insurance Plan Unit Supervisor, VDH Office of Licensure and Certification
  - Tim Perkins, VDH OEMS EMS Systems Planner served as staff support to the committee.

Objectives

The workgroup was charged with the following tasks:

- Review the rules, regulations and protocols governing use of air transportation services, also known as air ambulances, in emergency medical situations.
- Review the rules, regulations, and protocols governing dispatch of air transportation services providers in response to emergency medical situations.
- Develop recommendations for change to such rules, regulations, and protocols that will address differences in procedures governing dispatch of air transportation services providers in emergency medical situations, differences in billing that may affect individuals involved in emergency medical situations during which air transportation services providers are dispatched for the provision of air transportation, and other issues related to the use of air transportation services in emergency medical situations.

The workgroup served as an advisory body of subject matter experts to inform and advise the VDH as to potential findings and recommendations to be reported to the Governor and the General Assembly. The State Health Commissioner requested a draft of the final report be submitted to the Office of the Commissioner no later than October 15, 2017.

Prior to the initial meeting, as well as during the timeframe that the workgroup was active, workgroup members were provided numerous current and historical documents, articles, and other related materials for review to provide information and background. A listing of all reference documents provided to workgroup members can be found at http://www.vdh.virginia.gov/emergency-medical-services/other-ems-programs-and-links/Medevac-system/house-bill-1728-workgroup/.

Process

Seven meetings were conducted in the Richmond area between April 24 and October 4, 2017. The minutes for all of the meetings of the HB1728 workgroup can be found at http://www.vdh.virginia.gov/emergency-medical-services/other-ems-programs-and-links/Medevac-system/house-bill-1728-workgroup/.

The initial meeting focused on ensuring that workgroup representatives were familiar with the language of the House Bill itself, the charge of the workgroup, as well as ensuring they were familiar with the history of the Medevac system in Virginia, the current available Medevac resources, and the Airline Deregulation Act of 1978.

Subsequent meetings were conducted in a manner where workgroup members were split into three smaller workgroups: focusing on Medevac regulations, Medevac dispatch, and the billing aspect of Medevac service, respectively. Each subgroup reviewed their respective policies and/or procedures, and discussed ways in which these aspects could be changed, and perhaps improved. Some overlap between the topics became evident during the discussions.

Discussion

Medevac Regulations

The VDH provides regulations for the provision of emergency medical services within the Commonwealth. Regulations regarding Virginia Medevac services can be found beginning in section 12VAC5-31-870. Air medical public service agencies must meet or exceed FAR, 14 CFR Part 91, and commercial operators must meet or exceed 14 CFR Part 135. These regulations also include such aspects as application for licensure, operations and safety, air medical services personnel classifications, training and equipment.

The sections of the EMS Regulations pertaining to Medevac were reviewed and revised by the State Medevac Committee in July of 2016.[8] Much discussion related to Medevac regulations involved the creation and maintenance of a resource that describes air medical services providers that are based in, or operate inside, the Commonwealth of Virginia. The resource would include items such as, but not limited to, base locations, operational considerations and information regarding billing practices for increased transparency to the community. This document would be available to providers, particularly those requiring inter-facility transport.

A substantial amount of work has been completed, and will continue within the Virginia State Medevac Committee, relative to educational resources for providers and dispatch centers regarding both pre-hospital and inter-facility Medevac service operations and safety. The OEMS currently has resources available to the public. The subgroup also provided the suggestion of adding a representative of the Communications Committee of the Advisory Board to the Medevac Committee of the Advisory Board for further process improvement and an expansion of statewide collaboration.

The Regulations subgroup also met with the Medevac Committee during a meeting held on August 3, 2017 to discuss the recommendations that will be forthcoming, and the Committee were in agreement. In addition, the State EMS Medical Director has put forth the suggestion that a resource, or resources, be developed to educate hospital staff involved in requesting/arranging air medical inter-facility patient transfers. This suggestion is to develop materials that should include, but not be limited to, identification of local/regional inter-facility transfer resources and their capabilities, including ground and air medical resources, and the appropriate use of interfacility transport modalities. The opportunity for real-time consultation in planning transfers

should be considered as well. Inter-facility transfers should be reviewed to identify opportunities for improved utilization of appropriate resources. This is intended to be a joint effort between the State Medical Direction Committee and the State Medevac Committee to ensure that hospital personnel are educated in the appropriate use of emergency medical services inter-facility transport modalities. The VHHA is not in consensus with this suggestion.

Medevac Dispatch

The transport of patients from the scene, including the decision for air medical service, is based on criteria for air medical transport contained in the State Trauma Triage Plan. No single dispatch policy is used by dispatch centers across the Commonwealth due to the diversity of resources and needs at the local level.

A local EMS crew typically initiates a request for air medical services to the scene. This can be during the response to the scene or shortly upon arrival and contact with the patient. The EMS crew will advise their dispatch center of the need for air medical services and provide basic information on the patient such as mechanism of injury, condition, age, and vitals. The EMS crew will also provide the location of the landing zone to be utilized by air medical services.

Following local procedures, the dispatch center will contact the Medevac dispatcher for the air medical service and relay the information provided by the EMS crew. The Medevac dispatcher will then follow their protocols for accepting or denying the request. Should the request be denied, because for example the Medevac crew is unavailable or due to weather conditions that would prohibit safe flight, the dispatch center will then follow local procedures to contact the next available air medical service. Should the request be accepted, the Medevac dispatcher provides information such as estimated flight time to the landing zone if available.

Upon confirmation of the Medevac response, the dispatch center will notify the EMS crew and dispatch additional resources as needed such as fire department and law enforcement to establish the landing zone and assist the EMS crew. The EMS crew, dispatch center, Medevac dispatcher, and flight crew once in radio range, will relay any necessary updates to each other. Once the helicopter is within radio communication and/or visual range of the landing zone, the on-scene responders take over primary radio communications with the helicopter during the approach, landing, and departure phases.

The subgroup members were in agreement that dispatch across the state is adequate, by and large, to ensure that the closest resource is dispatched in a reasonable amount of time. The subgroup acknowledged that there have been prior discussions related to centralized Medevac dispatch, but the subgroup determined that centralized Medevac dispatch would add an extra step in the process of Medevac dispatch, which is often time critical. The subgroup also determined that much of the issue that generated HB1728 was related to differences in services provided and billing practices, and not related to the actual dispatch of Medevac services. The subgroup was clear that any changes to Medevac billing practices or regulations should not add burden to dispatch centers and emergency field providers in requesting, accessing, and receiving critical time sensitive services from air medical providers. Finally, the subgroup discussed the possibility of implementation of a Geographical Information System (GIS) layer for dispatch centers that would provide information on the closest resource based on a specific location.

