



ASSOCIATION OF CRITICAL CARE TRANSPORT

S. 1407 The Air Ambulance Medicare Accreditation and Accountability Act Improving Air Ambulance Quality, Patient Safety and Access for Medicare Beneficiaries Sponsored by Senators Snowe (R-ME) and Cantwell (D-WA)

Purpose of S. 1407

Consistent with the national healthcare policy goals of simultaneously improving access to care, patient safety, quality, appropriate utilization, provider accountability, and cost effectiveness, the purpose of S.1407 is to advance these goals in the realm of air ambulance services. As the nation's largest purchaser of healthcare, Medicare is well positioned to drive improvements in the quality, patient safety and cost effectiveness of air ambulance services to assure that beneficiaries ill or injured enough to warrant air ambulance transport will receive high quality care in a clinically safe and medically appropriate environment by sufficiently qualified and trained medical professionals equipped to meet their clinical needs.

As budgetary pressures intensify to restrain Medicare spending and the Congress considers ways to reduce reimbursement, it is imperative that reimbursement for essential and life-saving air ambulance services not be reduced in a haphazard or across the board manner. While Medicare payments for air ambulance services have increased 434% over the past decade, reimbursement has not recognized the developing variation in quality, patient safety and capability to serve more complex patients. Currently, Medicare reimbursement is paid to air ambulance providers at the same base rate despite the substantial variation in clinical capability among air ambulance providers. S.1407 will align the methodology for air ambulance reimbursement to better reflect the differential in costs and quality of air ambulance services without impeding access to care. S.1407 will create accountability for air ambulance providers for quality and patient safety.

S.1407 is aligned with the unprecedented 2009 NTSB study of helicopter air ambulances calling on CMS to establish a Medicare accreditation process to assure the highest levels of patient safety for patients and their caregivers. S.1407 establishes a Medicare accreditation requirement, tiered with three levels of accreditation, based on clinical capabilities as a first step towards incentivizing the highest levels of patient safety.. S. 1407 is consistent with recommendations by the National Quality Forum to measure all care provided by pre-hospital professionals. S.1407 will also improve access by incentivizing services in un- or underserved geographic areas.

S.1407 will also promote appropriate utilization of air ambulance services to ensure value for beneficiaries and taxpayers including an essential study of ground critical care transport services to evaluate potential impediments to appropriate use and reimbursement for ground critical care transport as medically indicated.

Improving the Quality of Air Ambulance Services

In order to assure value for beneficiaries and taxpayers, Medicare is driving improvements in quality for health care providers and increasingly holding them financially accountable for the quality and cost-effectiveness of care. While Medicare is incorporating new quality, safety, and efficiency systems for hospitals, physicians and other providers, currently there are only minimal requirements for air ambulance providers. There are no conditions of participation or accreditation requirements of air ambulances to assure high quality of care and appropriateness of services for Medicare beneficiaries whose lives are at stake. Even X-Ray suppliers have accreditation requirements not currently imposed upon air ambulances. S.1407 will establish defined standards of quality and clinical capability for all air ambulance services choosing to serve Medicare beneficiaries including minimum requirements for the air ambulance patient care environment to assure patient safety. Quality measures will be developed and air ambulances must report on those quality measures to receive a full annual payment update, similar to required reporting for other health care providers. S.1407 establishes new patient safety standards for non-coverage events for which air ambulance services will not be paid such as a patient death from running out of oxygen.

Establishing Accountability for Clinical Capabilities through Accreditation

S.1407 establishes standards for *clinical* (not aviation) capability at each level of accreditation to assure that the needs of patients with varying complexity of medical conditions are appropriately met. Air ambulance providers are free to choose the level of accreditation they wish to pursue. The accreditation levels are graduated with the highest clinical capability as a Level I service reflecting the continuity of specialty care during inter-hospital transport. These requirements relate to the *capability* of the air ambulance environment to meet the clinical and timely transport needs of critically ill and injured patients. The higher capability requirements of Level II and I are designed to maintain or establish the level of care (e.g. ED or ICU) needed by more clinically complex patients, most often being transported between hospitals or specialty care centers.

For example, similar to the extensive clinical capabilities of trauma centers to manage a variety of patient injuries that they employ selectively based upon the patient's medical condition, S.1407 establishes clinical capabilities at each accreditation level that may be selectively employed if needed by the patient. Air ambulances are not required to utilize the full extent of their capabilities at all times and for all patients just as trauma centers only activate services when medically indicated out of a wide array of capabilities (such as up to 16 subspecialist physicians on call in Level I trauma centers). S.1407 does not require air ambulances to have physicians or every drug or device found in an ED or ICU on board -- just the capability to maintain continuity of care during transport as appropriate to the clinical needs of the patient.

Level III requires the capability to provide physician directed advanced care and resuscitation at a level beyond the scope of practice of a paramedic, such as by a combination nurse and paramedic team. Every current accredited air ambulance meets these standards (over half the air ambulances are voluntarily accredited). Unstable ill or injured patients aboard an air ambulance should be assured these standards of care. All air ambulances must be accredited at least at level III to receive Medicare reimbursement.

