

[PRINT ON AAMS LETTERHEAD]

November ____, 2007

Emilie Alvarez, Regulations Coordinator
Department of Managed Health Care
Office of Legal Services
980 Ninth Street, Suite 500
Sacramento, CA 95814

Re: Comments on Proposed Rule re Plan and Provider Claims Settlement; Criteria for Determining Reasonable and Customary Value of Health Care Services; Expedited Payment Pending Claims Dispute Resolution; Definition of Unfair Provider Billing Patterns; and Independent Dispute Resolution Process; Proposed Adoption of Section 1300.71.39; and Proposed Revision of Sections 1300.71 and 1300.71.38; Control No. 2007-1253

Dear Ms. Alvarez:

The Association of Air Medical Services (“AAMS”) is an international association that serves and represents more than 500 providers of air and surface service medical transport systems. AAMS is a non-profit organization which encourages and supports its members in maintaining a standard of performance and practice that reflects safe operations and efficient, ethical and high quality patient care. AAMS membership includes providers that perform services in the State of California, including some of the largest air medical providers in the state. AAMS appreciates the opportunity to comment on the above-referenced Proposed Rule (the “Proposed Rule”).

Formatted: Highlight

SUMMARY

We are concerned that the Proposed Rule would exacerbate the difficulties which emergency services providers currently have in securing fair and adequate payment from Knox-Keene plans, which would negatively impact access to care. More specifically, the proposed revision to the “Gould Criteria” would permit plans to utilize low Medicare rates and discounted rates paid by plans to their contract providers as justification for paying inadequate rates to emergency providers. We are also concerned that the provisions precluding emergency providers from balance billing members would foreclose those providers from exercising the only viable option they currently have for securing fair and adequate reimbursement from plans. We believe this prohibition would conflict with Section 1357.11 of the Knox-Keene Act (the “Act”) as to all ambulance providers and, as to air providers, would be preempted by the federal Airline Deregulation Act. We will elaborate on our concerns below.

DISCUSSION

1. Proposed Revision to the Gould Criteria

As discussed in Part 4 below, federal aviation law preempts any state statute or regulation that limits the rates air ambulance providers are entitled to charge or collect. Because proposed Section 1300.71(a)(3)(B) -¹ has that effect, it is preempted as to those providers.

In the event the Department disagrees with our preemption analysis, we have other concerns with the proposed changes to Section 1300.71(a)(3)(B). That section currently lists six criteria for determining the “reasonable and customary value” of services rendered by non-contracting providers. These criteria were set forth in the well known Gould v. WCAB court decision and are referred to as the “Gould Criteria.” The Proposed Rule would add two additional criteria not included by the court:

“(6) that Medicare reimbursement rates are based on a federal government reimbursement methodology and should not be solely used as a basis for payment; and

(7) that contracted rates normally reflect a discount, and therefore shall not be solely used as the basis for payment . . . ”

(Emphasis added.)

While we agree that neither Medicare rates nor contract rates should be used as the basis for determining the “reasonable and customary value” of services, the use of the word “solely” in each of these criteria essentially flips this concept on its head. The statement that these factors shall not be “solely” used as the basis for such determinations suggests that these factors may be used as substantial or perhaps even primary criteria in establishing rates. Rather than prohibiting or discouraging the use of these criteria, which is the appropriate approach, this wording would effectively validate and encourage this practice.

This change would be unfair to non-contracting providers because neither Medicare rates nor contract rates constitute an appropriate standard for establishing fair and reasonable compensation. Medicare is a budget tool for federal public health programs and does not reflect the actual cost of providing services. Many providers accept Medicare rates in order to assure service to the nation’s elderly population or because it is not feasible for an emergency provider to operate without participating in that program. Medicare rates do not reflect fair and reasonable compensation. Using contract rates as a basis for determining non-contracted rates is also inappropriate because non-contracted providers do not receive all of the benefits of a contractual relationship, such as enhanced volume. Further, many providers agree to accept deeply discounted contract rates to secure prompt payment and to avoid the administrative burdens that plans typically impose on non-contracting providers.

¹ All section references herein are to Title 28 of the California Code of Regulations, unless otherwise indicated.

Allowing the use of either of these criteria would reduce the incentive of plans to offer contract rates to providers because they could pay similarly low rates to non-contracted providers. Conversely, since plans would have little incentive to offer more favorable terms to contract providers, it would likely reduce the incentives providers would have to enter into contracts. For these reasons, we recommend that the Department delete the word “solely” from both of the proposed new criteria. Should the Department decide to retain this provision, for reasons we discuss in Part 3 below, air ambulance providers should be excluded.