Medevac Billing

HB 1728 directs the work group to review differences in billing that may affect individuals involved in emergency medical situations during which air transportation services

providers are dispatched for the provision of air transportation, and other issues related to the use of air transportation services in emergency medical situations.

Air Ambulance Billing Issues for the Enrollee

There has been growing attention focused on excessive out-of-pocket costs incurred by patients for air ambulance services resulting from balanced bills assessed by out-of-network air ambulance providers and limited carrier and health plan reimbursements for those services, which have sparked legislative efforts in states such as Maryland, Montana, West Virginia, and North Dakota. These costs to the consumer can be substantial. A survey conducted by the North Dakota Insurance Commission during a recent debate found that the average balance bill complaint for a consumer was $23,250, and a survey in Montana showed an average of $53,397.[9] The Virginia Bureau of Insurance reports that the average balance bill complaint for the period 2015-2017 was $27,438 for fully-insured plans.

According a report by Xcenda, ten percent of flights nationally are self-pay by the patient.[10] Self-pay cases do not have any form of insurance and the patient is responsible for payment of their own bills. These patients are often unable to pay and cost of these services are built into the commercial rates of the air ambulance providers.

Medicare and Medicaid make up nearly 60 percent of flights nationally, and do not allow for balance billing by participating providers under applicable law. Any provider accepting Medicare and Medicaid must accept the rate as payment in full for the enrollee. Medicare established the current air medical service payment methodology in 2002 based on an estimated 1998 cost pool and since its inception, Medicare has increased the payment rates solely by an inflationary factor and has not revalued the payment system to reflect significant market changes.[11]

The position of the air medical industry is that the Medicare methodology was calculated without regard to the cost of providing the service, uncompensated care costs of treating uninsured and underinsured patients, inadequate payment from third party payers, the type of air transport used, or a locality-based geographic adjustment factor. Health plans negotiate commercial rates based on the Medicare rate and their market contracts in the region. Carriers have an obligation to keep health care costs low for their members. The in-network negotiated rates are solely negotiated by the carrier for their commercial members and are agreed to by providers in the network. The Medicare based rotary wing (helicopter) rate in 2017 for Virginia from the federal Centers for Medicare and Medicaid Services (CMS) is $3,480.84 with a mileage rate of $22.84 in urban areas and $5,221.25 in rural areas with a mileage rate of $34.26 per mile.[12] Medicaid fee-for-service pays a rate adopted by DMAS. Medicaid Managed Care Organizations (MCOs) negotiate rates with in-network service providers. Out-of-network providers not participating with the Medicaid MCO may bill for the full amount.

For the commercially insured, the type of health benefit plan a patient has will determine the reimbursement rate for air ambulance services, the patient payment responsibility, the responsibility for gaining authorization, and whether the service is a covered benefit. A plan is fully-insured in Virginia when all benefits are guaranteed under a contract of insurance that transfers that risk to a health carrier regulated by the State Corporation Commission Bureau of Insurance. There are fully insured plans in both the individual and small group markets. Employer-sponsored group health benefit plans may be self-insured or fully-insured. A plan is self-insured (or self-funded) when the employer assumes the financial risk for providing health care benefits to its employees. The Employee Retirement Income Security Act (ERISA) of 1974 preempts states from regulating self-funded employer plans. There are also differences between

a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and a Point-of-Service (POS) as to the patient payment responsibilities, and the ability to obtain authorization for services. Consumer education is needed so that the patients understand their responsibilities when it comes to air ambulance services, their insurance benefit for air transport, as well as other medical services they may receive.

For fully insured plans subject to the Patient Protection and Affordable Care Act (ACA), emergency transportation by ambulance is covered as an Essential Health Benefit in Virginia as follows:

"- From the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when the health plan requires you to move from an Out-of-Network Hospital to an In-Network Hospital
- Between a Hospital and an approved Facility."[13]

Like many other covered services, ambulance services (including air ambulances) are subject to medical necessity reviews by the health plan to determine whether the services are needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and meets accepted standards of medicine. If an in-network air ambulance provider is used and the plan is an HMO, the consumer might be held harmless from any balance billing. If an out-of-network air ambulance provider is used, the air ambulance provider may bill the patient for any charges that exceed the Plan's Maximum Allowed Amount. If the service is determined to be not medically necessary by the health plan, whether in-network or out-of-network, the enrollee may be responsible for paying the full amount of charges.[14]

The air medical providers argue that one of the additional barriers for in-network discussion has been the medical necessity denials for emergent patients and the perception of

delays in reimbursement due to "process" issues with the carriers. There needs to be an improved process developed that assures both parties have timely submission of information and prompt payment.

If a claim is denied, or the fully insured patient believes the health carrier has not paid the correct amount, the fully insured patient has the option to appeal the decision. The fully insured patient must first appeal to the health plan carrier for review. The health carrier's Medical Director may participate in the review of the case for a determination. If the fully insured patient is not satisfied with the health carrier's (final) adverse determination where services are denied for being either "not medically necessary" or "experimental/investigational", the fully insured patient may file an External Review with the Bureau of Insurance. The Bureau assigns eligible External Reviews to an Independent Review Organization (IRO), which assigns a peer physician to review the denial and make a determination to uphold or overturn the denial. The outcome of the IRO review is binding on the carrier.

For a self-insured entity, the ultimate responsibility for payment lies with the plan sponsor, typically an employer. The latest employer-sponsored benefit report shows that in 2015, nearly 60 percent of workers employed are in self-insured (employer sponsored) plans.[15] These plans typically contract with commercial carriers to act as third party administrators to manage the benefit and use their provider networks. The third party administrator follows the plan document for determining the services the employer has agreed to cover. Any appeal is typically mediated by the employer's Human Resources Manager. However, if the employer uses the third party administrator's network, its employees would be subject to the same balance billing terms as those applicable to a fully-insured individual.

While ambulance services, including air transport, are covered services for fully-insured plans and are typically covered services for self-insured plans, medical necessity determinations and in-network versus out-of-network status can affect payment for services. Health carriers contract for an in-network rate with a provider to ensure payment certainty, the elimination of balanced billing to their members, and to provide their members with a network of qualified providers. When health carriers do not have a contract with a provider, they pay an out-of-network rate and the provider may bill the patient for the remainder of the bill (balanced billing). In air ambulance circumstances, the balance of the bill can be a substantial sum, based on the carrier's determination of fair and reasonable rates, regional differences in reimbursement, and availability of services, that many consumers cannot afford.

