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January 13, 2011

The Honorable Edward J. Kasemeyer
Chair, Senate Budget & Taxation Committee
3 West, Miller Senate Office Building
Annapolis, Maryland 21401

The Honorable Delegate Norman H. Conway
Chair, House Appropriations Committee
House Office Building, Room 121
Annapolis, Maryland 21401

Re: 2011 JCR – Page 85

Gentlemen:

The 2011 Joint Chairmen's Report requested that the State Emergency Medical Services (EMS) Board, in coordination with the Maryland Institute for EMS Systems (MIEMSS), Maryland State Police Aviation Division (MSPAC), the Maryland Firemen's Association, the Maryland Insurance Administration, the Maryland Health Care Commission, the Department of Health & Mental Hygiene Office of Health Services (formerly the Medical Care Programs Administration), and the Office of the Attorney General to evaluate the legality, feasibility and ramifications of transitioning the MSPAC Medevac Program to insurance-only billing of Maryland residents and full billing of nonresidents for Medevac services.

The enclosed report, "Evaluating the Feasibility of Insurance Provider Billing for Medevac Services," is submitted in compliance with that request.

Please do not hesitate to contact us if you have any questions or if we may provide you with any further information. Thank you for your continuing support of Maryland's statewide emergency medical services system and medevac program.

Very truly yours,

Robert R. Bass, MD, FACEP
Executive Director

Cc: Donald L. DeVries, Jr., Esq., Chairman, State EMS Board
Cathy Kramer, DLS (electronic copy)
Sarah Albert, DLS Library & Information Services (5 copies by mail)

Report Evaluating the Feasibility of
Insurance Provider Billing for Medevac Services

Executive Summary

The 2011 Joint Chairmen's Report directed the State Emergency Medical Services (EMS) Board, in coordination with the Maryland Institute for EMS Systems (MIEMSS), Maryland State Police Aviation Command (MSPAC), the Maryland State Firemen's Association, the Maryland Insurance Administration, the Maryland Health Care Commission, the Department of Health and Mental Hygiene Office of Health Services (formerly the Medical Care Programs Administration), and the Office of the Attorney General, to evaluate the legality, feasibility and ramifications of transitioning the Maryland State Police Aviation Command (MSPAC) Medevac Program to insurance-only billing of Maryland residents and full billing of nonresidents for Medevac Services. As discussed herein, the Study Report includes the following information:

- In order to bill for patient transports, the MSPAC will likely require statutory authority from the Maryland General Assembly.

- It is likely the MSPAC could limit billing for helicopter transport of patients who are Maryland residents to amounts paid by insurance, but co-pays and uninsured amounts must be collected from non-residents.

- Insurance-only billing would be limited to transport in vehicles owned by the State and would not apply to those instances where commercial ambulance service helicopters provide scene transport as they currently do from time to time.

- Billing for patient transport would render the MSPAC a Covered Entity under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a Covered Entity, the MSPAC would be subject to the extensive privacy and security regulations promulgated under HIPAA.

- Currently, insurance reimbursement for emergency air transport is inconsistent among the spectrum of payors (e.g., Medicare, Medicaid, commercial insurance). It is not a State mandated benefit and even it if it were, insurers would only reimburse if the service was deemed medically necessary. The impact of the Patient Protection and Affordable Care Act (ACA) on State mandates is unknown at present.

- MSPAC's current fleet of Eurocopter Dauphin AS-365 helicopters will be phased out as the Agusta Westland AW-139 helicopters are placed into service. Until the entire MSPAC helicopter fleet is replaced with Agusta Westland AW-139 helicopters and until all of those helicopters are certified as operational under *FAA Part 135*, it will not be practical for MSPAC to bill for transport services.

- The attenuated delivery schedule for the new helicopters significantly mitigates the impact of projected annual revenues from patient billing until after 2015.

Introduction

The 2011 Joint Chairmen's Report contained the following language:

> **"Report Evaluating the Feasibility of Insurance Provider Billing for Medevac Services:** In November 2008, the Maryland Institute for Emergency Medical Services Systems (MIEMSS) convened an expert helicopter panel to evaluate recent changes to the State's Medevac protocols. One of the recommendations issued by the panel was that all Medevac operations be conducted under Part 135 of the Federal Aviation Administration (FAA) regulations. Consistent with the panel's recommendations, the 2009 Joint Chairmen's Report included committee narrative directing the Maryland State Police Aviation Command (MSPAC) to take immediate steps to seek Part 135 certification. Since that time, MSPAC has been actively pursuing Part 135 aviation requirements and, therefore, is prohibited from charging patients for Medevac services. However, once MSPAC becomes Part 135 certified, the State will have the option to insurance-only bill Maryland residents and to fully bill nonresidents for Medevac services, thereby creating a potential revenue source for the Maryland Emergency System [sic] Operations Fund. In light of the numerous implications that may result from implementing this new billing practice, the budget committees request that by January 1, 2012, the Emergency Medical Services (EMS) Board, in coordination with MIEMMS [sic], MSPAC, the Maryland State Firemen's Association, the Maryland Insurance Administration (MIA), the Maryland Health Care Commission (MHCC), the Department of Health and Mental Hygiene (DHMH) Medical Care Programs Administration, and the Office of the Attorney General (OAG), submit a report to the budget committees evaluating the legality, feasibility, and ramifications (e.g., impact on provider insurance rates) of transitioning to the aforementioned billing practice. The report shall also discuss charges for Medevac services provided, including billing practices; reimbursement by insurance providers; State and federal laws applicable to the operations of Medevac services in Maryland; and a timeline by which MSPAC shall achieve Part 135 certification. Lastly, in addition to the budget committees, the report shall be submitted to any policy committee that is likely to have oversight over this issue."

