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Air Ambulance Quality and Patient Safety (AAQPS) Advisory Committee Public Meeting #3 – Meeting Notes, July 10, 2025

The Air Ambulance Quality and Patient Safety (AAQPS) Advisory Committee met virtually via Zoom.gov on July 10, 2025. The attached appendix identifies the AAQPS Advisory Committee members, agency employees, and others who attended the meeting. In accordance with the Federal Advisory Committee Act (FACA), 5 U.S.C. App. 2, the meeting was open to the public. The transcript and slides of the meeting are available at: [AAQPS Advisory Committee](#)

The meeting covered several topics: (1) a review of the findings and clarification on recommendations not resolved during the May 8 AAQPS Committee meeting; (2) additional context provided by Committee members and other subject matter experts regarding the Subcommittee recommendations; (3) consensus and a vote on the remaining Subcommittee recommendations. Meeting sessions included presentations and opportunities for discussion. The presentation materials are available for public review and comment at [AAQPS Advisory Committee](#). The agenda for the meeting and a list of the AAQPS Advisory Committee members are attached to this summary as an appendix.

Introduction and Background

Welcome

Jeff Richey, RN, MHA, FACHE, AAQPS Committee Chair

David Wright, Center for Clinical Standards and Quality (CCSQ), Designated Federal Officer

The AAQPS Advisory Committee (Committee) meeting began at 10:00 AM EST on July 10, 2025. Mr. David Wright, the Designated Federal Officer, gave welcoming remarks and shared meeting logistics. Mr. Wright thanked Committee members for their ongoing commitment to safety. Mr. Jeff Richey introduced himself as the Chair of the Committee, offered welcoming remarks, took roll call of Committee members, and shared meeting objectives and the agenda.

Mr. Richey shared background information on the Clinical Standards and Flight Safety Subcommittees. Both Subcommittees provided updates to the Committee on their deliberations, looked to the Committee for guidance on prioritization, and helped Committee members understand the background and nuance of each of their recommendations.

Mr. Richey described the structured process for voting on each recommendation and discussed how he would move the Committee to a vote once deliberations had reached consensus or near-consensus. He emphasized this meeting was the Committee's final opportunity to put forward questions and comments for discussion. The Committee would have the opportunity to



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provide clarifications on meeting discussions in the Report to Congress but would not be able to add information that was not discussed during the Committee meetings.

Recap of the May 8, 2025, Meeting

Jeff Richey, RN, MHA, FACHE, AAQPS Committee Chair

Mr. Richey provided a comprehensive review of the Committee's deliberations during the meeting held on May 8, 2025. The Subcommittee chairs presented recommendations for AAQPS consideration and answered questions. The Committee discussed and deliberated on those recommendations and voted on and passed nine recommendations to be included in the Report to Congress. The Committee also agreed to discuss one additional Flight Safety-focused recommendation and five Clinical Standards-focused recommendations during the final Committee meeting held on July 10, 2025.

Mr. Richey shared the nine recommendations adopted by the Committee during the Committee meeting held on May 8, 2025:

- **AAQPS Recommendation:** Congress should pass legislation to establish air ambulance as a provider type regulated by Medicare so that CMS may establish Conditions of Participation and enforce basic clinical safety standards.
- **AAQPS Recommendation:** Congress should direct HHS to develop a Patient Safety Structural Measure (PSSM) adapted for the air ambulance setting, and to establish a new quality reporting program for air ambulance which includes reporting on the PSSM.
- **AAQPS Recommendation:** HHS should issue guidance to hospitals and air ambulance providers clarifying that HIPAA does not prevent sharing patient clinical data for quality improvement purposes and clarifying the specific limitations and requirements for hospitals to share patient clinical data back to air ambulance providers.
- **AAQPS Recommendation:** Congress should provide additional funding to bolster existing state and federal efforts to develop and promote health information exchange. This funding should specifically support improving the bidirectional exchange of patient clinical data between air ambulance providers and hospitals.
- **AAQPS Recommendation:** Congress should allocate funding to expand weather services in non-terminal areas and invest in the research and development of new and innovative weather reporting and forecasting technologies through targeted grants and initiatives. Congress should direct the Federal Aviation Administration (FAA) to expand access to FAA-approved sources of real-time weather data and advanced predictive capabilities, prioritizing non-terminal areas. This effort should prioritize: deploying additional new Visual Weather Observation Systems (VWOS); installing weather cameras to enable real-time monitoring across the U.S.; increasing access to Terminal Doppler Weather Radar (TDWR) systems; enhancing surface detection capabilities, improving forecasting accuracy, and advancing predictive analysis tools; integrating approved weather sources



