

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

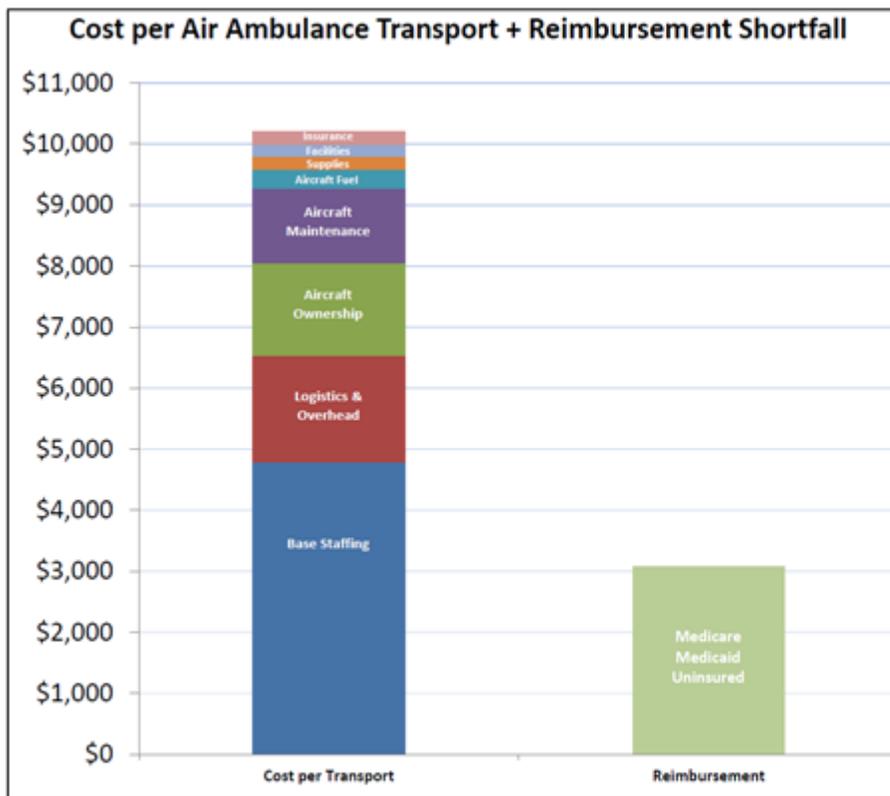
Air medical services are a vital component of rural health care access because of both the level of care and the direct access they provide to specialized interventional therapies for critical patients, but these services are strained under the current reimbursement environment. We believe it is necessary 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

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. & Wertz, 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.

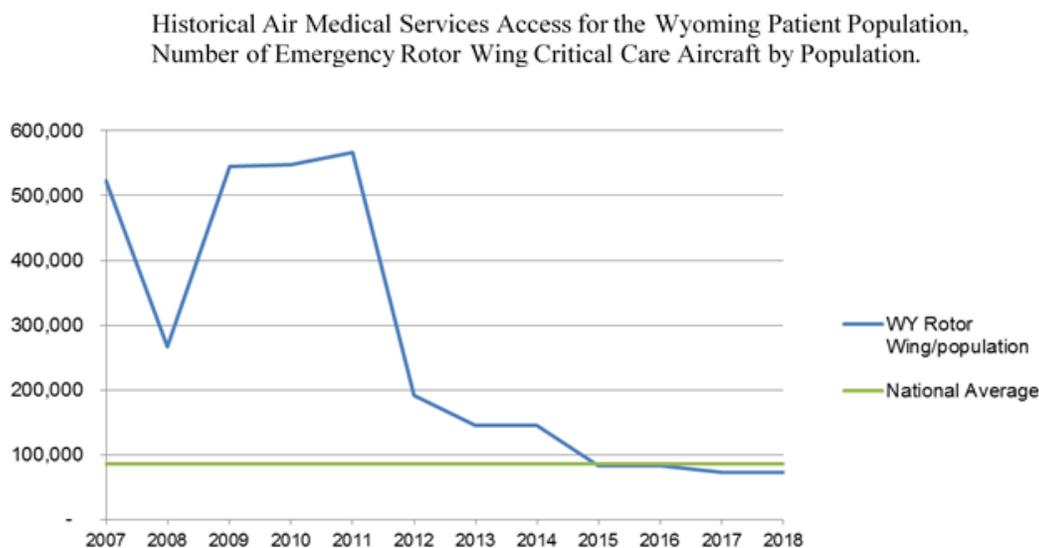
¹¹ Industry data is used because cost data is not collected for this provider group by the federal government.

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.



Calculated using CMS RUCS 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 the 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 194⁵¹, 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).

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 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 is 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.