Virginia air ambulance providers report that historically there are some reasons that providers do not contract with some health carriers. Payment issues can have a significant impact on an air ambulance provider's decision to contract with a commercial carrier to become an in-network provider or remain out-of-network. Commercial carriers have a set allowed amount at which they begin negotiations with an air ambulance provider for an in-network rate. Commercial carriers often use the Medicare reimbursement rate as a reference base price and then add to it based on region and carrier. The carriers start negotiation with the stated Medicare rate as well as their average. In the instances in which a provider declines to accept the payment rate established by the commercial carrier, the provider often claims that the rate is insufficient to cover operating costs and that a higher payment rate is necessary to help offset uncompensated care costs of treating uninsured and underinsured patients, and low payments resulting from providing services to Medicare and Medicaid patients.

In Virginia, almost all air ambulance providers have an in-network agreement with almost every carrier in the region in which they operate. However, in some areas of the Commonwealth, air ambulance providers and carriers cannot reach agreement to contract and become an in-network provider. It is in the carrier's and enrollee's economic interest to have an inclusive network and the payment certainty of in-network contracted rates. As discussed above, in-network billing benefits the patient because the in-network payment must be accepted as payment in full and the provider may not balance bill the patient.

These factors are addressed in the Xcenda report on air ambulance industry costs, which has been accepted by the Congressional Budget Office.[16]

1) insufficient payments by Medicare (e.g., for 2015, Medicare paid on average 59% of industry cost),
2) insufficient payments by commercial health carriers who often base their payments on Medicare's reimbursement amount, and
3) the resulting payment is unsustainable from the industry's point of view, especially in light of uncompensated care costs of treating uninsured and underinsured patients.

State legislatures attempting to address problems with balance billing may have limited options due to applicable federal laws. The Airline Deregulation Act of 1978 (ADA) preempts the states' ability to enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route or services of an air carrier.[17] Accordingly, this law may preclude states seeking to protect patients from large out-of-pocket costs resulting from out-of-network provider billing through the establishment of a statewide fee schedule or methodology for determining payment rates. This may explain why only a few states have attempted to pass

legislation to resolve out-of-network billing issues for air ambulance services or give patients a better understanding of their options.

The Emergency Medical Treatment and Active Labor Act (EMTALA), known as the patient "anti-dumping law," places limitations on the states' ability to address billing and payment issues related to air ambulance services. EMTALA requires hospitals to provide a medical screening examination to determine if an emergency medical condition exists, and if one does exist, provide stabilizing treatment within the capabilities of the hospital. If the hospital does not have the capability or capacity to provide stabilizing treatment, an appropriate transfer is required.[18] EMTALA prohibits medical screening and stabilizing treatment from being delayed in order to inquire about the patient's method of payment or insurance status.[19] There are limited circumstances where a hospital may inquire about insurance information or payment obligations. For example, if the patient initiates an inquiry about the obligation to pay for emergency services, the hospital may respond with specific financial information, so long as, the hospital continues to offer, and conversations do not delay, a medical screening examination for an emergency medical condition, and if one exists, stabilizing treatment. Further, the hospital is expected to make at least a minimal effort to defer such discussions.[20]

A hospital's obligations under EMTALA continue through transfer of the patient. A patient that can withstand the risk of transfer does not mean that the patient is stabilized and that the hospital's obligation has ended. The term "stable for transfer" is not a term used in EMTALA, and is not equivalent to the term "stabilized" for EMTALA purposes.[21] The term "appropriate transfer" assumes that the patient has an emergency medical condition that has not been stabilized, that the hospital lacks the capability or capacity to provide stabilizing treatment, and the benefits of transfer outweigh the increased risks. Accordingly, the patient remains

protected under EMTALA before, during and after the transfer and it would be impermissible to inquire about the patient's method of payment or insurance status.[22]

Hospitals are prohibited by EMTALA from seeking a prior authorization for services from a carrier or managed care plan until after a medical screening examination has been provided and necessary stabilizing treatment is underway (which as discussed above may not commence until after the transfer is complete where not within the capabilities of the hospital).[23] Other federal laws prohibit fully insured plans subject to the ACA and Medicare and Medicaid MCOs from requiring prior authorization of emergency services, even if the services are provided on an out-of-network basis.[24]

Hospital Transport Process

When the need arises to emergently transfer a patient with a time sensitive illness or injury from one hospital to another, there are key areas that need to be considered. Presumably the patient is in need of specialized care that cannot be provided at the transferring hospital. The key areas to be considered are that there is a medical necessity for the transfer, the consent of a patient during a non-emergency and stable situation or implied consent if an emergency and unstable situation, and the receiving hospital provides the needed service and will accept the patient. Finally, an appropriate mode of transport must be determined; basic life support ambulance, advanced life support ambulance, ground critical care transport ambulance, or air medical services.

The sending physician at the transferring hospital is responsible for the transfer of the patient. The transferring hospital will contact the receiving hospital and make it aware of the need to transfer the patient. The receiving hospital will ensure the specialty service is available, it has a bed available for the patient, and a physician willing to admit the patient. The

transferring physician is responsible for determining the mode of transportation to be used. In some cases, the receiving hospital will provide suggestions to the transferring hospital about the best way to stabilize the patient for transfer and will suggest the most appropriate mode of transportation. If it is determined that air medical services are required, the transferring hospital may ask the receiving hospital to assist with finding an air ambulance provider or it will call the closest air medical services base to its hospital to provide the service.

State Policy Options

Three states (Montana, North Dakota, and West Virginia) facing similar challenges with air ambulance services have considered legislative solutions. Some have chosen more direct routes to address balance billing practices, while others have focused on some of the more systemic problems with insufficient payments for air ambulance services within the state.

Balance Billing Prohibitions

Montana, North Dakota, and West Virginia have enacted specific legislation attempting to address problems with balance billing by out-of-network air ambulance providers. Similar legislation was proposed in Maryland, but it did not pass.

Montana

Montana SB 44, signed into law April 25, 2017, holds patients harmless from balance billing by air ambulance providers and creates a dispute resolution process for air ambulance providers and carriers to agree to fair market prices for air ambulance services. Fair market prices are required to take into consideration factors such as whether the service was provided in a rural or urban area, what the applicable Medicare payment for the service is, and any fees incurred while operating the aircraft.[25]

The legislation was specifically designed to prevent patients from incurring excessive out-of-pocket costs for air ambulance services in a manner that is not preempted by the ADA. A framework within the dispute resolution process allows air ambulance providers and carriers to agree to fair market prices as determined by an independent reviewer as opposed to having them established directly by the state, which according to the air ambulance industry, could be pre-empted by the ADA. This could also create an incentive for air ambulance providers and carriers to more proactively engage in contract discussions to become in-network as opposed to relying upon an independent reviewer, which could further reduce instances of balance billing going forward.