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into the National Airspace Data Interchange (NADIN) for Graphical Forecasts for Aviation – Low Altitude (GFA-LA).

- **AAQPS Recommendation:** Congress should authorize funding and establish initiatives to modernize and digitize the Airport Data Information Portal (ADIP) in collaboration with the FAA and industry stakeholders. This effort should ensure accurate and comprehensive data on heliports, helipads, and landing zones, including critical information such as weight limits, markings, and Instrument Flight Rules (IFR) compatibility. This effort should prioritize: integrating updated helipad and heliport data into commercially available pilot navigation tools; establishing competitive grants to upgrade substandard helipads and heliports to meet FAA design standards (e.g., Advisory Circular 150/5390-2D); Including maintenance of hospital helipad data in the ADIP as a Condition of Participation (CoP) to be evaluated by hospital accreditation organizations; adding IFR-compatible infrastructure to improve safety and reliability, especially in rural and underserved areas (non-terminal areas); incorporating locations with medical services into the U.S. Notices to Airmen (NOTAM) system.
- **AAQPS Recommendation:** Congress should direct the FAA to develop low-altitude IFR routes and enhance air traffic control (ATC) capabilities. Congress should increase Helicopter Air Ambulance (HAA) use of the IFR system by funding the required infrastructure and directing the FAA to adopt policies and procedures to support its use by all low altitude aircraft, crewed and uncrewed. Infrastructure needs include adding additional Automatic Dependent Surveillance–Broadcast (ADS-B) transmitters, radar systems, controller–pilot data link communications (CPDLC), and communication equipment and incentivizing hospitals and operators to adopt IFR-compatible infrastructure. Necessary policies and procedures include expansion of low-altitude IFR routes and approaches, including an HAA Performance Based IFR route structure. Additionally, Congress should direct the FAA to develop a traffic management framework to mitigate risks associated with the growth of unmanned aircraft system (UAS) and advanced air mobility operations.
- **AAQPS Recommendation:** Congress should mandate that new air ambulance helicopters be equipped with Stability Augmentation Systems (SAS) or Auto Flight Control Systems (AFCS) and require pilot training on their use. Additionally, Congress should provide funding incentives to retrofit existing helicopters and support FAA research into enhanced vision technologies, workload reduction systems, and advanced simulation tools (including virtual reality), with expedited development through industry collaboration.
- **AAQPS Recommendation:** Congress should mandate that the FAA develop performance-based standards and establish standardized policies and procedures, across all offices, to streamline the certification process for advanced aircraft systems and medical equipment. Congress should also mandate the development of expedited approval pathways for technologies critical to patient care and operational safety, ensuring timely certification of innovations that enhance emergency medical services to include a



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dedicated liaison team within the FAA Aircraft Certification Service to improve communication with operators and manufacturers, expedite approvals, and provide regulatory guidance.

Flight Safety Subcommittee: Recommendation

Background

Jason Quisling, SVP Flight Operations and Aircom, Air Methods, Flight Safety Subcommittee Chair

The two topics that the Flight Safety Subcommittee studied and addressed in their recommendations are as follows:

- Options for improving service reliability during poor weather, night conditions, or other adverse conditions, and
- Differences between air ambulance vehicle types, services, and technologies, and other flight capability standards, and the impact of such differences on patient safety.

