

ADMINISTRATIVE ACTIONS TO PRESERVE PATIENT ACCESS TO CRITICAL AIR AMBULANCE SERVICES

Health Insurance Payor Behavior and the QPA Presumption for Air Ambulance Services

The No Surprises Act and the Interim Final Rules, as currently being implemented, are leading to significant financial hardships for air ambulance providers due to health plan tactics and violations and unfair implementation of the NSA. If the Departments do not enforce health plan accountability and create a level playing field for air ambulances, air ambulance providers will be unable to meet the cost of providing services to their communities, leading to base closures.

Key Issues

Continued QPA “Weighting” for Air Ambulances: The policy governing the weighting of the Qualifying Payment Amount (QPA) in the Independent Dispute Resolution (IDR) process currently set forth in the interim final No Surprises Act (NSA) rules issued by the Departments of Health and Human Services (HHS), Labor, and the Treasury holds air medical providers to a different standard in the IDR process and, in doing so, threatens patient access to critical air ambulance services. Specifically, CMS guidance on the IDR process instructs IDR entities to apply the presumption in favor of the QPA to air ambulance providers' services. For all other providers, CMS guidance directs the IDR entities to weight all factors equally.

The inability to have all the factors considered fairly and independently effectively ensures that the IDR process for air ambulance providers – and only for air ambulance providers- favors insurers whose only goal is to lower their payment at the expense of critical air ambulance services without regard for the cost of the services or the need to preserve access. This policy indirectly gives health plans the consent by the Administration to continue practices that effectively limits air ambulance provider's ability to receive prompt payment, or sufficient payment, for emergency medical services already provided. It also ensures that almost all claims will go to the IDR process and payment will be underestimated and delayed.

Payors are Ignoring NSA Requirements, Including Timelines and QPA Reports: The industry is aware of multiple violations of the NSA and the IFR by plans and issuers. These violations include, but are not limited to:

- failure to either make initial payments or send notices of denials of payments;
- failure to even acknowledge receipt of claims, resulting in weeks or months of delays in making an initial payment or sending a notice of denial of payment, far beyond the 30 days required;
- failure by insurers and plans to report the Qualified Payment Amount (QPA) with initial payments to air ambulance providers and provide the rationale behind the amount they propose.

Solutions

Treat All Providers Equally: CMS Should Vacate the Following Regulations in IFR II*, and Correct Existing Guidance to IDRE's:

In *Texas Medical Association. v. U.S. Department of Health and Human Services*, No. 6:21-cv-00425 (TMA) (Dkt. 53-1), the court determined that the NSA is unambiguous in its requirement that an IDR entity must consider not only the QPA but also additional information. The court rejected the Departments' position that they have authority to place limitations on the IDR entity's consideration of additional information, concluding that such position contravenes the statute. The same reasoning applies here for air ambulance providers, because the provisions read identically to the vacated provisions in the Texas ruling:

This information must also clearly demonstrate that the qualifying payment amount is materially different from the appropriate out-of-network rate.

Based on *Texas Medical Association*, CMS should immediately revise guidance to the IDR Entities on the consideration of the QPA for air ambulance providers that aligns with all other healthcare providers. In the Final Rule, the air ambulance-specific provisions at the second sentence of 45 C.F.R. § 149.520(b)(2) and its analogs, which establish a threshold identical to the vacated provisions in the *Texas Medical Association*, i.e., requiring a demonstration that the QPA is materially different from the appropriate out-of-network rate, should be removed.

This will ensure patient access to critical air ambulance services, ensure parity across the market, and honor the reasoning of the court. It also will ultimately lead to improved health plan practices, transparency, and a willingness to negotiate with air providers.

CMS Should Exercise Enforcement Discretion: the Departments should announce an exercise of enforcement discretion as to the air ambulance-specific provisions identified above. It is critical that they do so to ensure patient access to critical air ambulance services, to ensure parity across the market, and to honor the reasoning of the *Texas Medical Association* federal court. This would effectively vacate those provisions.

*Vacating these additional provisions are currently the subject of two lawsuits in federal court.

Address Insurers Tactics of Delay and Lack of Transparency: CMS Must Enforce the No Surprises Act (SEC. 2799B-4), Federal Regulations (IFR II): The Departments should announce an exercise of enforcement discretion per the No Surprises Act and the Interim Final Rule II. It is critical that they do so to ensure patient access to critical air ambulance services.

1. HHS should recognize that, based on volume of complaints, states are not adequately enforcing the No Surprises Act.
2. HHS should immediately begin investigations into repeated violations of the NSA by payors (and providers); based on those investigations HHS can exercise legal authority.

HHS Should Address of Issues Non-Compliance Through the Final Rule:

1. In the final rule, the Departments should make clear that HHS has the authority to level monetary penalties against payors and providers for violations of the NSA. Include specific penalties for specific violations.
2. HHS should immediately address the lack of payment or denial required by the NSA and the IFR by issuing guidance that insurers/plans have 10 days to request any additional information necessary to determine payment or denial, and then an additional 10 days to verify receipt and make payment or denial for air ambulance services.