In response to this request, a Helicopter EMS Billing Study Group was convened. The Study Group, which was convened by the EMS Board, included representatives from MIEMSS, MSPAC, the Maryland State Firemen's Association, the Maryland Insurance Administration, the Maryland Health Care Commission, the Department of Health and Mental Hygiene Office of Health Services (formerly the Medical Care Programs Administration), and the Office of the Attorney General. The Study Group developed the report over the course of three meetings in 2011 (August 23, October 24, and November 17).

Policy Context for the Study

Since the 1970's, the Maryland State Police Aviation Command (MSPAC) has operated a fleet of helicopters that provide air ambulance (medevac) transport of emergency patients from the site of an incident to a trauma center or specialty referral hospital. At the present time, the MSPAC has eleven (11) helicopters that operate as "public aircraft" while complying with the Federal Aviation Administration (FAA) regulations set forth in *14 CFR Part 91*[1] Applicable to both "public" and "civil" aircraft operations. Aircraft operators not certified by the FAA as an "air carrier" to conduct flight operations under *14 CFR Part 135* cannot charge for medevac services. The MSPAC is in the process of purchasing a new fleet of Agusta Westland AW-139 helicopters[2] and becoming a FAA certified "air carrier" approved to conduct medevac transports under the more stringent FAA regulations set forth in *14 CFR Part 135* helicopters. The MSPAC is pursuing *Part 135* certification as an operational and safety enhancement.

MSPAC's decision to pursue FAA air carrier certification and to conduct medevac tranports under *14 CFR Part 135* stemmed from the 2008 report "Expert Panel Review of Helicopter Utilization and Protocols in Maryland.[3]" To help assure that all flights are operated at the highest levels of medical transportation safety standards, one of the recommendations contained in the Expert Panel's report was that "[a]ll Maryland HEMS operations should be conducted under Part 135 of the Federal Aviation regulations, including Federal Aviation Administration's Air Ambulance Operations Specifications..."[4]

The MSPAC will not seek FAA approval to conduct medevac transports under *14 CFR Part 135* with the existing helicopter fleet. It is anticipated that once the MSPAC achieves FAA air carrier certification to conduct flight operations under *14 CFR Part 135*, the MSPAC will no longer be prohibited from charging for medevac services when transporting patients in the new helicopters. Moreover, the MSPAC will greatly benefit from maintaining the infrastructure required of FAA certificated air carriers and the additional program "oversight" that the FAA is required to provide to all certificated air carriers conducting medevac flight operations under *14 CFR Part 135*.

The Maryland Emergency Medical Services Operations Fund (MEMSOF) supports the MSPAC medevac and search and rescue functions, while General Funds support law enforcement and homeland security functions. The funding split for the MSPAC has remained at 80% MEMSOF

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[1] FAA regulations are contained in Title 14 of the Code of Federal Regulations which is sometimes referred to herein as "FAA Part".

[2] The Maryland General Assembly has authorized the purchase of up to eleven (11) helicopters to replace the existing fleet.

[3] http://www.miemss.org/home/LinkClick.aspx?fileticket=Wc3WFoQSevY%3d&tabid=58&mid=450

[4] "Expert Panel Review of Helicopter Utilization and Protocols in Maryland," Baltimore MD, November 24-25, 2008, page 6.

and 20% General Funds since fiscal year 2003, based on the ratio of medevac flights to non-medically related flights.

The MEMSOF also funds MIEMSS, the Maryland Fire & Rescue Institute, the R Adams Cowley Shock Trauma Center, Local Grants under the Senator William H. Ammos Fire, Ambulance and Rescue Fund, and the Voluntary Company Assistance Fund. The FY12 budget analysis for the MEMSOF that was completed by the Department of Legislative Services (DLS) concluded that MEMSOF was viable only through fiscal year 2013 because MEMSOF is funded by a vehicle registration fee surcharge that is insensitive to inflation and there was a lack of diversity in the fund's revenue sources. DLS recommended that alternative revenue sources be explored, one of which was MSPAC insurance-only billing for Maryland residents and full billing of nonresidents. DLS noted that the fiscal impact of this option was unknown, however, and a study was required to determine the ramifications of this option.

Background

The MSPAC provides the primary scene helicopter transport for the State of Maryland and has transported over 138,000 patients since its inception. Currently, the MSPAC's eleven (11) AS-365 helicopters are operated as "public aircraft" and the MSPAC cannot charge for medevac services under FAA regulations. The MSPAC is in the process of purchasing a fleet of new AW-139 helicopters and is concurrently pursuing FAA certification as an "air carrier" approved to conduct medevac transports under the more stringent FAA regulations outlined within *14 CFR Part 135*. Once the MSPAC achieves FAA air carrier certification and is approved to conduct operations under *14 CFR Part 135*, the MSPAC will not be prohibited from charging for medevac services when transporting patients in the new helicopters.