In studying and addressing these topics, the Flight Safety Subcommittee recognized that air ambulance safety has gained public and legislative attention. The Subcommittee considered the increased demand for air ambulance services, especially in rural and remote areas with limited access to critical care facilities. They also considered infrastructure and technology improvements that could address safety concerns specific to adverse weather conditions. The Subcommittee noted that despite advancements, crash survivability remains a challenge, and that further improvements in aircraft design are possible. Additionally, cost barriers have impeded the adoption of some advanced technologies, such as terrain awareness and warning systems (TAWS), which could improve operational safety for air ambulance crews. Finally, the Subcommittee discussed the role of performance-based standards in designing more efficient and safety-compliant aircraft, as well as streamlining the certification process.

Mr. Quisling described the Flight Safety Subcommittee's five meetings from December 2024 through April 2025. During these meetings, the Subcommittee discussed the two statutory areas and identified key concerns including infrastructure gaps, human factors, low-altitude congestion, and unimplemented recommendations. They then considered potential ways to address these concerns, such as improved weather reporting, updated infrastructure, unified standards, and enhanced technology and regulations. The Subcommittee prioritized potential solutions and, finally, reviewed and finalized draft recommendations to present to the full Committee.



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Mr. Quisling described the recommendations adopted by the AAQPS Committee in the May 8, 2025, meeting. These recommendations are AAQPS Recommendations 5 through 9, listed above.

Overview of Recommendation FS-6: Mandate Critical Safety Standards for Air Ambulance Occupant Protection

Jason Quisling, SVP Flight Operations and Aircom, Air Methods, Flight Safety Subcommittee Chair

Mr. Quisling reviewed the problem statement, goal for addressing the problem statement, and recommendation proposed by the Flight Safety Subcommittee:

Problem statement:

Occupant Safety Standards (Addressing NTSB Recommendations): A regulatory gap exists that allows certain helicopters with Type Certificates issued prior to 1994 and manufactured prior to 2020 to operate without meeting current safety and certification standards outlined in CFR 14 Parts 27 and 29. These certification requirements have been proven to reduce injuries and fatalities for occupants of helicopters. Allowing helicopters with a type certificate prior to 1994 to continue to operate in the absence of mandatory adherence to updated safety standards – such as crash-resistant fuel systems, enhanced occupant protection, and structural integrity requirements – heightens the likelihood of preventable injuries and fatalities in the event of an accident.

Goal: Mandate critical safety standards for air ambulance occupant protection

- ✓ **Recommendation FS-6:** Congress should mandate the implementation of FAA Part 135 ARAC recommendations on helicopter air ambulance occupant protective technologies, including crashworthy fuel systems as referenced in SAFO 19006. Legislative action is necessary to ensure industry-wide compliance with proven safety standards and bring all helicopters utilized for air ambulance operations into compliance with CFR 14 Part 27 and 29 in the following areas:
 - CFR 27/29.952(a)(1)(2)(3)(5)(6), 27/29.952(f), and 27.963(g)/29.963(b)
 - CFR 27/29.562, 27/29.785(c) and (g)
 - CFR 27/29.561

Mr. Quisling provided context for this recommendation. The Flight Safety Subcommittee considered open recommendations from the NTSB and FAA Working Groups. Specifically, they considered the 2018 FAA Rotorcraft Occupant Protection Working Group (ROPWG) Crash Resistant Seats and Structures (CRSS) and Crash Resistant Fuel Systems (CRFS) recommendations accepted by the FAA Aviation Rulemaking Advisory Committee (ARAC). Aircraft with a Type Certification issued after 1994 must comply with the requirements outlined in CFR 14 Parts 27 and 29. Aircraft manufactured between 1994 and 2020 under type



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certificates issued prior to 1994 are not required to comply with these standards. The Subcommittee identified this gap as a safety concern which increases the likelihood of preventable injuries and fatalities. The Subcommittee determined legislative action was necessary to close this regulatory gap and ensure the highest level of safety for air ambulance passengers and crew. Closing this gap would ensure manufacturers implement proven protective capabilities and would align practices with established safety standards. This would, in turn, create a safer operational framework while reducing the financial and societal consequences of preventable injuries and fatalities.

