October 15, 2019

The Honorable Alex M. Azar II
Secretary of the United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Azar,

In Wyoming, air ambulance service is not an "option" or a "luxury." It is nothing short of necessary, lifesaving infrastructure. Whether a helicopter airlifts a truck driver out of a remote I-80 pileup in the middle of the Red Desert, or a fixed-wing ambulance flies a vulnerable newborn from a small hospital in Wheatland to a neonatal intensive care unit in Denver, Wyoming's citizens must have this vital capability.

As Governor of a frontier state, however, it is clear to me that the way we pay for this system is broken. My constituents are routinely hit with absurdly high surprise bills, and employers are consistently asked to cover escalating costs. The deeper problem is this: no-one — not providers, not employers, not consumers, not state government — has any say over how much air ambulance service we need, or how much we are expected to pay for it.

While we are officially asking you in this application to waive certain provisions of the Social Security Act to implement a comprehensive all-payer air ambulance system through our Wyoming Medicaid program, we recognize that this is not an ordinary 1115 waiver.

What we have assembled is an innovative proposal to use the power of the free market to fundamentally reform how air ambulance services are delivered and compensated. Our proposal's goal of increasing value is precisely the kind of healthcare reform this administration seeks to deliver to the American people.

It's also important to emphasize that this waiver will not cost the Federal government a dime.

I recognize that some states may design waivers to gain additional Federal dollars through optimistic projections of future savings. In this case, however, the State of Wyoming can absolutely commit to making the United States government whole.

Although we do not need additional federal funds, we do need your approval to proceed with this unique proposal. I respectfully request that you approach this application with an open mind.

Thank you for your time and consideration.

[redacted]

Mark Gordon
Governor

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WYOMING MEDICAID COORDINATED AIR AMBULANCE NETWORK

1115 Waiver Application

Wyoming Department of Health
October 15th, 2019

EXECUTIVE SUMMARY

In Wyoming, the average cost of air ambulance is too high and access to care is uneven. This waiver addresses these issues by expanding Medicaid coverage to all State residents for the specific benefit of air ambulance transportation.

Under the plan, Medicaid would:

- **Determine holistic Statewide requirements** for air ambulance coverage;
- **Issue competitive bids** for a selected network of air ambulance providers to meet those requirements;
- Stand up a **centralized call center** that would direct all air ambulance volume to this network;
- Make **periodic flat payments** (similar to a gym membership) to these providers, eliminating the perverse incentives set up by the current fee-for-service model;
- Set **clear and transparent cost-sharing** for patients on a sliding-fee scale; and,
- **Recoup the revenue** needed to fund the system from the insurance companies, employer plans and individuals already paying for transports.

This plan is a common-sense, all-payer solution.

- It treats air ambulance coverage very similar to a **public utility**, regulating supply so air ambulance services can be provided efficiently and effectively;
- It injects **more free-market activity** into the industry than exists today, by emphasizing competitive bidding on the provider side and price transparency for patients. We believe these free-market principles are critical in reducing costs and overutilization.

While the waiver clearly advances the objectives of the Medicaid program while remaining budget neutral to the Federal government, it therefore also has significant benefit to all residents of Wyoming.

This application is structured along the lines of the Section 1115 Demonstration Program Template, available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/fillable-1115-demo-10-12v2.pdf

I. PROGRAM DESCRIPTION

1. Program summary [§ 431.412(a)(1)(i)]

1.1. Description of the proposed demonstration program.

This Section 1115 waiver proposed by the Wyoming Department of Health expands Medicaid coverage to all Wyoming residents for the specific and sole benefit of air ambulance transport.

Under the waiver, air ambulance services would be delivered to any State resident through a model similar to how a 'small town with long streets' would provide fire and police coverage — in essence, treating it like a public utility.

Under this proposal, Wyoming Medicaid would:

- Develop broad requirements for statewide air ambulance service. These requirements would specify both the *quantity* (e.g., number of bases or number of transports) and *quality* (e.g. accreditation requirements) for rotor-wing, fixed-wing and specialty air ambulance transports;

- Leverage the purchasing power of the entire State to competitively procure those requirements in the private market, and negotiate contracts on a fixed-price basis, similar to a gym membership, with Medicaid making flat payments to contracted providers;

- Procure a Statewide air ambulance call center that would route all air ambulance volume to these contracted Medicaid providers;

- Recoup revenue required to fund the system from private payers, Medicare, other public payers and individuals using Medicaid Third Party Liability 'pay and chase' authority; and,

- Set clear and transparent cost-sharing for patients on a sliding-fee scale.

1.2. How will this demonstration promote the objectives of the Medicaid program?

This demonstration aims to improve the quality of, access to, and cost-effectiveness of air ambulance services for **current** Medicaid members through an innovative all-payer framework.

We recognize that the primary objective of the Medicaid program is to assist States in furnishing medical and rehabilitative assistance to eligible [generally low-income] individuals.[1]

Beyond merely paying for services, however, Medicaid agencies are required to ensure that their members have access to a sufficient number of high-quality and cost-effective medical providers, to the extent these providers are available to the general population.[2]

By developing holistic Statewide requirements for air ambulance and moving the entire system away from a fee-for-service payment structure, this waiver concept promotes the objectives of the Medicaid program in two ways:

> (1) Improving the quality of and geographic access to air medical services available to current members and;
>
> (2) Eliminating the payment incentives behind unnecessary utilization that is evident in certain areas.

The waiver concept will improve the quality of air medical services for current members by allowing the State to require that providers meet certain standards in order to submit a competitive bid. These standards may include:

- Commission on Accreditation of Medical Transport Systems (CAMTS) accreditation. Currently only three of the six services operating in-State bases are CAMTS-accredited.

- Requirements for meeting operational benchmarks such as response times, flight times, scene times, patient care reporting, destination determination, communication capability, staffing levels, and training requirements.

- Requirements for meeting clinical and care delivery benchmarks centered on evidence-based best practices for out-of-hospital care, and monitored through a comprehensive quality improvement program.

- Inclusion of the contracted providers in statewide planning efforts around Wyoming's systems of care and emergency response.

The ability of the State to regulate these quality issues in the absence of this waiver remains slim to non-existent, largely due to the broad pre-emption issues in the 1978 Airline Deregulation Act.

At the same time, we do not believe Wyoming Medicaid can improve air ambulance services for its members without a comprehensive, all-payer solution.

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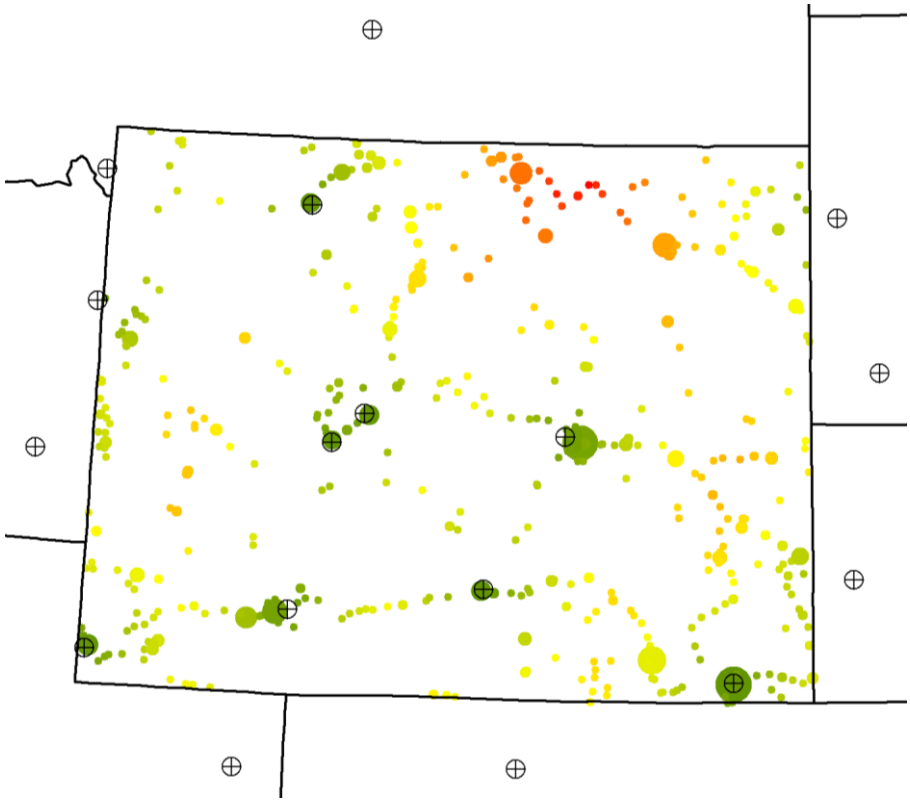
[1] Social Security Act §1901
[2] SSA §1902(a)(30)(A)

In addition to improving quality, the concept will also allow the State to even out geographic access to services around the State — access which is linked with life-or-death health outcomes, particularly in rural settings.[3]

Figure 1, below, illustrates disparities regarding rotor-wing access. On the figure, note that the north-eastern part of the State has little access to rotary-wing flights, while the Lander/Riverton area has two bases in close proximity.

Figure 1: Rotary-wing base locations in and around Wyoming (circles with cross) and distances to cities and towns (green is closer, red is further away) [4]

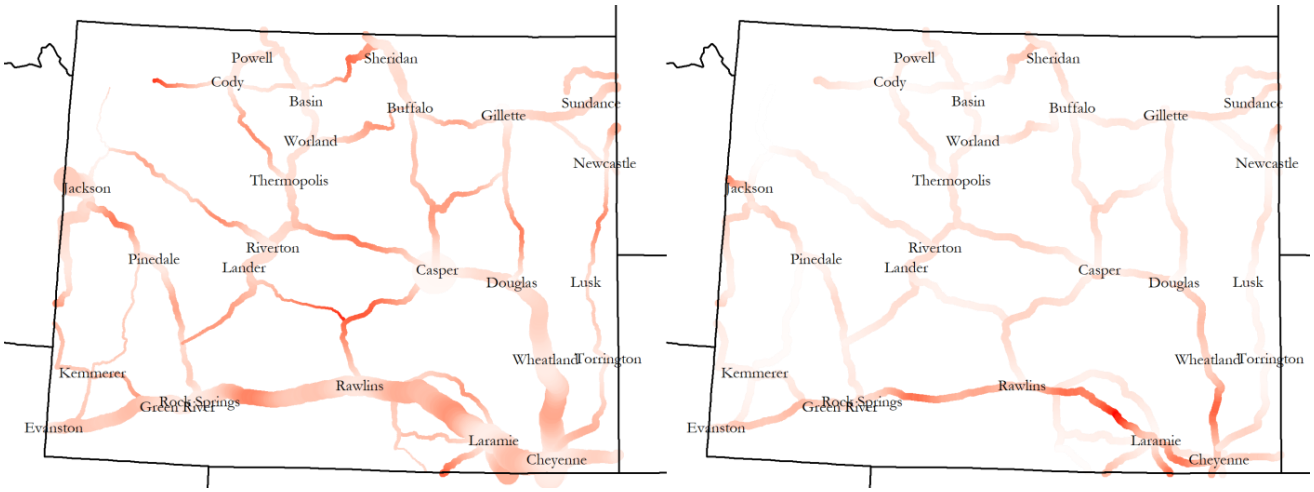


Other gaps can be seen when looking at Emergency Medical Services (EMS) response time around the State more broadly.

Figure 2, on the next page, shows a significant gap on the southern half of the State, when crash volume is multiplied by overall EMS (i.e., including ground and air) response times.

[3] Mann, Pinkney et al. "Injury mortality following the loss of air medical support for rural interhospital transport." Academic Emergency Medicine. 2002.
[4] Data from Wyoming Office of Emergency Medical Services, as of June, 2019..

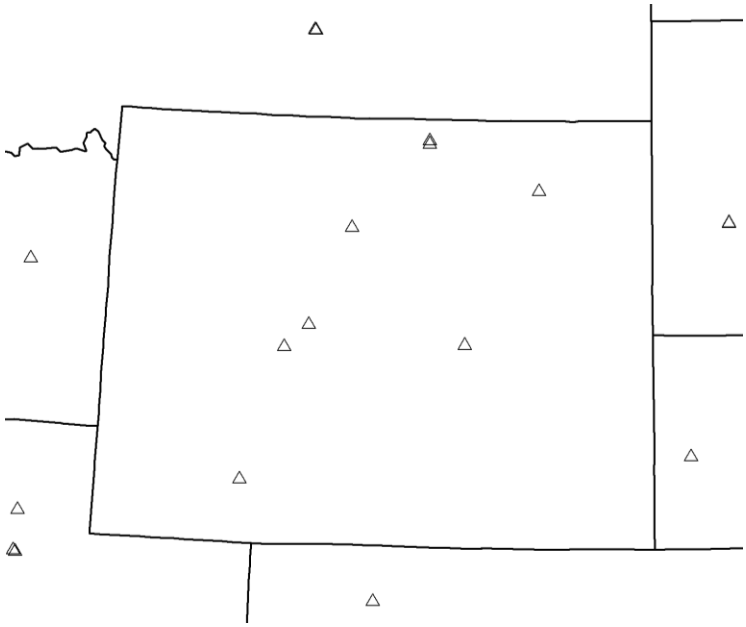
Figure 2: SFY 2014 - 2018 highway crash volume and EMS response times (left); multiplied together (right) [5]



At the same time that we see these gaps, we also see evidence of oversupply.

Fixed-wing (FW) air ambulance, for example, can only be used for inter-facility transfers — since, unlike rotary-wing (RW) trips, all nodes in the journey must involve an airstrip. Additionally, the range and speed of planes greatly exceed that of helicopters. For these reasons, geographic proximity to demand is less of a concern.

Figure 3: Fixed-wing base locations in and around Wyoming[6]



[5] Crash data and highway segments from Wyoming Department of Transportation for SFY 2013 - 2018. Poisson likelihood GAMs fit using HMC sampling in RStan and the brms package (Paul-Christian Bürkner (2017) <doi:10.18637/jss.v080.i01>

[6] Data from Wyoming OEMS; June 2019.

Significant efficiencies are therefore possible if fixed-wing volume were consolidated on to one or two centrally-located bases in the State, with enough planes to satisfy inter-facility demand at reasonable cost.

The uneven nature of access around the State manifests itself in utilization data.

Figure 4, below, illustrates how Fremont County — the same county with two RW bases and two FW bases — has disproportionately high inter-facility transfer volume.

Figure 4: Inter-facility transfers (count) by county and month for SFY 2018[7]

[7] Data from SFY 18 trips reported to the Wyoming Ambulance Trip Reporting System (WATRS), Poisson likelihood varying-effects model fit using HMC methods noted previously.

This volume (75 - 100 trips per month) is particularly disproportionate when you consider that its population (~40K people) is *less than half* that of Laramie (~98K people) or Natrona (~80K people) counties.

The potential overutilization here also affects the Medicaid program; approximately 40% of Medicaid's air ambulance volume comes from this single county, which has approximately 12% of total program members.

This waiver will decrease overutilization in three ways:

- The development of Statewide requirements will even out access throughout the State;

- Contracts structured around flat periodic payments will eliminate the natural incentive for volume driven by fee-for-service payments; and,

- Cost-sharing requirements on newly-eligible members will be made clear and transparent for inter-facility air ambulance transports;

These decreases in volume will result in savings not only to Medicaid, but other Federal payers, including Medicare, the U.S. Department of Veterans Affairs and TRICARE.

In order for the payment reforms in this proposed waiver to be effective, however, they must apply to the air ambulance system as a whole. **This waiver must be all-payer, because there is a fundamental inter-dependence between Medicaid and the rest of the payers in the system:**

- The Medicaid program needs the participation of other payers for any reforms to be effective, since Medicaid's share of the air ambulance payer market is low (~12-13%).

- At the same time, other payers need the joint Federal/State Medicaid program to implement any reforms in this particular industry, as the Airline Deregulation Act has effectively pre-empted most State-only regulation.[8]

2. Rationale for the demonstration. [§ 431.412(a)(1)(i)]

There are three underlying problems with air ambulance services that the waiver aims to address: improving quality, equalizing access and reducing system-wide cost.

The previous section (1.2) illustrated the quality and access issues that justify the waiver for current Medicaid members.

[8] Scarano and Bryant. "Federal Preemption of State Regulation over Air Ambulances." Air Medical Journal. 2009.

Cost, however, is a significant factor for all private payers in the State. Simply put, the *average cost per transport* is too high, and the burden of this cost largely falls on Wyoming employer groups.

This is, fundamentally, a structural problem in the system caused by high fixed costs being spread out over decreasing volumes of patients.

- Industry cost studies have estimated that the average cost for operating a single air ambulance helicopter or plane and its base is approximately $3 - $4 million per year.[9]

- These costs are dominated by fixed costs as opposed to variable costs. An estimated 80 - 85% of any given base is spent before the base responds to a single call. The reasons are intuitive:

    - Helicopters, planes, medical equipment, and flight simulators are capital-intensive.

    - Staffing (pilots and medical professionals) must be continuous, in order to respond to unpredictable demand (i.e., emergencies).

- Because 9-1-1 scene responses are relatively rare[10], most companies cover these high-fixed costs through volume from less-emergent transport situations (e.g. inter-facility transports).[11]

- This is exacerbated by the current fee-for-service model, which incentivizes the air ambulance to produce more and more volume as the aircraft generates no revenue unless the aircraft is transporting a patient.

- In spite of high fixed costs, the number of helicopters and planes in the industry has grown steadily in both Wyoming and the United States, as shown in Figure 5, on the next page.

- While this growth in supply may have benefits in terms of access, it has also occurred disproportionately to expected demand from natural population growth. As a consequence, productivity nationally has dropped from a high of 688 patients per helicopter per year in 1990 to 352 in 2016.[12]

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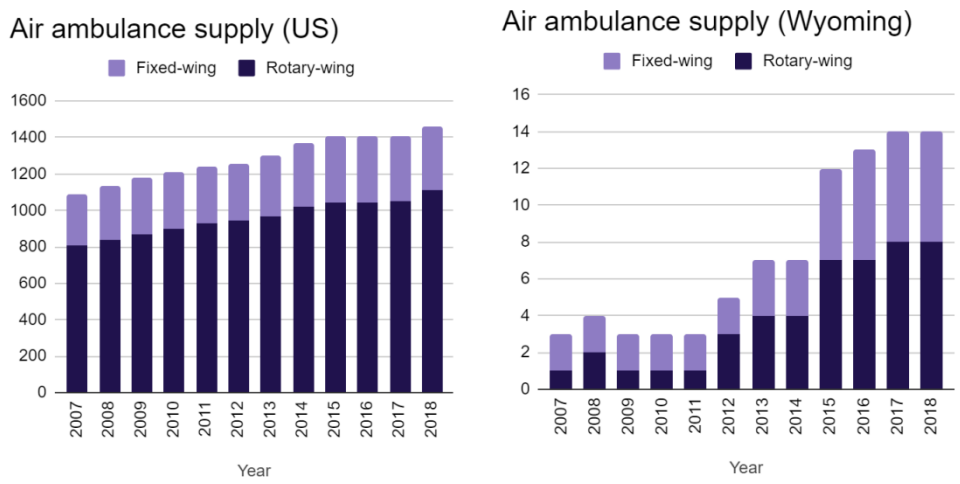
[9] Xcenda. Air Medical Services Cost Study Report. 2017. https://aams.org/wp-content/uploads/2017/04/Air-Medical-Services-Cost-Study-Report.pdf

[10] Data from Wyoming OEMS indicate that scene responses made up approximately 10% of all transports in SFY 2018.

[11] Maryland Health Care Commission. "Air ambulance study required under Senate Bill 770." Dec. 2006. 18.

[12] https://www.bloomberg.com/news/features/2018-06-11/private-equity-backed-air-ambulances-leave-behind-massive-bills

Figure 5: Growth in air ambulance supply, 2007 - 2018.[13]



- With high-fixed cost operations that are less and less productive, the **average cost per transport** has increased. In 2015, the national average cost per transport was estimated at ~$11,000[14] — over three times higher than an estimate from 2006 (~$3,200).[15]

- Medicaid and Medicare rates have not kept up with this increasing average cost. The same industry study estimates that Medicare cost-coverage per trip was approximately 59%.

- This leads to air ambulance providers increasing charges on private payers in order to make up revenue. The GAO has found, for example, that the median **billed charges** to payers have increased from ~$17K to ~$30K between 2010 and 2014.[16] A more recent GAO report pegged the median billed charge at ~$40K in 2017.[17]

- In Wyoming, self-insured employers seem to be paying a high percentage of these billed charges. The average **allowed amount** in SFY 2018 for Wyoming employers, for example, is estimated at $36K.[18]

- When payers accept these increased charges, it directly increases premiums. When they don't, it causes network negotiations to break down, directly increasing the likelihood of surprise billing on individuals.

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[13] Atlas and Database of Air Medical Services (ADAMS) http://www.adamsairmed.org/products.html
[14] Xcenda report.
[15] Maryland Health Care Commission. 29.
[16] GAO-17-637.
[17] GAO-19-292.
[18] Wyoming Multi-Payer Claims Database.

- When it comes to surprise billing, media headlines give the impression that people are routinely receiving bills in the $30 - $100K range. Yet air ambulance companies maintain that that the average they collect is ~ $300.

- Interestingly, both of these stories can be true. Combining data submitted by air ambulance providers with an air ambulance patient survey, we estimate that:
    - ~90% of individuals do not pay anything. They are on Medicaid, Medicare, are in-network and have met cost sharing requirements, or indigent.
    - Of the ~10% of patients who pay something out-of-pocket, the average is ~ $2,250; the median is ~ $1,200, and we estimate that 95% of this 10% group pays less than $7,000.

    - We estimate < 50 people per year in Wyoming (out of 4,000) pay more than $10,000 out of pocket, and < 4 people pay more than $40,000.

    - These estimates, however, only capture amounts paid; they don't capture any of the impact of the bills themselves (e.g. whether individuals paid in full, went on a payment plan, or declared medical bankruptcy).

This structural problem is fueled by a microeconomic market failure on the demand-side of the equation.

- While air ambulance companies often compete for contracts and referral arrangements with specific hospitals, particularly in more urban areas[19], hospitals aren't ultimately paying the bills — individual patients are.

- In emergency situations, these patients often have no choice on what services are used, much less *which* provider is called based on price or quality. In many cases, patients may be unconscious and unable to make a choice, even if offered.

- In less-emergent situations (i.e., inter-facility transfers), out-of-pocket costs are often a complex function of network arrangements, insurance plan and cost-sharing design, and the risk of medical necessity reviews. These create significant information barriers for patients who may be in a position to weigh cost in their medical treatment decisions.

- Despite decreasing volume, the continued expansion of the air ambulance industry suggests that profitability is simply a matter of increasing billed

[19] Maryland Health Care Commission. 19.

charges.[20] Ultimately, the only market check on prices charged may be the inherent difficulties in extracting surprise bills from patients.

Given these issues, it is difficult to imagine that the current distribution of air ambulance services has been determined to be optimal by a free market — i.e., that people are voting with their dollars for access or quality on an individual level.

In addition to advancing the objectives of the Medicaid program, the State therefore believes that this waiver has the potential to benefit all other State residents (newly-eligible under the waiver), by:

- Lowering the average cost per transport by concentrating the State's air ambulance volume on contracted providers;
- Thereby reducing the effects of cost-shifting from public payers, without increasing Medicaid or Medicare rates;
- Thereby reducing prices charged to private payers and eliminating surprise billing on individuals;
- Implementing standardized and transparent cost-sharing for patients;
- Reducing overutilization; and,
- Coordinating air medical services with ground EMS for optimal coverage.

3. Hypotheses [§ 431.412(a)(1)(vii)]

The following hypotheses will be tested by this demonstration, using the measures and data sources listed:

(a) **Geographic rotor-wing trauma response coverage will improve**.

To test this hypothesis, the State will **measure**:

- Evaluating geographic (haversine) distance from contracted bases to points Statewide.
    - Data: new base locations, Wyoming cities and towns locations

[20] Similar economic arguments are outlined here: https://www.managedcaremag.com/archives/2019/4/air-ambulance-turbulence-consolidation-cost-shifting-and-surprise-billing

- Measuring changes in overall EMS response time to highway crashes.
    - Data: Highway crash data collected by the Wyoming Department of Transportation.
- Measuring changes in air ambulance response times.
    - Data: Air ambulance trip data collected by the Wyoming Ambulance Trip Reporting System.

(b) **Disproportionate air ambulance utilization will decrease for both the traditional Medicaid population and newly-eligible members**. To test this hypothesis, the State will **measure**:

- Count of fixed- and rotor-wing air ambulance trips by county and county subdivision.
    - Data: Air ambulance trip data collected by the Wyoming Ambulance Trip Reporting System.

(c) **The average cost per flight will decrease**. To test this hypothesis, the State will **measure**:

- Average cost per flight.
    - Data: Total amount of air ambulance costs, as paid by Wyoming Medicaid in fixed-price contracts, divided by the total number of trips delivered.

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II. ELIGIBILITY

1. Newly-eligible populations. [§ 431.412(a)(1)(ii)]

The demonstration would expand eligibility to all persons requiring an air ambulance flight in Wyoming, regardless of residency or income level, for the specific benefit of air ambulance transport.

For the purposes of this application, we will refer to this group as the "Air Ambulance Expansion" (AAE) group.

2. Eligibility standards and methodologies. [§ 431.412(a)(1)(ii)]

There would be no eligibility changes for existing Medicaid members.

For the AAE group, eligibility would be processed retroactively upon having an air ambulance flight. Once processed (see how this interacts with cost-sharing and TPL identification in the next section), AAE eligibility would expire after 12 months, though would be renewed upon having a subsequent transport.

With the exception of waiving freedom of choice (i.e., any willing provider) for all Medicaid members, this demonstration would not affect any other statutory protections associated with Medicaid eligibility, either for the traditional Medicaid population or this air ambulance expansion group (e.g. comparability, reasonable promptness, ADA, non-discrimination, A/D/S, due process, continued benefits, etc.).

3. Enrollment limits. [§ 431.412(a)(1)(ii)]

There would be no limits on enrollment. Any person receiving a flight from a contracted Wyoming Medicaid air ambulance provider would be processed retroactively for Medicaid eligibility, per the flowchart in Section III.