We also have another concern about the use of the current Gould Criteria as applied to air ambulance services. The current six criteria for determining the "reasonable and customary value" of services rendered by non-contracting providers were intended for physician services, and never intended for ambulance providers. One must look no further than Section (a)(3)(B) (i)-- "the provider's training, qualifications, and length of time in practice"-- to understand that these criteria are designed for physician services and are not relevant to ambulance services. If these criteria are to be used in determining the "reasonable and customary value" of an ambulance provider's charges, an entirely new criterion applicable specifically to them must be established to reflect the differences between ambulance and physician providers. Unlike physicians, air ambulance providers are subject to large variations in operating costs for items outside their ability to control (i.e. jet fuel, aviation insurance, etc.), requiring them to adjust their rates on an irregular basis. Because of these huge swings in costs, historic charges of a provider are irrelevant, as are the historical "prevailing" rates charged by other air ambulance providers.

2. Prohibition on Balance Billing by Providers

Sections 1300.71(a)(3)(B) and 1300.71.39 of the Proposed Rule would both prohibit emergency providers from balance billing members when plans pay an inadequate amount. The former provision would preclude providers from balance billing members in the event the plan disputes the provider's charges and makes an expedited payment in an amount equal to 150% of the 2007 Medicare rate, as adjusted in the future by a Department *ad hoc* task force. Acceptance by the provider of this amount will be “deemed” to constitute an agreement not to balance bill the beneficiary. While the “deemed agreement” language suggests that the provider has the option of declining the expedited payment and balance billing the beneficiary, the latter new provision eliminates this option by defining balance billing as an “unfair claims pattern,” subject to an exception for ambulance services discussed below.

Section 1300.71(a)(3)(B)(iii) states that the specified expedited payment amount “is not intended to reflect reasonable and customary value of services rendered and the provider's acceptance of an expedited payment amount would not constitute an agreement by the provider that the claim has been satisfied.” However, the provider's only recourse upon receipt of this amount would be to either sue the plan for the balance of it's payment, or to pursue an untried and untested independent dispute resolution process (“IDRP”) to be established under the Proposed Rule by a third party. Both options would be expensive and time consuming, and would deprive providers of the only effective means they currently have to secure fair payment, i.e., billing the member for the unpaid balance due. Because the member is the only party with direct contractual rights against the plan, he or she is in the best position to force a plan to behave

in a reasonable manner. While most emergency providers wish this option were not necessary, unfair payment practices by plans leave providers with no choice.

The Department recognizes in proposed Section 1300.71.39 that it is precluded by statute from prohibiting medical transportation providers from balance billing. That section creates an exception from the “unfair billing pattern” characterization for “services subject to the requirements of 1367.11 of the Act.” Section 1367.11 specifically authorizes providers of “medical transportation services” to “demand payment from the enrollee for any portion of the provider’s fee” that is not paid by the plan directly to the provider. This provision provides non-contracting ambulance providers with the clear right to balance bill members in an amount equal to the difference between what the plan pays and the provider’s charges.

Since the Department recognizes that ambulance providers must be carved out of the balance billing prohibition in 1300.71.39, it is puzzling that the Department believes it can prohibit such providers from balance billing in Section 1300.71(a)(3)(B)(iii). Perhaps the Department believes that the fictitious existence of a “deemed agreement” not to balance bill in the latter section overcomes this problem. However, we respectfully submit that the disingenuous use of the word “agreement” does not change the fact that this section would effectively *require* providers to accept the expedited payment amount, thereby depriving them of the option of balance billing. Section 1367.11 of the Act precludes this.

Even in the absence of Section 1367.11 of the Act, the Department would lack the authority to prohibit non-contracting providers from balance billing. The Act provides the Department with jurisdiction over plans but does not provide it with authority to regulate non-contracting providers. Section 1341 of the Act charges the Department with “the execution of the laws of the state relating to health care service plans and health care service plan business,” but does not extend to providers. The California Court of Appeal recognized this in Bell vs. Blue Cross of California, 131 Cal.App. 4th at 217-218. While AB 1455 directed the Department to collect information and make recommendations to the legislature regarding billing practices of non-contracted providers, the legislature intentionally stopped short of providing the Department with authority to regulate such practices. Notably, the legislature itself has wisely not seen fit to do so.