The Subcommittee recognized several challenges to implementing this recommendation. Specifically, they acknowledged the cost of either retrofitting aircraft to meet these requirements or purchasing compliant aircraft, which could disrupt air ambulance operations and affect service reliability. They also noted that taking aircraft out of service for upgrades could further impact operations. Additionally, industry resistance due to cost concerns could delay compliance. Finally, the Subcommittee expressed concern that enforcement would require coordination among Congress, the FAA, and stakeholders, potentially leading to complex processes and oversight challenges.

Committee Discussion FS-6

Flight Safety Subcommittee Chair
AAQPS Committee Members

Mr. Judge stated his strong support for recommendations to improve crash survivability. While there has been significant work to improve crash resistance, gaps remain. The FAA has a helicopter occupant safety toolkit on their website which highlights which aircraft are compliant but does not provide complete information on which features are available to operators. Adopting this recommendation would represent patients who do not have a choice of carrier and need to trust they are being transported in a fully equipped vehicle.

Voting FS-6

Jeff Richey, RN, MHA, FACHE, Associate Administrator, Airlift Northwest, AAQPS Committee Chair

Mr. Richey facilitated the voting process. Recommendation FS-6 was adopted by the Committee.

Voting Member	FS-6
Com. Arnold	Yes
Mr. Clark	Yes
Mr. Clayton	Yes
Col. Coffee	Yes

Voting Member	FS-6
Ms. Frazer	Yes
Dr. Gamber	Yes
Dr. Hinckley	Yes
Mr. Houser	Yes
Mr. Judge	Yes
Mr. Julander	Not present
Dr. Pritzker	Yes
Mr. Quisling	Yes
Mr. Reckert	Abstain
Mr. Richey	Yes
Vote Count	Yes: 12 No: 0 Abstain: 1 Not Present: 1

Flight Safety Subcommittee: Language Update and Review

Background and Proposal to Update Report Language

Jason Quisling, SVP Flight Operations and Aircom, Air Methods, Flight Safety Subcommittee Chair

Mr. Quisling reviewed a request made during the Committee meeting held on May 8, 2025, for language clarifying whether each recommendation applies to both helicopter and fixed-wing air ambulances or one type of aircraft. Mr. Quisling also reviewed the clarifying language proposed by the Subcommittee for inclusion in the Report to Congress.

Proposed Language for the Report to Congress:

- Report Introduction: *“Throughout this report and in individual recommendations, air ambulance refers to both fixed-wing and helicopter aircraft unless otherwise specified.”*
- For Recommendation FS-3, the recommendation specifies “helicopter air ambulance.” In the Report, include that the problem statement for this recommendation is *“focused on helicopter air ambulance, but fixed-wing aircraft will also be impacted by UAS and airspace congestion.”*
- For Recommendation FS-4, the recommendation specifies “air ambulance helicopters.” The report should note *“although this recommendation focuses on air ambulance helicopters, the Committee also recommends exploring opportunities to support new technology for fixed-wing air ambulances.”*



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- For Recommendation FS-5, the recommendation refers to “advanced aircraft systems” but does not refer to air ambulances at all. In the Report, include language that notes *“this recommendation impacts both fixed-wing and helicopter air ambulances.”*

Mr. Quisling stated the Flight Safety Subcommittee reviewed the language of all the recommendations to determine whether clarification was needed regarding vehicle type. The Subcommittee concluded that the first two recommendations (Recommendations 5 and 6) were already clear with regards to vehicle type and that it would be appropriate to add clarifying language to the Report to Congress.

Committee Discussion on Proposed Language for the Report to Congress

Flight Safety Subcommittee Chair

AAQPS Committee Members

Several Committee members requested clarification of how this language would affect the recommendations that have been previously approved by the Committee. Mr. Quisling clarified the first item “Throughout this report and in individual recommendations, air ambulance refers to both fixed-wing and helicopter aircraft unless otherwise specified” would be included in the introduction to the Report to Congress and the other sentences would be updated in the report’s background section for those individual recommendations.