To achieve Part 135 status, the MSPAC has retained the services of an Air Carrier Certification Consultant Group that is assisting the MSPAC with obtaining FAA air carrier certification to conduct medevac flight operations under *14 CFR Part 135*. The MSPAC plans to obtain FAA air carrier certification shortly after the delivery of the first two AW-139 helicopters. The MSPAC will add each additional AW-139 helicopter to their FAA issued "Operations Specifications" (OpSpecs)[5] shortly after they are delivered, enabling them to conduct flight operations under *14 CFR 135*. The delivery of the first two (2) helicopters is expected in May 2012. Until all of the new helicopters are delivered, which is anticipated to occur by February 2015, the MSPAC will be flying a mixed fleet of both the new and the existing helicopters. The MSPAC will not conduct any medevac flight operations under *14 CFR Part 135* regulations with the existing fleet of AS-365 helicopters. Once delivery has been made of all the new helicopters is complete, the MSPAC will no longer fly the existing fleet of helicopters.

The National Park Police, operating out of Washington, D.C., and the Delaware State Police, operating out of bases in Georgetown and Middletown, Delaware, provide primary scene support to the MSPAC when requested. These two public safety entities operate their aircraft as "public aircraft" under FAA Part 91 and are prohibited from billing patients.

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[5] Operations Specifications (OpSpecs) is defined by the FAA as "[t]he authorizations, limitations, and certain procedures under which each kind of operation, if applicable, is to be conducted."

Three (3) commercial air ambulance companies operating in Maryland that provide inter-hospital patient transport services have a Memoranda of Understanding (MOU) with the State to provide back-up to the MSPAC for scene response when the MSPAC requests them to do so. These companies, which are FAA certified air carriers and approved to conduct operations under *14 CFR Part 135*, bill patients or third party payors for the services they provide. The terms of the MOU prohibit the companies from seeking reimbursement from the State, a local jurisdiction, a municipality, or volunteer fire company.

The numbers of the MSPAC transports, those completed by the NPP and the DESP, as well as private air ambulance transports, functioning as backup to the MSPAC, for the past three fiscal years are shown in Table 1.

Table 1
Completed Patient Transports by Agency and Fiscal Year, FY 2009 - FY 2011
All Jurisdictions

Agency	FY 2009	FY 2010	FY 2011	Total
MSP, All Troopers	2414	2044	2248	6706
USPP	112	58	58	228
DSP	15	12	14	41
Commercial Providers	39	25	17	81
Total	***2580***	***2139***	***2337***	***7056***

Legal Considerations

1. May the Department of State Police (MSP) charge fees for patient transport via helicopter?

In order to bill for patient transports, the MSP will likely require statutory authority from the General Assembly.

In 1991, the Office of Attorney General (OAG) opined that:

> Although the question is not at all free from doubt, in our view the State Police may charge fees under current law for inter-hospital transfers. However, we recommend consideration of legislation that would grant explicit authority over the operational details of the Medevac program, including fees. *76 Op. Atty Gen. Md. 95 (1991)*

The 1991 OAG opinion cites Article 14 of the Maryland Constitution's Declaration of Rights, which provides "[t]hat no aid, charge, tax, burthern, or fees ought to be rated or levied, under any pretense without the consent of the Legislature." Hence, a State agency many not charge a fee for its services without legislative approval.

The 1991 OAG opinion points out there was then, as today, no specific statutory authority for the MSP to provide medevac services. Rather, MSP authority for such services was premised on the MSP's "general duty to safeguard the lives and safety of all persons in the State ...". *Md. Code Ann., Article 88B, § 3 (1991)* and the Superintendents authority to "to make any rules necessary to promote the effective and efficient performance . . ." of the State Police. *Md. Code Ann., Article 88B, § 15(a) (1991).*

Article 88B was recodified as Title 2 of the Public Safety Article in 2003. The provisions cited in the 1991 OAG opinion, Sections 3 and 15 of Article 88B (1991), were recodified as part of sections 2-301 and 2-205 of the Public Safety Article without substantive modification.

The Medevac program has been developed administratively under these statutes. In 1991, the General Assembly had not enacted any statute addressing the Medevac program, but it had referenced the program in session laws and budget bills. The 1991 OAG opinion indicated that the grant of authority by *Md. Code Ann., Article 88B, §§ 3 and 15 (1991)* was sufficient to enable the MSP to decide the operational details of the Medevac program. The 1991 OAG opinion concluded that the charging of fees could be considered another operational detail.

After the 1991 OAG opinion, in 1992 the General Assembly created the Maryland Emergency Medical System Operations Fund (the "MEMSOF") now codified at *Md. Code Ann., Transportation, § 13-955.* The MEMSOF is funded by a motor vehicle registration fee surcharge created expressly for that purpose, which is authorized by *Md. Code Ann., Transportation, § 13-954(b)(1).*

Historically, the General Assembly has approved increases in the *§13-954(b)(1)* registration fee surcharge because, among other things, the surcharge funded no-charge Medevac services to the citizens of Maryland.

Part of the legislation enacted in 1992, specifically recognizes the MSP Medevac program by providing funding for "medically oriented functions of the Department of State Police, Special Operations Bureau, Aviation Division" from the MEMSOF. *Md. Code Ann., Transportation, § 13-955(e) (1).* Such funding includes the MSP Medevac program. See *93 Op. Atty Gen. Md. 3 (2008).*

The MEMSOF legislation recognizes the potential for billing by the MSP but does not authorize it. *Section 13-955(c)* provides:

> (c) The Fund consists of:
> (1) Registration surcharges collected under *§13-954* of this subtitle; and
> (2) All funds, **including charges for accident scene transports and interhospital transfers of patients**, generated by an entity specified in subsection (e) of this section that is a unit of State government. (*emphasis supplied)*

Under all of the circumstances, the MSP should obtain specific legislative authority before commencing to bill for air medical transport.