Level II requires the capability to provide the level of care and scope consistent with a hospital emergency department to be able to maintain that level of care during transport between hospitals. Accordingly, the air ambulance must have physician directed critical care teams with the capability to administer medicines that would be used in a hospital ED, the ability to provide point of care lab testing, ventilators to provide volume or pressure ventilation, multiple infusion pumps to deliver necessary medications and the capability for invasive patient monitoring during transport. These medical capabilities are appropriate for patients seriously ill or injured enough to require air ambulance transport between hospitals. The majority of existing air ambulances are expected to meet the Level II requirements.

Level I requires a higher level of capability to meet the needs of specialty patients requiring more intense, invasive and costly medical interventions or the capability to transport multiple patients when needed. Level I air ambulances must have medical technology, supplies, scope of practice, specialist physician direction, and medical personnel to manage complex and unstable medical conditions within the transport environment consistent with the care provided in specialty hospital center, (such as neonatal, high risk obstetrical or cardiac patients needing intra-aortic balloon pumps). For example, if a patient's medical condition warrants, the medical bay has the capacity to allow the addition of specialized equipment and/ or a respiratory therapist or physician to the nurse/paramedic team to the transport thus providing for a higher level of care for the patient. A Level I air ambulance must also be able to fly a patient a minimum of 100 miles without refueling to ensure the capability to undertake long distance travel when needed by a patient to minimize amount of out-of-hospital time en route to specialty care centers.

Aligning Reimbursement with Clinical Capabilities

Over the past decade, costs and capabilities of air ambulance services have widened, yet Medicare reimburses all air ambulances at the same rate regardless of their quality, clinical capability, or specific mission requirements S.1407 establishes a process to define standards with increasing medical complexity and reimburses air ambulance according to the established payment for each accreditation level for all the patients they fly, even if certain patients have lower acuity. This policy is designed to recognize the higher fixed costs of the advanced medical capabilities provided to critically ill and injured patients warranting Level II air ambulance transport and for specialty patients warranting Level I transport. Based upon the independent cost analysis, the Secretary would stratify reimbursement rates to better align Medicare reimbursement with the actual costs of providing air ambulance services at each accreditation level. Air ambulances would still receive add-on payments for mileage and for transports by newly designated sole community air ambulances. Payment changes must be made on a budget neutral basis for all air ambulance services, taking into account future updates.

Enhancing Access to Air Ambulance Services in Rural Areas

S.1407 improves access to care by establishing a new category for sole community air ambulances with a higher level of reimbursement to incentivize air ambulance suppliers to provide services in remote rural areas. In addition, in establishing the new accreditation structure and commensurate reimbursement, medical and service standards, the Secretary must ensure that the criteria: does not adversely impact access to air ambulances (particularly

in rural areas); addresses the needs of rural and government providers; is economically and technically feasible; incorporates implementation timeframes so as not to impede access (particularly in rural areas) and is developed with stakeholder input in a transparent manner. Further, the Secretary must exempt any air ambulance for the first 5 years from a requirement if it would either require the provider to replace its air ambulance in order to be accredited at Level III or impose an undue economic burden with respect to compliance costs. These directives to the Secretary will ensure the ability of air ambulances to transition toward the new accreditation system without impeding access to lifesaving air ambulance services.

Addressing Cost-Effectiveness and Appropriate Utilization of Critical Care Transport Services

In 2009 the Arizona Department of Health published a study of air ambulance utilization and found a 43% discharge rate of patients from the ED under 24 hours as well as low injury severity scores. While these are imperfect tools in measuring appropriate utilization of air ambulances, it is clear that other areas of the country have higher injury severity scores and much lower rates of discharge by the ED under 24 hours for patients flown by air ambulances. S.1407 would require air ambulances to begin reporting essential data to better enable policy makers to evaluate appropriate utilization of air ambulance services. Further, S.1407 requires the Secretary to address appropriate utilization and service standards for air ambulances based in states that do not have such standards. S.1407 also requires states, as a condition of federal matching for air ambulance services under Medicaid, to implement pending guidelines being developed by the Federal Interagency Committee on Emergency Medical Services (and the Centers for Disease Control) regarding the appropriate use and mode of critical care transport.

Examining Appropriate Utilization and Reimbursement for Ground Critical Care Transport

Since the implementation of the CMS ambulance fee schedule, numerous ground critical care ambulances have ceased services to patients with complex medical needs but not having time sensitive medical needs, especially in rural areas. A neutral scientific study to examine the use and need for ground critical care transport is necessary to determine whether under reimbursement from Medicare is impeding access for critically ill and injured patients who might be more appropriately transported by ground critical care at a lower cost to Medicare.

Complementing Existing Federal and State Oversight of Air Ambulances

Under current law, states may generally impose medically related requirements related to the medical bay, medical equipment and personnel for patient care purposes, subject to FAA aviation safety requirements, and subject to the Airline Deregulation Act preemption of state regulation over the prices, routes and services of air carriers. S.1407 does not alter FAA authority nor does it empower CMS to regulate aviation safety of air ambulances. Aviation safety remains the sole purview of the FAA. FAA requirements regarding aviation safety and flight operations (such as placement of medical equipment and weight and power) will continue to define and regulate aircraft airworthiness. Given the wide variation in state requirements over air ambulance clinical capabilities, S. 1407 establishes minimum federal clinical standards for air ambulances choosing to serve Medicare beneficiaries. Further, S.1407 makes it clear that states may continue to license and set medical standards for air ambulances to the extent permitted under federal law and there is nothing that prevents states from exceeding the medical standards set by the Secretary for the purpose of Medicare reimbursement.