Voting on Proposed Language for the Report to Congress

Jeff Richey, RN, MHA, FACHE, Associate Administrator, Airlift Northwest, AAQPS Committee Chair

Mr. Richey facilitated the voting process. The language proposed for inclusion in the Report to Congress was adopted by the Committee.

Voting Member	Report Language
Com. Arnold	Yes
Mr. Clark	Yes
Mr. Clayton	Yes
Col. Coffee	Yes
Ms. Frazer	Yes
Dr. Gamber	Yes
Dr. Hinckley	Yes
Mr. Houser	Yes
Mr. Judge	Yes
Mr. Julander	Not present
Dr. Pritzker	Yes



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Voting Member	Report Language
Mr. Quisling	Yes
Mr. Reckert	Yes
Mr. Richey	Yes
Vote Count	Yes: 13 No: 0 Abstain: 0 Not Present: 1

Review of Flight Safety Recommendations Adopted May 8, 2025

Jason Quisling, SVP Flight Operations and Aircom, Air Methods, Flight Safety Subcommittee Chair

Mr. Quisling reviewed the voting results from recommendations voted on and adopted during the Committee meeting held on May 8, 2025.

- **Recommendation #FS-1:** Enhance Weather Reporting and Infrastructure in Non-Terminal Areas
 - **Voting Results: 12 Yes; 0 No; 2 Abstain**
- **Recommendation #FS-2:** Modernize Helipad Data, Infrastructure, and Safety Standards
 - **Voting Results: 11 Yes; 0 No; 3 Abstain**
- **Recommendation #FS-3:** Improve Low-Altitude IFR infrastructure
 - **Voting Results: 12 Yes; 0 No; 2 Abstain**
 - **Verbal Confirmation of Vote:** Mark Gamber
- **Recommendation #FS-4:** Enhance Safety and Technology for Single-Pilot Operations
 - **Voting Results: 11 Yes; 0 No; 3 Abstain**
 - **Verbal Confirmation of Vote:** Paul Julander, Mark Gamber
- **Recommendation #FS-5:** Streamline Certification and Expedite Approval Pathways for Air Ambulance Technologies and Medical Equipment
 - **Voting Results: 13 Yes; 0 No; 1 Abstain**
 - **Verbal Confirmation of Vote:** Paul Julander, Mark Gamber

Clinical Standards Subcommittee: Statutory Overview

Background

Keith A. McMinn, Director, Life Lion, Penn State Health Milton S. Hershey Medical Center, Clinical Standards Subcommittee Co-chair

Mr. McMinn began with a review of the Clinical Standards Subcommittee's charge and the process the Subcommittee used to develop recommendations for the following three topic areas outlined under the AAQPS Committee's statutory mandate:



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- Qualifications of different clinical capability levels and tiering of such levels;
- Patient safety and quality standards and;
- Clinical triage criteria for air ambulances

He noted the Subcommittee began by articulating the most critical challenges facing the industry in these areas. The five problem statements developed by the Clinical Standards Subcommittee included the following topics:

- Claim denials related to medical necessity
- Market availability of the appropriate clinical capabilities
- Lack of minimum clinical national standards
- Promoting a just culture framework for patient safety
- Availability of follow-up patient clinical information to inform quality improvement

As part of the process for developing recommendations to address each problem statement, the Subcommittee reviewed the recommendations of the Advisory Committee on Air Ambulance Patient Billing (AAPB) and determined which Clinical Standards problem statements might be addressed (in whole or in part) by the AAPB recommendations. Finally, the Subcommittee focused its remaining time performing options analysis and developing new recommendations for the remaining problem statements, to address existing gaps. While these were reviewed during the May 8 AAQPS Committee Meeting, the Subcommittee Chairs devoted additional time in this meeting to explaining why the Subcommittee chose these problem statements and associated recommendations to address the questions in the statute.