The legislation also expressly addresses EMTALA concerns by establishing that the hold harmless provision applies to situations where the enrollee receives air ambulance services for an "emergency medical condition." The definition included in the statute matches the definition of emergency medical condition in EMTALA.[26] Since the patient is held harmless, it is not necessary to discuss insurance information or payment obligations or risk discouraging decision-making based solely upon financial implications in violation of EMTALA.

VAHP supports removing the patient from the process, however, the Montana legislation still seems to set a rate for the service. The legislation calls for an "independent review" if one of the parties requests a hearing. However, this appointed independent reviewer has the power to "determine the fair market value" of each individual transport. This still equates to the state setting the rate for each transport and would seem to violate the federal law.

VHHA prefers the hold harmless and independent dispute resolution approach taken in the law. Such an approach has the effect of protecting the patient from financial hardship while at the same time encouraging good faith negotiation of payment rates between insurers and air

ambulance providers. The law also expressly addresses EMTALA concerns present in a majority of transfer cases where air ambulance services are required. The air ambulance industry is a proponent of holding the patient harmless and looks favorably on the Montana legislation.

North Dakota

North Dakota has recently passed SB 2231 requiring that in non-emergency situations, prior to referring a patient to an air ambulance provider, hospitals must provide enrollees with a list published by the state insurance department of which air ambulance providers are in and out of network.[27] This is intended to give the patient more information to make an informed decision on choosing an air ambulance services provider or form of transportation and, when possible, the patient may request, and the hospital may arrange for, an in-network transport. Hospitals are expressly exempt from this requirement if the hospital determines that due to emergency circumstances, compliance might jeopardize the health or safety of the patient. Similar to the Montana law, this appears to address EMTALA concerns, although not in as direct a manner as the Montana statute that contains an identical definition of emergency medical condition used in the federal law.

The law calls for a health benefit plan's reimbursement for out-of-network services to be equal to the average of the carrier's in-network rates for air ambulance services. Additionally, for the purposes of settling a claim made by the enrollee, a payment made by a carrier of the average of its in-network rate is deemed to be the same as an in-network payment and is considered a full and final payment by the enrollee for out-of-network air ambulance services billed to the enrollee.

VAHP supports the patient protections in the North Dakota legislation. By supplying a list of in network providers to the hospital or locality, the opportunity would exist for the patient

to have an understanding of the financial risk involved in the transport. It would also inform the agent responsible for arranging the transport to take the network status into account when arranging for a transport. In addition, using the average of in-network rates holds the patient harmless, without the Commonwealth setting the fair market rate. The legislation calls for an independent review to ensure that the correct payment is made, however, the use of the individual plan's in network rate allows the market to determine the fair market rate.

VHHA has several concerns with the North Dakota law. Instead of simply holding the patient harmless, the law establishes payment rates at the health plan average. Such a methodology bears little or no relationship to the air ambulance provider's costs or the value of services and does not take into account market variations. VHHA does however, support the creation of a published list of air ambulance provider network status for provider and patient education and awareness. Further, the North Dakota law does not expressly address EMTALA concerns in Section 1 "Air ambulances – Informed Decisions – Publication" or in Section 7 "Preferred provider arrangements – Requirements for accessing air ambulance providers."

The air industry position is that the North Dakota law does not expressly address EMTALA, and may violate the ADA.

West Virginia

The 2016 West Virginia Legislature passed HB 4315, which provides that for the state employees insurance plan, an out-of-network air ambulance provider may not collect from the plan and the covered employee a combined amount which exceeds the Medicare reimbursement amount, including any applicable Geographic Practice Cost Index.[28]

The 2017 West Virginia Legislature introduced similar legislation, SB 276, which extends balance billing prohibitions to other types of insurance regulated by the state, including

accident and sickness insurance and health maintenance organizations.[29] The legislation specifies that the out-of-network air ambulance provider must bill the carrier before submitting any bill to the enrollee and may not collect from the enrollee an amount which exceeds the Medicare reimbursement amount, including any applicable Geographic Practice Cost Index. The legislation permits, however, the air ambulance provider to seek additional amounts from the carrier. The net effect of this is to protect and hold harmless the enrollee from unreasonably high out-of-pocket costs.

The legislation does not implicate EMTALA since it does not impose any obligation upon health care providers to inquire about the insurance status of patients or ability to pay. The legislation solely addresses billing and payment aspects of out-of-network air ambulance services.

VAHP supports using the Medicare rate as the "fair market value", however, it is likely that the West Virginia legislation violates the law by setting the rate at the state level. VHHA favors the hold harmless approach taken in the law, however, establishing the Medicare reimbursement amount as the base rate is arbitrary in the commercial insurance context and does not take into account the air ambulance provider's costs, the value of services or market variations. VHHA also favors the approach taken to circumventing any EMTALA implications. An air ambulance company has filed a federal lawsuit over this legislation, as they believe this violates the ADA.

Maryland

The 2016 Maryland General Assembly considered legislation that would have certain carriers and health maintenance organizations that provide benefits for air ambulance services to ensure that its provider panel includes a sufficient number of providers of air ambulance

transport services to meet the health care needs of its insureds and enrollees and that if an insured or enrollee is balance billed by an air ambulance transport services provider that is not on a carrier's provider panel, the carrier must hold the enrollee or enrollee harmless for the amount of the balance bill.[30] This bill took a "hold harmless" approach similar to that taken in the West Virginia legislation. The legislation did not pass, failing to receive a favorable report from the House Health and Government Operations Committee. VHHA favors the hold harmless approach taken in the law. Similar to the West Virginia statute, it is crafted in a manner that circumvents any EMTALA implications.

Balance Billing Law - General Discussion

As a general matter, VHHA does not believe that creation of a statute to prohibit balance billing is necessary to address the underlying problem with out-of-network air ambulance billing. The out-of-network balance billing issue would be better resolved by addressing market shortfalls and encouraging providers and health plans to enter into good faith negotiations to adequately address the access needs in Virginia. To the extent that the legislature determines that a legislative solution is needed, VHHA believes that hold harmless provisions that protect patients instead of regulating market prices are the most appropriate measure available. Patients should not be put in the position of disputing payment amounts for services covered by their insurance and this is a matter best addressed through private arrangements between providers and the health plans. Additionally, VHHA believes that any legislation should expressly address EMTALA concerns to ensure that patients are protected and providers are not put in a position of non-compliance with applicable federal laws.