4. Projected demonstration enrollment and impact on overall Medicaid enrollment. [§ 431.412(a)(1)(iii) and [§ 431.412(a)(1)(iv)]

As of June 2019, there were 54,982 members in Wyoming Medicaid. The State of Wyoming has an estimated population of 577,737 people.

As noted above, however, eligibility would be processed retroactively upon having an air ambulance flight. This means that the actual number of individuals enrolled in the AAE group will be proportionate to the volume of air ambulance transports.

The following estimate uses the conservative assumption that there will be no decrease in air ambulance trip volume.

- In SFY 2018, there were ~ 4,000 air ambulance trips for the entire State. 500 of these were for current Medicaid members.

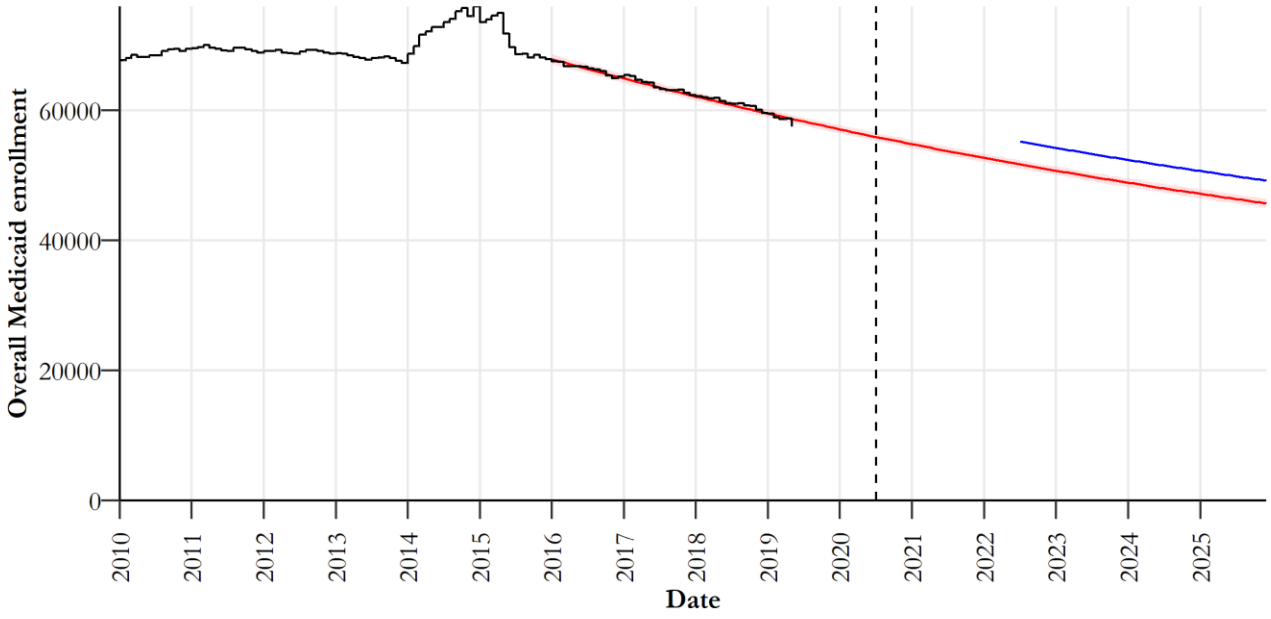
- An estimated 3,500 people would therefore be processed for eligibility each year under the waiver, upon having an air ambulance flight from a contracted Medicaid provider.

- Because air ambulance transport is a relatively rare event, and because AAE eligibility would expire after 12 months, we estimate that this new AAE eligibility group would remain at approximately 3,500 members, with relatively high churn rates, due to the relative rarity of air ambulance transportation.

As such, we anticipate total monthly Medicaid eligibility to increase to 3,500 people above projected levels.

Figure 6 below shows actual total monthly Medicaid enrollment (black), projected without-waiver Medicaid enrollment (red), and projected with-waiver enrollment (blue), assuming that the waiver is approved July 2020 (dashed line) and implemented two years later (see implementation section).

Figure 6: Medicaid enrollment trends, with and without waiver



Note that the projection used in this figure assumes a linear trend for all major eligibility groups, fitted on 2016 - 2019 data, coupled with a lognormal likelihood (as counts of eligible individuals cannot be negative).

Economic conditions obviously affect eligibility, particularly for the largest groups (children, low-income adults), and there is no guarantee current trends in that regard will continue until 2025.

Nonetheless, by the beginning of waiver implementation (here, July of 2022), we assume total monthly Medicaid enrollment will be approximately ~51,700 without the waiver and ~55,200 with the waiver. By year, we estimate the following annual average enrollments:

Year	2021	2022	2023	2024	2025
Without waiver	53,850	51,800	49,886	48,115	46,452
With waiver		54,800	53,386	51,615	49,951

5. Post-eligibility treatment of income. [§ 431.412(a)(1)(ii)]

AAE members will only be treated by income when it comes to cost-sharing requirements, as discussed in a later section.

6. Eligibility procedure changes. [§ 431.412(a)(1)(v)]

As noted above, AAE members will be made eligible retroactively.

The State is not intending to undertake changes to Medicaid or CHIP eligibility standards.

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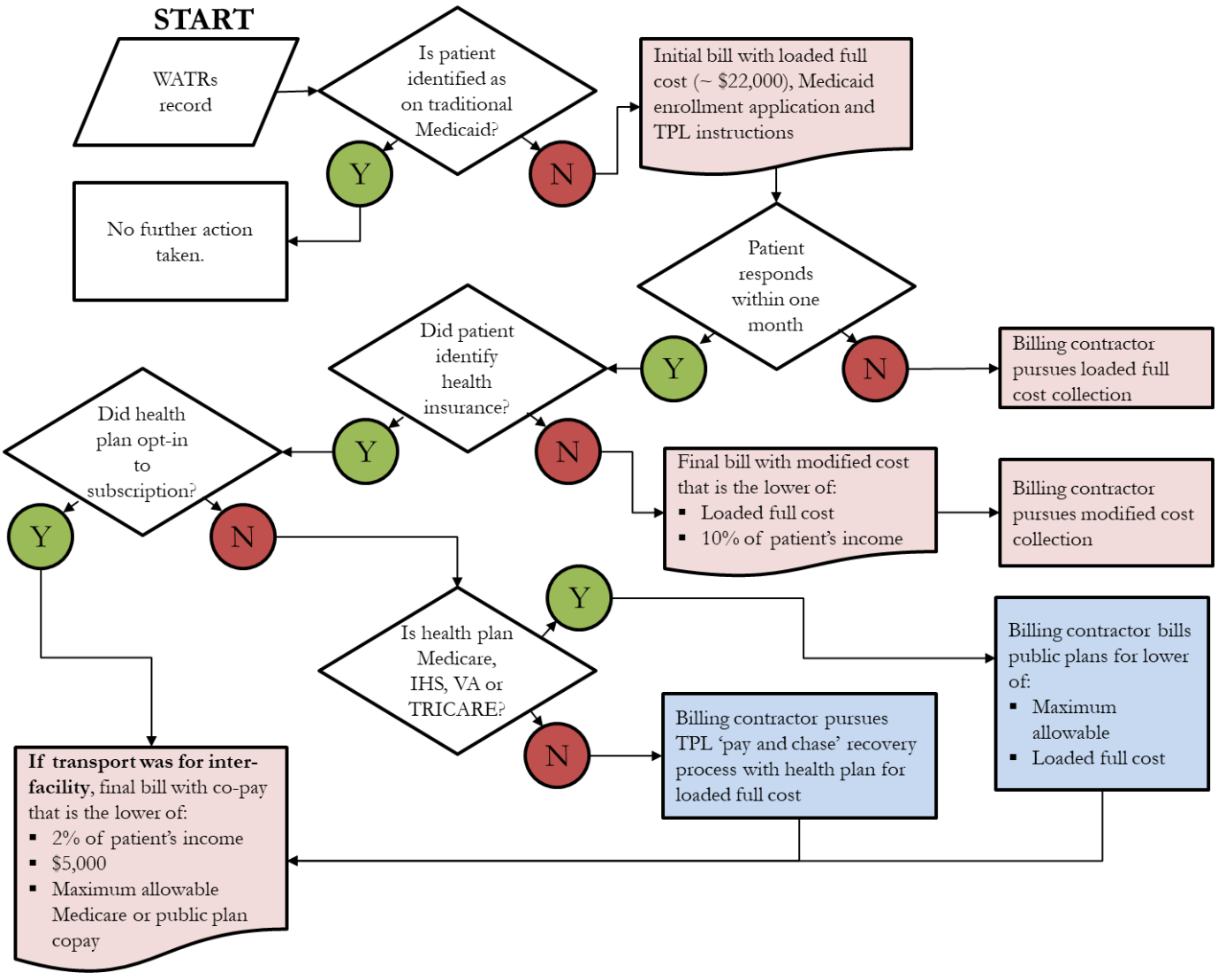
III. Benefits and Cost Sharing

1. Benefits for the new AAE group will differ from current Medicaid and/or CHIP members under the current State plan. [§ 431.412(a)(1)(ii)]

The sole medical benefit available for the AAE group will be air ambulance transportation that: (a) must be ordered by a medical professional through the centralized call center and (b) must be provided by a contracted Medicaid air ambulance provider.

2. Cost-sharing for the AAE group will also differ from current Medicaid and/or CHIP members. [§ 431.412(a)(1)(ii)]

From the patient's perspective, we anticipate the following interaction with the Medicaid system. In the flowchart, pink items represent steps observed by the patient, and blue items represent steps observed by other payers.



Note on the figure that the co-pay will be for inter-facility transports (i.e., *not* 9-1-1 scene responses) only. The copayment will be capped at the lower of:

- A full amount set by Wyoming Medicaid in policy (e.g. $5,000); or,
- A certain percent of gross income (e.g. 2%); or,
- For Medicare, IHS, VA or TRICARE members, the maximum allowable copayment.

The full copayment will, in effect, be a rebuttable presumption of patient liability if proof of income is not submitted by the individual. Similarly, the flowchart illustrates how Medicaid enrollment, demonstration of income, and TPL identification are pathways to avoiding a fully-loaded bill.

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IV. DELIVERY SYSTEM

The waiver proposes the creation of a comprehensive and coordinated all-payer air medical system under the Medicaid umbrella that will significantly improve quality and value in this particular sector of the State's health care system.

1. Overview [§ 431.412(a)(1)(ii)]

As noted in the description, this system can be seen as a hybrid of two perspectives: (1) regulating air ambulance as a utility and (2) implementing aspects of managed care for air ambulance.

There is a strong justification for regulating air ambulance services as a **public utility**. In cases where an industry has high fixed costs, it often makes more sense for society to provide that good or service through a regulated monopoly. This avoids duplication of expensive infrastructure caused by multiple providers competing in the same area.

Electricity, water and natural gas transmission infrastructure are all good examples. So are public roads. It wouldn't make sense to have nine competing water utility companies digging and connecting water lines to your house, nor would it make sense to have ten toll road operators building roads from the same origin to the same destination.

Closer to air ambulance in operation, fire departments, police services, and even ground EMS services are all often regulated monopolies chosen by their local jurisdictions for the same reasons.

Concentrating the State's volume of air ambulance services among a subset of providers therefore offers the possibility of lowering the average cost per transport, because the high fixed costs can be used more productively.

Unlike a utility model, however, where rates are set to guarantee a return on capital while allowing variable costs to be passed to the consumer, the State is interested in **paying a selected number of air ambulance providers through fixed-price contracts, similar to how a state might contract with regional managed care organizations**. The fixed-price contract puts the risk of volume on the provider, discouraging volume that is not medically-necessary, and thereby reducing inappropriate utilization.

2. Managed-care considerations [§ 431.412(a)(1)(ii)]

This aspect brings the model closer to a managed-care framework, though the only benefit being provided would be air ambulance services. Specific to this framework:

(a) Member enrollment in the plan would be mandatory, in a sense, as the contracted providers would be the only available providers in the State. A central air ambulance call center would direct all State volume to contracted providers.

(b) The system would be statewide, though different providers could certainly be contracted to serve different regions or to meet different requirements (e.g. rotor-wing vs. specialty fixed-wing).

(c) Rollout of the system will depend on the quantity and quality of bids received in response to the State's Request For Proposals (RFP). No action will be taken to re-direct volume to contracted providers until they are in place and ready to operate.

(d) Access to care and depth of provider networks would be determined by the State, for the entire State population, during the requirements development process.

(e) Medicaid air ambulance providers would be selected based on a competitive bid process. As noted previously in the waiver, quality and cost would be significant factors in deciding to award contracts to providers.

3. Procurement process [§ 431.412(a)(1)(ii)]

To implement this model, the State would go through a series of steps:

- Develop broad requirements for statewide air ambulance service.
- Competitively procure those requirements on the private market. Contracts would be negotiated on a fixed-price basis, with Medicaid making flat monthly/quarterly payments to contracted providers;
- Competitively procure a centralized air ambulance call center that would route all air ambulance volume through these contracted Medicaid providers;
- Monitor access and quality metrics from these providers; and,

- Recoup revenue required to fund the system from private payers, Medicare, other public payers, individuals, and potentially local governments using Medicaid Third Party Liability 'pay and chase' authority.

3.1. Development of requirements

In the first step under this framework, the State would determine the required level of air ambulance service. Generally speaking, the State would examine these requirements in three categories:

- General rotor-wing scene response and inter-facility transport;
- General fixed-wing inter-facility transport;
- Specialty fixed-wing inter-facility transport.

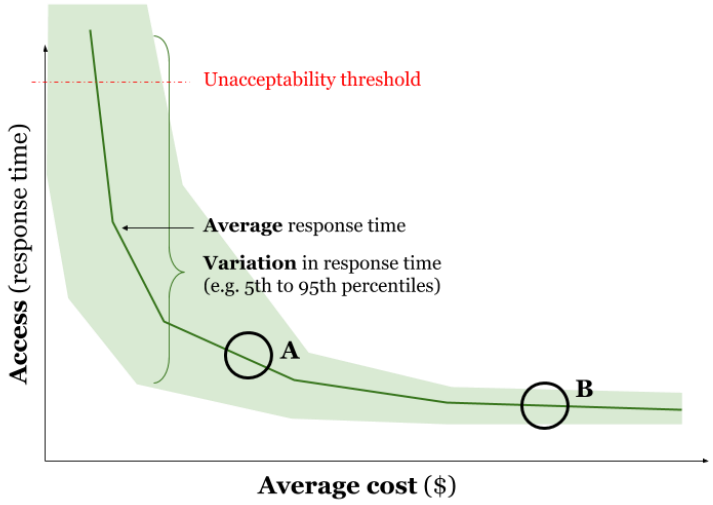
Setting requirements will necessitate making tradeoffs between cost and access. Using general rotor-wing scene response as an example, response time to any given scene is largely a function of how many bases there are in the State.

Figure 7, below, illustrates the hypothetical tradeoff, using response time as a simplified measure of access. Note on the figure that, the more bases (i.e., helicopters) that the State requires:

- The higher the average cost;
- The shorter (i.e., the better) the expected response time; and,
- The less variation (this is also better) there is in individual response times.

Note as well the diminishing marginal returns to more bases. At some point, even if you have a base in every town, there is still a floor to the response time. It takes 10 - 20 minutes, for example, between the time the call comes in and the helicopter takes off.

Figure 7: Hypothesized relationship between cost and access



The real question for the State, in this hypothetical example is, "are we at point A or point B?"

- If we're at point A, it'd be difficult to reduce the number of bases (move left on the curve) without dramatically affecting response time.

- But if we're at point B, significant savings could be made on the cost side without meaningful reductions in service.

Extensive modeling and simulation efforts during the requirements development phase will assist State decision-makers in evaluating the optimal number and geographic distribution of bases in the State.

3.2. Competitive procurement

Once the requirements are developed, the State would issue competitive Requests for Proposals (RFPs) to air ambulance companies nationally. While air ambulance infrastructure is expensive, it also happens to be more mobile than electric transmission towers or water lines. There are good reasons to suspect that many companies with no existing presence in Wyoming may be interested in responding to the RFPs. They may be interested in getting a foothold in a new market, they may find the guaranteed fixed payments attractive, or they may be interested in the reduced administrative load.

By leveraging the purchasing power of the entire State, the RFPs are also likely to attract interest nationally, making the bids more competitive. We therefore believe that this competitive procurement process will inject more free-market activity into the sector than exists in the status quo, and that this free-market activity will further drive down average per-flight costs.

The bid winners will become the *only* Medicaid air ambulance providers for selected regions in the State, will be based at locations selected by the previously-described public process, and will meet all requirements developed by the State and specified in its RFP.

3.3. Payments to contractors

Similar to managed care capitation, payment in the contract will be mostly fixed-price — i.e., defined monthly or quarterly payments just for capacity. Providers will therefore be at risk for volume of services provided. In addition to the fixed-price base payments, however, the State will include:

- Payments based on meeting quality targets (i.e., a percentage of randomly-sampled delivered according to clinical best practices, using data collected in the Wyoming Ambulance Trip Reporting System) and,

- Provider risk for situations where call volume temporarily exceeds capacity. All qualified bidders, for example, would be required to demonstrate contractual relationships in place with out-of-State bases that could be called upon in case of unexpectedly high demand. In these situations, the selected provider would pay for these flights out of their own pocket, pricing that risk into their flat-rate bids.

3.4. Operations

Once contracted providers are set up, the single Medicaid call center would begin fielding Medicaid air ambulance service calls for the State. These would include both 9-1-1 scene responses and inter-facility transport requests. As all State residents would be serviced by the contracted Medicaid provider(s), hospitals, physicians, highway patrol, EMS agencies, and all other first responders would be instructed to call the single center for any air ambulance service calls.

For each call, the call center would evaluate which base would be most appropriate (based on anticipated response time and requested capabilities), and route that call to the base location. The contracted air ambulance companies would provide services per the contract, and report all trip information into the existing Wyoming Ambulance Trip Reporting System (WATRS).

While it is conceivable that some of the existing (approximately six) air ambulance companies in the State who do not win contracts might attempt to continue to operate, the channeling of Medicaid (i.e., all) emergency and inter-facility demand volume through the central call center would likely eliminate demand signals to non-contracted providers.

3.5. Funding

To be clear, this model has the State Medicaid program assume the risk of paying for all air ambulance costs in the State. This means the State will need to ensure adequate revenue to fund the system, while remaining budget neutral to the Federal government.

For the purposes of this analysis, we assume a status quo number of bases and trip volume — though the ultimate goal is to develop coordinated statewide requirements, streamline the number and location of bases, and reduce unnecessary utilization.

Assuming each base costs $4 million per year to operate (i.e., no reduction in average cost),[21] the existing 11 bases in Wyoming likely cost the entire system ~ $45 million annually. This is a significant figure that cannot be covered by Medicaid alone.

3.5.1 State payers - Medicaid and Worker's Compensation

Of this total, State payers (Medicaid and Workforce Services) would contribute approximately $4.5 million annually through capitated per-member per-month payments.

Wyoming Medicaid expends approximately $2 - $3 million each year on air ambulance, on approximately 400 – 500 recipients. This is shown in Table 1, below.

Table 1: Annual Medicaid spending and recipients for air ambulance[22]

SFY	Expenditures	Recipients	Avg. paid per recipient (~ trip)
2013	$2,151,703	426	$5,050.95
2014	$2,371,206	505	$4,695.46
2015	$2,803,182	555	$5,050.78
2016	$2,322,223	484	$4,797.98
2017	$2,009,744	509	$3,948.42
2018	$1,977,432	358	$5,523.55
2013	$2,151,703	426	$5,050.95

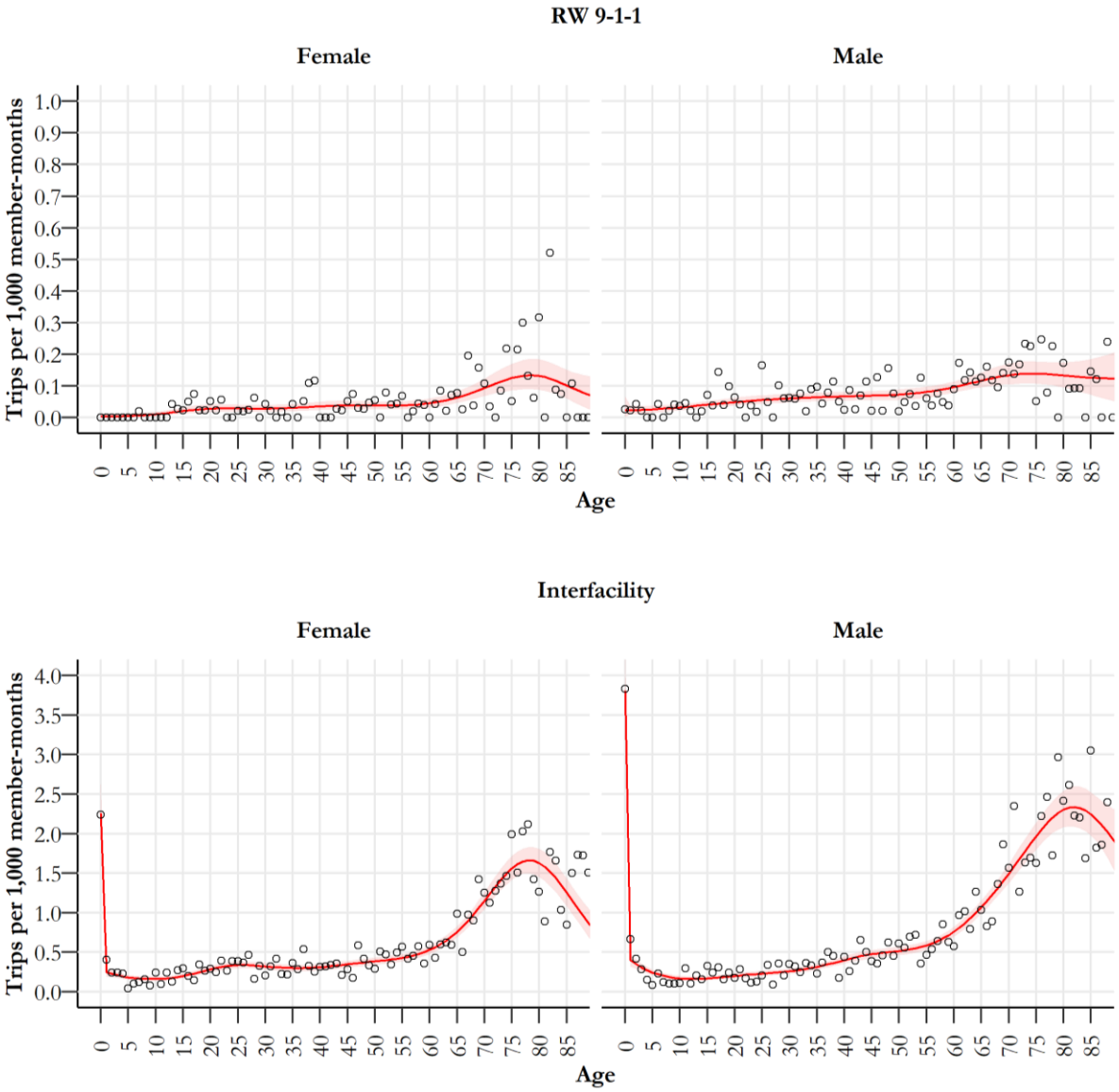
The Wyoming Department of Workforce Services expends approximately $2 million each year on 80 – 100 flights.

In order to maintain budget stability for each of these payers, a number of air ambulance trips per-member per-month ("trips PMPM") would be estimated for each risk pool, based on State-wide data from the previous year. The PMPM could

[21] Xcenda report.
[22] Wyoming Medicaid Annual Report, SFY 2018. Note that SFY 2018 data not included due to longer lag on incurred but not reported (IBNR) claims.

be age-rated, or differentiate between inter-facility or rotary-wing 9-1-1 responses, as shown in Figure 8, below.

Figure 8: Trip risk by age and sex for inter-facility and 9-1-1 scene responses. Black dots show observed rates for SFY 18, red line and shaded region show *fitted* rates and 95% credible regions.[23]



Once total annual counts are estimated for each payer's risk pool based on a model similar to Figure 8, that count would be multiplied by a per-trip "price" that would be similar to the average price currently paid by that particular payer. For Medicaid, this would be approximately $4,800 per trip.

[23] Poisson likelihood GAM fit on trip data from WATRS, using ACS 2016 1-year estimates of age-sex cells as offset, fit using HMC methods noted previously.

This kind of split (trip PMPM vs. price) capitation model allows both an actuarially-fair estimate of air ambulance risk for a given pool of covered lives while retaining the ability to charge different payers different prices.

3.5.2. Medicare

As implied by Figure 8, Wyoming residents on **Medicare** will require a large share of air transports. Based on SFY 18 trips, we anticipate that of the ~4,000 trips, Medicare members will be on ~ 1,500 of them (approximately 35%).

While, for the purposes of the central call center, dispatch, and service, Medicare members will need to be considered Medicaid-eligible for this service, Medicaid will also need to recoup whatever Medicare *would have* paid to the air ambulance provider on a fee-for-service basis by billing Medicare's Administrative Contractors similar to any other Medicare provider.

We roughly estimate Medicare revenue of approximately $12 - 13M per year, based on the data in Table 2, below.

Table 2: Estimated revenue from Medicare based on current trends

Mode	Annual trips	Base rate	Average distance	Mileage rate	Avg. trip paid	Est. total paid
Fixed-wing	750	$5,278.75	159	$13.28	$7,390.27	$5.5 M
Rotary-wing	750	$6,137.34	91	$35.43	$9,361.47	$7.0 M
Total	1,500					$12.5M

3.5.3. Self-pay

We assume ~ 10% of trips (400) will be from **self-pay** patients, based on the reported payer mix of a large air ambulance provider.[24] Some of these patients will be indigent, and the cost of uncompensated care will need to be loaded on to private payers. In the absence of prior information, we assume that this is high and that ~ 75% of costs will need to be written off.

3.5.4. Other government payers.

We estimate an additional ~5% (200) will be from other government payers (e.g. VA, TRICARE).[25] We assume these payers pay rates similar to Medicaid rates.

[24] Form 10-K SEC filing by Air Methods Corporation in 2016.
[25] Air Methods 10-K.