2. Federal Aviation Administration (FAA) requirements for Air Medical Transport Billing.

MSPAC helicopters currently conduct air ambulance (medevac) transports as "public aircraft," as defined by *49 USC 40102(a) (41)*. "Public aircraft" are subject to certains sections of *14 CFR Part 91*[6] , but they are not subject to the more stringent requirements of *14 CFR 135*[7] which apply to "civil aircraft" conducting "air carrier" flight operations.

Billing for medevac (air ambulance) transports would cause MSPAC's helicopters to be classified as "civil aircraft" (*49 USC 40102(a) 16)*) because they would be providing a "commercial service" as defined by *49 USC 40125(a) (1)*. In order to provide a "commercial service" and bill for patient transport, the MSPAC would be required to become FAA certified as an "air carrier" under *14 CFR 119* and to conduct all air ambulance (medevac) flight operations for which MSPAC bills under *FAA Part 135*. In addition, the MSPAC would be required to maintain the minimum liability insurance coverage requirements as set forth in *FAA Part 205.5* and required by *14 CFR 298*. (The MSPAC currently meets or exceeds those insurance requirements.)

In July of 2009, the MSPAC began the process of becoming a FAA "air carrier" certificate holder under *14 CFR 119* to conduct air ambulance transports under *14 CFR Part 135* regulations as part of the MSPAC's efforts to improve the safety and operations of its medevac program. Prior to that time, the MSPAC met or exceeded many of the operational requirements outlined in *14 CFR Part 135* in the interest of safety even though all flight operations were being conducted as "public aircraft."

The new Agusta Westland AW-139 helicopters being purchased by the State of Maryland for the MSPAC to replace its current fleet of Eurocopter Dauphin AS-365 helicopters will meet and/or exceed the requirements of *14 CFR 135*, as well as that the regulations that the FAA has recently proposed for air ambulance and commercial helicopter operators[8]. It is anticipated that the MSPAC will receive air carrier certification by the FAA shortly after taking delivery of the first two AW-139 helicopters. It is MSPAC's intention to conduct all air ambulance (medevac) operations with the Agusta Westland AW-139 helicopters under *FAA Part 135* to the extent possible[9]. In order to do so, each AW-139 helicopter will need to be inspected and approved by the FAA after delivery and then added to MSPAC's "operational specifications" (OpSpecs) prior

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[6] Although all aircraft must follow certain sections of *FAA Part 91*, public aircraft operators do not have to comply with safety regulations, including maintenance rules under *FAA Part 43* or pilot certification standards under *FAA Part 61*. Generally, *FAA Part 91* allows greater flexibility in pilot hours and other operations, as well as less regulatory oversight.

[7] *FAA Part 135* imposes additional requirements for an aircraft and crew. The aircraft must conform to more-stringent safety and equipment requirements, and required operations manuals and training programs must be implemented.

[8] 75 FR 62620 (October 12, 2010).

[9] A few patient transports result from search and rescue recoveries. A search and rescue flight typically cannot be carried out under the *14 CFR 135* requirements. In those cases, the patient cannot be billed. The FAA requirements for which flights are subject to *14 CFR 135* are complex and evolving.

to conducting patient transports under *14 CFR Part 135*. Thus, all patient transports utilizing the Agusta Westland AW-139 aircraft will meet FAA standards for billing.

The MSPAC's current fleet of Eurocopter Dauphin AS-365 helicopters will be phased out as the new AW-139 helicopters are delivered, inspected and approved by the FAA to conduct flight operations under *CFR Part 135* and are placed into service. As the MSPAC transitions into the AW-139 helicopters, all air ambulance (medevac) patient transports utilizing the Eurocopter Dauphin AS-365 helicopters will be conducted by the MSPAC as a "public aircraft" operation. Patient transports conducted by the MSPAC utilizing the Eurocopter Dauphin AS-365 helicopter will not meet FAA standards for billing. Accordingly, it will not be practical for MSPAC to bill for transport services until the entire MSPAC helicopter fleet of AS-365 helicopters is replaced with the AW-139 helicopters and all air ambulance (medevac) operations are conducted under *14 CFR Part 135*.

3. Can the MSPAC bill insurance providers without seeking any payment from the patient?

It is likely the MSPAC can limit billing for helicopter transport of patients who are Maryland residents to amounts paid by insurance, but co pays and uninsured amounts must be collected from non-residents.

Under applicable federal law, state or local governments can treat certain tax revenues as the patient portion of a charge for medical transport that would not be paid by an insurer (co-pay, coinsurance or deductible) for those patients who are *bona fide* residents of the jurisdiction in which the taxes or other revenues are collected. The Office of the Inspector General of the Department of Health and Human Services (OIG) has repeatedly over the past several years issued advisory opinions[10] that such instances of "insurance only billing" would not be prosecuted as violations of the federal anti-kickback laws.

