

November 29, 2019

The Honorable Danny Davis
U.S. House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup
U.S. House of Representatives
2159 Rayburn House Office Building
Washington, DC 20515

The Honorable Jodey Arrington
U.S. House of Representatives
1029 Longworth House Office Building
Washington, DC 20515

The Honorable Terri Sewell
U.S. House of Representatives
2201 Rayburn House Office Building
Washington, DC 20515

RE: House Ways & Means Committee Rural and Underserved Communities Health Task Force Request for Information

Submitted electronically to Rural_Urban@mail.house.gov

Dear Representatives Davis, Sewell, Wenstrup, and Arrington:

On behalf of Global Medical Response, Inc. (GMR), thank you for the opportunity to submit comments regarding the delivery and financing of health services in urban and rural underserved areas in response to the Request for Information (RFI) issued by the House Ways & Means Committee's Rural and Underserved Communities Health Task Force on November 15, 2019.

GMR is an industry-leading medical transportation company formed in March 2018 by bringing together two industry leaders: Air Medical Group Holdings and American Medical Response (AMR). With more than 35,000 employees, GMR provides emergency and non-emergency air and ground patient transport and medical services in the United States and patient repatriation transport around the world. Specifically, GMR provides emergency air medical services in Alaska, Hawaii, and most of the lower 48 states from more than 335 bases with over 300 helicopters and 100 airplanes. GMR's air medical services programs include our independent brands AeroCare, Air Evac Lifestream, AirLink CCT, Arizona Lifeline, First Flight, Guardian Flight, Lifestar, Life Star of Kansas, MidAtlantic Medevac, MidWest Aerocare, Mississippi Air Rescue, REACH Air Medical Services, Regional One and WINGS Air Rescue, and several brands operated in affiliation with hospitals, such as: Carillon Lifeguard (Carillon Clinic), Erianger Life Force (Chattanooga-Hamilton County Hospital Authority d/b/a Erianger Health System), GHS MedTrans (Greenville Hospital System), Meducare Air (Medical University Hospital Authority), MU Health (University of Missouri Medical Center), Novant Health Med Flight (Novant Health), ShandsCair (Shands Teaching Hospital and Clinics), Shannon AirMed1 (Shannon Medical Center), SkyHealth (North Shore LIJ Health System and Yale New Haven Health System), Trauma One (Shands Jacksonville Medical Center), and UT Lifestar (University Health System).

Access to care is critically important for patients in rural and underserved areas, and it is here that emergency air ambulance transportation plays a vital role. For 85 million Americans, emergency air medical transport is their only way to receive care at a Level I or Level II trauma center within 60 minutes of a medical emergency (the life-saving “Golden Hour”). In addition, another 30 million Americans lack access to a Level I or II trauma center within 60 minutes, even by air. This situation is likely to be exacerbated by rural hospital closures across the nation, increasing the number of people who are dependent on emergency air medical services. The experience of Jacksonville, Alabama, a small town of less than 15,000 people, is a case in point. Jacksonville’s hospital closed in 2018; as a result, the closest Level I trauma center to Jacksonville is now more than 75 miles away in Birmingham. Only an air ambulance can transport a critically injured patient that distance within the first 60 minutes when medical intervention has the greatest ability to improve the outcome of treatment. But Jacksonville no longer has access to air medical services, because the nearest air medical services provider recently closed its doors. This state of affairs has forced the city government to plead with air medical services providers to come to Jacksonville. Ex. A. Absent an increase in reimbursement rates, however, it is unlikely that any air medical services provider will be able to afford to do so.

In light of these rural hospital closures, Health and Human Services (HHS) Secretary Alex Azar has called for policymakers to “think more broadly” about rural health care delivery. While he highlighted the importance of telemedicine and community health centers, neither of these address the gap in patient access to trauma care that is filled by emergency air ambulance transport.

In recent years, the majority of air ambulance expansion has been into rural areas, increasing access and coverage in areas where rural hospitals have closed their doors. However, the cost of providing air medical services has increased significantly over time. Air ambulance teams must respond to requests by first responders and physicians and transport all patients regardless of the patient’s ability to pay, as required by state ambulance licensure and duties to act. Our programs must be staffed and prepared to dispatch at any time. Providing 24-hour a day, 7 days a week, 365 days a year staffing and readiness is one of the largest costs of operating air medical services, especially in rural areas. These costs are fixed and the salaries of our team members – including pilots, nurses, paramedics, support staff, and others – that are required to ensure we can provide these services have risen dramatically. The rising cost of fuel and the cost of updating and maintaining our aviation equipment to ever-changing and increasingly stringent Federal Aviation Administration (FAA) standards have also exerted financial pressure on our programs. Meanwhile, air ambulance suppliers are required to accept assignment from Medicare and cannot bill for costs that exceed reimbursement.

The situation has reached a crisis point, with 42 air medical bases closing to date this year alone – nearly all in rural areas – and the nation’s third largest air medical services provider filed for bankruptcy. Other bases have been forced to consolidate and redeploy resources away from rural areas. According to an independent study commissioned by

the Association of Air Medical Services (AAMS) in 2016, nearly one-third of all air medical services providers are operating in the red. The combination of fewer air bases and rural hospitals should be of great concern to Congress. Increasing the time to transport a critically ill or injured patient to an appropriate facility brings with it the risks of life-altering complications, additional costs to the health care system, and even death.