3.5.5. Private insured and self-insured plans

Subtracting the trips noted in items above from the total estimate of 4,000 trips per year yields approximately 1,300 trips that are likely covered by **privately-insured** and **self-insured** plans.

When all unreimbursed and uncompensated costs are loaded onto these private payers, an estimated ~$28 million will need to be collected, as shown in Table 3, below.

Table 3: Estimated trips, cost and revenue by payer

Payer	Est. trips	Est. cost (millions $)	Est. revenue (millions $)	Avg. price per trip (thousands $)
Medicaid	500	$5.94	$2.4	$4.8
Medicare	1,500	$17.81	$12.5	$8.3
Workforce Services	100	$1.19	$2.0	$20.0
Self-pay	400	$4.75	$1.2	$3.0
Other government	200	$2.38	$1.0	$4.8
Private plans + EGI	1,300	$15.44	$28.4	$21.9
Total (+5% admin)	4,000	$47.5	$47.5	$11.8

Interestingly, the estimated average required price per trip of ~$22K for private insured and self-insured plans is significantly less than what is currently being paid by plans and members tracked by the Wyoming Multi-Payer Claims Database.

These plans — which include the Wyoming State Employees' and Officials' Group Insurance plan — expend approximately $4 million on approximately 100 - 120 trips per year, with an average total price of $36,800. The full history by State Fiscal Year is shown in Table 4, below.

Table 4: Total air ambulance expenditures and trips for Wyoming self-insured payers in the Wyoming Multi-Payer Claims Database by SFY

SFY	Plan Paid	Member Paid	Trips	Avg. paid per trip
2015	$3,297,158	$36,290	102	$32,680
2016	$3,597,658	$32,445	103	$35,243
2017	$3,921,149	$26,327	112	$35,245
2018	$4,354,600	$27,287	119	$36,822

We are not clear if this discrepancy ($36.8K per flight vs. $21.9K per flight) lies in our assumptions about cost, provider profit margins, Medicare rates and uncompensated care, or if these payers are just paying a higher price in a private market that has some distribution of rates.

Nevertheless, this analysis hints at the potential cost savings to employers and insurers statewide from implementing this waiver.

When it comes to collecting, private payers and self-insured employers would be invited to "pre-pay" on a capitated PMPM basis, with their "price" being set on required revenue similar to Table 3, and the estimated number of total trips calculated from their risk pool demographics and a methodology similar to Figure 4. This invitation would be voluntary, but would likely be attractive to smaller employer groups, if only for its budget stability.

As an example for this 'opt-in' system, suppose a small employer — Acme Corporation — was covering a pool of 29 individuals in 11 households. Table 5 below shows how the expected trip risk is calculated for each individual based on age and gender, using the model illustrated in Figure 8. The total expected number of trips is then summed up for the pool, and the price per trip is applied to arrive at an estimated annual 'opt-in' premium for Acme Corp. of ~$3,800.

Table 5: Example "opt-in" premium calculation for Acme Corp.

Gender	Age	Expected trips	
		Inter-facility	RW 9-1-1
Male	34	0.00362	0.00076
Female	33	0.00368	0.00035
Male	2	0.00419	0.00027
Male	40	0.00483	0.00080
Female	38	0.00363	0.00040
Female	12	0.00205	0.00017
Male	62	0.01042	0.00125
Female	64	0.00840	0.00071
Female	17	0.00279	0.00029
Female	25	0.00405	0.00034
Male	55	0.00705	0.00097
Female	55	0.00516	0.00046
Male	17	0.00217	0.00053
Female	15	0.00242	0.00025
Male	13	0.00197	0.00045
Male	30	0.00313	0.00072
Female	30	0.00388	0.00034
Male	22	0.00258	0.00062
Female	21	0.00360	0.00034
Male	0	0.04572	0.00027
Male	35	0.00379	0.00077
Female	30	0.00388	0.00034
Female	5	0.00220	0.00006
Male	3	0.00370	0.00029

Male	28	0.00297	0.00070
Male	32	0.00334	0.00074
Male	45	0.00571	0.00083
Female	44	0.00409	0.00045
Male	12	0.00197	0.00043
Subtotal		0.15697	0.01488
Expected total flights			0.171849
Loaded price per flight			$22,000
Annual premium			$3,780.68

Those private health insurers or employer plans who do not 'opt-in' to this pre-payment system would be required to reimburse the State for each trip on a fee-for-service basis, using trip data reported by the contracted air ambulance companies and average prices required to sustain the fixed-price contract. This is further described in the next section.

3.5.6. Third Party Liability authority

Because **all patients would be considered Medicaid-eligible for the sole benefit of air ambulance — and their trip costs would have already been paid for by Medicaid up front** — collection efforts for individuals, private, and public payers would be undertaken through Medicaid's Third-Party Liability "pay-and-chase" authority.

These recoveries would be required from all privately-insured and ERISA plans that hold themselves out as health insurance companies in the State. Medicare, TRICARE and the Veterans Health Administration would be billed for services under their respective rules, with the State receiving the allowed amounts.

State statue would be amended accordingly to allow Medicaid to collect from all other payers TPL recoveries either:

- Based on the "opt-in" PMPM system; or,

- Through an average-cost fee-for-service methodology that loads the total costs of the system onto the volume, while balancing for under-payments from public payers and indigent clients.

This waiver would not remove obligations of health plans to provide emergency transportation services under the Patient Protection and Affordable Care Act.

V. IMPLEMENTATION

1. Implementation schedule [§ 431.412(a)(1)(ii)]

Implementation will be conditional on CMS approval and required State statutory changes being made effective. Table 6, below, describes the schedule in terms of month after the effective date.

Table 6: Notional implementation schedule

Months	Milestone
+ 0	CMS approval and State Legislative changes effective date
+ 9	State completes requirements development and issues RFPs
+ 12	Contracts awarded to selected air ambulance providers; rules promulgated re: cost-sharing and TPL rates.
+ 24	Providers in place and ready to answer calls; system activated
+ 36	First year evaluation and rate adjustments
+ 48	Second year evaluation and rate adjustments
+ 60	Third year evaluation and rate adjustments

2. Notification of enrollment for demonstration participants.

Upon implementation, participants will be enrolled retroactively in case of air ambulance transport. This eligibility process will be concurrent with cost-sharing collection and establishment of third party liability for each transport.

3. Procurement

Procurement actions will be required; these are described in Section IV(3) of this application.

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VI. Financing and Budget Neutrality

This section follows the structure of the Demonstration Financing Form located at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf

1. The State proposes to finance the non-Federal share of expenditures using the following:

- State General Funds
- Other: Third Party Liability collections

To meet budget neutrality, the State proposes operating the waiver under the "aggregate cap" methodology.

2. We acknowledge that Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan.

Under this waiver, providers will receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS).

3. We acknowledge that providers will not participate in any intergovernmental transfers (IGTs) or certified public expenditures (CPEs), and no portion of payments will be returned to the State, a local governmental entity, or other intermediary organization.

4. We acknowledge that Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

The State of Wyoming will assume risk of adequately funding the system.

- Initially, the non-Federal Share (NFS) of the payments to air ambulance providers will be funded through State General Funds appropriated by the Legislature to the Wyoming Medicaid program, located in the Wyoming Department of Health.

- However, a robust State Third Party Liability (TPL) process will recoup State and Federal costs from existing payers in the system (private insurers, self-insured plans, Medicare, and individuals), on a loaded average-cost (i.e.,

including administrative costs, reserving costs, and uncompensated care costs) basis in order to ensure the system is self-sustaining.

- TPL revenues (or State General Funds, if necessary) will be remitted to the Federal government based on Wyoming's Federal match formula to ensure budget neutrality to the Federal government.

- Table 7, below, estimates the Federal and non-Federal shares for the current Medicaid system, as well as the Air Ambulance Expansion (AAE) group.

Table 7: Federal and non-Federal fund breakdown

Category	State/Federal	Current Medicaid	AAE	System
Gross program costs	Federal	$1.2	$22.6	$23.8
	State	$1.2	$22.6	$23.8
	Total	$2.4	$45.1	$47.5
TPL recovery and cost sharing collection	Federal	($0.0)	($22.6)	($22.6)
	State	($0.0)	($20.6)	($20.6)
	Total	($0.0)	($43.1)	($43.1)
Net costs	Federal	$1.2	$0.0	$1.2
	State	$1.2	$2.0[26]	$3.2
	Total	$2.4	$2.0	$4.4

5. Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan.

- No supplemental payments will be made to providers, nor does the State intend to use an Upper Payment Limit to draw additional Federal matching funds.

- The "cost" of services will be determined through a competitive bidding process. Contractors payments will therefore depend on what bids are received and which contracts are awarded. However, the State believes that the average cost per flight will be lower under the proposed system than under the status quo, for three reasons:

    - The bidding process will be competitive, and national in scope;
    - The State will be leveraging the purchasing power of all residents;
    - The requirements development process will ensure optimal use of resources, maximizing productivity of very expensive fixed assets.

[26] This amount represents the State costs for the Workers' Compensation program.

- The waiver contemplates a Third Party Liability process that would recoup Federal funds expended for Medicare, VA, TRICARE and IHS clients, but these funds are being expended today under the status quo and are not 'new' funds being used for the demonstration.

6. Noting that all demonstrations must be budget neutral to the Federal government, the State proposes to use the aggregate cap method to demonstrate neutrality.

That is, the State will be at risk for both the number of member months used under the demonstration, as well as the per capita cost for demonstration participants; to the extent these exceed the total "without waiver" costs that are agreed upon.

In this particular case, the State proposes an **aggregate cap of $3.5 million,** which represents the upper bound of the 95% credible interval of projected WOW totals from CY 2019 to CY 2025, shown in Table 8, below. In other words, assuming current trends continue, the State of Wyoming estimates there is a 95% chance that annual "WOW" expenditures will be below $3.5 million.

Table 8: Historical and projected without waiver ("WOW") Medicaid air ambulance expenditures

Data	CY	Amount	95% uncertainty interval	
			Lower	Upper
Actual expenditures by service date	2010	$1,826,119	NA	
	2011	$1,754,349		
	2012	$2,194,438		
	2013	$2,167,716		
	2014	$2,626,582		
	2015	$2,638,819		
	2016	$2,367,467		
	2017	$1,775,903		
	2018	$1,945,139		
WOW model-based projected expenditures	2019	$1,911,408	$1,527,453	$2,306,217
	2020	$1,884,722	$1,354,359	$2,439,617
	2021	$1,867,777	$1,196,551	$2,599,276
	2022	$1,860,507	$1,053,867	$2,784,135
	2023	$1,862,989	$902,434	$2,971,920
	2024	$1,875,454	$773,299	$3,196,950
	2025	$1,898,153	$647,401	**$3,442,009**

To project these without-waiver expenditures, we trend forward the number of fixed-wing (FW) and rotary-wing (RW) trips and mileage, since total costs are a

function of both. Figures 9 through 11, below, show both the past trends (dots, smoothed averages, and 95% credible intervals around both the fitted trend and posterior distribution), as well as the projection for 2019 - 2025.[27]

For the projection, we assume a linear trend starting in CY 2016, largely because the Medicaid program has been in a 'steady state' since: (a) the 'woodwork effect' of the mandatory expansion in 2014, and (b) a new eligibility system coming online later that year.

Figure 9: Trend and linear projection for FW and RW air ambulance trips

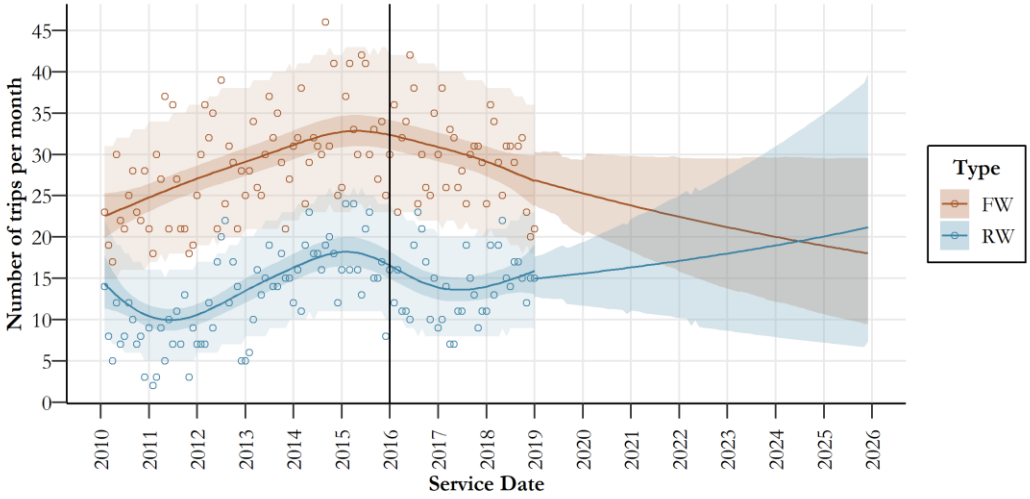
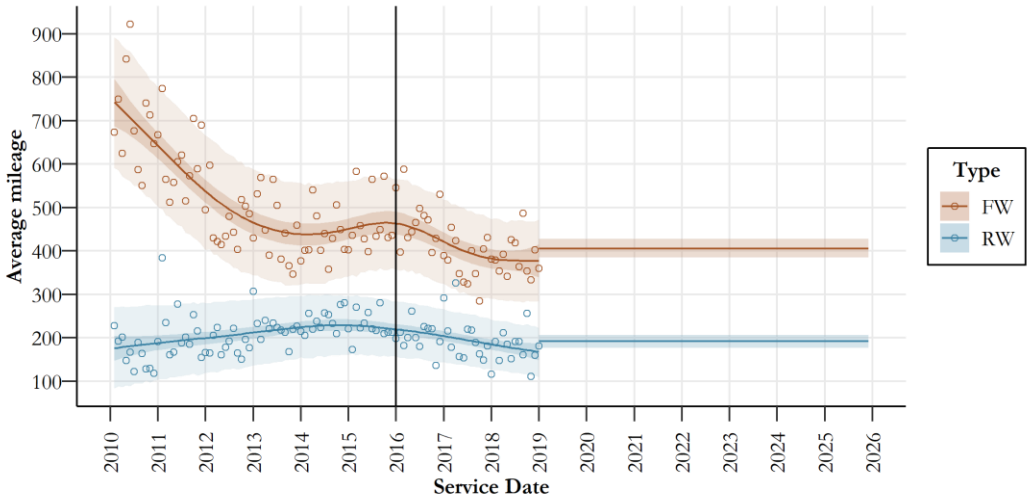


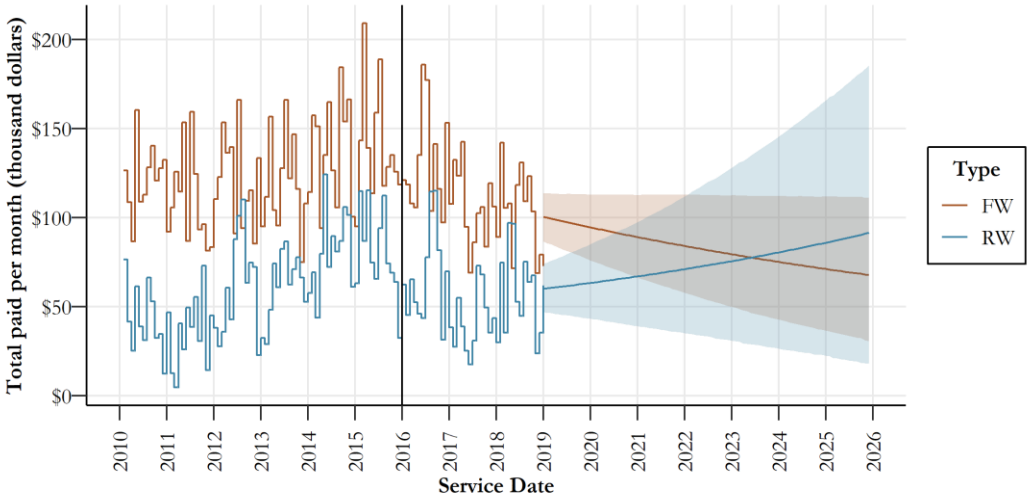
Figure 10: Trend and linear projection for FW and RW average mileage



[27] Trip models assume Poisson likelihood; mileage models assume Gaussian. Historical data fit using GAM; projecting fit using linear assumption of trend (trips) and constant (mileage). Models fit using HMC methods noted previously.

Note on Figure 10, that we assume average mileage has stabilized and will remain at the CY 2016 - 2018 average. This is due to the likely slowing of air ambulance growth since 2010, shown in Figure 5; i.e., so while fixed-wing mileage has fallen, we do not anticipate it falling further.

Figure 11: Projection for FW and RW paid per month



On Figure 11, the monthly paid amounts were generated from a multivariate model based on the projections from Figure 8 and Figure 9.

Projecting "with waiver" expenditures is much more difficult, since there are so many unknowns. With apologies to a former Secretary of Defense, the "known unknowns" include:

- How many bids will be received? What will be the average annual cost per base?
- How will volume respond to the changing payment incentives?
- How much can be collected from individuals, self-insured plans and private plans?

That said, we anticipate a total system cost of approximately $47 - 48 million per year. As previously noted the State intends to cover these costs through Third Party Liability recoveries — including assuming risk for any Federal expenditures over the $3.5M cap.

Table 9, on the next page, illustrates historical and projected with-waiver expenditures, breaking down funding sources into State General Fund (SGF), Federal Funds (FF) and Third Party Liability (TPL) collections.

Table 9: Historical and projected with waiver ("WW") Medicaid air ambulance expenditures

Data	CY	Amount	Net Medicaid expenditures		
			SGF	FF	TPL
Actual expenditures by service date	2010	$1,826,119	$913,059	$913,059	
	2011	$1,754,349	$877,174	$877,174	
	2012	$2,194,438	$1,097,219	$1,097,219	
	2013	$2,167,716	$1,083,858	$1,083,858	
	2014	$2,626,582	$1,313,291	$1,313,291	
	2015	$2,638,819	$1,319,409	$1,319,409	
	2016	$2,367,467	$1,183,733	$1,183,733	
	2017	$1,775,903	$887,951	$887,951	
	2018	$1,945,139	$972,569	$972,569	
WW projected expenditures	2019	$1,911,408	$955,704	$955,704	
	2020	$1,884,722	$942,361	$942,361	
	2021	$1,867,777	$933,888	$933,888	
	2022	~$47,500,000	~$950,000	~$950,000	~$45,600,000
	2023	~$47,500,000	~$950,000	~$950,000	~$45,600,000
	2024	~$47,500,000	~$950,000	~$950,000	~$45,600,000
	2025	~$47,500,000	~$950,000	~$950,000	~$45,600,000

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VII. Waivers and Expenditure Authority

1. Waivers [§ 431.412(a)(1)(vi)]

The State of Wyoming would apply to waive the following provisions in the Social Security Act:

- **Eligibility.** Sec. 1902 (a)(10)

  Under the proposed plan, every Wyoming resident would be covered by air ambulance services as provided through the "utility" / "managed care" model operated by Wyoming Medicaid.

- **Freedom of Choice.** Sec. 1902(a)(23)

  This project would waive "freedom of choice" of providers for Wyoming Medicaid members, as well as all Wyoming residents who would be newly-covered for air ambulance services under the waiver.

  The State plans to competitively procure air ambulance services on a regional or statewide basis, similar to how states procure Medicaid managed care plans under Section 1915. Under this model, air ambulance providers would be contracted to provide air ambulance services for all residents of a particular region. Therefore, participants would not have a choice of provider.

  It is important to note, however, that there is little consumer choice of provider in the current air ambulance market. Patients requiring air ambulance services are often incapacitated and rarely — if ever — "shop" for providers.

- **Third Party Liability recovery**. Sec 1902(a)(25)

  In order to fund the new system after paying for it up front, Wyoming Medicaid will need to recoup costs from Medicare, private insurers and self-insured plans who also cover the Air Ambulance Expansion population.

  For these individuals, the State proposes a version of "pay and chase" TPL authority where these payers are charged (and, in the case of private insurers and ERISA plans, required to pay) an average cost-based rate that includes State administrative and reserving fees. This version of TPL would be implemented in State statute specifically for this waiver.

VIII. PUBLIC NOTICE

1. The following documents will be provided upon submission of the final application to CMS. [§ 431.412(a)(1)(viii)]

1. Start and end dates of the state's public comment period.

- August 26th through September 30st, 2019.

2. Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

- So certified. The State has maintained https://airambulancewaiver.wyo.gov since May, conducted over ten public meetings, and noticed newspapers through press releases. Example: https://health.wyo.gov/more-public-input-sought-on-air-ambulance-medicaid-waiver/

3. Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

- The State has conducted the following public meetings:

Table 10: Air ambulance waiver presentations and public meetings

Date	Location	Web	Type
5/3/2019	Webinar	Yes	Limited stakeholder group
5/7/2019	Webinar	Yes	Open stakeholder group
5/8/2019	Webinar	Yes	Open stakeholder group
5/15/2019 (AM)	Riverton, WY	No	Tribal health meeting
5/15/2019 (PM)	Riverton, WY	Yes	Noticed public meeting
5/16/2019	Casper, WY	Yes	Noticed public meeting
6/14/2019	Riverton, WY	Yes	Legislative meeting
7/25/2019	Casper, WY	No	Limited stakeholder group
8/5/2019	Cheyenne, WY	Yes	Noticed public meeting
8/8/2019	Riverton, WY	Yes	Noticed public meeting
8/14/2019	Cheyenne, WY	No	Limited stakeholder group
9/3/2019	Torrington, WY	Yes	Noticed public meeting
9/5/2019	Laramie, WY	Yes	Noticed public meeting

4. Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used);

- The State has put together an open electronic mailing list of any stakeholder who expressed interest in receiving emails.

5. Comments received by the state during the 30-day public notice period.

- See Attachment A, public comments and responses.

6. Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

- See Attachment A, public comments and responses.

7. Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

- Tribal consultation was conducted on 5/15/2019 in Riverton as part of a larger WDH tribal engagement meeting.

- An additional Tribal public comment period began concurrently with the official public comment period on 8/26/2019.

IX. Demonstration Administration

The State's point of contact for this demonstration application is:

Franz Fuchs
Policy Analyst
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Attachment A: Public Comment and State Response

Public comment was accepted online from 5/2/2019 to 9/30/2019. These comments, along with a response from the Department of Health, are shown in Table 1, below.

In addition to these online comments, the Department received letters from five organizations:

- The American Heart Association (9/13/2019)
- The ERISA Industry Committee (9/24/2019)
- Children's Hospital of Colorado, Cheyenne Regional, and Wyoming Medical Center (9/28/2019)
- Air Methods (9/30/2019)
- GMR (9/30/2019)

These letters are appended to the end of this attachment. The Department's responses are shown after Table 1.