The anti-kickback statute is described in *OIG Advisory Opinion No. 11-13,* issued August 29, 2011:

> The anti-kickback statute makes it a criminal offense knowingly and willfully to offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. See section 1128B(b) of the [Social Security] Act. Where remuneration is paid purposefully to induce or reward referrals of items or services payable by a Federal health care program, the anti-kickback statute is violated. By its terms, the statute ascribes criminal liability to parties on both sides of an impermissible "kickback" transaction. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.
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> The statute has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further

[10] Advisory Opinions are voluntary and are by their terms only applicable to the person requesting the opinion and are limited to the facts as stated in the Opinion. The State may seek its own Advisory Opinion regarding the MSPAC billing insurance only by requesting such an opinion from the HHS Office of the Inspector General.

> referrals. [citations omitted]. Violation of the statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. Conviction will also lead to automatic exclusion from Federal health care programs, including Medicare and Medicaid. Where a party commits an act described in section 1128B(b) of the Act, the OIG may initiate administrative proceedings to impose civil monetary penalties on such party under section 1128A(a)(7) of the Act. The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs under section 1128(b)(7) of the Act.
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> Section 1128A(a)(5) of the Act provides for the imposition of civil monetary penalties against any person who gives something of value to a Medicare or state health care program, including Medicaid, beneficiary that the benefactor knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicare or a state health care program, including Medicaid. The OIG may also initiate administrative proceedings to exclude such party from the Federal health care programs. Section 1128A(i)(6) of the Act defines "remuneration" for purposes of section 1128A(a)(5) as including, inter alia, the waiver of cost-sharing obligations (or any part thereof).

OIG Advisory Opinion No. 11-1, also provides that insurance only billing by a governmental entity is allowed as an exception to Medicare's general prohibition against the waiver of cost-sharing amounts for reasons unrelated to individualized, good faith assessments of financial hardship.

The OIG will not approve insurance only billing for persons who are not *bona fide* residents of Maryland. See *OIG Advisory Opinion No. 02-15*, issued September 30, 2002.

The OIG advisory opinions only address the allowance for insurance only billing by federal programs, Medicaid and Medicare. There is no direct authority as to whether commercial health care insurers would accept insurance only billing by the State, but it is reasonable to assume they would take the same position as the federal authorities. There is no reported objection by a commercial health care insurer to insurance only billing of residents by a state or municipality for EMS transport.

Insurance only billing would be limited to transport in vehicles owned by the State. Thus, it would not apply to those instances where commercial ambulance service helicopters provide scene transport as they currently do from time to time.

> ... note that this provision of the CMS manual [allowing insurance only billing by government entities that collect taxes] applies only to situations in which the governmental unit is the ambulance supplier; it does not apply to contracts with outside ambulance suppliers. For example, where a municipality contracts with an outside ambulance supplier for the provision of services to residents of its service area, the municipality cannot require the ambulance supplier to waive out-of-pocket cost-sharing amounts unless the municipality pays the cost-sharing amounts owed or otherwise makes provisions for the payment of such cost-sharing amounts. See, e.g., OIG Advisory Opinion No. 01-12 (July 20, 2001). There is an important difference between a

municipally-owned ambulance company voluntarily waiving cost-sharing amounts for its own residents and a municipality requiring a private company to bill "insurance only" as a condition of getting the municipality's EMS transportation business, including Medicare business. *OIG Advisory Opinion No. 11-13*, issued August 29, 2011.

However, *OIG Advisory Opinion No. 11-13* points out that it may be possible for a commercial service to bill insurance only if the State makes periodic payments to the commercial service to cover the amounts not paid by the patient if such payments "...are reasonably calculated to cover the expected uncollected cost-sharing amounts."

Insurance reimbursement will need to be addressed because it may not be possible to secure a signed assignment of benefits authorization for ambulance transports due to the urgency of the situation or the condition of the patient. *Section 15-138* of the Insurance Article provides for direct reimbursement to ambulance service providers. However, that section may need to be modified to allow for emergency air transport.

4. How would MSPAC billing affect liability?

MSPAC billing would have no affect on liability.

MSPAC employees are immune from tort liability as State employees under the provisions of the Maryland Tort Claims Act, provided the employees act within the scope of their employment and without malice or gross negligence. *Md. Code Ann., State Gov, § 12-105; Courts and Judicial Proceedings, § 5-522(b)*. Billing for patient transport would not affect this immunity

The State is immune from liability for amounts over $200,000 under the Maryland Tort Claims Act. *Md. Code Ann., State Gov, § 12-104.*

Immunity under the Good Samaritan Act, *Md. Code Ann., Cts and Jud Proc§3-603,* would be affected by billing. Immunity under that statue is lost if the patient is billed by the service providing the transport. *Chase v. Mayor & City Council of Baltimore, 1*26 Md. App. 427 (1999); rev'd on other grounds *360 Md. 121 (2000).* However, the MSP and its employees would retain immunity under the Maryland Tort Claims Act.

As noted in Part 2 above, the FAA requires certain insurance coverage for air medical transport carriers under *FAA Part 298.* Procurement of insurance would not affect immunity. *See Buffington v. Baltimore County, 913 F.2d 113, 124 (4th Cir. Md. 1990).*

5. HIPAA requirements for billing.

Billing[11] for patient transport would render the MSP a Covered Entity under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a Covered Entity, the MSP

[11] Billing would necessarily involve the transmission of health information in electronic form in connection with transactions related to claims processing listed in regulations promulgated under HIPAA contained in 45 CFR 160.163. Nearly all current health care billing is electronic, and Medicare requires billing for Medicare covered services to be electronic. Engaging in such electronic transmission of health

would be subject to the extensive privacy and security regulations promulgated under HIPAA plus additional obligations supplementing HIPAA enacted in the federal Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH ACT).