The key issue identified for clinical triage criteria was claim denials for medical necessity, which can discourage providers from ordering medically necessary air transport. The AAPB offered a recommendation that focused on the process for medical necessary air transport, presuming a physician's order for air transport is medically necessary under certain conditions rather than defining specific clinical criteria. This approach is favored due to the complexity of such decisions, which require clinical operational judgement and cannot be standardized across communities. The recommendation primarily addresses out-of-network claim denials, which are a significant concern and have a clear potential federal mechanism for resolution. The Subcommittee did not identify a federal mechanism of action to address in-network claim denials and invited the Committee's input on this issue.

For clinical capability levels, the Subcommittee focused on two problem statements. The first of these problem statements, related to market availability of appropriate clinical capabilities, had two outstanding recommendations from AAPB that the Clinical Standards Subcommittee noted, if implemented, would make important improvements and collect critical data to support future policy refinement in the future. The first of these two recommendations is related to the adequacy of Medicare reimbursement, and the latter is related to data collection which would



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be critical to better understanding existing availability of gaps for capabilities and informing the reimbursement adequacy study. The Subcommittee endorsed the existing AAPB recommendations and urged that Congress and HHS explore differentiated reimbursement for specialty care. Inadequate reimbursement is a major barrier to provide specialty clinical services, as the flat transport fee does not cover the higher costs of the necessary equipment, specialty staff, and training required to treat more complex and specialty populations. To address this, the Subcommittee recommended that HHS consider implementing add-on payments, modifier codes, and/or procedure codes to ensure clarity and efficiency in claims processing while incentivizing and covering the costs of intensive transports.

The statutory mandate specifically covered levels or tiering of capabilities. The Subcommittee discussed this in detail and felt strongly that tiering was not the most practical way to characterize air ambulance services and capabilities. The Subcommittee agreed with the intent behind tiering, which is to recognize there are greater expenses and expertise associated with more complex clinical care and being prepared 24/7 to serve a variety of specialty populations, and recommended an alternative approach to categorizing clinical capabilities for purposes of reimbursement.

The next problem statement under clinical capabilities is related to minimum national standards. The first recommendation associated with this problem statement was adopted by the Committee in the May 8 meeting; the second recommendation was discussed in more detail later in this meeting.

Finally, the Subcommittee had two problem statements and associated recommendations addressing patient safety and quality standards, the last category in the statute. These were discussed in detail in the May 8 meeting. One was around promoting a just culture framework for patient safety, which serves as a foundation for a wide variety of risk management and quality improvement activities; the other around improving access to patient clinical data in order to enable quality improvement activities.

Discussion

Clinical Standards Subcommittee Co-Chairs
AAQPS Committee Members

Commissioner Grace Arnold requested clarification regarding the AAPB recommendations selected by the Subcommittee and its decision-making process. Mr. McMinn explained that time has been allocated later in the meeting to discuss the AAPB recommendations in greater detail. Mr. Kolbet further explained that the Subcommittee tried to strike a balance between promoting more standardization across the industry while also recognizing that one-size-fits-all solutions were likely to have unintended consequences due to the diversity of communities and geography served by air medical.



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Dr. Hinkley requested clarification regarding the Subcommittee's stance on tiering. Mr. McMinn noted that the Subcommittee did not recommend tiering. While the Subcommittee agreed with the intent behind tiering, it ultimately determined implementing such a structure would be extremely difficult to operationalize and likely result in unintended consequences.

Mr. Kolbet referenced the May 8 meeting, during which the Committee voted to designate air ambulance operators as a Medicare provider type – the Subcommittee noted it was important to develop and implement a national standard baseline as a first step. For more complex capabilities, the complexity of care and populations were better characterized using modifier codes rather than tiers. This approach would ensure that all providers are appropriately recognized, reimbursed, and equipped to meet local area needs.

Commissioner Arnold asked about the process, specifically noting the recommendation's narrow focus on Medicare may not yield sufficient data on cross-subsidization. She asked where the appropriate place is to raise the issue of data collection. Mr. Kolbet explained the recommendation stems from existing legislation, and while some of the recommendations focus on Medicare, Medicare was an important reference point for all payers. Commissioner Arnold raised the possibility of using a tri-agency process to address these concerns. Mr. Kolbet noted the recommendation focused on a cost study and did not address reimbursement.