Table 1: Online public comments

What comments or feedback do you have?	Response from Department of Health
In September 2017, my life was saved when an air ambulance took me to Casper while I was enduring a heart attack. My insurance policy stated this service was covered. In February 2018, I received a bill for the ambulance in excess of $49,000. After several phone calls between all the entities, my insurance did send them payment, of just over $26,000, with the remainder written off. I do not understand how the company bills so much, when they willingly accept close to half the amount. Let's get real with costs. The air ambulance companies offer annual insurance for their services or $50 or $100 per person. How about Medicaid or Medicare pay directly for that insurance for each person on those insurance. It would save the government costs.	Thanks for sharing your story. As seems to be the case in a lot of the health care industry, the initial bill people or payers receive is often just the starting point for negotiations. This hopefully helps explain why (a) the initial bill was so high and (b) the company was willing to accept much less at the end of the day. As far as paying for "memberships," we did consider that option, but rejected it for two reasons: (1) it wouldn't really address the root problem (escalating average costs) and (2) it'd be administratively complex to administer. Imagine the State trying to collect premiums from 580,000 people, figuring out who's in good standing, etc.
I believe too much reliance is placed on air ambulance services by (corporate generally) medical practitioners. Many air trips could have likely been effected more cheaply by ground transport, or by having proper medical staff at outlying hospital facilities. I carry notification in my wallet, stuck to my driver license,	This is certainly true in cases, but air ambulance is still an important resource, particularly in areas ground ambulance can't get too, or where distances are prohibitive. This plan attempts to put financial incentives in place for both providers and

advising that no air ambulance services be called in an emergency, and expressing my preference for transport to facilities in an adjacent county. My preference is for publicly owned and operated ambulance services. Privatized medicine needs to become a thing of the past.	patients in order to reduce unnecessary transports.
The state is paying for things for private citizens because they are expensive? This is insane. Is the DOT going to start providing a new engine for my car because it will cause a fiscal hardship and I have little control over having to replace it? Is the County Coroner supposed to pay for Grandma's funeral because it's expensive and I had no control over her time of passing? Is WDH going to start paying for hospital visits now too? Those are just as expensive and have the same cause. Life is not fair, and if I need a new engine or to pay for grandma's funeral or a trip in a helicopter to save my life that is up to me to figure out.	Personal responsibility is important. And while administered through Medicaid, this plan would look very different from how Medicaid works today. Air ambulance, for example, will not be free; we are streamlining and simplifying the co-pay to make it transparent to everyone, and we will be recouping the revenue needed to fund this system from existing payers. The proposed plan does have an income-based discount, but the reality is that low-income folks often have their bills written off today.
Please don't leave us without air ambulance. I know it's expensive to fly but Wyoming needs it. I would be more than happy to pay an annual insurance fee if needed rather than to be hit by an unpayable $50,000 transportation fee on top of the medical fees I would incur in a bad accident in the middle of nowhere Wyoming. Please , please address this. Just this last week 8 people were involved in killer accidents in places very hard to find help for them quickly.	This plan doesn't eliminate air ambulance in the State; we recognize how important access is -- particularly rotor-wing 9-1-1 scene response.
If you get into trouble in the backcountry there is search and rescue. To offset the cost of a rescue they use volunteers, and donations from the hunting licenses. If you donated then you get services without charge. Raising the cost of Wyoming licenses or of license plates for all of us in Wyoming could offset the use of helicopters in accident rescues and the costs could be averaged and anticipated yearly. I suspect part of the problem lies in that helicopters are owned and operated by our health care systems which are notoriously overcharging.	Some kind of fee or tax would definitely provide a more solid revenue base, but we recognize as well that raising taxes is a difficult proposition in Wyoming. The model we are proposing funds the system using the money already paying for the system, while hopefully reducing costs to those payers.
Please advertise on county 10 so your meetings will have relevant representation. A web page and email from dept. of health is not going to reach many of the general public.	Thanks for the comment. We did reach out to County 10 in later meeting notices.
This Has been successfully addressed in Maryland and	Our OEMS has met and toured with the

Virginia and the district of Columbia in rapid response and the golden hour of trauma I suggest you contact Howard r. Hampion, former head r Adams cowley trauma unit and MedSTAR trauma unit Washington DC, consultant trauma defense department his address is in Annapolis Maryland In you need assistance please contact me He is a world expert in trauma and systems	Maryland State Police, who operate a unique model re: trauma transports.
This has been a long time coming for most of Rural Wyoming. I applaud the efforts to bring streamline and cost effective air ambulance service to the state.	Thanks for the comment.
I am lucky to be able to access a policy for air ambulance through my work at the Hospital in Jackson. We have Federal BC/BS but as I discovered from a co worker who has the same insurance. Her husband needed AAS and they had a huge bill for this service. Having to choose between air transport in a crisis and the idea of financial hardship for this kind of service should not be a part of the decision for people. We live in a state with very isolated places and small rural hospitals for the most part. WE need a system in place that accounts for this.	This plan does emphasize the need to develop Statewide requirements that are holistic, and based on where the demand happens. Particularly re: rotor-wing, geographic access is a critical component.
Maryland has a State funded Air service that is operated through their State Police. A State funded program could work in WY. 3 mill. Per year per base. Take all money currently being spent on air ambulance services and pool it together. Take your current State funds that are being spent on air ambulances and put it in the pool. Talk to private insurance companies and Medicare and offer a reduced flat rate off of totals being spent on air services per year.	This plan is similar to what you're proposing, only we will be issuing competitive bids to operate the system vs. actually owning the assets like the Maryland State Police does. We would argue that competitive bidding through the private sector has the potential to reduce costs and spur innovation, compared with State ownership, but that of course depends on how much competition there is in the industry.
In the Riverton area, we are FORCED to buy air ambulance insurance due to the costs incurred and also the hospital operating rules. If you have a heart issue in Riverton, you HAVE to fly to Casper for a cost exceeding $30,000! Now, the hospital in their infinite wisdom decided if you need an ambulance outside of 12 miles from the hospital, again, life flight will be called and you will be handed an outrageous bill. You have NO choice but to buy flight insurance from BOTH air ambulance companies. That's a fact of life in Fremont County and apparently ONLY in Fremont County. This borders on extortion and yet, the hospital in ca-hoots with BOTH air ambulance companies get	If this plan were implemented, these memberships would become obsolete; while flying would not be free to patients, we do cap the financial exposure as a percentage of income.

away with it!	
I recently took a Guardian flight from Lander to Casper. I did so after the ER doctor in Lander told me that I had a serious abdominal infection that could kill me and I needed to be treated in Casper. Guardian picked me up in an ambulance, took me to the Lander airport and loaded me on their Kingair. This was a training flight for a new employee which involved her being observed by three additional employees while she was the only one attending to me. We flew to the Casper airport. I was placed in ground ambulance for transport to Wyoming Medical Center. Total elapsed time Lander Hospital to Wyoming Medical Center about "TWO HOURS". Five guardian employees on board, the cabin heater did not work (the trainee spent the flight trying to keep me warm) and I heard the stall warning twice in the landing pattern in Casper. All of this when we could have driven in about the same time and then told by the Doctors in Casper that I was fine and did not need to be there. They found a bed for me to spend the night and dismissed me early the next morning. According to my Medicare supplement insurer Guardian Flight LLC billed Medicare a total of $62,384.00 of which Medicare approved $6,233.51 and my supplement paid $1,246.70 as coinsurance and/or deductible. Guardian and Sagewest are both private companies so we cannot access the records to examine Guardians justifications of charges or to see if Sagewest receives a referral fee for ordering Guardian transport.	Thanks for sharing your story. We have heard similar anecdotes that illustrate the range of cases that get flown. The plan we're proposing structures financial incentives for both providers and patients to only fly when necessary. Additionally, the bidding process would let the State impose minimum quality requirements on eligible companies.
I understand that air ambulances are expensive. I also understand that those that (majority) are given the flights are in a life and death situation. when a ambulance service calls for a bird there are guidelines that have to be followed to ensure correct usage. what some people fail to remember is the distance to facilities and the lack of facilities that are able to handle certain emergencies. for example strokes. I live in the North east corner of the state and the closest neurological centers are Rapid city, SD and Casper, wy. rapid is a 80 minute drive at the best. casper is a 3 hour drive. when time is brain what do you want to have happen? flight where you can be at a hospital that can	Air ambulance is definitely connected to the realities of the existing health care system. We are not proposing eliminating air ambulance flights -- just setting up the system so the existing assets are used more productively. If hospital capabilities were improved in certain areas, the State would factor that in to its requirements development process. The "insurance" offered by air ambulance companies may seem cheap, but that is only because it covers the patient out-of-pocket

take care of you in just over an hour after being seen at a facility that can start treating you or the slow road by ground? cardiac centers, yes gillette has a cath lab but those patients that need cardiac surgery, billings, Mt or Casper, wy. again time is muscle or even a life. what would you want? so lets look at the cost per flight hour for the helicopters and planes. the equipment that is needed to make sure you arrive to the facility safely and hopefully alive. the personnel needed to be on stand by because they have to be at a facility at relativity quick to assess and get the pt ready for the flight. most of these people are on shift for a couple of days at a time because of the potential emergency that requires the attention of their expertise 24/7/365. Majority of all of theses services offers some type of insurance and it is somewhat cheap in the aspect of the flight. I read some of the house bill, and as a tax payer i'm not to happy that we are going to allow someone to get onto medicare and have the taxpayers foot the bill as long as they can get approved within 90 days of the flight. totally unacceptable. because of the earned wages that my family earns you would deny us in a heart beat, and allow the company to bill us 50% of a yearly wage. i believe in the thought process you abused your body for a life time and now you need advance care you can also pay for your decisions. the taxpayers didn't force you to drink, smoke, etc your entire life. I wouldn't expect the taxpayers to foot my bills either. if you want to cap the amount money a service can charge than you better do something to make healthcare accessible in all areas and not just in isolated areas. I also heard that the state is upset about all the flights going out of state same issue lack of healthcare for specialties.	exposure. The real bill is being paid largely by employers in the State. Re: the taxpayers footing the bill -- (1) this plan is paid for, by the existing dollars in the system. No additional State or Federal funds should be spent, at least once its up and running. (2) Flights will not be free for people. Unlike Medicaid, we will be charging people clear and transparent co-pays. Financial exposure will be capped as a percent of income, but that is essentially happening today (air ambulance companies writing off uncompensated care), albeit in a haphazard fashion.
This is the stupidest thing ever. Living in a rural area air ambulance is a huge necessity. Our local AMR ambulance service can't staff a crew half the time let alone transport critical patients. 90% of the time you	Thanks for your comment. This plan does not intend to get rid of air ambulance; as mentioned in our previous responses, we want to prioritize geographic coverage for

barely have an AlS attendant available. The state of WYOMING is all the same. Patients can't survive a 3-6 hr ground transport when in need of a surgeon or cardiologist asap. Maybe if someone in the legislative family was in life or death need they would open their eyes and see what a necessity this service is. Look at other areas that need attention like healthcare charges at hospitals.	rotor-wing 9-1-1 response, particularly in rural areas where ground ambulance distances become long.
I am chairman of the Big Horn County Rural Health Care District # 4. I am also an employee of the Big Horn County Sheriff's Office and I sit on the insurance committee for Big Horn County. We are self insured for health insurance we offer to our county employees. The problem I see with the air ambulance, in south Big Horn County, is that they fly a huge percentage of their patients out of this small facility (South Big Horn County Hospital) to Billings, MT. Most of the flights are not necessary. Most of those patients could be send on to another facility by ground ambulance. Not only does the cost of the air ambulance have a drastic effect on people (the expense), but it also harms our ground ambulance service that loses business due to most of the patients being flown. Our insurance does pay fairly well on medical flights, but it has to be medically necessary. If Billings deems it not medically necessary for the flight, our people are charged the full flight cost. Our local hospital needs to utilize the ground ambulance service that is available.	We have heard similar anecdotes re: medical necessity, but believe that this is a result of the payment system (fee-for-service) that encourages volume. Changing those financial incentives on the front end will reduce the need to police medical necessity in the claims denial / utilization review process.
This is a very awkward and difficult time to make decisions about air ambulance system. Personally, I receive medical benefits from the VA and am also covered under Cigna, the state insurance. We were told by many that we need coverage in case of an accident needing the air ambulance. Since this is not covered by the VA or insurance, this insurance was presumed necessary to avoid medical bankruptcy in an emergency. Then it was explained that since we have two services, that we needed to get insurance for both air services. Not only for me but also my son who is at uw for the school year and only here for the summer. It just doesn't seem right and you hear all the horror stories about the huge medical bills even for people who are insured. Thanks for the opportunity to provide input.	As we noted above, if this plan were implemented, financial exposure to large bills would be capped as a percent of income, and buying 'memberships' with individual companies would not be necessary. Thanks for your comment!
Since we have no choice in which type if ambulance will be available when needed,, the cost should be	Under this plan, air ambulance companies would be agnostic about where patients

affordable so insurance and Medicare cover it. We should not be required to purchase separate ambulance coverage. Also, the patient and his or her family should be able to go the the medical facility of their choice, not be limited by county lines.	should be transported. Cost to the patient would be capped at a percent of income in order to minimize risk, but also incorporate some measure of personal responsibility in making the decision.
This is a much needed reform, using Medicaid to create an economy of scale is a reasonable and appropriate use of public resources.	Thanks for your comment.
I am concerned that this waiver does not address the problem of over utilization. It clearly appears that the main suspect for over utilization is Fremont County. I think that there must be some system accountability, if in fact over utilization is occurring. Given that the air ambulance company only responds to requests in good faith, it is not their prerogative or duty to decide which patients should go by air ambulance and which should go by ground. I am not convinced that just paying a fixed rate will solve this problem.	It is certainly true that Fremont County, for whatever reason, appears to be an outlier when it comes to utilization. The State, however, doesn't have the legal standing by itself to regulate the rates, routes, or services of an air carrier under the 1978 Airline Deregulation Act. Further, the health economics literature (i.e., see https://www.sciencedirect.com/science/article/pii/S0167268115001158 for a recent study) has shown that payment incentives matter when it comes to provision of care.
I wanted to let you know that I was very pleased to see that this is being looked at. As a Wyoming citizen, I am concerned about the increasing costs of air ambulance services. After reviewing the material, I was surprised to see that Fremont County tends to use these services at a higher rate than others. I live in Fremont County and this has been on my mind for several years. Currently, we have three air ambulance services in our Lander Community. (Two that are established, one that just moved in this month.) Clearly, these businesses are coming here for a reason - it is profitable. Currently, I have a membership with one of the companies, but there is nothing to say that the other company wouldn't be the one that would be there for me or my family if I needed the service. There doesn't seem to be a system in place to protect the consumer/patient. I do have insurance through the state, but I am concerned about balance billing after my insurance pays. I found it shocking that all of these companies in Wyoming are all out of network providers. I am concerned about the cost and expense these services have for families in our community. At a moment's notice, a family could experience extreme financial hardship by being life flighted out of our community. Another concern is that many of these companies have similar names and operate under an umbrella company with another	Thanks for your comments. It's clear that air ambulance interacts with the broader health care system, so some of the volume from Fremont county certainly may be driven by lack of specialists, etc. Under the proposed plan, the State would evaluate air ambulance requirements holistically, taking these differences into account.

name, and to be honest, I couldn't even tell you which one I have the membership with, and which one I don't. Ten years ago I was life flighted just prior to the birth of our twins to Denver, and at that time, we didn't have any life flight companies in Riverton or Lander. The air ambulance came from Denver to get me in Riverton. As someone who has had to use this service before, it does cause stress in the back of my mind. I know it is expensive and I know there aren't other options when you are in a situation like that. Now, we have three companies in Lander alone. A lot has changed in 10 years, but I don't think there is a better financial model 10 years later. Perhaps we need to also look at improving medical resources in Fremont County as the statistics were pretty shocking for our community. Too many people are being shipped out because they can't get the medical care they need in our community. I would like to see these conversations continue, and I'd to hear from the air ambulance and hospitals are saying in response. I'd like to make this a better situation for consumers/patients.	
My ultimate concerns are for a service that is ultimately available by both primary or backup methods. If air service is mandatory due to circumstances no one should hear response is unavailable due to in service response limitations. Further more, air service ,should meet a stringent maintenance and set rotation out of equipment guidelines . Air service is almost exclusively due to life and limb preservation. Hence those who require this service can not shop around for providers or cost associated with same and often have limited awareness of events around them. Hence they deserve to have the best response time, equipment / staffing, care and supplies at cost effectiveness available to them for a situation completely outside their control. Seems to me that services could be agreed upon for a set cost on a three tier method. Limited income. Retired but insured and finally fully employed and insured. It also seems as a limited population state with high tourists levels that a possible way to support Wyoming	The State intends to build risk into the contracts for providers to be able to call upon out-of-State assets in cases where demand momentarily exceeds available helicopters and plans. This tail risk would obviously be priced into the bid. Further, the State would ensure that minimum requirements are met for any providers in the RFP (e.g., CAMTS accreditation, certain equipment, etc.). In essence, we are designing a patient cost-sharing system that is more-or-less tiered as you suggest, due to the inclusion of the sliding scale based on income. Other revenue sources outside TPL are certainly possible; we wanted this waiver to be budget-neutral to both the State and Federal governments, as well as 'paying for itself", but things are certainly flexible if the Legislature desires.

residents and keep tourism strong might be if you have lodging, camp, ski, hunt, boat, fish etc you might pay x fee to support your air support if you find yourself in need and if not helps the residents of the state you choose to vacation in. Thank you.	
I think the state owned Air Ambulance program is the ay to go. In rural areas helicopters should launch on 911 calls for 2 reasons....Time=quality of life and rural communities cannot should not sent there only ambulance on a 2-5hr ground transport. That ambulance needs to be available for 911 calls. I would like to see the state bill insurance companies for the transport and then have the state/tax payers fund the remaining costs of the program. Question would the WY program be allowed to transport patients out of state Salt Lake City, Denver, Billings etc? Make sure he state specifies in the bid that helicopters must be AS350B3e/H125, AW109, or Bell407EagleHP. These are the only helicopters that work in Wyomings high altitude and high temps. I would hate to see WY get this program approved and then have the provider give us helicopters that can't lift anything. Feel free to contact me with Helicopter specific questions.	Thanks for your feedback. We recognize how important air ambulance services are, particularly in areas where ground service isn't available. The two modes (ground/air) should complement each other, not compete. Re: funding, we are, in essence, making the people who currently pay for the system (insurers and employers) continue to pay for it. Currently there is no plan for an additional State or taxpayer burden, but that could be added if the Legislature wills it. Regarding your question, yes -- patients would be flown wherever the physician and patient decide; air ambulance companies would be required to be neutral. Re: helicopters, thanks for those suggestions -- we certainly can evaluate bids based on the equipment and staffing plan companies propose, or even require certain helicopters, assuming it doesn't drive out the other bidders.
Your slides show cost recovery from Medicare. However, my experience with Medicare is they sometimes disallow coverage and if they pay it is only 80% of their approved amounts. Their approved amounts are ALWAYS lower than the actual charges and frequently much lower. It is not clear how the costs unpaid by Medicare would be handled; perhaps billed back to the individual? Current memberships in present air ambulance services are not addressed. How would these be handled? Would they be accepted by the new contracted provider(s)?	We would extract whatever is possible from Medicare, noting the very valid point you're raising here. What we can't extract would be loaded on to the other payers in the system, just as it is today, along with underpayments from indigent clients, those on the sliding scale, and Medicaid. However, if the State can succeed in lowering the average cost per transport (one of the major goals), then the degree of cost-shifting required on to private payers would also decrease, without those public payers having to raise rates. Regarding your second question, current memberships would not be honored, but nor would they be necessary. The plan would cap financial exposure to patients

	based on a percent of income. However, we do want to ensure those who fly pay something -- it shouldn't be free -- in order to reflect the cost of this very expensive mode of transportation.
I still don't really understand this from reading all the information.	We know this is a complicated subject. Is there any aspect that is particularly difficult to understand? Any way we can clarify the application or slide deck?
What will it cost me for a air ambulance ride?	If you have health insurance and the trip was between two hospitals (not 9-1-1 response), under this plan your copay would be $5000 or 2% of your annual household income, whichever is lower. If you were uninsured, then the cost would be the full average cost (we're estimating $22K) or 10% of your income, whichever is lower
When will you try to control your budget and reduce spending for a change? Haven't you heard of the state budget deficit? Duh.	Wyoming doesn't operate on a deficit; every budget must be paid for through funds available. So while there will be additional appropriations (spending authority) required for this waiver, the intent is that it will be budget-neutral to both the Federal and State government. We will be recouping all funds needed for the system from the people that are already paying for air ambulance -- Medicare, private insurers, individuals, and employer health plans, etc. Under the plan, in fact, total air ambulance spending has a better chance of being contained through both free-market levers -- competitive bidding processes, price transparency on consumers -- as well as regulatory measures (State developing the requirements for air ambulance).
I think this waiver is desperately needed. Given the vast distances in this state, air ambulance is often not a choice but a life saving necessity. Our family has had to use it once years ago and it was costly even then. The patient was covered by insurance, but insurance had a 'cap' for ambulance payments which was pretty minimal. So we paid out of pocket for the rest, I seem to recall it cost us almost $2,000. A huge sum for a $24,000 annual income. The 2% of income proposal for co-pays seems reasonable.	Thanks for your comments.

Wyoming Medicaid Coordinated Air Ambulance Network – Response Cc: Fremont County Commissioner Larry Allen 1. Does this plan cover air ambulance only? Ground ambulance will not be affected? 2. Pg. 1 - A centralized call center will be established: How will the centralized call center be paid for and what will the costs be for a staffed, 24-7 center? What kind of delay is this going to create in requesting air ambulance service for emergency transport, especially from the scene of an accident? How will this affect local E-911 dispatch centers? 3. Pg. 1 – Make periodic flat payments: This sounds more like "subsidizing" private industry which would be paid for by tax payers. How can this be justified when some counties are experiencing economic downturns? Is the State going to provide funds to help with this? Will this affect the yearly payments from the State to the counties, if yes, then the State has not given full consideration to the programs counties will have to drop in lieu of paying for air ambulance service? If the State is funding any portion of this plan, are they going to back out at some future point leaving the counties/other payers to bear the financial burden? 4. Pg. 1 – Set clear and transparent cost-sharing for patients on a sliding fee scale AND Recoup the revenue needed to fund the system from the insurance companies, employer plans and individuals already paying for transports: Again, this is all at the tax payers; expense, those who can pay will be doing all the paying! How will this affect those businesses/gov. agencies/private individuals who already have contracted for Air Ambulance Services? 5. Pg. 1 - "We believe these free-market principles are critical in reducing costs and "Overutilization". How can you consider it "free-market" when the State is planning on awarding bids to a select few providers? Will there be enough RWs in the state if this plan moves forward? Who will determine which agency is used when one is needed if there is more than one provider? And if overutilization is a problem, how is it	Thanks for your comments. I'll attempt to address these individually, below: 1. Yes, this plan only covers air ambulance, not ground ambulance. The waiver does, however, anticipate increased coordination with ground services happening. 2. The costs of the central call center, along with the other administrative costs of the system, will be loaded on to the bills to employers, insurers and individuals receive -- just as they are today (air ambulance providers have to pay for their own call centers now). We anticipate that a single call center that can coordinate all bases in the State will be more efficient and more effective than the current system (i.e., calling multiple providers to see who's available). Delays and inefficiencies should decrease. 3. The periodic flat payments are payment for services, not subsidies. Including the quality bonuses, they represent payment in full. Taxpayers would not be footing the bill here; funding would come from the employers and insurers already paying for air ambulance. So this should not affect State grants to the counties, etc. 4. As noted above, the waiver will not incur additional taxpayer expense. Businesses and organizations who currently contract for air ambulance services will find those contracts not to be necessary. 5. While certainly involving government regulation, the State developing Requests For Proposals (RFPs) and bidding them out on the open market injects **more** free-market activity into this sector than currently exists, as well as adding performance targets and quality standards that do not exist today. The RFP process itself would not be materially different from how the State does business today, whether

going to be curtailed in the future? Who/how will use be determined if there are caps? 6. Pg. 1 – While the waiver clearly advances the objectives of the Medicaid program while remaining budget neutral to the Federal government, it therefore also has significant benefits to all residents of Wyoming: Since the Feds will not be kicking in any money, this will solely be on the backs of WY tax payers (Gillette coal mines just laid off approx. 600/700 people, and wages are not keeping up with the cost of living in WY). There are going to be those who are having to pay a lot more than others! While stating this "clearly advances the objectives of the Medicaid program", raises concerns that any excess funds from this type of plan will be raided to fix/supplement Medicaid and not for the sole use of air ambulance service; if that is the case, if you are going to ask everyone to pay for it, everyone should reap all Medicaid benefits, not just air ambulance service. 7. Pg. 2 – Expands Medicaid coverage to all Wyoming residents…for air ambulance transport. Yet the term "current members" is used. The document later makes statements about those who do not opt-in, and collecting (pay/chase) and "loading" costs onto third-party - businesses/residents? Explain "pay/chase". Will this require another agency or more staffing? If so, how is that going to be paid for? 8. Pg. 6 - Significant efficiencies are therefore possible…consolidated on to one or two centrally-located bases in the state… Will this cut response times for those needing service who are farthest away from these "centrally-located bases"? Fixed wing can only go airport-to-airport so smaller communities would not necessarily have that as an option, how are you going to balance this out in deciding where these "centrally-located bases" will be? 9. Fremont County – usage…has disproportionately… What is the issue here, misuse of air service? Since these are 2018 stats, how has those stats been affected by the hospital policy changes (patients being sent to Lander, or anywhere else, etc. because Riverton no longer deals with many health issues), current ground ambulance policy/air service policy? Is there a higher	it's contracting consulting services or building a school. The number of helicopters and planes would be determined by the State from the beginning in order to meet needs. When there are multiple providers, the central call center will coordinate to ensure the most appropriate (closest or most responsive) asset is used in each case. Overutilization will naturally be curtailed by the economic incentives the waiver puts on providers (flat payments) and patients (clear cost-sharing). The State does not anticipate needing to conduct utilization review or medical necessity determinations. 6. As noted above, the waiver is not going to incur additional costs to either Federal or State governments, so it will not burden taxpayers. The people that will pay for the system will be the people using the system, and their health insurers. There is no intention of using this program to pay for Medicaid more broadly -- in Wyoming, all Medicaid expenditures must be budgeted for. 7. In order for this waiver to be approved, we have to demonstrate the benefit to the current Medicaid program, but we do spend a significant amount of time showing the benefits to the State as a whole. The term "pay and chase" basically means that Medicaid has already paid for the medical services (by paying providers that flat rate, up front) and therefore must now "chase" other payers to recoup the revenue through billing. This billing process will be contracted out to a single entity, which is another administrative cost (like the call center) of the system. It's important to note though, that this function isn't new -- air ambulance companies today all have to retain billing companies to recoup revenue. So this waiver actually reduces administrative costs in total.

proportion of elderly in Fremont County? If misuse is occurring shouldn't Medicaid look at their own policies/procedures first for improvement before trying to create a new program or policies? 10. Because 9-1-1 scene responses are relatively rare…again, has the policies (or policies in the works) of local agencies been looked at (1st Responder meetings wherein discussion of flights being auto-dispatched to a scene? Surely this affects cost and "over-utilization"?). 11. Pg. 13 - …expand eligibility to all persons requiring an air ambulance flight in WY… This is already available by yearly membership to the air ambulance service of the individual's choice. 12. Pg. 17 – regulate air ambulance services as a public utility. Doesn't "public utility" mean a monopoly? Again, does this really help in regulating anything except narrowing public choice and free enterprise? 13. Pg. 19 – The State would determine the required level of air ambulance service: Why would the public want the State determining this! And if that is how it will go, why not determine the level of service now and resolve the current issues (disproportionate use, or shortfalls). And the term disproportionate does not explain whether true need is the driving force? Sounds as if the State is planning on limiting flights in each county to "X" number of flights and who is the State to say how many flights are necessary anywhere! 14. Pg. 19 – the higher the average cost; the shorter (ie better) the response time – this sounds like response times are based on whether the air service is getting bigger/better payments for services rendered. 15. Pg. 20 – The bid winners will become the only providers for "SELECTED REGIONS" in the state. If this is a state-wide program, why the words "selected regions"? And is this going to serve the public well while limiting choices and access in time of need? 16. Pg. 21 – The Medicaid call center would begin fielding Medicaid air ambulance service calls… - Explain how this call center is going to get these calls?	8. When the State is evaluating requirements, it will have to factor in how response time changes for all State residents. The objective will to provide the most efficient and effective geographic coverage for rotor-wing, since distance matters far more here. These bases will not be "centrally-located," unlike the fixed-wing bases. In the case of small towns without airstrips, rotor-wing bases could certainly make hospital-to-hospital transfers. The determination of which asset is best positioned to respond would be made by the call center. 9. There are a lot of hypotheses why Fremont County is an outlier; many of these are in previous comments. We're not in a position to say what's driving the disproportionate volume -- it affects all payers, not just Medicaid. That said, the problem is more the uneven nature of access around the State. Some places have a lot of air ambulance, some places have very little. 10. The 9-1-1 scene responses are rare compared to inter-facility. We do not see an issue with overutilization here. 11. The memberships do not cover the cost of the flight -- just the patient's risk of balance billing. If balance billing were the only issue here, then yes, there are plenty of private-sector alternatives that would cover this. 12. Yes, "public utility" does mean a regulated monopoly here. The State regulating the supply through this waiver is the best way to reduce overall costs in the system while ensuring a given level of access. In the fee-for-service alternative, for example, the State would control prices, but would not be able to ensure providers would stick around under those prices. We

From local E-911 centers? If it still involves using E-911 dispatch, what burden will this place on them in extra steps to put calls in to the "call center"? How will this affect response times? 17. Pg. 21 – While it is conceivable that some of the existing companies…the channeling of Medicaid (i.e. all) emergency and inter-facility demand volume …would likely eliminate demand signals to non-contracted providers. Government directly curtailing free enterprise? 18. Pg. 22 – Worker's Comp. – how are these payments going to affect small business owners (who are already overburdened with the high cost of health for their employees)? 19. Pg. 24 – Self-pay: Isn't this contradictory to this proposed plan providing Medicaid air ambulance service to all WY citizens? 20. Pg. 25 – When all unreimbursed and uncompensated costs are LOADED onto these private payers, an estimated $28 million will need to be collected… This is a staggering amount that the State is planning on forcing tax payers to bear. Is this an annual amount? 21. There are people who do not want an air service "plan", they can purchase it from the air service if they do, yet this is going to force them to participate whether they want to or not. 22. Pg. 26 – "Invited" to prepay… - can or have to? Is it cheaper as opposed to having to pay monthly, yearly…? 23. Pg. 27 – Those private health insurers or employer plans who do not op-in… Are citizens/employers going to be held hostage for payment…What agency is going to be formed to act as collection agency and what is that going to cost? 24. Pg. 35 – This project would waive "Freedom of choice" – this statement really says it all!	would argue that choice of provider is not likely or relevant under any system, since air ambulances are called under emergencies. 13. Currently, no one is determining the level of access. In a free market, consumers would do this. But there is no free market here; consumers have little ability to 'vote' with their dollars on price or quality. If the State determines access, it would be done through a transparent and accountable public process. The State's interest is in ensuring fair access around the State to this important capability. 14. This page just generally describes the tradeoff between access and cost that the State would have to make. It doesn't prescribe a payment methodology. The same tradeoff exists today, only no one is making any decisions as to how to balance the two. 15. The State would likely issue multiple RFPs as opposed to a single Statewide RFP. Each base could potentially be bid out individually to ensure the most competition in the bid process, so there likely will be multiple providers in the system. We haven't worked out the details, but each base would likely serve a primary area (or "selected region"), while allowing for the central call center to draw on resources Statewide as circumstances dictate. The intent is to ensure fair, effective and efficient coverage around the State. 16. The call center would have one number that any EMS agency, provider, or hospital could call for air ambulance service. There are currently as many call centers today as there are air ambulance providers, so having a single point of contact simplifies the process, while ensuring all assets in the State can be drawn upon. 17. All we're saying here is that while the

	government would not directly prohibit non-contracted air ambulance companies from operating, it's very likely that channeling of most or all volume through the call center would effectively make it impossible for them to do business in the State. 18. If successful in reducing system-wide costs, the costs to small business owners should decrease under this plan. In other words, they will be paying less than they do today. Small employers are, in fact, the ones who stand to benefit the most (financially) from this plan. 19. While this is done under Medicaid, we do not intend for air ambulance to be free. Since its an extremely expensive mode of transportation, patients need to have some skin in the game. 20. As noted above, this waiver is not being funded by taxpayers. The unreimbursed care and uncompensated care costs that you note are already being loaded onto bills today. While the problem doesn't go away for the State, if the waiver is successful in lowering costs, the problem can be mitigated. 21. This waiver does not force anyone to buy a plan. The only people that will notice costs here are (a) employers and insurers, who are already paying for this service, and (b) individuals who have an air ambulance flight. 22. The "opt-in" pre-pay would be optional for health plans. The alternative would be "waiting to be billed if one of your members has an air ambulance flight." While it wouldn't be cheaper from an actuarial perspective, it would definitely be more predictable, especially for smaller employer groups.