The basic confidentiality requirements for medical records under HIPAA are essentially the same as those provided by the Maryland Confidentiality of Medical Records Act, *Md. Code Ann., Health General, § 4-301 et seq.* However, HIPAA imposes significant additional procedural and security requirements.

The United States Department of Health and Human Services (HHS) Office of Civil Rights (OCR) enforces the HIPAA Privacy and Security regulations. OCR has begun to meet out substantial financial penalties for even inadvertent HIPAA violations by Covered Entities. In February of 2011, OCR required Massachusetts General Hospital to pay a $1 million penalty for HIPAA violations when a hospital employee inadvertently left 192 paper patient records on a subway.

In addition, the American Recovery and Reinvestment Act of 2009, in Section 13411 of the HITECH Act, requires HHS to provide for periodic audits to ensure covered entities associates are complying with the HIPAA Privacy and Security Rules and Breach Notification standards.

In order to minimize the HIPAA impact, the MSP would probably need to separate its Medevac operations from its other operations by becoming a hybrid entity under the HIPAA privacy regulations. This would limit most of the HIPAA requirements to the Medevac operation, but the MSP would retain overall responsibility for the Medevac operation complying with HIPAA.

Coverage by Payors

Generally, reimbursement is available for emergency air transport if the service is considered to be medically necessary by the payor. Medicare considers air transport medically necessary when the patient's condition is such that other forms of patient transport, i.e., ground transport are medically contraindicated. In such an instance, transport to the nearest hospital offering the service needed by the patient will generally be covered.[12]

Medicare. When the patient is covered by Medicare, air ambulance services are typically billed and reimbursed using a base fee plus the miles flown from pick-up to destination multiplied by a per mile rate (i.e., base rate + miles flown from pick-up to destination x per mile rate). Payment rates are higher when the point of patient pick-up occurs in a rural area (i.e., base rate + miles flown x per mile rate = subtotal + subtotal x .50 = total). Only a relative small portion of Maryland's geography is considered "rural" for Medicare reimbursement purposes, however.

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information would therefore render MSPAC a Covered Entity under HIPAA regulations thereby making it subject to those regulations.

[12] Medicare Claims Processing Manual, Chapter 15 (Ambulance), Section 10.2 (Summary of the Benefit); Medicare Benefit Policy Manual, Chapter 10 (Ambulance Service), Section 10.2.1 (Necessity for the Service).

Medicaid. Maryland Medicaid provides coverage for air transport for interhospital transfer when certain criteria are met. Emergency air transport from the scene of any incident, however, is specifically excluded from Maryland Medicaid coverage[13].

Private Insurers. Private insurer payments are generally based on Medicare rates: in-network allowed charges are approximately 113 percent of Medicare allowed amounts; and allowed charges for non-contracting providers are approximately 130 percent of Medicare allowed amounts (not including the patient's balance bill).[14]

Even if considered medically necessary, however, most private insurers in Maryland do not include air ambulance transport as a covered benefit. Nearly all contracts issued by fully insured plans contain an exclusion similar to the language found in COMAR 31.11.06.06, which excludes "services for which a covered person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan." Although this regulation only applies to the small group market, similar language is found in most individual and large group contracts. The private insurer will not pay if the provider (emergency air transport) only charges insured individuals and does not charge the uninsured individuals.

In its 2006 "Air Ambulance Study," the Maryland Health Care Commission described the situation as follows:

> "The inclusion of emergency ambulance services in insurance products offered in Maryland varies. Although not specifically referred to in regulations, air ambulance transport services would appear to be included in the Comprehensive Standard Health Benefit Plan (CSHBP) product, but such services are not a "mandated benefit" and, therefore, not required in either large group or individual products sold in Maryland. For the latter two products, the plan sponsor (employer) and the payor have flexibility to define the scope of any ambulance benefit, if offered at all. Some such contracts cover ground ambulance only, others cover ground ambulance and cap air ambulance services at a relatively low threshold — perhaps $250 — and still others treat all ambulance services as a covered service subject to the same rules and conditions as any other covered benefit.
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> Health Maintenance Organizations (HMOs) typically cover air ambulance services based on their interpretation of the Maryland HMO statute even though the service is not a required medical service under the Health General Article. HMOs rely on Federal law which broadly defines emergency services that must be offered to qualify as a federally qualified HMO.
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> Given that air ambulance service is not a mandated benefit, the State has limited ability to control the conditions under which the benefit can be offered. If rigid conditions are

[13] "Guidelines for Air Ambulance Services Under the Maryland Medicaid Program," Office of Health Services Medical Care Programs, Department of Health & Mental Hygiene, July 2009, p. 5.

[14] The Maryland Health Care Commission, "Air Ambulance Study Required Under Senate Bill 770," December 2006, page 35.