3. The Amount of the Expedited Payment.

We also object to the proposal in Section 1300.71(a)(3)(B)(ii) that the "expedited payment" for ambulance providers be equal to 150% of the Medicare rates. Medicare rates for ambulance services were developed in an entirely different manner than was done for hospitals and physicians, and it would be erroneous to assume that it would be reasonable to use the same percentage of Medicare for all provider types. Unlike Medicare payments made to hospitals, the current Medicare rates for ambulance services were not based on the current or historic cost of providing the service, and consequently have no relationship to them. Further, air ambulance providers are subject to large variations in operating costs for items outside their ability to control (i.e. jet fuel, aviation insurance, etc.), requiring them to adjust their rates accordingly.

While most air ambulance services provided in California are not rendered under a written contract, those contracts that are in place often exceed (200?) % of the current

Medicare rates. Should the proposed regulatory change be implemented, those insurance companies which are already operating under a contract would have every incentive to cancel them. The loss in cash flow alone could be enough to place many providers in financial crisis. We believe plans should be required to make an "expedited payment" amount equal to providers' full billed charges. If the Department rejects this position, the "expedited payment" rate for air ambulance services be at least (300?)% of the Medicare Rate. The Department should also clarify that in applying this rule, plans must take into account the fact that the Medicare rates for ambulance services originating in certain rural areas are calculated using a rural modifier.

4. The Proposed Rule is Preempted As to Air Ambulance Providers by the Airline Deregulation Act

Separate and apart from the preclusive effect of Section 1367.11 of the Act as to all ambulance providers, the Proposed Rule is preempted as to air providers by federal law. The Proposed Rule would establish substantive rules regarding the amounts that providers can expect to collect for their services, thereby impacting their rates. As applied to ambulance providers, these provisions are preempted by the Airline Deregulation Act ("ADA"), 29 U.S.C. Section 41713(b), which is part of the Federal Aviation Act.

The Federal Aviation Act extensively regulates air carriers, including air ambulance providers. In 1978, Congress amended that Act by passing the ADA. The ADA preempts states and local governments from "enact[ing] or enforc[ing] a law, regulation or other provision having the force and effect of law *related to a price, route or service of an air carrier.* . ." 29 U.S.C. Section 41713(b); emphasis added. This provision has been expansively interpreted by the United States Supreme Court in Morales vs. Transworld Airlines, Inc., 504 U.S. 374, 378 (1992), as well as other courts, as prohibiting any statutes or regulations which have any material impact on the rates charged or collected by air providers. The Morales and other cases further indicate that, to be preempted, a state law or regulation need not be one specifically addressing the airline industry. Any law, including a law of general application, that relates to "prices, routes or services" of an air carrier are preempted. Therefore, the fact that the regulation at issue here is not directly and specifically aimed at air ambulance providers will not save it from preemption.

The federal Department of Transportation,² as well as the three courts³ and several state attorneys general⁴ who have addressed the issue, have unanimously found that the preemption provisions of Federal Aviation Act and the ADA apply to air ambulance providers.

² Letter dated Feb. 20, 2007 from James R. Dann, Deputy Assistant General Counsel of DOT to Donald Jansky, Office of General Counsel of Texas DSHS.

³ *Hiawatha Aviation of Rochester, Inc. v. Minnesota Dept. of Health*, 389 N.W.2d 507 (Minn. 1986); *Rocky Mountain Holdings vs. Ronald W. Cates, Director, Missouri Department of Health*, No. 97-4165-CV-C-9 (W.D.

Because the Proposed Rule “relates to” the rates air ambulance providers can expect to collect, it is preempted as applied to such providers. Notably, the precise question of whether a proposed state law governing balance billing would be preempted by the ADA was considered by the Maryland State Attorney General last year. At that time, the Maryland legislature was considering legislation (House Bill 718/Senate Bill 770) that would have enacted a prohibition on balance billing by air ambulance companies, similar to the impact of the Proposed Rule. The State Attorney General opined that, if enacted, the bill would be preempted, as follows:

“There is little question that House Bill 718/Senate Bill 770 attempt[s] to regulate rates by prohibiting helicopter transportation providers from billing a patient for any balance charged above the amount an insurer, non-profit health service plan, or health maintenance organization is required to pay for such services. To the extent that the helicopter carriers services are governed by the ADA, the bills are preempted by federal law.”