	23. Under this plan, the State would contract with a billing agency to collect revenue -- as air ambulance providers do today to collect revenue. Since there would only be one billing agency (as opposed to multiple today, as each company likely contracts that function out), there would be less administrative cost in the system. 24. "Freedom of choice" is a Medicaid requirement for Medicaid members. However, in this particular industry, it's much less relevant. Very few people -- if any -- choose which air ambulance provider picks them up. This issue is really more of a technicality regarding Medicaid statutes than a meaningful change in how people interact with their health care providers.
This bill would make a huge impact to increasing our excellent level of care offered in WY. Statistics show we are one of the highest in average insurance cost and out of pocket to our consumers. A bill like this would greatly impact the overall wellness of our health program offered to our citizens. Price gouging and cornering of the market due to a limited rural resource pool have cost insurance companies and consumers an overwhelming amount just in the air ambulance services. Monopolizing a market as the air ambulance companies have done in Wyoming is at the very least an unethical practice especially when you see the demographic that generally needs air ambulance transportation. There is no set rate schedule or reasonable and customary cost structure as there is with every other covered emergency transportation. Our elderly, our infants, rural accident related trauma cases. These individuals should be concerned with getting to the best hospital not with declining air ambulance transportation due to exorbent costs. Most covered individuals also purchase memberships to these companies under the assumption it covers all air ambulance rides and as most have found this is most times a coverage offered by the air ambulance companies and covers a few that are out there but in the event of an emergency often times it is whoever they can contract to transport the patient not necssarily who they have a membership or set price with. This bill just makes sense it elimates the price gouging, it is a	Thanks for your comments.

very well thought out budget and pulling funds to take care of this program from liabilities employers are paying for these employees already and by eliminating the need in a private plan to have this covered should shift the cost of health plans for the better.	
I fully support the Air Ambulance Waiver proposal. It will help Wyoming citizens and self-insured employers.	Thanks for your comments.
I can understand patient's issues with the large bills they receive. I also know time is a huge factor in patient outcomes. I live on the western border in high mountains. How is a crew based out of Riverton going to improve my patients timely arrival at a higher level of care?	Good question. Short of the colossally expensive proposition of having a helicopter base in every single community, there will always be places in the State where air ambulance service will be uneven. This waiver doesn't make that problem go away; what it does is have the State make an explicit choice of how much access we need vs. how much we're willing to pay for it. We also note that 'rationalizing' the base locations -- putting them in places where they serve as many people as equitably as possible -- is a goal of this process. The devil, of course, is in the details. If this waiver is approved, there will have be a long public process of developing requirements: how many bases, what time, where should they be, etc.
The Wyoming Business Coalition on Health, a group of local Wyoming self-insured employers fully supports this waiver application. We believe this is an innovative, well thought out and appropriate response to current market conditions. It makes sense to us that a service such as air ambulance could be treated as a utility. This is a business that does not function under normal market conditions; the usual self-regulation of supply and demand does not apply to air ambulance services. We strongly urge CMS to approve this waiver and allow this process to continue. We've not seen a better suggestion for addressing the incredibly high cost of this air ambulance service to health plans (fully or self-insured) nor have we seen a better suggestion for how to deal with the surprise medical bills individual receive following air ambulance services.	Thanks for your comments.

State response to letters received

(1) American Heart Association letter to Director Ceballos, dated September 13th, 2019.

The AHA expresses support for the waiver application, but specifically requests the State consider policy implications on three topics: premiums, a sliding scale for cost-sharing, and evaluation and reporting.

The State believes these issues are addressed in the waiver. Specifically:

- **Premiums**. As the State notes in this waiver application, the intent is to lower costs for employers and insurers. Even if prices are lowered, however, the impact on premiums will likely be small, since air ambulance volume makes up a relatively small fraction of overall PMPM costs.

- **Sliding scale**. This waiver incorporates a de facto sliding scale for co-payments based on income.

- **Evaluation and reporting**. The State intends to track outcomes through its existing Wyoming Ambulance Trip Reporting System database.

(2) The ERISA Industry Committee letter to Franz Fuchs, dated September 24th, 2019.

ERIC appears to be in general support for the waiver, but takes exception to the Medicaid TPL recoveries on ERISA plans and requests that references to ERISA plans be removed.

Unfortunately, in order to recover the revenue required to fund this system, all payers must participate, either on the predictable "opt-in" basis, or on a "pay and chase" basis if the ERISA plan opts-out. Given that ERISA plans cover the vast majority of privately-insured lives in Wyoming, the State simply cannot afford to exempt ERISA plans from paying for air ambulance under this construct.

(3) Letter from Children's Hospital Colorado, Cheyenne Regional Medical Center, and Wyoming Medical Center to Franz Fuchs, dated September 28th, 2019.

This letter focuses on pediatric care, highlighting the connections that Children's Colorado has built with CRMC and WMC.

The letter requests that, should the waiver be approved and the State proceeds with its RFP process, winners of the bid should direct volume to a Level I Pediatric Trauma Center that operates an air ambulance service.

This is certainly a requirement that could be put into any awarded contract, but this will be up to whatever publicly accountable body ends up managing the RFP process. We note, however, that if

the scope of RFP requirements is narrowed too much, then bids could easily become less competitive. As with everything in this waiver, there is a tradeoff between access and cost.

(4) Letter from Air Methods to the Wyoming Department of Health, dated 9/30/2019.

This letter provides a long and detailed argument against waiver approval and recommends that the State pursue alternative means to address cost and access.

The State response is that the waiver application stands on its own merits. We note, however, this letter is probably the most comprehensive of the many objections we have heard to this waiver from the air ambulance industry, and it is therefore worth the attention of CMS in evaluating this proposal.

While the State's potential counterarguments are clear in this waiver application, the Department of Health is happy to clarify any points on a case-by-case basis as requested.

(5) Letter from GMR to Franz Fuchs, dated 9/30/2019.

As with the Air Methods letter, this feedback contains detailed arguments against submission of this waiver, not feedback on improving the application itself. We therefore cannot incorporate any specific suggestions from this comment.

American Heart Association.

Submitted Electronically to franz.fuchs@wyo.gov

September 13, 2019

Michael Ceballos, Director
Wyoming Department of Health
478 Hathaway Building
Cheyenne, WY 82001

Re: Wyoming 1115 Waiver – Air Ambulance Transportation Services

Dear Director Ceballos,

On behalf of the American Heart Association (AHA), I would like to thank you for the state of Wyoming's interest in addressing air ambulance needs through the state's 1115 demonstration waiver. The rising cost of healthcare continues to be a barrier to treatment and recovery for millions of Americans, including many with cardiovascular diseases and stroke. Air ambulances play a critical role in emergency care services, yet often come at higher costs, causing significant financial burdens on the uninsured, under-insured, and even insured patients.

As the nation's oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke, we would like to show our support for this waiver application. The AHA is deeply concerned about the impact of high medical bills as a result of emergency air transportation in the state of Wyoming and across the country. Each year nearly 800,000 Americans experience a stroke and more than 350,000 cardiac arrests occur outside of hospital settings.[1,2] Emergency transportation services reduce transport time for patients during life-threatening situations and are a critical component of successful treatment for individuals experiencing a cardiovascular event. Patients in these situations have no choice over who provides care or how they are transported and are frequently balance billed as a result. A GAO report published in 2017 found that between 2010 and 2014, the median prices for emergency air transportation services doubled, from approximately $15,000 to more than $30,000.[3]

[1] American Heart Association Heart Disease and Stroke Statistics 2018 At-A Glance. https://professional.heart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_498848.pdf
[2] American Heart Association Heart Disease and Stroke Statistics-2019 Update.
[3] https://www.gao.gov/products/GAO-19-292

The need for a comprehensive, uniform policy to protect all citizens from medical transport barriers positions the state of Wyoming as forward thinking in the access to care sector. For thousands of CVD and stroke patients, bills that result from emergency or routine care, including emergency air or ground transportation, can be life-altering.

As the state considers how to best expand coverage for these important services, the AHA would like you to consider the following policy implications on the market that could impact CVD and stroke patients:

- **Premium Impact:** the AHA asks the department to carefully consider any potential impacts on premiums as a result of the waiver across all insurance markets. Ensuring that air ambulance services are available to patients and consumers is contingent on developing a sustainable and affordable model that provides services while also controlling costs.
- **Sliding scale:** Additionally, the AHA askes that, a comprehensive approach is taken to developing a sliding scale model to ensure affordability to all residents of Wyoming.
- **Evaluation & reporting:** the AHA also encourages the state to develop a public evaluation and reporting mechanism in order to ensure the effective implementation and monitoring of this program, if approved.

AHA is ready to work with you and your stakeholders to ensure Wyomingites are protected from financial hardships as a result of balance bills, including those that result from emergency air transportation. Thank you for the opportunity to share our thoughts with you as you work to address this issue. If you have any questions or would like to discuss these comments further, please contact Mike Mores, Government Relations Director for Wyoming at the American Heart Association at mike.mores@heart.org.

Sincerely,

Mike Mores
Government Relations Director

Air Methods®

Date: September 30, 2019

To: Wyoming Department of Health

From: Air Methods Government Affairs

Re: Public Comments on Wyoming Department of Health 1115 Waiver Application: Wyoming Medicaid Coordinated Air Ambulance Network

On behalf of Air Methods' crewmembers and patients in the State of Wyoming, we appreciate the opportunity to provide the Wyoming Department of Health with our perspective on and objections to the Wyoming Medicaid Coordinated Air Ambulance Network Waiver Application ("Waiver Application"). Our goal is to provide insight to the State from our expertise operating air medical services across our diverse national footprint and built through almost 40 years of experience in this highly specialized industry. We understand how to address the true root problems of billing issues without putting patients at risk of losing access to these critical services upon which they depend. We also are pleased to provide the Department with details on the successful strategies that Air Methods has already undertaken to protect our patients from balance bills, including covering an additional 25 million lives in 2019 alone through new in-network agreements. As discussed below, as written the Waiver Application poses a direct risk to all Wyoming patients, including Medicaid beneficiaries, through diminished access to emergency critical care services. This health care risk is apparent to us as providers currently providing these services to Wyoming residents, from both our bases located in the state and outside of it, and we feel compelled to bring attention to the threats to rural health care access this Waiver Application will create if implemented as proposed by the State. Our comments also raise a number of significant legal impediments to adoption, including Federal preemption of ERISA and Medicare Advantage plans, as well as preemption under the ADA.

Air Methods would like to work with the State on an alternative course of action from this Waiver Application. Accordingly, Air Methods provides in our comments a list of legislative and regulatory steps that the State could take in its current authority and jurisdiction to protect both air medical patients and continued, sustainable access to these critical emergency medical services for all Wyomingites. We thank the State for the opportunity to continue to work on our shared goals of providing clinical care of the highest quality and value to the patients we represent and serve.

I. Background

Air Methods is one of the largest emergency air medical providers in the country, with roughly 300 bases located in 43 states, transporting over 70,000 patients in 48 states annually. Our team consists of approximately 5,000 individuals across the United States including paramedics, pilots, nurses, mechanics, engineers, communications specialists and patient advocates who work tirelessly every day to ensure that patients experiencing critical, often life-threatening conditions are transported to the appropriate tertiary facility in a timely manner.

As emergency air medical providers, our flight crews only respond when called by a physician or first responder. We never self-dispatch. Only first responders or physicians determine whether patients need emergency air medical services based on a variety of factors, including but not limited to, the higher level of care offered by an air medical flight crew (airway stabilization, blood transfusions, etc.); the level of care needed if the patient's condition deteriorates in-transport; the need for more rapid transport than a ground transport would allow based on the patient's condition; or the geography in remote or rural areas of the state and distance to travel to tertiary care. We are called to respond to both on-scene requests from first responders and emergency interfacility transfer ordered by physicians, both of which are medically emergent transports.

Emergency air medical crew members are highly trained with years of experience in critical care, emergency procedures and practice at a higher level of care than a ground ambulance which typically provides Advanced Life Support (ALS). Generally the patients who need the highest level of clinical care will also need the fastest mode of transport due to the criticality of their injuries or illness. For example: intubating patients at the scene of an accident or in the sending facility, initiating blood products, managing multiple intravenous medications, insertion of chest tubes for trauma patients or managing an intra-aortic balloon pump for a cardiac patient. As the distances between hospitals grow, rural hospitals' capabilities and resources are progressively scaled back, and as rural hospitals close, the definitive care air medical brings to critical patients that are at rural hospitals or at the scene of an accident is crucial. As a result, almost 70% of our patients are transported from CMS-designated rural zip codes.

Being ready to respond to a dispatch call requires substantial investment and involves significant fixed costs. Like a fire station, our advanced aircraft fleet and highly trained clinicians, pilots, and mechanics are ready to answer emergency calls—24 hours a day, seven days a week, 365 days of the year. Currently, the average cost of operating a base is roughly $2.9 million annually, with 85% of these costs being fixed.[1]

Our air medical bases operate in three different models. In the traditional model, we work as part of a hospital program. Our hospital partners own the program and provide the medical personnel and communications, and we provide the aircraft operations and maintenance. Our partnership with AirLife Denver based out of Cheyenne Regional Medical Center is an example of this type of staffing model. Another model is the community-based model, where Air Methods provides the aviation and clinical crews, as well as medical oversight, fuel, aviation, aircraft, billing, dispatch, and EMS licensure. These are standalone, wholly owned and are often found in the rural areas of the country, established at the request of both communities and rural hospitals who depend on the base as a resource. Our Casper Wyoming LifeFlight operations, requiring a team of 24 line crew and three mechanics at the base to staff and maintain both the helicopter and fixed-wing operations at Casper/Natrona County International Airport is an example of this model. For this base we also have two Medical Directors who oversee the clinical scope of practice of Wyoming LifeFlight. The last model is the hybrid model, where our hospital partners outsource the aviation and billing operations but still maintain their branding, medical protocols and clinical teams.

Air Methods is the industry leader in clinical and aviation training standards and advancement. The State's Waiver Application does not acknowledge that the level of quality of

[1] Xcenda. (2017) Air medical services cost study report. https://www.xcenda.com/insights/xcenda-conducts-unique-research-on-air-medical-services-costs.

air ambulance service currently available to Wyoming residents can only be provided by providers who go far above the requirements of government licensure and certification. AMC pilots travel to Denver throughout the year on rotation for FAA-mandated recurrent flight training. Air Methods is the industry leader for such training because of its investment in full-motion flight simulators with partner Flight Safety International. This is a cost-intensive undertaking that provides the highest level of training available to pilots, equivalent to the training programs used for airline pilots. Additionally, all of Air Methods' clinicians are required to complete over 100 hours of recurrent clinical training which is way above minimum standards, to include cadaver labs and training with state-of-the-art human patient simulators. Air Methods is also the first and only air medical provider outside of a hospital or university to establish an Institutional Review Board (IRB) publishing peer-reviewed clinical research, much like a university or hospital would. As a result of this clinical research, Air Methods has developed the HEAVEN criteria which is a predictor for a difficult airway and a checklist for Rapid Sequence Intubation (RSI) in 2015, which has since been published in clinical textbooks, medical journals and adopted by the Commission on Accreditation of Medical Transport Systems (CAMTS) as an industry best practice and standard.[2]

Furthermore, all Air Methods aircraft in Wyoming carry packed red blood cells as well as plasma in-flight, which is an additional cost and logistics burden for both our programs and our partners in supplies, procurement, training, licensure and compliance costs. While carrying blood in-flight is above the licensing requirements for air ambulance services in Wyoming and most states, it is a medical treatment that is truly life-saving for some, ensuring higher survivability for trauma patients. In fact, most rural hospitals in Wyoming have less blood available than Wyoming LifeFlight brings with them to an interfacility transport to initiate a transfusion. For high acuity patients in rural and remote Wyoming experiencing medical emergencies, air medical is often the only health care they have in their community or region that can intervene to give them a chance at survival.

II. Reimbursement challenges

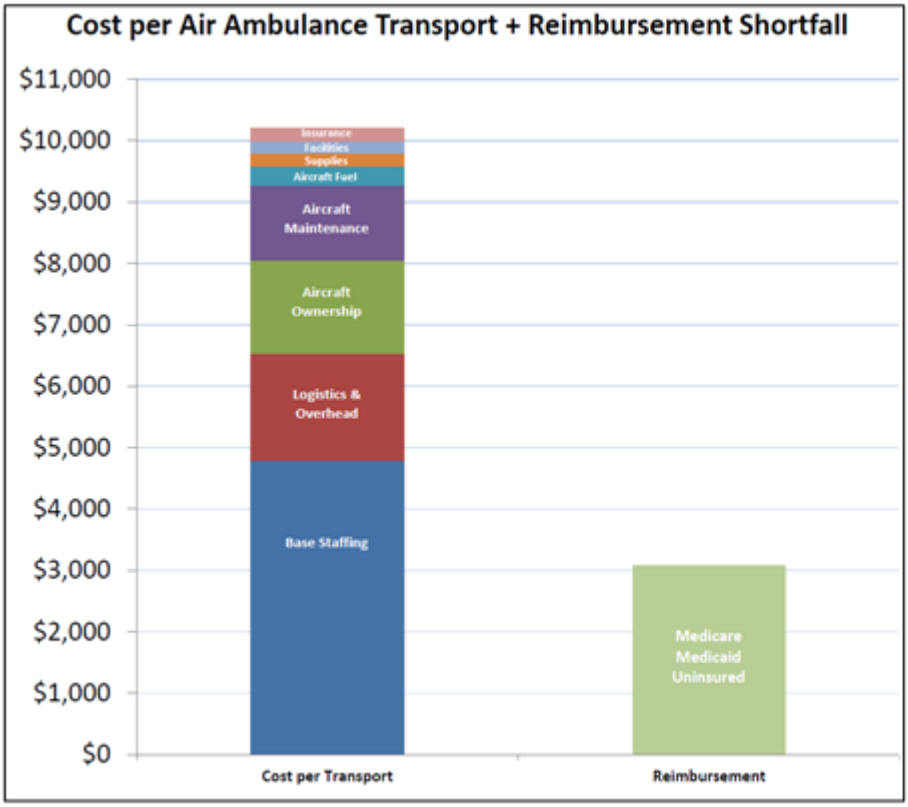
Air medical services are a vital component of rural health care access because of both the level of care and the direct access they provide to specialized interventional therapies for critical patients, but these services are strained under the current reimbursement environment. We believe it is necessary to understand completely the financial realities within which air medical services operate in order to understand the risks posed by the Waiver Application to the provision of air medical services. Under current payment methodologies, it is generally accepted that Medicaid and Medicare do not come close to covering the costs of air medical services provided in Wyoming. Cost-shifting from Medicaid and Medicare to commercial health plans is a much-maligned result of this system. Yet, rather than consider commonsense reforms (discussed below), the State is now proposing an untested model that relies entirely on reducing patient access to critical care services in order to "manage" costs. The State does not make a strong case that they will be able to cover the costs of cost-shifting they are assuming in totality for the emergency air medical system in Wyoming, instead relying on future state appropriations of unspecified amounts to cover millions of dollars in underpayments from the Wyoming Medicaid fee schedule, the Medicare fee schedule and non-payments from treating uninsured and indigent individuals. Not only does the State plan to deliver diminished levels of

[2] Kuzmack, E., Inglis, T., Olvera, D., Wolfe, A., Seng, K., & Davis, D. (2018). A novel difficult-airway prediction tool for emergency airway management: Validation of the HEAVEN criteria in a large air medical cohort. Journal of Emergency Medical Services, 54(4), 395-401. https://doi.org/10.1016/j.jemermed.2017.12.005.

service by cutting the number of bases that will be allowed to serve the State and setting quota levels for transports under the public utility model, but the State does not have a contingency plan if it finds the program insolvent due to inadequate state appropriations. It seems that such a situation will force the State to further cut levels of service in Wyoming, resulting in even greater risk to Wyoming patients.

A. Shifting reimbursement dynamics.

Over the past ten years, there has been a dramatic shift in the payor mix for emergency air medical transports. Transports with privately insured patients have declined dramatically and government-sponsored patients have increased, as a result of both the national trends of Medicaid Expansion and the sociodemographic shifts of an aging population into Medicare. At the same time, the gap between the cost to provide emergency air medical care and reimbursement for government-sponsored patients has only grown wider. Today, over 70% of air medical patients are covered by Medicare, Medicaid or are uninsured; yet government programs reimburse less than 30% of the operational costs for transporting these patients on average. Compared with hospitals being reimbursed almost 90% of their costs by Medicare, it is clear that the under-reimbursement of air medical services is an outlier for a health care provider group and unsustainable long-term.[3]



Depiction of per-transport air medical costs, by cost center. Based on Air Methods' cost data, and comparing per-transport operational costs with the average per-transport reimbursement for air medical Medicare, Medicaid and Uninsured patients, which on average are 70% of air medical patients.

In 2007, 44% of our transports were covered by private insurance, while today private insurance covers less than 30% of our transports. During the same time Medicare has

[3] American Hospital Association. (2018). Trendwatch chartbook 2018: Trends affecting hospitals and health systems. Retrieved from https://www.aha.org/guidesreports/2018-05-22-trendwatch-chartbook-2018.

increased from 23% of our transports to 36% of all transports. For Air Methods, 27% of our transports drive 75% of reimbursement to cover our costs. This severe underpayment is putting growing pressure on the health care system and creating an unsustainable cost-shift to those with private coverage. Coupled with continued cost growth related to technological and training upgrades required to comply with federal aviation standards and new clinical capabilities, this shortfall in government reimbursement threatens access to all emergency air medical services, especially in rural communities. Unlike other health care providers, we do not receive any tax subsidies or DSH payments and are entirely dependent upon the reimbursement for our transports. These same reimbursement and cost challenges led Air Methods to make the difficult decision to close 25 bases across the nation earlier this year, as low reimbursement left the bases financially insolvent.

At the same time, private insurance has responded by increasingly setting rates arbitrarily or denying payments through medical necessity denials, underpayments, and other tactics. For example, nearly half of all out of network claims are initially denied reimbursement by the private health plan. 37% of these denials are based on insurers' after-the-fact assessment of medical necessity – contradicting a decision made by the attending physician or first responder based on medical protocols and state EMS protocols, not by the air medical provider. On average, if a trip is denied, it is denied 1.5 times per claim, meaning multiple denials per claim through the appeals process. Moreover, the appeals process for denied claims can last nearly 8 months – the average time to resolve an insurance company denial is more than 239 days. Another tactic that confuses patients and unnecessarily puts the patient in the middle is when health plans reimburse patients directly the air provider.