> established by the State, the plan sponsor can decide to simply drop the benefit under the contract. Given that air ambulance service is not a required covered service, except in the small group market, debates on how the service is offered and the amount a carrier should pay are constrained. It is difficult to define an appropriate payment level when the service is mandated; setting a fee when a service is not required under State law is even more difficult because payors can avoid, in their view, an unacceptably high payment by dropping the service from the benefit package.[15]

Maryland insurance statutes have been modified many times to include certain "mandated benefits" that require Maryland insurance companies to cover specific benefits, e.g., various diagnostic screenings for certain cancers; hospitalization for women and newborns after childbirth. Even if emergency air transport was a State mandated benefit, the Federal Employee Retirement Income Security Act of 1974 (ERISA)[16] exempts self-insured health care plans and government health care plans from compliance with State insurance laws. As a result, self-insured entities are not subject to most State insurance requirements, including State-imposed mandates for insurance coverage. In 2010, 49.6% of the under age 65 population in Maryland was covered under a self-insured group plan and 16.9% was covered under the federal employees health benefit plan. This means that in 2010, at least 66.5% of Maryland residents with health insurance were covered by a self-insured plan. These plans are not subject to the Maryland Insurance Administration's jurisdiction.[17]

Additionally, the federal Patient Protection and Affordable Care Act of 2010 (Public Law 111–148)(the "ACA") requires certain health plans to cover "essential health benefits" in 2014. The ACA identified emergency services as a health care service category. Which particular benefits are essential within that category is unclear at this time. Federal regulations regarding "essential benefits" are expected in 2012. Insurance policies will have to cover at least the "essential benefits" in each service category in order to be certified and offered in each state's Health Benefit Exchanges, and all Medicaid State plans must cover the "essential benefits" by 2014. Starting in 2014, the State must pay for any increase in premium costs associated with a state mandated benefit that is not an "essential health benefit."

PIP. Personal Injury Protection (PIP) coverage available in Maryland can be used for reasonable and necessary medical bills, lost wages, and other costs arising from an automobile crash. The minimum amount of coverage that must be offered by the insurer is $2,500; the maximum available is generally $10,000. Exclusions from coverage may include motorcycles, individuals who intentionally cause a crash, and other factors.

While PIP coverage is a required component of most automobile liability policies offered in Maryland, PIP coverage can be waived by the policy owner. Once waived, the policy owner is not eligible to collect PIP benefits, although passengers traveling in the car with the policy owner

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[15] Ibid, pages 13 and 14.

[16] Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat 829 (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

[17] Maryland Insurance Administration: 2010 Covered Lives Report, www.mdinsurance.state.md.us.

are generally eligible for PIP benefits unless they have waived PIP coverage for a vehicle they own, or live with a family member who has waived PIP coverage on their policy.

Claims submitted for PIP coverage are reviewed for reasonableness. Recovery for all PIP claims is limited to the amount of PIP coverage purchased.

Self-Pay / Uninsured. Regarding self-pay / uninsured in Maryland, it is estimated that there are currently approximately 740,000 uninsured in Maryland[18].

Billing and Reimbursement Projections

Billing Projections

Amount to be Billed. It is assumed that MSPAC Medevac services would be billed per medevac mission and reimbursed using a Base Fee + Mileage Rate based on loaded miles (i.e., one-way transport of the patient from the point of patient pick-up at the scene to the destination of the receiving hospital destination).

The simplest method of calculating the amount to be billed would be to divide the MSPAC appropriation from MEMSOF by the number of completed medevac missions. By statute, MEMSOF monies can only be used for the medically-oriented functions of the MSPAC; funds for the non-medically-oriented functions must come from other sources.

MSPAC – Annual Aviation Appropriation from the Maryland EMS Operations Fund (MEMSOF)

FY	Appropriation	# Completed Transports	Cost per Transport
2009	$18,722,509	2,414	$7,755
2010	$19,311,584	2,044	$9,447
2011	$19,862,356	2,248	$8,835
Average	$19,298,816	2,235	$8,634

MSPAC Average Mileage. MSPAC average loaded miles is assumed to be 35.

Reimbursement Levels. Potential reimbursement levels are shown below:

Medicare 2011 Ambulance Fee Schedule:

Base Rate: $3,304.58		
Urban Base Rate / Urban Mileage:	$3,443.37	$21.51
Rural Base Rate / Rural Mileage:	$5,156.06	$32.27

[18] Source: Maryland Insurance Administration.

A very limited number of geographic areas in Maryland are considered "rural" under Medicare reimbursement guidelines. Further, there are a limited number of MSPAC helicopter transports from rural areas. Consequently, for the purposes of estimating Medicare reimbursement for this report, all transports are considered to fall within the Medicare urban base rate.

Medicaid – Maryland Medicaid does not reimburse helicopter transports from the scene of an incident.

Private Payor[19]-- Base Rate Per Trip / Mileage: $3,529 $19.14

When considering potential reimbursement from private payors, however, it is important to keep in mind that most private insurance plans in Maryland do not include air ambulance transport as a covered benefit and approximately 2/3 of Maryland residents with health insurance are covered by a self-insured plan not subject to the Maryland Insurance Administration's jurisdiction.

Payor Mix[20]. Most of the transports are projected to be trauma patients. An estimated payor mix is required for billing projections. The payor mix used for projections in this report is estimated as follows:

Medicare =	20.4%
Medicaid =	21.53%
Private Payor & Other Government Payor =	45.42%
Self Pay / Uninsured =	12.5%
PIP =	Unknown[21]

Estimated Fees Billed Per Year

Medicare = $1,900,608

Calculations: 20.4% x 2235 = 456 Medicare patients/year

$3443.37 urban base rate + $725 mileage = $4,168 x 456 patients

Medicaid = $0

Calculations: 21.53% x 2235 = 481 Medicaid patients / year

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[19] The Maryland Health Care Commission, "Air Ambulance Study Required Under Senate Bill 770," December 2006, pages 31 and 34.