It is VAHP's position that in circumstances in which the patient has capacity to participate in decision making and being transferred from one hospital to another, the patient

should be notified on the network status of the air ambulance provider. A provision is included in the North Dakota legislation providing an exemption for emergency medical conditions, as defined in EMTALA.

Air Ambulance Funds

Other states have addressed concerns regarding the financial implications of air ambulance services by establishing state funds to assist in payment for use of air ambulance services in an emergency. California's Emergency Medical Air Transportation Act (EMATA), imposes an additional penalty on certain convictions for an offense involving a vehicle violation. Each county board of supervisors is required to establish in the county treasury an emergency medical air transportation act fund into which the penalty collected is deposited, which are then deposited into the statewide Emergency Medical Air Transportation Act Fund. Monies in the Emergency Medical Air Transportation Act Fund are available through appropriation for the purposes of offsetting the state portion of the Medi-Cal (Medicaid) reimbursement rate for emergency medical air transportation services and augmenting emergency medical air transportation reimbursement payments made through the Medi-Cal program.[31] It is the position of the air ambulance industry that because of the federal matching funds of this program, California also gets a positive budget result of having the EMATA in place.

Legislatures in other states have undertaken similar efforts; however, legislation has not passed. Florida considered, but ultimately did not pass, SB 1234 to establish the Emergency Medical Air Transportation Act Account within the Emergency Medical Services Trust Fund; providing conditions for the department to increase Florida Medicaid reimbursement payments to emergency medical air transportation services providers through an additional penalty to be imposed for certain moving violations.[32] Illinois General Assembly also considered, but did not

pass, SB 3342 to create the Emergency Medical Air Transportation Act Fund to (i) offset the State portion of the Medicaid reimbursement rate for emergency medical air transportation services; (ii) augment emergency medical air transportation reimbursement payments made through the Medicaid program; and (iii) pay administrative costs associated with administering the Act.[33] VHHA supports the approaches taken under California and Florida law, as well as the efforts to establish a pool of funds to supplement air ambulance reimbursement.

VAHP Policy Suggestions Related to Medevac Billing:

1. Pass legislation including the tenets of the North Dakota legislation including:
    a. Patient notification of the network status of the air ambulance provider when possible.
    b. When there is a dispute with an out-of-network provider, the carrier shall pay the average of its in-network rates and the provider shall accept this as full and fair payment.
2. Explore the viability, including funding options, of a statewide Emergency Medical Air Ambulance Transport Fund to subsidize the cost of air ambulance services.
3. Carriers should provide a list of network participation for distribution to hospitals, localities and patients to better inform and educate provider decisions.

VHHA and Air Operator Policy Suggestions Related to Medevac Billing:

1. Develop and adopt a statewide list of air ambulance providers and health plan and carrier participation status.
2. Statewide effort by health plans and carriers to educate enrollees about their options for air ambulance services and the financial implications of receiving services from out-of-network air ambulance providers.

3. Statewide effort by health care providers to educate patients about options for in-network referrals to air ambulance providers in non-emergency situations.
4. Develop a statewide Emergency Medical Air Ambulance Transport Fund to subsidize current Medicaid payment rates for air ambulance services.
5. Virginia Legislature should support Congressional House Resolution 3378.[34]

Recommendations from the House Bill 1728 Workgroup

The following items come to the Governor and Virginia General Assembly as recommendations as directed in the language of House Bill 1728. In addition, if any action has been taken based on these recommendations, that information is included. Note that there are some recommendations in one area that may also be applicable to others (ex. Regulation recommendation applies to Dispatch as well.)

Medevac Regulations Recommendations:

Recommendation 1: The development of training criteria for EMS field personnel and telecommunications personnel regarding the use of Medevac services should be assigned to the State Medevac Committee, State Medical Direction Committee, and the State Communications Committee.

This is intended to be a joint effort between the State Medevac Committee, the Medical Direction Committee and the State Communications Committee to ensure EMS field personnel, hospital personnel and telecommunicators have standard training in the proper use of Medevac services in Virginia to address any disparities that may exist.

Status: This is an agenda item for the next meeting of all committees. Documents related to the use of Medevac exist, and are in the process of being updated.

Recommendation 2: The State Communications Committee should review the feasibility of an additional statewide mutual aid radio frequencies for ground to air communications, to include costs.

This recommendation is to ensure consistent clear communications between ground units and dispatch centers and Medevac aircraft.

Status: This recommendation is being addressed in the new proposed EMS regulations and is being evaluated by the State Rules and Regulations Committee of the Advisory Board. The draft language is as follows:

12VAC5-32-725. EMS vehicle communications.

12. Air ambulances shall have immediate push-to-talk fixed or cross-patched communications equipment under the supervision of an agency dispatch center or governmental PSAP that provides direct two-way voice communications between the air-ambulance, other EMS vehicles in its primary response area and public safety vehicles or personnel at landing zones.

Recommendation 3: The State Medevac Committee should be assigned to determine how public education on air medical transport (to include costs) shall be deployed.

This recommendation is to ensure that the patient receiving Medevac service is educated in what agencies exist, the services they provide, and any costs that the patient may incur related to those services.

Status: This recommendation is being addressed by a newly created workgroup of the State Medevac Committee. The goal is to provide information to patients, as well as the general public on all aspects of Medevac services, including related costs.

Recommendation 4: A representative of the State Communications Committee should be added to the State Medevac Committee.

This recommendation is to ensure that communications is a consistent topic of discussion at all future meetings of the State Medevac Committee.

Status: At the August 4, 2017 meeting of the State Communications Committee, Melissa Wood from the City of Fredericksburg 911 Center was named the representative to the State Medevac Committee, with immediate effect.

Medevac Dispatch Recommendations:

Recommendation 1: A geographic information system (GIS) online resource map should be developed and maintained.

This recommendation is to develop and maintain a GIS layer to be used by dispatch centers to determine the closest resource for any location in Virginia where Medevac service is requested. It would also display the next 2-3 closest bases, in the event that the first aircraft is unavailable. This is intended to be a downloadable application or database that can be integrated into existing dispatch mapping systems.

Status: This recommendation is still in the discussion phase, and should be tasked to the State Communications Committee.