At the same time, Medicare rates for air medical services have failed to keep pace with cost growth in the industry, even as the volume of Medicare claims for emergency air transportation has increased. Specifically, Medicare reimbursement rates have dropped from covering 99% of air medical transportation costs in 1998 to covering just 56% of air medical transportation costs in 2015. The annual inflation updates in the Ambulance Fee Schedule average less than 2% and have been inadequate to address this concerning mismatch between costs and Medicare reimbursement, further threatening access to life-saving emergency care for Americans in rural and underserved areas.

In the Bipartisan Budget Act of 2018, Congress added a provision to the Medicare Act directing CMS to “develop a data collection system” to “collect cost, revenue, utilization, and other information” from providers and suppliers of *ground* ambulance services. Congress made clear that this system was intended to collect information on, among other things, “the extent to which reported costs” of providing *ground* ambulance services “relate to payment rates under” the ambulance fee schedule (AFS). In anticipation that the Secretary would promulgate a rule to implement Congress’s directive that CMS collect cost data from *ground* ambulance providers, AAMS met with agency decisionmakers several times this year to discuss the cost pressures facing the air medical services industry and urge them to consider taking cost data into account in setting rates for air medical services, as well.

On August 14, 2019, CMS published its proposed rule implementing a data collection system for ground ambulance service providers. In the proposed rule, CMS proposed to collect cost data *only* on ground ambulance services, but it noted that “air ambulance organizations have suggested they are interested in making this information available” to CMS as well, and it solicited “comments on the state of the air ambulance industry and how CMS can work within its statutory authority to ensure that appropriate payments are made to air ambulance organizations serving the Medicare population.” 84 Fed. Reg. 40,482, 40,683 (Aug. 14, 2019). During the comment period, GMR, AAMS and multiple air ambulance providers submitted comment letters to CMS, in which we (and they) again urged the agency to exercise its statutory authority to consider cost data related to air medical services.

In addition, Anthem, Inc. submitted a comment letter, stating: “We also encourage CMS to continue to explore ways to collect similar data on air ambulance services in Medicare. We believe ground and air ambulance services are increasingly contributing to growing healthcare expenditures and we appreciate CMS’ efforts to better understand the services and costs associated with these.”

Also, the American Heart Association submitted a comment letter, stating:

In response to CMS soliciting additional comments about air ambulance providers and suppliers, we encourage CMS to collect the same cost, revenue, and utilization data from air ambulance providers and suppliers that it proposes to collect from ground ambulance service providers and suppliers. We understand some air ambulance organizations have expressed interest in making these data available. Data on cost, revenue, and utilization of air ambulance services will provide CMS with a better understanding of costs and will inform reimbursement rates associated with air ambulance services. As with ground ambulance service data, AHA would welcome MedPAC's review of the air ambulance data as well as the opportunity for the public to view these data.

Collecting data about transportation to healthcare services is important for all Medicare beneficiaries but may be particularly relevant to Medicare beneficiaries in rural communities. Rural residents, who account for 15 percent of the U.S. population, face unique structural barriers to accessing health care. Residents in rural areas must travel considerable distances to access care and recent closures of rural hospitals have only exacerbated these barriers, particularly among economically marginalized rural populations, who are disproportionately affected by the loss of health services. From the standpoint of cardiovascular health, delays in access to cardiology services are associated with both rural residence and increased mortality. Unfortunately, ambulance transport in rural communities often takes longer than in urban communities. CMS's proposal to collect data on ground ambulance utilization will help it better understand and begin to address structural barriers to care in rural communities.

Ultimately, AHA believes these data are necessary to inform reimbursement for both ground and air ambulance services to ensure all Medicare beneficiaries, regardless of area of residence or mode of ambulance transportation, have prompt access to emergency care without being saddled with large, surprise bills. The Government Accountability Office (GAO) recently released a study outlining the problem of balance billing for air ambulance services among privately insured individuals. We are grateful CMS has proposed steps to address this issue for ground ambulance services for Medicare beneficiaries and hope that it will extend this review to air ambulance services as well. [citations and footnotes omitted]

In the final rule, published on November 15, 2019, CMS rejected this proposal. CMS agreed with AAMS and other commenters that "it is essential that Medicare beneficiaries have adequate access to ambulance services, especially in rural areas," and it stated that it "appreciate[d] the comments regarding the adequacy of the Medicare air ambulance rates and the suggestions regarding updating those rates." 84 Fed. Reg. 62,568, 62,865 (Nov. 15, 2019). However, CMS concluded that it it not have the authority to collect air ambulance cost data, and thus decided not to receive or consider any data on costs in the

air medical services industry, or to make any adjustments to the reimbursement rates for air medical services.