[20] Primary Source of Payment, University of Maryland Shock Trauma, 2010 HSCRC Discharge Abstract." Information provided by the Maryland Health Care Commission.

[21] Potential recovery from PIP is unknown. For that reason, PIP is not included in the Billing Projections.

Emergency air transport from the scene of any incident is specifically excluded from Maryland Medicaid coverage.

Self Pay / Uninsured = $0

Calculations: 12.5% x 2235 = 279 self pay / uninsured /year

Billing is assumed to be insurance-only; consequently, self-pay /uninsured patients would not be billed for services.

Private Payor & Other Government Programs = $1,406,330*

Calculations: 45.42% x 2235 = 1,105 total private payor patients / year

1,105 patients x .33 = 335 patients with coverage for air transport*

$3529 + $669 mileage = $4198 x 335 patients

*Private payor calculations assume that the approximately 1/3 of private plans subject to the authority of the Maryland Insurance Administration either offer coverage of air ambulance services or would be subject to a requirement to offer such coverage. This, in turn, may require passage of legislation requiring air transport as a mandated benefit of those plans. "Other Government Programs" is largely made up of Workman's Compensation; the reimbursement is similar to what is paid in the private sector.

Costs of Billing

It is assumed that MSPAC would contract with a billing entity to provide billing services. The costs associated with such billing are not able to be determined at this point. Public service ground-based ambulance services that contract with outside entities for billing purposes generally pay 8 – 10% of billing revenues received for billing services.

Estimated Fiscal Impact of Billing.

The estimated annual revenues from billing are shown below:

Estimated annual fees billed:	$3,306,938
Estimated annual cost of billing (10%)	- 330,694
Estimated annual revenues from billing	$2,976,244

Ramifications of Billing and Potential Issues

1. The potential impact on MEMSOF of additional revenues from MSPAC patient billing is significantly mitigated until after 2015 due to the attenuated delivery schedule for the new helicopters and the fact that the FAA 135 certification process must be completed for each new aircraft in order for the transport to be billed. While delivery of the initial two helicopters is projected to occur in May 2012, final delivery of all helicopters is not anticipated until 2015. Further, only the new helicopters will be FAA Part 135 compliant which is a prerequisite for billing for patient transport. Thus, the ability to bill for MSPAC services will depend on type of MSPAC helicopter transporting the patient. Until 2015, MSPAC will be operating a mixed fleet, with the new helicopters that are able to bill operating in certain geographic areas, and the existing helicopters that remain unable to bill operating in other geographic areas. Consequently, depending on the patient's location, the transport may or may not be able to be billed. As a result, until the entire MSPAC helicopter fleet is replaced with Agusta Westland AW-139 helicopters and until all of those helicopters are certified as operational under *FAA Part 135*, it will not be practical for MSPAC to bill for transport services. Also, a MSPAC mission that begins as a Search and Rescue, but ultimately requires transport of an injured patient may not be eligible for insurance billing. Finally, Park Police and Delaware State Police cannot bill, even when providing back-up to a geographic area otherwise covered by a new MSPAC helicopter that is FAA Part 135 certified (and able to bill).

2. Approximately 2/3 of Maryland residents with health insurance are covered by a self-insured plan not subject to Maryland mandates and not subject to Maryland Insurance Administration's jurisdiction. The feasibility of mandating coverage for the remaining 1/3 fully insured plans is unclear until the federal government provides more information about "essential health benefits" that must be covered by Medicaid and most private health plans starting January 2014. After that date, the Patient Protection and Affordable Care Act (ACA) requires the State to pay for any increase in premium costs associated with a state-mandated benefit that is not an "essential health benefit."

3. The reaction of EMS and Public safety providers to the possibility of MSPAC billing is likely to be negative, particularly among the volunteer community. This community has a strong and proud history and tradition of commitment to public service, and billing for services is often viewed as incompatible with providing life-saving treatment and transport to the ill and injured.

4. Many local jurisdictions charge ambulance transport fees to recover the cost of providing EMS services. The Department of Legislative Services conducted a survey in 2010 of counties and fire stations that charge fees for ground ambulance transport[22]. Survey results indicated that 19 of the 24 local jurisdictions charge ground ambulance transport fees. For these jurisdictions, fees billed range from a low of $300 per call to a high of $800 per call, depending on patient severity; mileage fees are also charged ranging from a low of $5 per mile to a high of $13 per mile. Thus, any fees charged by the MSPAC for

[22] Survey results were reported in the Department of Legislative Services "Analysis of the FY 2012 Maryland Executive Budget, 2011", J00I00 Maryland Aviation Administration, Maryland Department of Transportation, pages 28-30 and Appendix 2.

helicopter transport would be in addition to those already being charged by local jurisdictions, and patients with insurance who live in jurisdictions that charge for ambulance would be charged for this additional service arising from the same incident.

5. MSPAC billing processes and procedures for out-of-state residents will differ from billing for in-state residents since billing for out-of-state residents will not be limited to insurance only.

6. The reaction of the public to the possibility of MSPAC billing is unknown. Should the Legislature decide to pursue MSPAC billing, it would important to first determine the acceptability of such a change to the public. Further, given the apparent future insolvency of the MEMSOF, it would be important to determine the acceptability of MSPAC billing, as opposed to other revenue-producing approaches (e.g., an increase in the vehicle registration fee surcharge), as a way to strengthen MEMSOF solvency.