Medevac Billing Recommendations:

Based upon information available to the Work Group, including a review of state policy decisions observed in other states, the Work Group came to a consensus on the following policy recommendations:

Recommendation 1: A statewide legislative Air Medical Caucus should be developed, to be comprised of subject matter experts and legislators.

The caucus can inform legislators on:

1. In-network vs. out-of-network providers or participating vs. non-participating providers

2. The difference between health insurance contracts with providers and hospital contracts with providers
3. How air ambulance reimbursement rates are determined
4. Provide information on how the constituent can appeal a denied health insurance claim

Recommendation 2: Continue use of the Virginia State Medevac Committee to review current policies/procedures and address any issues related to quality improvement and safety standards and to determine how public education on air medical transports (including costs) shall be deployed by the OEMS.

References

[1] Data obtained from the Virginia Pre-Hospital Information Bridge (VPHIB).

[2] https://www.ecfr.gov/cgi-bin/text-idx?node=14:2.0.1.3.10.

[3] https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title14/14cfr135_main_02.tpl.

[4] https://www.ecfr.gov/cgi-bin/retrieveECFR?gp&r=PART&n=14y2.0.1.1.2.

[5] https://www.gpo.gov/fdsys/pkg/STATUTE-92/pdf/STATUTE-92-Pg1705.pdf.

[6] https://law.lis.virginia.gov/vacode/title32.1/chapter4/section32.1-111.4:1/.

[7] Delegate Ransone email to Tim Perkins – April 5, 2017.

[8] Regulatory Review Process: http://www.vdh.virginia.gov/content/uploads/sites/23/2016/05/RegReview.pdf

[9] Xcenda, Air Medical Services Cost Study Report, prepared for The Association of Air Medical Services Members (March 24, 2017). http://www.xcenda.com/Documents/Air%20Medical%20Services%20Cost%20Study%20Report_2017-03-24_FINAL.pdf.

[10] Xcenda, Air Medical Services Cost Study Report, prepared for The Association of Air Medical Services Members (March 24, 2017).

[11] Consumers Union. "Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation". Pg. 5. March 2017.

[12] Xcenda, Air Medical Services Cost Study Report, prepared for The Association of Air Medical Services Members (March 24, 2017).

[13] Centers for Medicare and Medicaid Services. "Ambulance Fee Schedule and Public Use Files, CY 2017". https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf.html.

[14] Centers for Medicare and Medicaid Services. 2017 Virginia Benchmark Plan. https://www.cms.gov/cciio/resources/data-resources/ehb.html.

[15] Under federal law, determinations about medical necessity for any services provided pursuant to the Emergency Medical Treatment and Active Labor Act (EMTALA) are based upon the information available to the treating physician at the time the item or service was ordered or provided. The determination cannot be based on the patient's principal diagnosis, or on the frequency with which the item or service was provided to the patient before or after the time of the admission or visit. See 42 C.F.R. § 412.60(c)(1), 412.513(b)(1).

[16] https://www.gao.gov/products/GAO-17-637

[17] Employee Benefit Research Institute. "Self-Enrollee Health Plans: Recent Trends by Firm Size, 1996-2015". July 2016. https://www.ebri.org/pdf/notespdf/EBRI_Notes_07-no7-July16.Self-Ins.pdf.

[18] Xcenda, Air Medical Services Cost Study Report, prepared for The Association of Air Medical Services Members (March 24, 2017). http://www.xcenda.com/Documents/Air%20Medical%20Services%20Cost%20Study%20Report_2017-03-24_FINAL.pdf.

[19] 49 U.S.C. §41713(b). The Supreme Court of the United States considered the scope of the Airline Deregulation Act in Morales v. TransWorld Airlines, Inc., 504 U.S. 374 (1992). The Court explained that in 1978, Congress determined that maximum reliance on competitive market forces would best further efficiency, innovation, and low prices. A preemption provision was added to the ADA ensure that the states would not undermine federal deregulation. Morales, supra, 504 U.S. at p. 388.

[20] 42 U.S.C. § 1395dd(b)(1).

[21] 42 U.S.C. § 1395dd(h); 42 C.F.R. § 489.24(d)(4)(i).

[22] See 64 Fed. Reg. 61,356 (Nov. 10, 1999).

[23] See Centers for Medicare & Medicaid Services, S&C: 14-06-Hospitals/CAHs (Dec. 13, 2013).

[24] See 42 C.F.R. 489.24(e).

[25] Montana 65th Legislature, SB 44. "(1) If a covered person receives services from a non-Montana hospital-controlled out-of-network air ambulance service for an emergency medical condition, a carrier or health plan shall assume the covered person's responsibility, if any, for amounts charged in excess of allowed amounts for covered services and supplies, applicable copayments, coinsurance, and deductibles. (2) An carrier or health plan that assumes a responsibility pursuant to subsection (1) shall notify the air ambulance service of that assumption no later than the date the carrier or health plan issues payment under subsection (4). (3) If an air ambulance service receives notice pursuant to subsection (2), with the exception of amounts owed for applicable copayments, coinsurance, and deductibles, the air ambulance service may not: (a) bill, collect, or attempt to collect from the covered person for the responsibility assumed under subsection (1); (b) report to a consumer reporting agency that the covered person is delinquent on the responsibility assumed under subsection (1); or (c) obtain a lien on the covered person's property in connection with the responsibility assumed under subsection."

[26] See 42 U.S.C. § 1396dd(e)(1).

[27] http://www.legis.nd.gov/assembly/65-2017/bill-actions/ba2231.html.

[28] W.V. Code, § 5-16-8a.

[29] West Virginia Legislature, 2017 Regular Session, SB 276, introduced Feb. 13, 2017. This legislation is still pending in the Senate Banking and Insurance Committee and Senate Judiciary Committee.

[30] 2016 Session Maryland General Assembly, HB 1376, introduced Feb. 12, 2016.

[31] California Assembly Bill 2173 (Ch. 547, Statutes of 2010), approved by the Governor Sept. 29, 2010.

[32] Florida Senate, SB 1234, introduced Feb. 24, 2017, indefinitely postponed and withdrawn from consideration.

[33] 99th Session Illinois General Assembly, SB 3342, introduced Feb. 19, 2016, referred to assignments.

[34] https://www.congress.gov/bill/115th-congress/house-bill/3378.

Appendix A – History of Air Medical Services in Virginia

1981 – Virginia's first air medical evacuation service (Life-Guard of America, Inc.) was dedicated in Salem, Virginia.

February 25, 1982 – Nightingale completed its first mission. Nightingale began service as the 38th hospital-based (Sentara Norfolk General Hospital) air medical helicopter program in the United States.