Letter from William R. Varga, Assistant Attorney General,
Maryland Office of Attorney General, to the Honorable Pete A.
Hammen, Chair, Health and Government Operations Committee,
Maryland House Delegates.

The Maryland Attorney General’s opinion on a state law prohibiting balance billing illustrates that the balance billing prohibitions in the Proposed Rule would be preempted by the ADA. Other provisions of the Proposed Rule affecting the amount air ambulance providers are entitled to charge or collect are similarly preempted.

5. The Department Should Solve the Balance Billing Problem by Exercising its Jurisdiction Over Plans.

Rather than attempting to prohibit providers from balance billing when it has no authority to do so, we recommend that the Department solve the balance billing problem by exercising its jurisdiction over plans. Specifically, we recommend that the Department require plans to pay an emergency provider’s full billed charges within the prompt payment time limit as currently defined by law. The burden would then be on the plan to challenge the provider’s charges through litigation or pursuant to the IDR process, if the provider agrees to submit to that process. This approach would provide ample incentive for plans to pay fairly and for providers to charge fair and reasonable amounts.

Mo. Central Division 1997); *Air Evac EMS v. Kenneth S. Robinson, Commissioner of Health*, Case No. 3:06-0239, U.S. District Court, M. D. of Tenn.

⁴See, e.g., 1987 Ariz. Op. Atty. Gen. 261, Op. Atty. Gen. i87-164 (December 28, 1987); see also Memorandum from Donald Jansky, Assistant General Counsel of Texas DSHS, to Air Medical Committee of GTAC dated Nov. 17, 2006.

6. The Definition of “Complete Claim”.

Finally, while the Department does not propose to revise the definition of “complete claim” in Section 1300.71(a)(2), we urge the Department to clarify its application to ambulance providers. Currently, it is not uncommon for plans to require ambulance providers to submit information or records that can only be obtained from hospital medical records. Since hospitals are often unwilling to provide such records to the ambulance provider, this places the provider in an untenable position. Moreover, this information is unnecessary and serves only to delay the claims adjudication process. Medical necessity determinations regarding ambulance services should be made based solely on the information received by the ambulance provider and documented in its dispatch record, and the record of the care rendered by the provider at the scene and during transport. Information regarding the care provided in the hospital is irrelevant, since the ambulance provider must render treatment based on the information available to it upon dispatch and during transport, and not on information created by the hospital. To the extent a plan nevertheless feels it needs hospital information, the plan can compel the hospital to provide it directly, whereas the ambulance provider cannot. We do not believe the current definition of “complete claim” permits plans to require this information from providers,⁵ but many plans nevertheless do so. We therefore urge the Department to clarify that this is not permissible.

CONCLUSION

For the reasons described above, we recommend that the Department withdraw or substantially revise the Proposed Rule. To summarize, our recommendations are as follows:

- Amend the proposed revisions to the Gould Criteria to eliminate the use of the word “solely”, to make it clear that Medicare rates and contracted rates are not relevant to the determination of what constitutes fair and reasonable compensation to non-contract providers. If this change is not made, air providers should be exempted from this provision based on the ADA.
- Eliminate the provisions in 1300.71(a)(b)(B) and 1300.71.39 prohibiting emergency providers from balance billing upon acceptance of the expedited payment from a plan. Alternatively, if that provision remains in the rule, establish an exception under both provisions for all ambulance providers based on Section 1367.11 of the Act, or at least a limited exception for air ambulance providers, based on the preemptive effect of the ADA.

⁵ See the definition of “reasonably relevant information” in Section 100.71(a)(10), which is included in the definition of “complete claim” and limits the information plans should request to that which is “generated by or in the possession of the provider...”

- Amend the Proposed Rule so the plans must pay an emergency provider's full billed charges within the prompt payment time limit as currently defined by law. The burden would then be on the plan to challenge the provider's charges through litigation or pursuant to the IDR process, if the provider agrees to submit to that process. If the Department rejects this position, the amount of the expedited payment should be set at no less than 300% of the Medicare rate, including any applicable rural adjustment.
- Clarify that a "Complete Claim" for ambulance providers should only include those records created by the provider.

The foregoing changes would address the problems currently posed by balance billing without authorizing plans to unfairly take advantage of providers.

We appreciate the opportunity to comment upon the Proposed Rule and would be pleased to provide further input or answer any questions that you may have.

Very truly yours,