Most of these issues could be eliminated or drastically reduced if insurance companies and air medical companies negotiate in-network agreements. Air Methods prioritizes these negotiations and has secured agreements with 47 health plans across the country, covering 60 million individuals. For the most part, insurance companies have little incentive to enter network agreements with air medical providers because the transports are low in frequency, insurers cannot drive volume for discounts, and insurers have the power to simply deny claims without proving their reasoning. Despite our best efforts over multiple years, Air Methods has not yet been able to negotiate an in-network agreement with the largest health insurer in Wyoming but has been successful with the major health plans covering most our privately insured patients in the neighboring states. ***This is a Wyoming-specific challenge on which we have requested the assistance of Wyoming state regulators and legislators on multiple instances in 2019, to no avail, despite the fact that it is the best and fastest way to immediately provide coverage and support to Wyoming patients at no additional cost to the state and to eliminate balance bills for patients.*** And, despite its importance, the Waiver Application does nothing to address the problem or suggest legislative coordination to do so.

B. Lack of data to support the State's claims.

It is important to note that contrary to what the State declares without any supporting data, emergency air medical transports are not a cost driver for health insurance companies and do not drive up health insurance premiums.[4] In fact, the cost of this life-saving service represents less than one tenth of one percent of all health care costs.[5, 6] According to testimony

[4] Wyoming Department of Health. (2019). Wyoming Medicaid Coordinated Air Ambulance Network: 1115 Waiver Application. Retrieved from https://airambulancewaiver.wyo.gov/ p. 10.

[5] MedPAC. (2013). Report to the Congress: Medicare and the health care delivery system. Mandated report: Medicare payment for ambulance services. Retrieved from http://www.medpac.gov/docs/default-

before the Montana Legislature Joint Economic Affairs Subcommittee in 2016, and supported by national health insurance data, coverage of the full cost of air medical services represents about $1.70 of the average monthly health insurance premium. While these services are expensive to operate and expensive per transport due to the nature of the service, the math shows that they can be covered easily by health insurers for mere dollars of a monthly insurance premium because emergency air ambulance is an extremely rare service and a diminutive portion of the health care delivery system. According to the 2019 Milliman Medical Index Study on health care costs, emergency air ambulance services represents a fraction of a percent of the "other" 2% of health care spending (Milliman's "other" category of costs also includes all ground ambulance spending, DME, home health and prosthetics).[7] To break it down even further, air ambulance transports account for less than 1% of all ambulance transports, as the majority of transports are ground ambulance.[8]

Congruent with this logic, inquiries from our legal counsel to the Wyoming Division of Workman's Compensation confirmed that covering emergency air ambulance claims in full would result in an insignificant premium increase – only $11 annually for a small employer. Thus, the State's own data analysis disproves their case of either the prevalence or magnitude of an air ambulance surprise billing issue financially burdening Wyoming patients.[9]

III. Operational Shortcomings of the Public Utility Model

A. Access Issues.

The Waiver Application misses many key points that are critical to ensuring adequate emergency critical care access, and includes missteps that will make this waiver both unworkable to deliver cost savings to the health care system and an irresponsible risk for the State to take against the interests of the very patients it serves. As drafted, the Waiver Application trades patient care and access for proposed cost savings in a very real way by cutting down the number of aircraft and future transports. Yet, the State's model does not add up to the cost savings it claims it can generate by cutting the number of aircraft and denying transports to patients, because the State's own cost projections for the program of $47—$48 million annually exceed the current aggregate cost estimates of what it would cost to provide air medical services in Wyoming today with 14 aircraft and base crews located in the state.[10] The 2017 cost analysis conducted by the air medical industry shows the median annual costs to run an air medical program are $2.9 million but the State is not decreasing the costs of the air medical system.[11, 12] Using the industry 2017 data, the current costs to operate the 14 aircraft

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source/reports/chapter-7-mandated-report-medicare-payment-for-ambulance-services-june-2013-report-.pdf?sfvrsn=0, pp. 169, 177.

[6] Kaiser Family Foundation. (2019). The facts on Medicare spending. Retrieved from https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/.

[7] Girod, C., Hart, S., Liner, D., Snook, T. & Weltz, S. (2019). 2019 Milliman Medical Index. Milliman. Retrieved from http://assets.milliman.com/ektron/2019-milliman-medical-index.pdf.

[8] MedPAC. (2013). p. 169.

[9] Wyoming Department of Health. (2019). Wyoming Medicaid air ambulance waiver. Director's Unit for Policy Research, and Evaluation. Slide 21. Retrieved from https://airambulancewaiver.wyo.gov/

[10] Wyoming Department of Health. (2019). p. 33.

[11] Industry data is used because cost data is not collected for this provider group by the federal government.

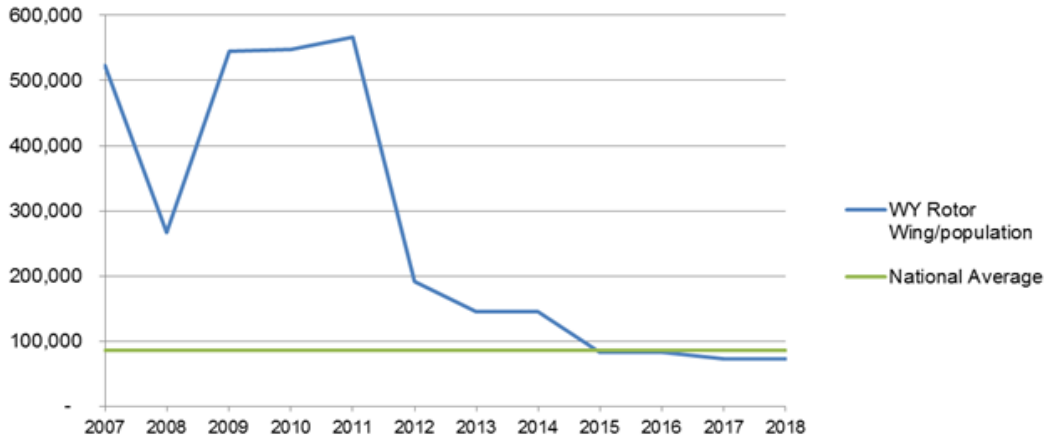
and bases in Wyoming are $40.6 million, which is $7.4 million less than the State's estimated Waiver Application costs, despite the fact that it proposes to cut the number of aircraft by at least 29% from current levels.[13] Cutting the number of bases in the state by 29% but still increasing spending by 18% would mean that the state is actually proposing a dramatic increase in spending on air medical resources per base in the state, rather than realizing savings through efficiencies and economies of scale, as is claimed.[14] The Waiver Application model is not positioned to deliver net health care cost savings for air medical services in the aggregate. Instead, we bring attention to the more critical human impact costs to patients of rationing care benefits by decreasing and controlling the emergency critical care provider market in Wyoming.

B. Right-sizing the Air Medical Market.

The Department fails to make a coherent argument to support its claim that too many air medical resources currently serve the residents of the State or its claims of clinical overutilization of these resources. Worse, the Waiver Application leans on data that presents increased trends of air medical utilization over the course of 25 years without context, using this data to support a premise that there are now too many aircraft in the State of Wyoming and in

Figure 1.

Historical Air Medical Services Access for the Wyoming Patient Population, Number of Emergency Rotor Wing Critical Care Aircraft by Population.



Calculated using CMS RUCA Super Rural zip codes and national air medical geographic data from the Association of Air Medical Services (AAMS), cross-referenced with the air ambulance supply data presented by the Wyoming Department of Health and U.S. Census Bureau Data for Wyoming State Population historically.

certain counties.[15] The Department fails to reconcile the fact that the State of Wyoming has had egregiously inadequate emergency air medical access until 2015 when the state reached air medical distribution rates commensurate with national averages (see Figure 1). The Waiver Application blindly claims that "it is difficult to imagine that the current distribution of air

[12] Xcenda. (2017). p. 10.

[13] Wyoming Department of Health. (2019). Slide 33.

[14] Wyoming Department of Health. (2019). pp. 6-12.

[15] Wyoming Department of Health. (2019). pp. 6, 8-9.

ambulance services has been determined to be optimal by a free market – i.e., that people are voting with their dollars for access or quality on an individual level." This statement ignores our repeated public testimony about the data in Figure 2 and continued evidence that air medical services are emergent, and therefore the market choice and clinical necessity exists on the part of the referring clinician charged with the care of the patient.[16]

Figure 2.

Comparison of the Distribution of CMS RUCA Zip Codes and Air Medical Aircraft in the United States.

	Percent of Total Zip codes (42,950)	Percent of Total Air Medical Aircraft (1,437)
CMS Urban Zip Codes	55%	55%
CMS Rural Zip Codes	27%	27%
CMS Super Rural Zip Codes	18%	17%

Calculated using CMS RUCA zip codes and national air medical geographic data from the Association of Air Medical Services (AAMS).

The State of Wyoming is a large remote state with an extremely sparse population. No evidence supports the Waiver Application's assertion that the State will be able to calculate the correct number of aircraft to serve Wyoming citizens more accurately than the free market appears to be able to dictate currently through need-based partnerships with hospitals, communities and local government. For instance, the State claims that they can realize "significant efficiencies" in the market "if fixed-wing volume were consolidated on to one or two centrally-located bases in the State," with absolutely no rationale data modeling to demonstrate how this would work in practice.[17] Operationally, the State needs to explain how they expect these transports to work, given the large number of Wyoming patients that routinely require emergency transport hundreds of miles away to Salt Lake City and Denver for specialized care. Will the Department authorize additional rotor wing flights to get patients hours away by ground transport to the two fixed-wing aircraft the Waiver Application calls for in the interior of the State? Or will the State protocol defy clinical protocols and instead dictate that all patients requiring emergency fixed-wing transport are transported by ground transportation to meet one of the two fixed-wing aircraft, regardless of distance or safety, so as to align with their intention to achieve cost savings? The patients whose lives depend and have depended on fixed-wing emergency transport in Wyoming would join Air Methods and our Medical Directors in respectfully disagreeing with the State's unsupported assertion that for these types of emergency transports, "geographic proximity to demand is less of a concern."[18]

[16] Wyoming Department of Health. (2019). p. 11.

[17] Wyoming Department of Health. (2019). p. 6.

[18] Wyoming Department of Health. (2019). p. 5.

Additionally, there are dozens of aircraft located outside of the state that serve Wyoming residents when they are called by Wyoming dispatch as the closest available, most appropriate aircraft. Air Methods alone has several of its air medical programs from five surrounding states licensed in Wyoming and regularly responding to emergency calls in Wyoming because of the rural and remote nature of the state and lack of specialty care resources. It is unclear how the Waiver Application model will ever be able to capture these aircraft and the services they provide for patients as a necessary emergent resource. The Waiver Application intends to capture out of state providers that currently serve the State of Wyoming by requiring contracted Wyoming providers to subcontract with these out of state providers. This places an additional burden on contracted Wyoming providers to procure contracts with other out of state providers with whom they currently do not have any official business relationship. Furthermore, this would seem to unfairly weight the State's favor toward the application of providers if they are part of a company or provider group that owns or has a business relationship with out of state providers, which will present conflicts for the State. The State also has inadequate data to make decisions as to which out of state providers must be included in contracted relationships in order to guarantee appropriate levels of critical care access for Wyoming air medical patients, nor does the Waiver Application disclose how the State will develop and provide its guidance and requirements for applicant providers on this metric.

C. Three Main Failures of the Waiver Application Model.

The Waiver Application adopts three premises that are simply wrong as a matter of fact, and render the model impossible operationally, unable to demonstrate health care cost savings and unable to deliver improved levels of care to fulfill the objectives of the Medicaid program:

- The Waiver Application ignores that air medical resources are already largely distributed according to the needs of the community they serve;
- The Waiver Application ignores that trained medical professionals treating the patient alone have the expertise, information and authority at the time of transport to be able determine whether a patient must be flown; and,
- The Waiver Application ignores that interfacility transports are no less emergent than scene transports.

First, when compared with the CMS RUCA zip codes by which ambulance services are reimbursed, air ambulance distribution demonstrates the success of the invisible hand of the market placing assets at ratios almost identical to the distribution of the RUCA zip codes themselves (see Figure 2). While this analysis is not an absolute in determining the proper distribution of aircraft, it is an indication that the market oversupply assertions put forth by the State to support the Waiver Application cannot withstand factual scrutiny. The State asserts, “Ultimately, the only market check on prices charged may be the inherent difficulties in extracting surprise bills from patients.” If this were true, the distribution of the air medical market in urban, rural and super-rural zip codes would be much more disproportionate than they are in Figure 2.[19] It should also not be overlooked that the State's claims about the dysfunction of the air medical market in Wyoming directly contradict the fact that their Waiver Application does not call for any reduction in rotor wing aircraft in Wyoming.[20] This leads Air Methods conclude that

[19] Wyoming Department of Health. (2019). p. 11.

[20] Wyoming Department of Health. (2019). Slide 33.

the State agrees that the free market in Wyoming has in fact not created an oversupply of air medical rotor wing resources.

Second, the Waiver Application does not acknowledge that emergency air medical patients are extremely critical, and that physicians and first responders uniquely have the clinical knowledge and information to make the determination as to the correct mode of transport. Ground ambulance services are usually equipped to provide a lower level of clinical care than air medical services. Because Wyoming is a large and an extremely rural state, critical patients must be transported long distances and air medical is more appropriate in most such instances than ground ambulances. In fact, most Air Methods emergency air patients in Wyoming are transported to another state because they care they need is not available in Wyoming. The lack of resources and long transport distances is a unique dynamic for Wyoming emergency medical services compared to neighboring states. The Waiver Application ignores the rural dynamics and the health needs of Wyoming by wrongly thinking that the State can, and should, realize market efficiencies by setting a policy to convince interfacility patients that they do not need to be flown, and by using the central state call center to control volume by denying transport requests for patients with medical emergencies.

Trained clinical personnel treating the patient are the only individuals who should make the determination as to whether a patient necessitates transport by air. Additionally, an air medical crew is the only party that can determine if they should accept a flight based on risk factors such as weather, distance, hours of service and crew fatigue. Central call center personnel, who are not medical professionals or on-site, would be ill-equipped to make these decisions based on objective data and would be pressured to make such decisions to meet the economic benchmarks the State sets. Additionally, there are hundreds of pages of federal regulations governing Part 135 operations in weather minimums, pilot duty time, flight risk determinations and many other factors that govern a crew's decision and prerogative to take a flight. Not only would call center personnel need to be educated in these aspects in order to understand how to properly dispatch the appropriate aircraft, but they would not legally be able to compel a contracted air medical crew to take a flight which the crew deemed unsafe. The call center would ultimately be required to defer to both the medical and aviation determinations of the individuals referring and accepting the flight, which runs contrary to the controls by the Waiver Application to suppress costs.

Third, the state continues to mischaracterize interfacility transports as being less emergent than scene transports, going so far as to suggest that air medical providers use the high fixed costs of scene transports to cover "volume from less-emergent transport situations (e.g. interfacility transports)."[21] This is completely false, and Air Methods personnel have testified in legislative hearings and provided written comment in order to educate the State on this fact on a number of occasions. On rare occasions, Air Methods will arrange a non-emergent transport, but our records for 2018 indicate that non-emergent patients accounted for only 0.04% of our flights and we did not have any non-emergent patients in the State of Wyoming in 2018. The State ignores the circumstances for which a patient is transported between facilities by emergency air medical transport. These patients have already been brought to the sending facility, and the attending physician recognizes that the facility does not have the clinical resources, medication or training to treat the patient. When air medical crews arrive to a Level III or Level IV trauma center, they assume charge of the patient as the highest level of care available to the patient. These patients are not clinically stable or are actively

[21] Wyoming Department of Health. (2019). p. 8.

experiencing a medical emergency. These patients are in the middle of a cardiac or stroke event, or at risk of losing the life of their child if they deliver at that facility with inadequate care, or requiring trauma surgery or neuro care. These are medical emergencies, even if there are not lights and sirens present, and should be recognized as such because an attending physician is making the determination that this patient will lose life or limb without the air medical transport and the intervention of the air medical crews in a timely manner. Additionally, an air medical crew brings not just the helicopter, but the highest level of in-transport care to the patient at a small rural sending facility, usually exceeding the level of care in the sending facility and bringing additional clinical resources such as a full ICU drug formulary and highly specialized therapies. Air medical crews maintain a specialized level of clinical skill to be able to titrate multiple intravenous medications for critical patients and manage complex airways in-transport, which is central to ensuring that a critical patient survives.

The State proclaims that far too many air medical transports originate in certain localities, like Fremont County, but the Waiver Application offers no clinical data to support its conclusion that these transports were in fact excessive or not medically necessary or that these transports contribute to the costs the State uses to justify its approach.[22] In its diagnosis of interfacility transports in Fremont County as an outlier, nowhere does the State acknowledge the complete absence of adequate trauma or specialty care in this county. The highest level of trauma care available in Fremont County is only Level IV.[23] For the types of patients requiring emergency air medical services, the nature of their injuries and illnesses are so time-sensitive that the two and a half hour drive to Casper may be fatal, and often require specialty care that only exists outside of the State of Wyoming, like NICU care. Additionally, these patients are at high risk of deterioration in-transport and even if the layperson or the insurance company may retroactively review the chart and think that the air medical clinical crew level of care is unnecessary, clinicians who ordered the transport did so based on their best clinical judgment.

The State can certainly study the utilization and protocols of emergency air medical services and how these services are used in certain localities and how these resources could be used more efficiently to the benefit of patients. The Wyoming Department of Health and its Office of Emergency Medical Services have the authority and jurisdiction to work with their stakeholder provider groups, collect and analyze data, and use policy levers to encourage, incentivize and inform the operations and protocols of emergency medical services in Wyoming. This sort of study and analysis is the administrative responsibility of the State to protect patients, and in no way does it require a $48 million public utility model that puts these same patients at risk of losing access to care.

IV. The Public Utility Model Ignores the Department's Data

Air Methods welcomed the data collection and transparency of the Department to help get to the bottom of the air medical billing situation in Wyoming. While Air Methods cannot speak for the other providers, we have worked to make sure that patients are assisted at every step of the billing process to file appeals with their insurer, help navigate the complex claims process, and work diligently to help patients not be responsible for any costs beyond their copayments and deductibles. If there are indeed providers that are not acting in the best of

[22] Wyoming Department of Health. (2019). p. 6.

[23] Office of Emergency Medical Services. (2018). Wyoming designated trauma centers: Update 2018. Wyoming Department of Health. Retrieved from https://health.wyo.gov/wp-content/uploads/2019/01/Updated-designation-list-12.2018.pdf.

patients or insurance not in the best interests of their customers, the State should seek ways to work with them and improve the situation. Air Methods was interested to understand how other members of the air medical industry and insurance in Wyoming view this issue, and hence, how the data shows how the system behaves in practice. As providers, we owe it to patients to investigate this issue and to hold our industry and insurers accountable.

The State's own data shows that patients are not paying "huge" air medical bills. The Waiver Application misrepresents anecdotal accounts of "surprise billing" to argue for the existence of the market failure they are trying to solve.[24] In fact, the State disproves its own rhetoric with the data it collected and the analysis that it conducted, showing that air ambulance patients pay $300 out-of-pocket on average for air medical claims, including cost-sharing payments and deductibles.[25] Furthermore, 90% of air medical patients pay nothing at all, and of the ten percent that do pay out-of-pocket, the average is $2,250.[26] These facts are a far cry from the anecdotal evidence used to justify the passage of HB 194 and media coverage which gives "the impression that people are routinely receiving bills in the $30 - $100K range."[27] The State's data analysis refutes this scenario, yet on the same page of the Waiver Application on which the State explains its data showing the extremely low air medical costs, the State returns to rhetoric alleging that "hospitals aren't [sic] ultimately paying the bills—individual patients are."[28]

A demonstration waiver must rely on data to support its claims, not just talking points. It is the State's burden when applying for the waiver to prove how the proposed program will impact patients, their access to care, and what health care or coverage benefits it can realize for the patient population. Before taking the drastic measure of turning a private health sector into publicly-funded health care, the State argument must be supported solely by the facts, and not just anecdotes, that there is indeed a pervasive problem to be solved and that their proposed solution is in the best interest of all its citizens.

V. Air Methods' Implemented Solutions to Protect Wyoming Patients

To protect patients facing high air medical charges, Air Methods has implemented a multi-pronged strategy that has effectively resolved the surprise billing issues facing patients.

First, Air Methods is actively negotiating with many insurance companies to secure in-network contracts. We recognize that when we are in-network, everybody wins. Over the past two years we have increased our in-network insurer-covered services from two percent to 35% of all privately insured patients we transport and aim to reach 40% by the end of this calendar year, a number that would be higher if Aetna, United Health Care and Cigna would negotiate in-network agreements. By being in-network, these patients do not receive a bill at all and will only be responsible for their coinsurance and/or deductible as set by their insurer's plan. In 2018, we negotiated contracts with the largest Blue Cross and Blue Shield Plan, Anthem, in addition to 15 other Blue Cross and Blue Shield Plans. Also, we have negotiated in-network contracts with Humana and numerous other health plans. While we are having success in a growing number

[24] Wyoming Department of Health. (2019). p. 10.

[25] Wyoming Department of Health. (2019). Slide 21.

[26] Wyoming Department of Health. (2019). p. 10.

[27] Wyoming Department of Health. (2019). p. 10.

[28] Wyoming Department of Health. (2019). p. 10.

of markets, this is a challenging undertaking and takes time. Some insurers, particularly those with market dominance in a state, refuse to contract at reasonable and fair rates or demand contract language that gives them power to play doctor and retroactively and unilaterally overrule emergency medical decisions made by patients' physicians and first responders.

For these reasons, we are not in-network with Wyoming Blue Cross Blue Shield, who has testified multiple times to the Wyoming legislature about their lack of in-network agreements with air ambulance providers in the State. Despite approaching BCBS of Wyoming as early as 2016, they have refused to make any changes to medical necessity language that does not apply to emergency air medical services. Additionally, BCBS of Wyoming has recently begun sending air medical provider reimbursement checks directly to patients, a draconian tactic that confuses patients and forces providers to have to pursue these payments from the patient, instead of from their insurer. This is the exact opposite of BCBS of Wyoming taking the patient out of the middle of the billing process, and we hope the State sees this for what it is, a revenge and bully tactic against medical providers who seek negotiations rather than the 'take it or leave it' demands of the insurer.[29] Other insurers have told us that they do not negotiate in-network agreements—*under any circumstance*—with emergency air ambulance companies. This is a failure of responsibility to patients, especially for an emergency service which patients cannot anticipate. However, we continue to work to find partners with as many insurance companies as possible and are in-network with all the Blue Cross Blue Shield and Anthem plans in the states neighboring Wyoming in which we operate bases.

Second, for incidences where we are out-of-network, we implemented a Patient Advocacy department two years ago where dedicated Patient Advocates work side-by-side with each patient to help them or their representative navigate the complex world of insurance claims. If and when, the insurance company underpays or rejects a first responder or physician's decision, our Patient Advocates to intervene with the patient's authorization to advocate on the patients' behalf to appeal these decisions and ensure they are covered fairly by the health plan - for which these patients dutifully pay their premiums in good faith. It is important to note that media reports an air ambulance "bill" received by a patient are typically referring to an Explanation of Benefits (EOB) from their health insurer, not an actual bill from Air Methods. An EOB does not represent the charge by Air Methods as the provider to the patient, but what the insurer sends to a patient to show their determination of what they deem as an appropriate coverage for emergency care and amount with which they are leaving the patient to pay outside of this determination of coverage. In other words, insurers use EOBs to dramatize the purported patient costs of air ambulance services when the insurers control the key factor contributing to the EOB bottom line – what the insurer decides to pay for emergency air ambulance services!

Contrary to how the media has portrayed this process, Air Methods always reaches out first to work with the patient, prior to requesting any type of payment due to an insurer's underpayment. Patient Advocacy works to streamline the claims process for patients and has led to our patients paying very little out-of-pocket for care, similar to what the State's data showed. The average out of pocket including copays and deductibles is less than $400 nationally for Air Methods and is even lower for Wyoming patients. Once all appeals have been exhausted, our flexible financial assistance policy helps patients based on their individual and unique situation. No patient is ever sent to collections except for extreme circumstances, such

[29] Drash, W. (2019) Insurer skips doctors and sends massive checks to patients, prompting million-dollar lawsuit. CNN Health. CNN. Retrieved from https://www.cnn.com/2019/03/01/health/anthem-insurance-payments-patients-eprise/index.html.

as they are unresponsive to months of attempts to contact them, or they receive direct payment from the insurer and unlawfully choose to keep the payment instead of remitting to the provider. We are committed to helping our patients from the onset of their medical emergency until months later when their claim is resolved.

VI. Legal Complications of the Waiver

In addition to the significant policy challenges raised by the proposed Waiver Application, the state ignores a number of significant legal hurdles underpinning its model. As discussed below, it remains unclear how the waiver can fulfill the "objectives" of the Medicare program, while simultaneously stifling the access to and quality of air ambulance services in the state. The Waiver also faces several Federal preemption challenges, as discussed below. In particular, the Waiver is very clearly preempted by the Airline Deregulation Act of 1978 (the "ADA"). To the extent the state wishes the waiver to apply beyond the Medicaid population (which, as currently designed, appears entirely necessary), Federal law would very clearly preempt its application to both the ERISA and Medicare Advantage populations.

A. The Legal Parameters of a Section 1115 Waiver.

The State is straying far outside the parameters of existing federal law to seek to bend the Section 1115 waiver process to meet its far-reaching goals. The authority of the Secretary of Health and Human Services under a Section 1115 waiver is broad, but not without limit. In fact, a Section 1115 waiver only pertains to the authority to waive specific areas of federal law, including Sections 1902 and 1903 of the Social Security Act for the purposes of this Waiver Application, but lacking authority to waive any provisions of CFR Title 14 which encompasses the ADA. As a result of the multiple ways in which the Waiver Application encroaches upon the federal jurisdiction of Congress established by the ADA, as well as the clarity of the parameters around Section 1115 waiver authority, it stands that the Waiver Application cannot possibly grant the State of Wyoming any authority to regulate the air ambulance market as a public utility.

Furthermore, the Waiver Application falls short of fulfilling or furthering the objectives of the Medicaid program, which are objectives by which a demonstration project covered by a Section 1115 waiver application must be measured. Through decades of operational expertise in this health care industry, Air Methods knows the Waiver Application would actually be detrimental to the CMS public health objectives of providing higher quality care, improving access to this care for Medicaid beneficiaries and driving a better quality of life for beneficiaries.