Commissioner Arnold raised a potential issue with the recommendation to incorporate medical necessity into the IDR process, noting the IDR manual indicates that medical necessity is not part of the IDR process. The recommendation proposed a presumption of medically necessary through the IDR process, but the IDR process is designed to address cost, not medical necessity.

Mr. Richey proposed deferring further discussion until the portion of the meeting focused on individual AAPB recommendations.

Clinical Standards Subcommittee: AAPB Recommendations

Background on the Advisory Committee on Air Ambulance Patient Billing

Kolby Kolbet, MSN, RN, FACHE, CMTE, FAASTN, Chief Innovation Officer, Life Link III, Clinical Standards Subcommittee Co-chair

Mr. Kolbet provided an overview of the Clinical Standards Subcommittee's process in evaluating potential solutions to the identified problem statements. The Subcommittee reviewed ongoing federal initiatives and recommendations from relevant federal advisory committees, with particular attention to avoiding duplication of recent efforts by the Air Ambulance and Patient Billing Advisory Committee (AAPB), which issued a Report to Congress in March 2022.



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The Subcommittee recommended the Committee's Report to Congress include an explicit endorsement of three AAPB recommendations. Endorsing these recommendations would allow for their full implementation and observed impact. The three AAPB recommendations correspond to two of the Subcommittee's problem statements. Recommendations CS-A, CS-B, and CS-D relate to medical necessity determinations, the adequacy of Medicare reimbursement, and the collection and analysis of air ambulance industry data to inform future policy and reimbursement discussions, respectively.

While the May 8 meeting materials included Recommendation CS-C regarding the Airline Deregulation Act (ADA) preemption of state authority, the Subcommittee, in consultation with the Committee Chair, elected not to advance that recommendation for Committee discussion. The Subcommittee determined the other recommendations under consideration were better positioned to achieve the intended outcome of Recommendation CS-C and supported prioritizing discussion of the most critical topics within the available meeting time.

Overview of Recommendation CS-A: Reduce claim denials for medical necessity

Kolby Kolbet, MSN, RN, FACHE, CMTE, FAASTN, Chief Innovation Officer, Life Link III, Clinical Standards Subcommittee Co-chair

Mr. Kolbet reviewed the problem statement, goal for addressing the problem statement, and recommendation proposed by the Clinical Standards Subcommittee:

Problem statement:

Claims can be denied due to medical necessity based on patient information collected after the transport or with lack of context regarding geography and available resources, even though it met triage standards (scene calls) or was certified by physician for air transport (interfacility transport) at the time of call.

Goal: Reduce claim denials for medical necessity.

- ✓ **Recommendation #CS-A:** Congress should direct HHS to implement the following AAPB recommendation clarifying that there should be a "rebuttable presumption" in the No Surprises Act Independent Dispute Resolution (IDR) process that the air ambulance service was medically necessary for purposes of adjudicating payment disputes for out of network services.

AAPB recommendation #12: The AAPB recommends that HHS should issue a regulation addressing medical necessity within the IDR process. Specifically, within the IDR process, there should be a rebuttable presumption that the air ambulance service was medically necessary, but an insurer can overcome that presumption by first presenting evidence that either the third-party first responder/medical professional who requested the transport was



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not a neutral third party, or that the air ambulance provider did not act in good faith. (See Chapter 5, page 42)

Mr. Kolbet described the phenomenon commonly referred to as the “Monday morning quarterback,” in which claims can be denied on the basis of medical necessity using information available after the encounter – information not available at the time a decision was made that transport was medically necessary. This issue can pose significant challenges not only to the financial viability of the air ambulance service but more importantly may deter a referring provider from ordering medically indicated air ambulance transport due to fear of catastrophic medical bills for the patient.