April 1, 1984 – Virginia State Police (VSP) Med-Flight I began operations and responds to calls for assistance in a 60-mile radius of Richmond.

1984 – Pegasus is founded, part of the University of Virginia Health System.

1986 – State Medevac Committee of the State EMS Advisory Board completed a State Medevac Plan that addresses the coordination of the various services within the state and sets forth expectations in terms of utilization, safety, flight crew training, recording keeping and evaluation.

January 1, 1987 – VSP Med-Flight II began operations and responds to calls for assistance in a 60 mile radius of Abingdon**.**

1990 House Document 60: Recognized the need for a study to determine the feasibility of establishing a Medevac program on the Eastern Shore of Virginia, to meet the needs of that area.

1997 – HJ636 Establishing a joint subcommittee to study the Air Medivac System in the Commonwealth

RESOLVED by the House of Delegates, the Senate concurring, that a joint subcommittee be established to study the Air Medivac System in the Commonwealth. The joint subcommittee

shall be composed of 9 legislative members as follows: 5 members of the House of Delegates, of whom three members shall be representative of the joint subcommittee established pursuant to HJR No. 139 (1996), and the House Committees on Health, Welfare and Institutions and on Appropriations to be appointed by the Speaker of the House; and 4 members of the Senate, of whom three members shall be representative of the joint subcommittee established pursuant to HJR No. 139 (1996), and the Senate Committees on Education and Health and on Finance to be appointed by the Senate Committee on Privileges and Elections.

Item 16I in the 1998 Appropriations Act requested JLARC to conduct a comprehensive review of air Medevac services in VA.

House Document 14 – October 1999 and report published in 2000. Review of Air Medevac Services in VA.

Executive Summary of House Document 14

Air medical evacuation (Medevac) services play an important role in the spectrum of emergency medical care. The key advantage of the providers of these services is that they quickly deliver a high level of medical care to the site of an accident or medical emergency, and rapidly transport seriously ill and injured patients to higher levels of medical care. In addition, in many accident situations, the Medevac crew provides the highest level of medical care on siteMore than 3,700 air Medevac missions were flown in Virginia during 1998. The seven air Medevac programs based in Virginia flew 90 percent of these missions. Three of the Virginia providers are operated by police agencies and four are affiliated with major hospitals. Five out-of-state air Medevac providers also respond to calls in Virginia.

Item 16.I. of the 1998 Appropriations Act directed the Joint Legislative Audit and Review Commission (JLARC) to study the air Medevac system in Virginia. The study was prompted by concerns about the adequacy of funding for air Medevac providers and about continued availability of the service statewide.

This study found that air Medevac coverage is adequate in most areas of the State. However, there are some inconsistencies in service that should be addressed. The location of the helipad for MCV Hospitals should be moved to a more appropriate site closer to the emergency room. Additionally, the Department of State Police should arrange for two medical crew members, the industry standard, upon acquiring a larger helicopter for its MedFlight I service.
In terms of the adequacy of funding, this review found that although commercial providers reported operating a loss, it appears unnecessary for the State to subsidize the commercial provider at this time. However, because there is a concern as to whether all programs can remain in operation over the long term, the Department of Health and Department of State Police should develop a contingency plan for the continuation of air Medevac services in any part of the State which loses service. Further, the Department of Health needs to strengthen planning and coordination activities for the air Medevac system. Reviewing the regulations governing the air Medevac providers is a necessary step, as well as updating the statutorily-required statewide Emergency Medical Services plan.

2000 – Delegate Orrock introduced House Bill 1243. The bill was carried over to 2001 session. Due to the lack of action, the bill was ultimately left in HWI and did not come up during the 2001 session of the VA General Assembly.

HB 1243 - Summary as introduced:

Virginia Medivac Authority. Directs the Board of Health, with input from the State Emergency Services Advisory Board, to organize the Virginia Medivac Authority to ensure that all regions of the state have access to medivac services. The Board must hold at least two public hearings before organizing the Authority. The Authority will be governed by a 15-member organization that consists predominantly of participants, i.e., public or private entities currently operating medivac services in Virginia. The Authority is given broad powers, including contracting, hiring, suing and being sued, and charging fees, etc., for its services. The revenues raised by the Authority must be geared to cover the expenses of its operation. The Board must promulgate emergency regulations.

September 1, 2000 – VSP Med-Flight III began operations and responds to calls for assistance predominately along the Lynchburg-Route 29 corridors to Danville and in a 60 mile radius of Lynchburg. (No longer in operation)

2001 – Virginia Commonwealth University (VCU) Health air medical transport system begins operation.

2003 – Delegate Orrock introduced House Bill 2751. The bill was passed by in HWI with a letter. Presume a letter was sent to Commissioner of Health requesting state EMS Advisory Board to look into this matter further.

HB2751 - Summary as introduced:

Virginia Medevac Authority. Directs the Board of Health, with input from the State Emergency Services Advisory Board, to organize the Virginia Medevac Authority to ensure that all regions of the Commonwealth have access to Medevac services. The Board must hold at least 2 public

hearings and receive input of the Advisory Board before organizing the Authority. The Authority will be governed by a 15-member organization that consists predominantly of participants, i.e., public or private entities currently operating Medevac services in Virginia. The Authority is given broad powers, including contracting, hiring, suing and being sued, and charging fees, etc., for its services. The revenues raised by the Authority must be geared to cover the expenses of its operation. The Board of Health is required to promulgate emergency regulations by a second enactment clause**.**

The Use and Financing of Trauma Centers in Virginia (HD No. 62) reported that air Medevac providers flew a total of 23,000 missions in 2003.

January 2004, Inova Health System partners with PHI to expand Inova AirCare using two (2) Bell 412SP helicopters. Inova AirCare based at Manassas Regional Airport and Spotsylvania County.

LifeEvac based in Richmond opens a second base of operations in Fredericksburg, VA

January 10, 2005, LifeEvac II based in Stafford County crashes into Potomac River just south of Woodrow Wilson Bridge after completing a mission to Washington Hospital Center. Paramedic Nicole "Nikki" Kieler and Pilot Joseph Schaffer were killed. Flight Nurse Jonathan Godfrey was injured in the crash, rescued from the water and treated at Washington Hospital Center.

February 4, 2005, State Medevac Committee voted to place a moratorium on new air medical agencies and any expansion of services by existing air medical programs. Special called meeting was held on March 18, 2005 and decision was made to remove the moratorium. The committee voted to develop new EMS Regulations for air medical services using Commission on

Accreditation of Medical Transport Systems (CAMTS) regulations and other resources as a guide.