The Waiver Application will cap patient access to critical emergency care, provide only the contracted care that the state can afford and procure through the RFP process, resulting altogether in less access to fewer services of lower quality. The State lacks any data to demonstrate that this model will elevate clinical care quality, improve response times or increase access to emergency air medical services for Medicaid beneficiaries. Court challenges have invalidated waivers in recent years on grounds that the Secretary failed to consider how the waiver would further the goals of the Medicaid program. In one case, the Secretary ignored public comment that alerted CMS to research and data showing that the waiver in question would result in loss of coverage for beneficiaries.[30, 31] Medicaid beneficiaries in the State of

[30] *Stewart v. Azar*, 313 F. Supp. 3d 237 (D.D.C. 2018).

[31] *Gresham v. Azar*, 1:18-cv-01900 (D.D.C. 2018).

Wyoming stand to lose access to quality emergency care as a direct result of this public utility model.

B. The Intent of the Airline Deregulation Act of 1978.

The ADA was established by Congress with the express intent to cultivate economic growth and competition among air carriers, a development which is the sole reason that the air ambulance market in rural Wyoming has improved over the past 25 years. The aim of the Waiver Application public utility model - to create a state-run monopoly - is exactly the sort of state regulation of an air carrier market the ADA was designed to prevent for the benefit of consumers and air providers alike. A heavily state regulated market will only result in diminished levels of service at lower quality and higher operational costs, eschewing market efficiencies in practice. Congress' intent on this preemption question has been interpreted broadly by the Supreme Court starting with *Morales v. Trans World Airlines, Inc.* (1992), establishing that the ADA applies to laws of general applicability and indirect effects on air carriers.[32] The shaky legal argument upon which the State has built the Waiver Application and the decades of precedent disproving its claims show that the State has no business regulating the complex economic market of the interstate air medical system serving the State of Wyoming.

Even though utility models used by the states for other services are not preempted by federal law, this model is, for good reason: the air ambulance service market is substantially more complex than providing water, sewer or cable television to residents of a discrete geographic community where utility models have worked. The Waiver Application is built on a series of cascading assumptions that the State will successfully:

- Procure contractual agreements with in-state providers and subcontracted agreements with out of state providers;
- Gather sufficient and accurate market and clinical data to calculate usage;
- Attract and retain trained medical personnel to administer the call center;
- Negotiate contracts with private insurers on terms adequate to fund the model and adequate state revenue to triple the Medicaid fee schedule rate and cover the cost-shift from Medicare;
- Maintain state-of-the-art clinical service at a cost the State can afford.

Nowhere in the nation has this sort of state-controlled, top-down, supply-constraining utility model been legislatively adopted, let alone implemented. It cannot be successful here or anywhere.

We contest the State's claim that a Section 1115 Medicaid waiver approved by CMS as a federal agency would circumvent the federal preemption of the Airline Deregulation Act of 1978 ("ADA") of any state regulation of an air carrier's rates, routes or services. This Waiver Application relies solely on such a legal argument, seeking to regulate all aspects of air ambulance operations and market dynamics as a regulated monopoly, hence regulating all

[32] *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 384 (1992).

three elements of air medical services – rates, routes and services - reserved for federal authority. We disagree with the State's premise that they can avoid the federal preemption of the ADA simply by procuring a Section 1115 Medicaid waiver; the preemption of the ADA does not evaporate simply because of the involvement of another federal agency in a state administered program. Rather, the State's argument is disproven by the limited sections of federal law to which a Section 1115 Medicaid waiver is applicable—none of which include Title 14 of the Code of Federal Regulations.

While a state can contract with an air ambulance provider, it cannot require such a contract for that provider to operate in the state and cannot prevent providers lacking such contracts from operating in the state. This directly violates the federal authority over regulation of an air carrier's routes and services and is inconsistent with decisions in federal court barring states from regulating air ambulance providers operations with certificate of need (CON) statutes.[33, 34] Separately, this waiver imposes price restrictions on air ambulance providers that contract under the model, or that provide service as a subcontractor, regulating what these providers can collect and establishing a centralized payment system so that air ambulances are paid by state funds for all Medicaid and uninsured transports and for any transports for privately insured patients whose health plans are contracted with the state. This comprehensive control of the market pricing of air ambulance services at the state level is a direct violation of the ADA and the federal government's authority over the rates of an air carrier. Lastly, the centralized call center and its unilateral decision-making authority for air ambulance transports violate the ADA in its control over the routes and services of providers. This call center does not call all capable licensed providers in and around the state and dispatch them according to distance, weather and clinical capability; rather, this call center will be restricted to call only certain providers contracted with the state and cap the calls at levels of volume consistent with the state's market model. This too regulates the routes and services of all Part 135 air medical providers in the Mountain West region currently serving Wyoming, in violation of the ADA.[35]

C. The Waiver Application is Preempted by the ADA.

1. The ADA Preempts State Law Claims Relating to Air Carrier Prices, Routes, or Services.

Through the 1978 enactment of the ADA, Congress "largely deregulated domestic air transport," *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 222 (1995), in an effort "to promote 'efficiency, innovation, and low prices' in the airline industry through 'maximum reliance on

[33] *Hiawatha Aviation of Rochester, Inc. v. Minnesota Department of Health*, 375 N.W.2d 496, 500 (Minn. Ct. App. 1985).

[34] *Baptist Hospital, Inc. v. CJ Critical Care Transport System of Florida, Inc.*, CV-07-900193, p. 2 (Cir. Ct. Montgomery Co., Ala., July 31, 2007).

[35] Part 135 air carriers are certificated under Title 14 CFR Part 135 and are classified as conducting on-demand, or non-scheduled, operations. Note that other aspects of operations, certification, pilot licensure, maintenance and aircraft certifications are all governed by other Parts of the Federal Aviation Regulations (FARs).

competitive market forces and on actual and potential competition,'" *Northwest, Inc. v. Ginsberg*, 572 U.S. 273, 280 (2014) (quoting 49 U.S.C. §§ 40101(a)(6), (12)(A)).[36]

"To ensure that the States would not undo federal deregulation with regulation of their own, the ADA included a pre-emption provision." *Morales v. Trans World Airlines*, Inc., 504 U.S. 374, 378 (1992). This express preemption provision directs that "a State . . . may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart." 49 U.S.C. § 41713(b)(1). Congress chose for air carriers to have a single, federal regulator—the DOT—with regard to their rates, routes, and services, rather than "a patchwork of state . . . laws, rules, and regulations." *Rowe v. N.H. Motor Transp. Ass'n*, 552 U.S. 364, 373 (2008) (interpreting similar preemption provision in the Federal Aviation Administration Authorization Act, or FAAAA).

The Supreme Court has broadly interpreted the ADA's preemptive effect, noting that "the key phrase, obviously, is 'relating to'" and determining that "[t]he ordinary meaning of these words is a broad one—'to stand in some relation; to have bearing or concern; to pertain; refer; to bring into association with or connection with,'—and the words thus express a broad pre-emptive purpose." *Morales*, 504 U.S. at 383 (quoting Black's Law Dictionary 1158 (5th ed. 1979)). Accordingly, the Supreme Court has held that the ADA preempts any state law "having a connection with, or reference to, airline rates, routes, or services." *Id*. at 384.

2. The Waiver Application Relates to Air Ambulances' Rates, Routes and Services.

The Wyoming Application will require an air ambulance to bid and enter into a contract with the State before it may provide services in Wyoming:

> Once the requirements are developed, the State would issue competitive Request for Proposals (RFPs) to air ambulance companies nationally…. The bid winners will become the only Medicaid air ambulance providers for selected regions in the State, will be based at locations selected by the previously-described public process, and will meet all requirements developed by the State and specified in its RFP.

Waiver Application, Section 3.2 Competitive procurement, p. 21 (emphasis in original). These mandated requirements attempt to regulate air ambulances' rates, routes and services and, thus, are preempted by the ADA.

"To the extent that [a state law] prescribes behavior necessary to operate [instate], it is clearly 'related to' plaintiff's price, route, or service under the ADA." *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 735 (E.D.N.C. 2008). "With respect to air ambulance services that are required to submit to the state's [statute], the statute constitutes a 'direct substitution of [the state's] own government commands for competitive market forces' in contravention of the Supreme Court's mandate . . . . The law is not general in effect. It targets a specific subset of the economy[.]" *Id*. And while such utility models as the Waiver Application contemplated here

[36] The ADA's definition of "air carrier" includes air ambulances. *Scarlett, et al. v. Air Methods Corp,, et al.*, 922 F.3d 1053, 1060-61 (10th Cir. 2019) (holding that air ambulances are "air carriers" and covered under the ADA).

"might not be preempted with respect to all providers," the utility model here "is preempted by the ADA as to air carriers" which would include air ambulances such as Air Methods. *Id*.

The Waiver Application's desire to prevent air ambulance companies from operating in the state unless they submit to this system is precisely what the ADA was designed to preempt. Prohibiting an air carrier like Air Methods from operating in the state "significantly affects the rates, routes, and services" of Air methods "in that it bars [Air Methods] from performing flights from point to point in" Wyoming. *Id*. "[I]f federal law preempts state efforts to regulate, and consequently to affect, the advertising about carrier rates and services at issue in Morales, it must preempt [Wyoming's] direct denial of [Air Methods'] ability to operate in state at all." *Id*.

Indeed, other courts faced with similar questions have likewise held preempted state statutes that prevent an air carrier from operating in a state absent participation in a state system. See *Rocky Mountain Holdings, LLC v. Cates*, 97–4165–CV–C–9 (W. D. Mo. Sept. 3, 1997) (finding that § 41713 preempts Missouri law mandating a determination that the 'public convenience and necessity' requires a proposed air ambulance service); *Hiawatha Aviation of Rochester, Inc. v. Minnesota Dep't of Health*, 375 N.W.2d 496, 500 (Minn. Ct. App. 1985) ("The Department of Health cannot regulate the entry into the market of Hiawatha's proposed enterprise because this is a matter of aviation services within the jurisdiction and control of the FAA"); *Baptist Hosp., Inc. v. CJ Critical Care Transp. Sys. of Florida, Inc.*, CV–07–900193, p. 2 (Cir. Ct. Montgomery Co., Ala., July 31, 2007) (finding that Alabama's "CON statute and any other statute or regulation which require [an air ambulance service] to obtain a CON prior to conducting air ambulance operations within the state are preempted under the ADA as related to the price, route, or service of an air carrier").

Additionally, the Waiver Application's fixed-price model is also preempted by the ADA: "Similar to managed care capitation, payment in the contract will be mostly fixed-price— i.e., defined monthly or quarterly payments just for capacity. Providers will therefore be at risk for volume of services provided." Waiver Application, Section 3.3 Payments to contractors, p. 22. This type of regulation of air ambulance rates has been repeatedly preempted by courts around the country, including Wyoming's statute and fee schedule which capped the reimbursement of air ambulance services provided under Wyoming's workers' compensation statute. *EagleMed LLC v. Cox*, 868 F.3d 893, 904 (10th Cir. 2017) (holding Section 401(e) of the Wyoming Workers Compensation Act and related fee schedules preempted to the extent they regulated air ambulances' rates); *Air Methods/Rocky Mountain Holdings, LLC v. State of Wyoming ex rel. Dept' of Workforce Services*, 432 P.3d 476 (Wyo. 2018) (holding that, in light of *EagleMed*, the Department of Workforce Services was required to pay air ambulance rates in full).

Accordingly, should the Waiver Application be enacted in Wyoming, it will undoubtedly be challenged by air ambulances and suffer the same fate that other state-wide statutes and regulations have suffered when attempting to mandate requirements for air ambulances to operate in their respective states—federal preemption under the ADA.

3. The Waiver Application's Attempt to Implicate Medicaid Does not Save it from Preemption under the ADA.

The Waiver Application implies that inclusion of all air ambulance services under Wyoming Medicaid allows the state to escape the "broad preemption issues" it faces under the ADA. Waiver Application, Section 1.2, "How will this demonstration promote the objectives of the Medicaid program?", p. 3. This argument lacks merit for several reasons.

First, there is an important difference between the federal Medicaid statutory scheme itself and a state plan implementing or administering Medicaid. To be sure, the ADA cannot preempt Medicaid itself. The ADA preempts state laws and state enforcement actions and is silent as to its interaction with other federal laws. However, in *Ray v. Spirit Airlines, Inc.*, the Eleventh Circuit addressed whether the ADA "preempted" the federal RICO statute. 767 F.3d 1220 (11th Cir. 2014). In *Ray*, the defendant air carrier claimed ADA preemption as a defense against a civil RICO claim brought by individual plaintiffs. *Id*. at 1222. The court rejected the premise that one federal statute could preempt another federal statute. *Id*. at 1224 ("This is not a preemption case. . . . [F]ederal statutes do not preempt other federal statutes."). Instead, when two federal statutes are alleged to conflict, the question is whether one of the statutes impliedly repealed the other statute. *Id*. Thus, the real question is not one of preemption, but instead whether the ADA impliedly repealed Medicaid. For a variety of reasons, there is no colorable argument that the ADA impliedly repealed Medicaid. Cf. *id*. at 1225–28 (giving various reasons for rejecting the argument that the ADA impliedly repealed the RICO statute). Likewise, Medicaid and its amendments are highly unlikely to be held to impliedly repeal the ADA. See *id*. Thus, the ADA and Medicaid coexist.

Second, the Waiver Application's attempt to regulate through Medicaid does not avoid the ADA preemption provision. A state plan implementing or administering Medicaid still constitutes a state "enact[ing] or enforce[ing] a law, regulation, or other provision having the force and effect of law" for the purposes of the ADA. 49 U.S.C. § 41713(b). Medicaid is a cooperative federal-state program in which federal funds are provided to "[s]tates that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980). While state Medicaid plans must comply with federal statutory requirements, states have wide latitude in implementing and administering their plans. 79 Am. Jur. 2d Welfare § 34. But "[t]he Supremacy Clause . . . compels compliance with federal law and regulations by participants in a state medical assistance program funded under Medicaid." *Id*. § 37. A state Medicaid statute that conflicts with federal law is invalid. See *Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006) ("Participation is voluntary, but if a state decides to participate, it must comply with all federal statutory and regulatory requirements."). For example, when a state Medicaid statute conflicts with a federal Medicaid statute, the state statute is preempted. See, e.g., *Cal. Ass'n of Rural Health Clinics v. Douglas*, 738 F.3d 1007 (9th Cir. 2013) (invalidating a state statute in conflict with the Medicaid Act); *Singleton v. Commonwealth of Kentucky*, 843 F.3d 238 (6th Cir. 2016) (same).

State Medicaid plans are also subject to constitutional challenge as state action. In *Soskin v. Reinertson*, 353 F.3d 1242 (10th Cir. 2004), the Tenth Circuit referenced the Fourteenth Amendment (applicable to state action) for an Equal Protection challenge against a Colorado statute adjusting Medicaid benefits, rather than the Fifth Amendment inquiry applicable to action by the federal government. Despite the state statute's relation to Medicaid, the Court still treated it as a state law. *Id*. at 1247. As a result, the Waiver Application, if enacted by Wyoming, would also be treated as a state law for purposes of assessing its validity under federal and constitutional law, including ADA preemption.

In a related field of federal preemption of state law, the federal Employee Retirement Income Security Act ("ERISA") includes a preemption provision superseding all state laws relating to covered employee benefit plans. 29 U.S.C. § 1144(a). In Belshe v. Laborers Health & Welfare Trust Fund, a federal district court held that a state Medicaid statute was subject to ERISA preemption as a state law relating to an employee benefit plan. 876 F. Supp. 216 (N.D. Cal. 1994). The Medicaid-nature of the state statute did not save it from federal preemption.

The same reasoning would suggest that a state Medicaid statute (such as contemplated in the Waiver Application) would not be sheltered from federal preemption under the ADA.

Accordingly, the Waiver Application, if accepted and then implemented by Wyoming, may modify the state's implementation of the federal Medicaid scheme, but it is still a state law, enacted by the state legislature, and implemented by the state. As a result, Wyoming has still enacted "a law related to a price, route, or service of an air carrier" and thus still faces ADA preemption.

D. The Waiver Application is Preempted as it Applies to ERISA Plans.

As currently written, the Waiver would specifically apply to all health plans in the state, including "ERISA plans that hold themselves as out as health insurance companies in the State." The inclusion of ERISA plans is not merely one of convenience – as the waiver notes, "In order to fund the new system after paying for it up front, Wyoming Medicaid will need to recoup costs from Medicare, private insurers and self- insured plans who also cover the Air Ambulance Expansion population." Yet, in its thorough analysis and 38-page application, the state has entirely failed to address the very clear fact that to the extent Wyoming attempts to regulate, either directly or indirectly, self-insured group health plans, such regulation would very clearly be preempted by the Employee Retirement Income Security Act (ERISA) of 1974.[37] In other words, the funding mechanism on which the waiver relies has a clear, fatal flaw.

ERISA was designed to bring national uniformity to the employee benefits market and is singular in its preemptive effect on underlying state insurance law. ERISA contains a preemption provision clarifying its relationship to state law; unlike standard "conflict preemption" statutes, however, the ERISA preemption statute has been interpreted by the courts as creating "field" preemption. That is, where state regulation of health insurance is concerned, ERISA preemption has been judicially interpreted as being so powerful as to completely occupy the field of employee health plan regulation, even when there is no direct conflict with underlying state law.[38] There are two kinds of ERISA preemption – express preemption under ERISA § 514(a) and implied preemption under ERISA § 502(a).[39]

ERISA § 514(a) broadly preempts "any and all state laws insofar as they may now or hereafter **relate to** any employee benefit plan."[40] A state law "relates" to a plan if it "has a connection with or reference to such a plan."[41] The Supreme Court has interpreted this language broadly, holding that "where a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . . that 'reference' will result in pre-emption."[42] The Supreme Court has also stated that "ERISA

[37] 29 U.S.C. §1001 et. seq.

[38] *Shaw v Delta Airlines*, 463 U.S. 85 (1983).

[39] The Supreme Court has held that ERISA § 502(a) preempts "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004).

[40] 29 U.S.C. § 1144(a).

[41] *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995).

[42] *Gobeille v. Liberty Mut. Ins. Co.*, 136 S. Ct. 936, 943 (2016) (internal citations omitted).

preemption is appropriate even where ERISA would not provide a remedy for a state law compliance."[43]

In the case at hand, it is clear from the plain language of the Waiver Application that the Wyoming waiver would "relate[ ] to" an ERISA health plan as it would be a state policy that operates directly and exclusively on health plans, governing the business practice of billing amounts. Even to the extent that employers would be permitted to opt-out of direct participation in the air ambulance account, the Waiver Application. contemplates a world in which the state (or its agent) operates as the exclusive billing contractor in the state for air ambulance services.

Further, even with respect to insured plans, we do not believe that the waiver would "saved" from pre-emption. Under the Court's broad interpretation of ERISA § 1144(a) in Supreme Court in Kentucky Association of Health Plans v Miller, only laws that are directed at the insurance industry, and address issues of financial risk, are saved from preemption.[44] We believe there is a strong argument that neither of these prongs are met in the instant case.

E. The Waiver Application is also Preempted as it Applies to Medicare Advantage Plans.

Like ERISA, the Medicare program, too, contains a preemption provision that exempts Medicare Advantage plans from Wyoming's attempts to regulate air ambulance services. While comprising only a small portion of Medicare enrollees in the state, given the waiver's heavy reliance on the Medicare population, this population will also be critical to the waiver's success.

Prior to the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA),[45] the Medicare+Choice program (now Medicare Advantage) only pre-empted state laws to the extent that they were "inconsistent with" standards established under the Medicare+Choice program.[46] In the MMA, however, Congress clearly adopted a broader pre-emption standard as applied to Medicare Advantage (MA) and Part D (prescription drug) plans. Accordingly, "State laws do not, and should not apply [to the re-named Medicare Advantage program], with the exception of state licensing laws or state laws relating to plan solvency."[47]

Under the MA preemption provision, the Medicare Act expressly preempts any state law "with respect to" a Medicare Advantage plan. The one exception to this broad preemption language is with regard to "state licensing laws or State laws relating to plan solvency."[48] The Courts have recognized the broader scope of pre-emption under the MMA. The 9th Circuit in *Uhm v. Humana*, 620 F.3d 1145 (9th Cir. 2010) developed a three part test for determining whether or not the MA program preempts a state law. The court first asks whether the federal government established "standards" in the Medicare Advantage program. Second, the court

[43] *Ore. Teamster Employers Trust v. Hillsboro Garbage Disposal, Inc.*, 800 F.3d 1151, 1157 n.4 (9th Cir. 2015) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987); *Wise v. Verizon Commc'ns, Inc.*, 600 F.3d 1180, 1190-91 (9th Cir. 2010).

[44] 538 U.S. 329 (2003).

[45] Pub. L. No. 108-173 § 232, 117 Stat. 2066, 2208 (Dec. 8, 2003).

[46] Social Security Act § 1856(b)(3), 42 U.S.C. § 139w-26(b)(3).

[47] See H.R. Rep. No. 108-391, 108th Cong., 1st Sess. at 556 – 57 (Nov. 21, 2003).

[48] Social Security Act § 1856(b)(3), 42 U.S.C. § 139w-26(b)(3).

asks whether there is a state law "with respect to" those standards? Finally, even if the answer to both questions is yes, is the law saved from pre-emption because it is a state law governing licensure or solvency? If not, the state law is pre-empted.

In examining the Waiver Application, it is clear the waiver is preempted as it applies to the MA population in the state. The Medicare program itself has extensive rules and regulations governing coverage and payment for ambulance services, including air ambulance services.[49] While MA plans are permitted some flexibility in administering their ambulance benefit, the original benefit rules generally apply.[50] The Federal government has thus developed standards for air ambulance services with "respect to" a Medicare Advantage plan.

The Wyoming Waiver Application, to the extent it creates a mandatory billing contract with statewide rates and charges, very clearly acts "with respect" to those standards developed by the Federal government for the MA program. Because the Wyoming Waiver Application is not one related to licensure or solvency, it is preempted as applied to Medicare Advantage enrollees.

F. The Department of Health Lacks the Statutory Authority to Pursue the Waiver Application.

House Bill 194[51], codified in pertinent part at Wyo. Stat. § 42-4-123, does not authorize the Department of Health to pursue the Waiver Application as constructed.[52] Key aspects of the utility model proposed by the Waiver Application are contrary to the terms of the statute.

The Wyoming Supreme Court has strictly defined the authority of administrative agencies:

> As a creature of the legislature, an administrative agency has only the powers granted to it by statute, and the justification for the exercise of any authority by the agency must be found within the applicable statute. A statute will be strictly construed when determining the authority granted to an agency. Any agency decision that falls outside the confines of the statutory guidelines articulated by the legislature is contrary to law and cannot stand. In other words, reasonable doubt of the existence of a power must be resolved against the exercise thereof. A doubtful power does not exist.

In re LePage, 18 P.3d 1177, 1180–81, 2001 WY 26, ¶¶ 10-13 (Wyo.,2001) (citations omitted).

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[49] 42 C.F.R. § 410.40. See also Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services.

[50] See for example, Medicare Benefit Policy Manual, Chapter 10, § 20.1.1 ("Any provider or supplier without a contract establishing payment amounts for services provided to a beneficiary enrolled in a Medicare Advantage (MA) coordinated care plan or MA private fee-for-service plan must accept, as payment in full, the amounts that they could collect if the beneficiary were enrolled in original Medicare. The provider or supplier can collect from the MA plan enrollee the cost-sharing amount required under the MA plan, and collect the remainder from the MA organization.").

[51] Also known as 2019 Wyoming Laws Ch. 189 and Enrolled Act 112.

[52] Like the Waiver Application, HB194 as enacted is preempted by the Airline Deregulation Act as it compels air ambulances into a state regulatory system in order to operate in Wyoming and dictates the amounts an air ambulance can charge for its services.

A corollary of the rule is that, when a statute provides a particular manner in which a power may be executed, the agency may not exercise its power in a different way. Any action taken by an agency without authority is ultra vires and void. *Horse Creek Conservation Dist. v. State ex rel. Wyo. Attorney Gen.*, 2009 WY 143, ¶ 30, 221 P.3d 306, 316 (Wyo. 2009) (citations omitted). "An agency is wholly without power to modify, dilute or change in any way the statutory provisions from which it derives its authority." *Platte Development Co. v. State, Environmental Quality Council*, 966 P.2d 972, 975 (Wyo.1998).

The Waiver Application seeks approval to create a system that contradicts the statute and Wyoming law in four key ways:

- HB194 authorized a Medicaid-based system with compelled participation for all air ambulance providers who otherwise provided services to Wyoming residents eligible for Medicaid;
- HB194 authorized a system in which air ambulance providers would be compensated at least partially through co-pays or cost-sharing by the patient, with the remainder of the allowed charge paid by the air ambulance coverage account;
- HB194 did not authorize the Department to require air ambulance providers to make medical necessity decisions;
- HB194 authorized a fee-for-service system that maintained Medicaid's role as the payer of last resort.

1. The Waiver Application Restricts Provider Participation in the Wyoming Market.

HB194 defined the scope of provider participation in the intended statutory system as follows:

> An air ambulance provider shall provide services under this section if the provider otherwise makes air ambulance transport services available to persons in Wyoming who are eligible for Medicaid independent of the coverage provided in this section. . . . Except as otherwise provided in subsection (d) of this section, an air ambulance provider who provides services under this section shall accept payment under this subsection as full satisfaction of all charges, costs and fees relating to air ambulance transport services.

Wyo. Stat. § 42-4-123(c).

Under this statutory scheme, all air ambulance providers would be free to decide whether to participate in the Wyoming market based on the rate setting and co-pay provisions established by the statute and related regulations. The legislation effectively required fee-for-service rates to be established by the Department in advance to permit all air ambulance providers to assess whether to operate in Wyoming and what services to provide.