CMS's decision not to consider cost data on air medical services and take that data into account in deciding whether to adjust the rates for air medical services in the AFS is unsupportable. Under the Medicare Act and the existing AFS regulations, the Secretary not only has authority to consider providers' costs when determining the fee schedule for air medical services, but is *required* to do so. That conclusion follows straightforwardly from the text of the Medicare Act, which states that the Secretary "*shall . . . consider adjustments to payment rates to account for inflation and other relevant factors.*" 42 U.S.C. § 1395m(l)(2). Providers' costs are clearly a "relevant" factor—and perhaps the *most* relevant factor—in determining whether the AFS reimbursement rates for air medical services are adequate. If Medicare rates are insufficient to cover providers' costs, providers will lose money on every Medicare patient they serve. At best, that result makes it much harder for providers to provide the highest quality of service to patients; at worst, it threatens to drive them out of business altogether.

We urge Congress to direct the Centers for Medicare and Medicaid Services (CMS) to use its existing authority to develop, with stakeholder input, a data collection process that would be transparent and provide CMS with current cost data that can be used to rebase the Ambulance Fee Schedule and bring Medicare payment rates in line with the costs of providing life-saving air medical services. CMS has not updated the fee schedule (except for base inflation updates) since 2002, exacerbating the imbalance between costs and reimbursement for these services.

Patients should be protected from surprise medical bills when they unknowingly receive services from out-of-network providers and should be kept out of any payment disputes between emergency service providers and insurance companies. Any surprise medical billing solution should address the insurers' harmful tactics, including denying claims for air ambulance services, arbitrarily setting rates or underpaying claims, or refusing to negotiate with providers, which put patient in the middle. Insurers have significant leverage over air ambulance providers because there are no network adequacy standards that would force them ensure to coverage.

Despite significant recent successes by air ambulance providers to negotiate in-network agreements, many insurance companies opt for narrow networks or offer inadequate reimbursement, which has left approximately two-thirds of commercial insurance customers without in-network emergency coverage. GMR has increased in-network agreements for air medical services from five percent to more than 30 percent in the last 18 months.

Nearly 60 percent of GMR's air ambulance emergency transports are initially denied by insurers despite being ordered by physicians or emergency first responders. We overturn 90 percent of those denials on appeal. However, the insurers' appeals processes take months and create uncertainty for patients about their financial responsibility for the air

ambulance care. When insurance companies refuse to cover or limit coverage of emergency air ambulance care, patients are stuck with the bill.

The Senate Health, Education, Labor and Pension (HELP) Committee's Lower Health Care Costs Act (S. 1895) ensures that insurance companies will never negotiate another in-network agreement with rates higher than the existing median. Instead of incentivizing in-network agreements, the legislation effectively sets a permanent cap at 2019 rates. Insurers that provide reimbursement above the median rate will refuse to renew existing contracts, forcing air ambulance service providers out-of-network. This will drive down the median in-network rate – a race to the bottom. The problem will be compounded because medical and aviation inflation and flight safety costs increase over time. Rural air ambulance bases will be impacted the most, due to the extreme payor mix and volume, and rural areas will simply lose access to emergency care. This is already happening, and it will get worse.

GMR is supportive of the Energy and Commerce Committee's No Surprises Act, which includes a provision to require both health plans and air medical providers to provide key data on claims and costs to foster transparency and accountability to federal regulators and patients.

Congress should ensure that any surprise billing proposal protects access to emergency air medical services, especially for Americans living in rural areas, and remember that air ambulance services are regulated as a health care service and as an airline.

We again thank you for the opportunity to comment on this issue. We are happy to serve as a resource as the Task Force and the Committee considers how to ensure that all Americans have access to health care, including air medical services.

Sincerely,



Randy Owen
President and Chief Executive Officer

MAYOR

Johnny L. Smith

CITY CLERK

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CITY OF JACKSONVILLE

April 17, 2019

Mr. Seth Myers, President

Air-Evac

Dear Mr. Myers,

I am writing this letter in an effort to secure better emergency services for Jacksonville and the surrounding areas. As you may be aware, our hospital, Jacksonville-RMC, closed in 2018. This closure caused, and continues to cause, great concern among our first responders and our citizens. Currently, all we have to offer in Jacksonville is ambulance services with patients carried to either Anniston RMC or Gadsden RMC, 20 minutes distance and 30 minutes distance, respectively; both of these hospitals are only a Level III Trauma Center. Our citizens are sitting in a very difficult situation if they have a stroke, heart attack, or other serious health issues/injuries, of which time is critical for the saving of lives.

Last week, we were informed that Lifesaver located in Rainbow City, Alabama, was also closing their doors. Because of their close proximity to Jacksonville, we had been relying mostly on this company for air transport. This is another huge hit for us and we are now tasked with finding another way to air transport critical injuries or serious health related patients to Birmingham, our closest hospitals that are Level I & II Trauma Centers.

For these reasons and to secure the emergency services that our first responders need and want to provide to our citizens, I am asking that you consider locating an air ambulance in Jacksonville. I fully believe that AirEvac would be a great asset to Jacksonville and the surrounding areas. With the loss of our hospital, there is a huge sense of apprehension among the people we are here to serve. I appreciate any consideration you would give to bringing an AirEvac helicopter to Jacksonville.

Sincerely,

Johnny L. Smith

Mayor

JLS/ps