2005 House Document 57 - Report on the use of funds provided from RSAF for VSP Med-Flight operations

Executive Summary of House Document 57

Report on the use of funds provided from the Rescue Squad Assistance Fund for aviation (Med Flight) operations.

Colonel Steve Flaherty reported that VSP doesn't account for Med-Flight costs separately from other aviation expenses. However, through the use of reports supplied by the Aviation Unit, they were able to calculate estimated expenditures in the amount of $3,404,788 that were incurred in FY05 related to Med-Flight Operations. The $1,045,375 provided to VSP from RSAF is used to offset the overall cost of Med-Flight operations.

January 12, 2006, State Medevac Committee voted to adopt draft "Air Medical Regulations"

Medevac Committee begins discussing the possibility of using a Certificate of Public Need (COPN) process for air medical providers in VA. Representative from the Office of the Attorney General (OAG) shared that air ambulance rates, routes and services are preempted by Federal Aviation Administration (FAA) laws. State can regulate the delivery of medical services, staffing requirements, the qualifications of personnel, equipment and standards of sanitary conditions.

July 2008, Composition of Medevac Committee changed to include consumer representative, hospital representative and operational medical director.

October 28, 2010, Dr. Karen Remley, State Health Commissioner tasked the State Medevac Committee to develop a vision and a five-year plan for the future of helicopter EMS in Virginia. Committee directed to partner with other stakeholders to propose a comprehensive voluntary statewide network committed to safety, access and quality of care.

February 2011, Medevac Committee partners with VHHA and VDEM using WebEOC and creates a portal for helicopter EMS programs. Medevac services will be able to access information and list their availability in cases of an MCI.

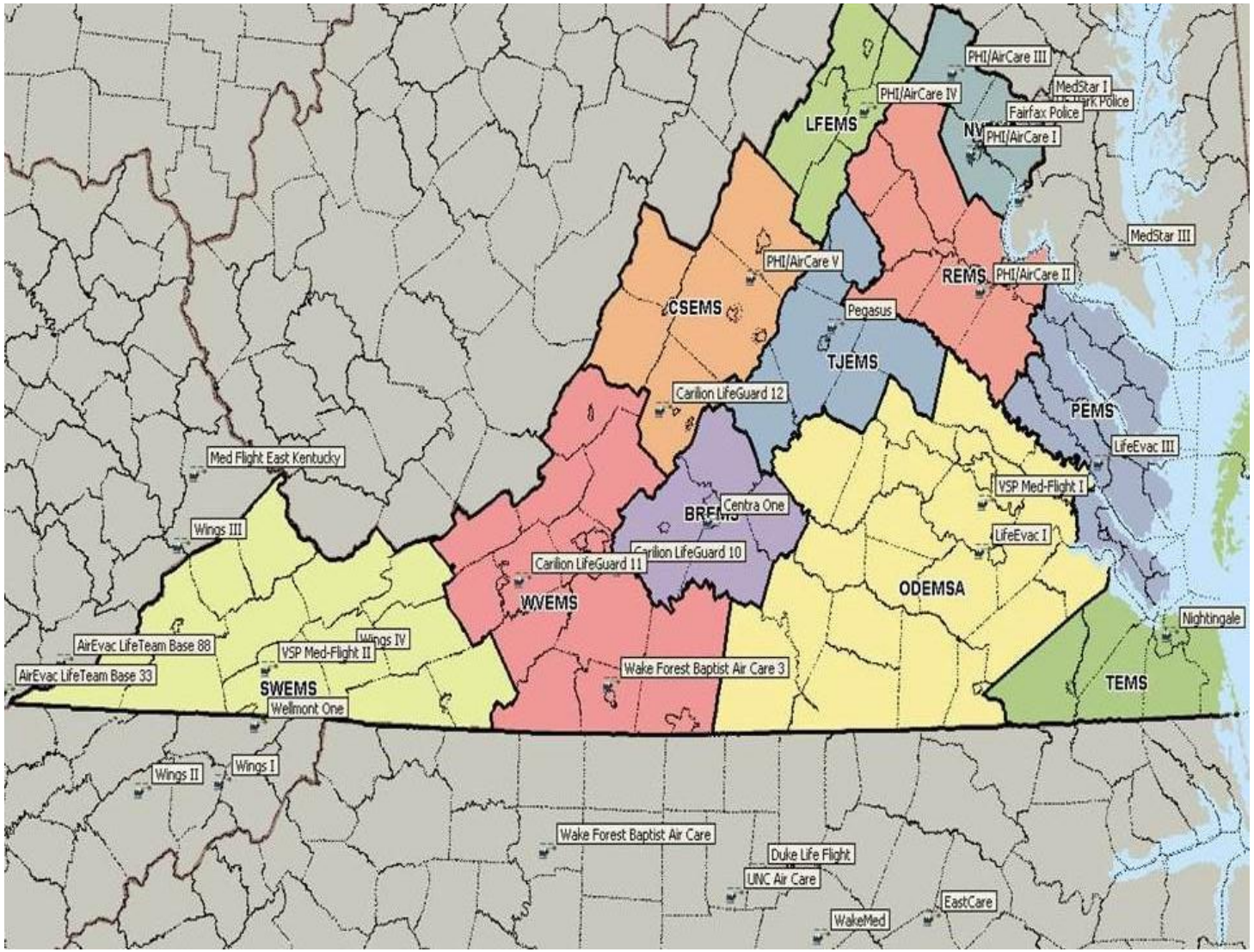
May 2011, State Medevac Committee develops an educational program for State Health Commissioner Dr. Karen Remley (Project Remley) that is directed towards physicians on when and how to access Medevac services.

September 2011, EMS Systems Planner at OEMS, working with Medevac system stakeholders as well as representatives of the VHHA builds an online landing zone (LZ) directory. Directory includes essential information (latitude and longitude, dimensions and weight capacity) on LZ's for each medical facility, radio frequencies and photos of the LZ site. A hazard notification has been built into the application to notify Medevac services about potential hazards (i.e. construction cranes, etc.) There is also a module built in for Medevac services to report their air transport status (number of units in service, patient capacity, status of aircraft). Information is essential in MCI's.

October 10, 2012, EMS Regulations (12VAC5-31) effective. Includes updated regulations that apply to air medical services operating in VA.

November 7, 2012, "Physician's Guide to Helicopter EMS Use in Virginia" presentation included as Appendix in quarterly report to members of the state EMS Advisory Board.

Appendix B – Map of Medevac Services in Virginia



This page intentionally left blank.