The Waiver Application restricts provider participation in Wyoming without statutory authority to only those providers who are willing to accept a flat fee contract and succeed in the Department's proposed competitive bidding process. The application admits that the intent of the waiver is to move "the entire system away from a fee-for-service payment structure . . ." and to eliminate patients' ability to select any willing provider. Waiver Application, pp. 3, 13, 35. Further, the Department straightforwardly admits a substantial policy motivation for this change:

> . . . the State is interested in paying a select number of air ambulance providers through fixed-price contracts, similar to how a state might contract with regional managed care organizations. The fixed price contract puts the risk of volume on the provider, discouraging volume that is not medically-necessary, and thereby reducing inappropriate utilization.

Waiver Application, p. 17 (bold in original).

The Department further defines the details in pursuit of these policy objectives: "Access to care and depth of provider networks would be determined by the State, for the entire State population, during the requirements development process." Waiver Application, p. 18. "The bid winners will become the *only* Medicaid air ambulance providers for the selected regions in the State . . ." Waiver Application, p. 20 (italics in original). "[T]he channeling of Medicaid (i.e., all) emergency and interfacility demand volume through the central call center would likely eliminate demand signals to non-contracted [air ambulance] providers." Waiver Application, p. 21.

Nothing in HB194 authorized the Department to directly restrict provider participation in the Wyoming air ambulance market through competitive bidding or flat-fee pricing. HB194 established a specific means of encouraging a change in air ambulance supply – by setting rates designed to control over-utilization and motivate adequate provider participation. See, Wyo. Stat. § 42-4-123(p)(i). HB194 was an undoubtedly a price-fixing scheme, but it stopped at price-fixing. The Waiver Application envisions a system where the Department of Health unilaterally fixes price and supply and restricts the freedom of providers to serve patients in Wyoming. The Waiver Application contradicts HB194 in its entirety by requiring air ambulance providers to accept full liability for an entire segment of transports in Wyoming or decide not to participate in the Wyoming market at all. This is a fundamental policy decision, which Wyoming law reserves for the Legislature.[53] As a result, the Department lacks authority to pursue the Waiver Application.

2. The Waiver Application Contradicts HB194's Fee-For-Service System.

As discussed above, the Waiver Application intentionally moves away from a fee-for-service system. However, HB194 mandated a fee-for-service system for the State and the patient:

> A Wyoming resident or air ambulance provider may make a claim for payment of air ambulance transport services to the department. A claim shall be submitted within ninety (90) days of air ambulance transport services occurring. . .
>
> An air ambulance provider shall collect a copay or other cost sharing requirement for services covered under this section, as established by the department and consistent with federal requirements . . .
>
> . . .any copay or cost sharing requirement shall be proportionate, based on income and shall not be greater than fifty percent (50%) of the allowable costs

[53] *Newport International University, Inc. v. Wyoming Department of Education*, 186 P.3d 382, 388 (Wyo. 2008).

> for air ambulance transport under this section, as determined by the department.

Wyo. Stat. § 42-4-123(c) and (d). Also, HB194 established guidelines for setting the fees for covered services. See, Wyo. Stat. § 42-4-123(p)(i).

Contrary to a fee-for-service system, the Waiver Application would intentionally create a system where the "successful" air ambulance provider would be compensated by a flat fee for all services rendered and take on the entire risk of utilization above the assumptions incorporated in the bidding and negotiation process. This model alters the supply of air ambulance services for Wyoming citizens on a call-by-call basis. Instead of providers making decisions about whether to provide service based on a defined fee-for-service as anticipated by HB194, which has the characteristic of being readily apparent and calculable, the Waiver Application directly (and intentionally) discourages the provision of service by the successful bidder and the dodging of accountability because the provider will receive its flat fee regardless of the number of flights it flies. Waiver Application, p. 17 ("The fixed-price contract puts the risk of volume on the provider, discouraging volume that is not medically-necessary, and thereby reducing inappropriate utilization.")

The Waiver Application's departure from fee-for-service pursues substantially different policy objectives and implementation than the methodology anticipated by HB194. The Department was not authorized to pursue a model that interferes with providers' assessment and collection of a fee based on the specific service provided to the patient.

3. The Waiver Application's Competitive Bidding Process Places the Risk of Medical Necessity Determinations on the Shoulders of Wyoming Citizens Contrary to the Department's Medicaid Regulations.

The Waiver Application is built on the assumption that competitive bidding will lead to better results with respect to costs and utilization, primarily by putting, "the risk of volume on the provider, discouraging volume that is not medically-necessary, and thereby reducing inappropriate utilization." Waiver Application, pp. 17, 20 (italics added). This aspect of the Waiver Application model exceeds the authority granted by HB194. Nothing in the legislation authorized the Department to require air ambulance providers to make or participate in medical necessity determinations. Indeed, the Waiver Application would require medical necessity decisions prior to transport beyond what a provider must demonstrate after transport for coverage under Wyoming Medicaid. Medicaid regulations require only that the air ambulance service meet the following criteria:

> (e) Air ambulance services are covered when:
>
> (i) Services are provided by a fixed-wing aircraft or helicopter licensed to provide ambulance services, and
>
> (ii) One of the following requirements is met:
>
> (A) The client has a life-threatening condition and the use of any other method of transportation, including ground ambulance, would endanger the health of the client;

> (B) The client's location is inaccessible by ground ambulance; or
>
> (C) Air transport is more cost effective than any alternative method of transportation.

Wyoming Medicaid Rules, Section 7, Covered Services; WY ADC 048.0037.15 § 7.

The Waiver Application's apparent intent to create new medical necessity rules to be applied by air ambulance providers prior to a flight exceeds the authority granted to the Department by HB194. More importantly, it ignores the reality that the need to dispatch air ambulance is almost always made by first responders at the scene or physicians at a Wyoming hospital. The unauthorized shifting of this decision to air ambulance providers, particularly when coupled with a profit motive to restrict service, will only result in the denial of service when needed by Wyoming citizens. Nothing in HB194 suggests legislative intent to authorize the Department to change how these life-and-death decisions are currently made. Yet the Waiver Application will do just that.

4. The Waiver Application Changes Medicaid Into A Payer of First Resort for Air Ambulance Services.

The Waiver Application seeks to establish a system through which the air ambulance trip costs for all Wyoming residents will be "paid for by Medicaid up front" and collection efforts from all other sources will be pursued under "pay-and-chase" authority. Waiver Application, pp. 27-28. HB194 authorized creation of a fee-for-service model under which air ambulance providers would agree accept payment of pre-determined fee from the air ambulance fund and a co-pay determined from the patient determined by a formula established by the Department based on the details of the service provided to the patient. HB194 did not authorize the Department to pay air ambulance providers in advance disassociated from actual services provided to patients. Under this model, Wyoming Medicaid will become the payer of first resort contrary to Wyoming law.

Wyoming Medicaid regulations state:

> (a) Payer of last resort. Medicaid is the payer of last resort. A provider may not seek Medicaid payment for services furnished to a recipient until payment from third parties has been sought pursuant to Chapter 4 and/or Chapter 35.

Section 11. Payment and submission of claims., WY ADC 048.0037.3 § 11.

Moreover, the United States Supreme Court and the Wyoming Supreme Court have recognized this vital characteristic of the Medicaid system. *Estate of Marusich v. State, ex rel., Dept. of Health, Office of Healthcare Financing/Equalitycare*, 313 P.3d 1272, 1276, 2013 WY 150, ¶ 9 (Wyo.,2013)("Medicaid is a program that provides medical benefits to qualified recipients and is designed to be a " 'payer of last resort.'") citing *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 291, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006), quoting S.Rep. No. 99–146 at 313 (1985).

The Waiver Application's "utility model" creates a system in which air ambulance providers are paid in advance based on a projected volume of services under conditions which encourage the provider to provide less service than projected. This disassociation of fee and

service is contrary to the payer-of-last-resort role required by law, and the fee-for-service model anticipated by HB194. As a result, the Waiver Application exceeds the Department's authority.

VII. Recommendations to the State

Due to the nature of the legal conflicts, budgetary burden and operational shortcomings of the Waiver Application, Air Methods recommends that the Department should act in the best interest of patients and taxpayers and abandon the Waiver Application. The Wyoming State Legislature presented the Department with an impossible course of action, because a Section 1115 waiver cannot waive areas of federal law outside of Sections 1902 and 1903 of the Social Security Act and both HB194 and the Waiver Application violate the Airline Deregulation Act of 1978 by imposing state regulation on the rates, routes and services of air ambulance providers serving the Wyoming patient population. Because the waiver is preempted as it applies to ERISA and Medicare Advantage plans, the funding mechanism underlying the waiver in inherently flawed. Additionally, the Waiver Application model does not meet any of the current criteria established by the Secretary of Health and Human Services to assess whether a proposed waiver promotes the goals of the Medicaid program.

Air Methods urges the Department to pursue an alternate course of action that would hold providers and payors accountable using the state regulatory and legislative powers retained by the State to foment policy ensuring that air medical services remain sustainable to provide critical care service for Wyomingites. The following is a list of legislative and regulatory actions that could be taken by the Wyoming State Legislature, the Wyoming Department of Insurance, the Wyoming Department of Health and the Wyoming Office of Emergency Medical Services in pursuit of the service quality, market efficiency and patient protection goals outlined in the Department's waiver and the preamble to HB 194 as being of paramount importance to the State. Several of these legislative and regulatory powers were brought to the legislature's attention in public testimony in the course of the passage of HB 194, urging the State to take an alternative course of action that is more reasonable and pragmatic and that does not overstep state authority, or overreach or bend federal authority:

- Enhance and update the air ambulance licensure requirements for the State of Wyoming, to meet the standards of the State EMS Licensure Compact;
- Establish an air ambulance subcommittee to the State EMS Board;
- Review and update the dispatch protocols for air ambulance services in the State of Wyoming, particularly regarding the availability or lack thereof, of ground critical care transport services in certain areas;
- Establish medical necessity standards for air ambulance transports for health coverage under state jurisdiction;
- Establish network adequacy requirements for insurance plans offered under state jurisdiction regarding air ambulance network agreements;
- Review the assignment of benefits laws and establish a direct claim for providers with health plans under State jurisdiction;
- Collect air ambulance claims data from health insurance under State jurisdiction to inform the State regulation of these benefits, including denial rates and reason for

denials, payment rates, length of time to resolve, number of appeals, copay and deductible trends, patient out of pocket costs, number of providers in-network and denial rates and claim characteristics for in-network versus out of providers;

- Regulate air ambulance membership products, which are separate from the operations of an air ambulance provider as an air carrier and consequently not subject to the jurisdiction of the Airline Deregulation Act of 1978;

- Conduct a study through a third-party contractor to collect and aggregate air ambulance costs in the State of Wyoming from providers with confidentiality under the Wyoming Public Records Act and report back on those costs and the operation and utilization of air ambulance services;

- Update the Wyoming Medicaid air ambulance fee schedule to better cover operational costs of providers;

- Implement a provider assessment model (compliant with the Anti-Head Tax Act) to further improve the Medicaid under-reimbursement in Wyoming, incurring no costs to the state budget.

We welcome the opportunity to continue to work with the Wyoming Department of Health and the Wyoming State Legislature on future policy that benefits the safety, health and well-being of our patients and all Wyomingites.

THE ERISA INDUSTRY COMMITTEE
Shaping benefit policies before they shape you.

CARLY STERNBERG
Associate, Health Policy

September 24, 2019

Wyoming Health Department
2300 Capitol Ave. Ste. 401
Cheyenne, WY 82001

Dear Mr. Fuchs,

On behalf of The ERISA Industry Committee (ERIC), thank you for the opportunity to submit comments on Wyoming's Air Ambulance Medicaid Waiver to improve the delivery and affordability of air ambulance services. We share your concern about the surprise medical billing crisis, especially as it relates to air ambulance transport.

ERIC is the only national association that advocates exclusively for large employers on health, retirement, and compensation public policies at the federal, state, and local levels. Our member companies are leaders in every sector of the economy with workers, retirees, and their families located in every community in the nation. We speak in one voice for large employers on their employee benefit and compensation public policy interests, including many member companies with employees and retirees in Wyoming.

Large employers like ERIC member companies self-insure their health care plans and as plan sponsor fiduciaries, strive to provide the best health care possible to their employees, retirees, and families at an affordable cost. ERIC advocates for federal and state policies that support and enhance the ability of our member companies to provide high-quality, affordable health care.

One such critical area relates to air ambulance or emergent transport. We recognize the significant opportunity available to leverage more efficient regulation of emergent transport to modernize health care delivery and improve access to quality medical care, especially for workers and dependents in rural states. As such, we commend the Wyoming Department of Health's diligent and innovative efforts to find a state-administered solution to the current surprise billing crisis, particularly as it arises from the air ambulance industry.

As you are no doubt aware, the air ambulance industry has undergone significant changes over the past decade, especially as air ambulance providers have been bought up by private equity companies. These Wall Street investment firms have found ways to enhance their profits by keeping air ambulances out of traditional health care networks, either by directly refusing network contracts, or by demanding unreasonable reimbursement rates that no reasonable plan fiduciary could agree to. At the same time, these actors have flooded the market with many more aircraft and air ambulance bases than are needed and used this oversaturation as justification for unsustainably high prices. The status quo is completely untenable, and solutions are badly needed. Wyoming deserves serious credit for taking the issue on directly, especially as the federal government has yet to act.

ERIC supports the overall innovative efforts to reduce air ambulance surprise bills and offers the following comments with requests that certain measures in the proposal be considered and modified as they relate to federally-regulated health plans:

One tenet of the proposal specifies that private health insurers, including self-funded plans governed under the federal Employee Retirement Income Security Act (ERISA), who do not "opt-in" to Medicaid expansion for air ambulances would be required to reimburse the state on a fee-for-service basis to ensure that the financial burden is evenly divided to the population. We urge you to consider that the large, national health care plans offered by ERIC members are regulated exclusively by the federal Department of Labor. Any state law that attempts to regulate, or relates to, an ERISA plan could be subject to federal preemption, and struck down.

On page 26 of the proposal, the state acknowledges they cannot mandate employers "opt-in" but rather can collect reimbursement from employers who choose not to "opt-in" through Medicaid's "pay and chase" authority. Based on discussions with our large employer member companies, in our judgement employers will have to closely assess the costs they currently incur via their pre-existing contracts with air ambulance companies, the toll the current system is taking on their plan's beneficiaries, the costs of opting in, and any potential liability under Medicaid's "pay and chase" authority for employers that choose to not opt in. ERIC believes that the volume of Wyoming air ambulance patients enrolled in ERISA plans is low, and that the inclusion of self-insured ERISA plans (beyond an option to opt-in) may be counterproductive. As such, we request that the reference to charging self-insured, non-participating plans be removed.

Ultimately, ERIC shares your goal of decreasing surprise medical bills for Wyoming residents. We appreciate this opportunity to express our thoughts and concerns as you continue to develop the proposed 1115 waiver and look forward to working with the state to ensure that the program implemented will align both with the best interests of patients, and with applicable laws including ERISA. If you have any questions concerning our comments, or if we can be of further assistance, please contact me at 202.627.1914 or csternberg@eric.org.

Sincerely,

Carly Sternberg

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Monday
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82741

Mr. Franz Fuchs
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Via Email to franz.fuchs@wyo.gov

RE: GMR PUBLIC COMMENTS REGARDING WYOMING MEDICAID COORDINATED AIR AMBULANCE NETWORK – 1115 Waiver Application

Dear Franz:

Background—This legislative process ostensibly started because of concern about surprise billing related to air ambulance services. Despite efforts by the air ambulance providers ("AAPs"), the Legislature did not review the totality of the circumstances surrounding surprise billing. Specifically, neither the legislature nor the Wyoming Department of Health ("DOH") delved into the role of the insurance industry in this issue. As a result, the legislation that passed as well as this new concept focus on prices only and not the real reason patients get bills from AA providers. As we learned from public meetings and some additional research by DOH, unless the Legislature addresses these insurance issues, any bill will fail to achieve its objectives.

GMR (formerly AMGH) has been actively involved in this process since the original air ambulance legislation was proposed, though it was not consulted before the original bills were introduced. We appreciate DOH's willingness to involve AAPs in this process. Throughout the process, we have provided the Legislature, the Governor, and DOH with substantial information about the nature of the industry, the inherent problems as a result of the payor mix, the breadth of the issue, and information about efforts made by other states and the federal government. We incorporate that information by reference into these public comments.

Specific comments:

1. The research done by DOH suggests Wyoming does not actually have a significant problem to address—at least not with AA prices. Per the data described in the Waiver and prior PowerPoint outlining the Waiver Concept, very few Wyomingites received large bills from AAPs and even fewer pay the billed amount. See, e.g., p. 10 of Waiver Application.

2. Rather, public comments show that patients received large surprise bills because certain insurers paid $10,000 or less for air ambulance service. These insurers KNOW that these minimal payments will subject their insureds to high balance bills. Additionally, some insures, even those with better reimbursement rates, deny claims outright for lack of medical necessity subjecting the insured to the entire AAP bill. Many AAPs have patient advocates that help negotiate with insurers and work with patients to increase insurer reimbursement, lower the overall bill and/or spread the payments over time. Insurers do not offer the same service.

3. The Application says it will decrease the cost of air ambulance service, but then estimates the total cost of service in Wyoming will stay the same after implementation of this proposed program.

4. The Waiver Application mentions quality issues but does not specify that there are any actual quality issues that justify this new government program. Quality of service has never been an issue throughout this process.

5. This new proposal does nothing to address improper denials of coverage by insurers nor does it contain a solution when an insurer issues such an improper denial. It does nothing to address insurance policies and plans that do not provide adequate coverage for air ambulance service at a time when their insureds need it most.

   a. DOH accepts insurers' contentions that some flights are not medically necessary, but has done nothing to determine if this assertion is true and, if so, the prevalence of the problem. Interestingly, the comments at public meetings reveal that some insurers pay a paltry amount for covered services.

   b. DOH is also aware of at least one case where the insurer denied the claim based on medical necessity contrary to the statements of the attending physician. Anecdotally, several AAPs described ongoing problems with patients whose insurance claim was denied for medical necessity despite confirmation of medical necessity from the health care professionals who actually treated the patient.

6. This new proposal does nothing to address the alleged, but unproven, assumption regarding overutilization of AAP services. The proposal shows a lack of understanding of the reality of air ambulance service by assuming this model will incentivize AAPs to not transport patients where there is not a medical necessity. But, as DOH is aware, AAPs do not self-dispatch. Rather, they answer the call from first responders, doctors, and medical professionals and transport all patients regardless of financial status, type of insurance, or ability to pay. Medical professionals should and do make the determination of whether a life flight is necessary—not the AAPs or dispatchers. Any assumption that this proposal will impact utilization rates is misguided. Since AAPs do not self-dispatch, there simply is no payment incentive that causes unnecessary utilization.

7. Of course, GMR questions the wisdom of having the State make decisions about the proper utilization of AAP resources. The AAPs are the experts in the field. The suggestion that AAPs open new bases without due consideration of all the relevant factors is simply wrong as is the notion that the market lacks true competition. Just because the market does not include the equivalent of web-based travel sites does not mean competitive forces are not at work.

8. Nevertheless, this new proposal is premised on the hypothesis that AAP prices are too high because of oversupply and overutilization. In other words, the proposal *speculates* that Wyoming has too many air ambulance bases and that by cutting bases, the overall cost of service will decrease. The data does not support this theory.

a. By its own terms, the current proposal is unlikely to save any money and may increase the overall cost of air ambulance service. In fact, some patients with good insurance will likely pay more under the new proposal. At best, it shifts the costs of those with insufficient insurance to those with better coverage.

b. Any potential savings come from decreasing the supply based on the managed public utility model where the State—not the market—determines the number and locations of bases. DOH admits it has not determined whether the current supply is adequate, insufficient, or whether there is actually an oversupply.

9. Note that only 7 years ago, Wyoming had 5 AAP aircraft in the entire state and now has only 14. See slide # 22 from Draft Waiver Concept. Given the recent diminishing access to higher levels of health care, the State must carefully consider whether it is worth trying to save a few dollars via a new government program that cuts access and increases response time.

10. The public utility analogy is not really appropriate. Unlike police and fire department, citizens will not pay for air ambulance service regardless of whether they actually use the service. Further, unlike utility services, the number of those actually using the service is very small. Unlike a public utility, this proposal does nothing to spread the cost among the majority of Wyoming citizens.

11. The plan does not address the income side of the equation in a meaningful way. If several (or more) self-funded plans do not opt-in to the program, or continue to refuse to pay meritorious claims, or pay too little, the cost to the State of this new proposal may increase dramatically. The so-called "pay and chase" authority likely does not extend to insurers who are simply following policy provisions that do not require payment (or pay a small portion of the bill) and may not extend to questionable claims decisions. It seems unlikely the State is prepared to cover these types of shortfalls. Further, it is unclear whether the plan anticipates the administrative costs inherent in the plan.

12. This new proposal does nothing to help traditional Medicaid recipients who already pay one of the lowest reimbursement rates of any patient group. Rather, the plan incorporates Medicaid as a thinly veiled attempt to avoid ADA preemption. While the State assumes any new Medicaid-for-all proposal will withstand ADA preemption scrutiny, this is not at all a certainty. First, this proposal and all like it are obviously contrary to the true purpose of Medicaid. Second, it directly contradicts the purposes and Congressional intent behind the ADA. Third, Medicaid is an opt-in program. While there may be logistical issues, under current law, an AAP can continue to operate in Wyoming even if it is not chosen to service a region in the state. Finally, this proposal may run afoul of ERISA preemption as well. The State should let the federal effort to address these same issues run its course before enacting piecemeal legislation.

Please feel free to call with any questions or to discuss these issues further.

Yours very truly,

HIRST APPLEGATE, LLP

BY: RICHARD A. MINCER
KHALE J. LENHART

RAM/njh

Children's Hospital Colorado
Here, it's different.

Cheyenne Regional Medical Center

Wyoming Medical Center

September 28, 2019

Franz Fuchs
Wyoming Department of Health
2300 Capitol Avenue
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Cheyenne, WY 82002

RE: Wyoming Medicaid Air Ambulance Waiver

Dear Mr. Fuchs:

Thank you for the opportunity to provide comments on the Wyoming air ambulance waiver. On behalf of Children's Hospital Colorado and our Care Alliance partners, Wyoming Medical Center and Cheyenne Regional Medical Center, we would like to offer our recommendation for ensuring Wyoming kids continue to receive the best care possible if the waiver moves forward.

Children's Colorado's mission is to give all kids—regardless of where they live—the chance to grow up healthy and strong. Even though Children's Colorado is located in Aurora, the hospital touches the lives of kids in Wyoming every day. We are committed to providing our pediatric expertise to Wyoming families, children, primary care physicians, hospitals and urgent care clinics to ensure that children get the best possible care in their local communities. To support that commitment, Children's Colorado has a number of initiatives in Wyoming to ensure children and families can stay close to home whenever possible. Highlights of our efforts include:

- **Care Alliance partnerships** with Cheyenne Regional Medical Center and Wyoming Medical Center. Our partnerships with these two highly regarded organizations aim to 1) elevate the care that is available close to home for children so they can stay local when possible and 2) coordinate the care between our organizations and providers, so that when a child and their family do have to travel, it's a seamless and coordinated experience for families, providers and most importantly, the child. To meet these goals, Children's Colorado provides education, training, care pathways and other essential tools to pediatric providers in Wyoming communities to ensure they are practicing with the latest guidelines and information.
- **Pediatric Specialty Outreach Clinics** in five locations across Wyoming to deliver pediatric specialty care in person and via telemedicine for seven different specialties currently, with continued plans for expansion of services to meet the sub-specialty care needs of children in Wyoming.
- **Tele-neonatology** will be implemented in October 2019 with our two care alliance partners in Wyoming to give Neonatal Intensive Care Unit (NICU) providers in Wyoming communities access to the neonatology expertise at Children's Colorado and to support transfer decision-making and care consultations. A main goal of this initiative is to avoid unnecessary transfers and support babies and families staying in Wyoming.

When critical services aren't available in-state, we want to ensure children can get to the best medical destination for them in a timely manner, because in pediatrics, a child can go from sick to critical in a matter of moments.

Children's Hospital Colorado
Here, it's different.

Cheyenne Regional Medical Center

Wyoming Medical Center

Our mission not only encompasses the care provided at Children's Colorado, but also the modality by which children are transported—whether to Children's Colorado or to another medical destination that their healthcare provider has determined is right for them. Children's Colorado is the only freestanding, Level One Pediatric Trauma Center in a seven-state region and as such, we play a critical role in providing air ambulance services to children across the state of Wyoming who require life-saving, acute care. Our neonatal and pediatric air medical teams care for a significant proportion of children with serious injuries, illnesses and conditions throughout the region, including Wyoming, as they transfer children to our facility as well as to other non-affiliated locations. Our Emergency and Trauma Outreach Team spends numerous hours in the field providing education and hands on training to first responders and emergency department staff across the region about stabilizing and transfer preparation of kids. This education enhances the care coordination and hand off of pediatric patients when moments matter.

Children's Colorado and our partners, Cheyenne Regional Medical Center and Wyoming Medical Center, believe Wyoming kids deserve the highest level of care when seriously ill or injured. To meet this values-based approach, if the RFP process outlined in the waiver moves forward, we encourage the state of Wyoming to direct the winner of the air ambulance contract to subcontract with a partner that can comprehensively serve the neonatal and pediatric air ambulance transfer needs of the state. The partner should be designated a level I pediatric trauma center by the American College of Surgeons, have attained the highest level NICU (IV) as designated by the American Academy of Pediatrics and operate air ambulance transfers with pediatric staff, equipment and protocols.

Kids are not just "smaller adults," so it's vital that the medical team transporting them is trained specifically to manage a child's needs. Pediatric teams are accustomed to managing pediatric dosing, smaller equipment and supplies to rapidly care for a child and meet their needs in every situation.

We understand and empathize with the concerns of Wyoming's citizens that air ambulance costs are too high. And we applaud the legislature and the Department of Health for taking a thoughtful approach to addressing this issue while considering stakeholder input. As the waiver moves forward, every child in Wyoming should have access to the highest quality of care during air medical transport, and we believe the standards outlined above can accomplish the state's overall goals while protecting child health in the process.

Thank you for your consideration of these comments. If you have any additional questions, please do not hesitate to contact us for additional information.

Sincerely,

/s/

Zach Zaslow
Senior Director of Government Affairs
Children's Hospital Colorado

/s/

Joe Darmofal
Director of Transport & EMS Outreach, EMS Administration
Children's Hospital Colorado