The No Surprises Act (NSA) created an IDR process, providing a mechanism for providers and insurers to resolve certain billing disputes. The AAPB Committee recommended if a physician certified the patient for air transport at the time of the call and the claim was later denied on grounds of medical necessity, the IDR process should include a “rebuttable presumption” of medical necessity. This would shift the burden of proof on the insurer, requiring them to demonstrate transport was not medically necessary. The Subcommittee endorsed that AAPB recommendation.

The Subcommittee also added a nuance beyond the AAPB Committee’s Recommendation 12. After reviewing the AAPB Committee’s original recommendation, HHS did not implement the recommendation because HHS determined the recommendation was not within their statutory authority to implement. Therefore, the Subcommittee recommended Congress enact the necessary legislation for the AAPB Committee’s recommendation to be implemented.

The Subcommittee recognized the issue of claim denials was not limited to out-of-network claims, but these claims did represent a substantial proportion of the instances where the field encountered these issues. There was a clear federal mechanism of action authorized under the NSA and a specific recommendation from the AAPB Committee on this topic. The Subcommittee suggested it might be helpful to explore a recommendation around in-network medical necessity denials, but this would require a separate analysis to determine what would be the federal mechanism of action, given the NSA would not apply in those cases.

Discussion CS-A

Clinical Standards Subcommittee Co-Chairs
AAQPS Committee Members

Mr. Judge clarified the Congress’ charge was to develop triage criteria, but the AAPB Committee’s recommendation addressed a separate issue related to the post-transport decisions and payment disputes. Post-transport denial of triage decisions undermines the triage process. While the AAPB recommendation included an important provision allowing



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insurers to challenge presumptions with evidence, the recommendation conflated triage with payment issues and required modification. Agreeing with Mr. Judge, Mr. Quisling was supportive of including language related to increasing patient access to air ambulance transport.

Mr. Clayton emphasized the value of decentralized decision-making over complex national rules. Creating a national triage rule for all physicians and EMS providers would be overly complicated. Instead, he suggested relying on physician and first responder expertise, which was the intent behind establishing a “rebuttable presumption” of medical necessity.

Commissioner Arnold noted the importance of addressing patient complaints and emphasized that the IDR process was not designed to handle medical necessity issues – there are different mechanisms for resolving disputes over medical necessity. The courts had struck down the concept of a “rebuttable presumption,” and so implementing the Subcommittee’s recommendation might not be permissible. She described established mechanisms for disputing medical necessity and raised concerns that the recommendation, by presuming medical necessity regardless of the facts, complicated that process. Placing medical necessity discussions into a cost-focused IDR process created a misalignment and undermined the intent of IDR. Commissioner Arnold proposed modifying the recommendation’s focus on developing guidelines for triaging through an HHS advisory group. The guidelines would provide a framework for state regulators to reference with addressing medical necessity disputes or enforcing action on insurers, making the recommendation more actionable and aligned with existing processes. Mr. Houser agreed with both Mr. Clayton’s and Commissioner Arnold’s comments.

Mr. Quisling requested clarification around triage and ensuring alignment with respect to the Committee’s mandate, expressing his concern that the recommendation seemed to be a billing issue and he was unsure of the connection to patient safety and quality. Mr. Kolbet explained that there are situations where providers hesitate to request medically indicated air medical services due to concerns about patients facing large bills; this can result in a “chilling effect” where a patient does not receive medically indicated air medical services, which undermines patient safety and quality. Mr. Kolbet also highlighted how rigid triage criteria can harm air ambulance providers, citing cases like abdominal aortic aneurysms, where stable patients are often denied medical necessity due to being considered “stable” despite requiring urgent transport to treat a medical emergency before the patient destabilizes. He recommended that triage criteria should be flexible, allowing EMS providers to make decisions based on local resources, assessments, and state direction, as the appropriateness of air transport can depend on all of these factors in addition to the clinical condition of the individual patient. Mr. Kolbet described the challenge of triage criteria being too specific for some areas based on geography if the specific triage criteria cannot be met. Dr. Pritzker agreed with Commissioner Arnold and



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Mr. Kolbet's comments. He also raised a concern about the last sentence in the recommendation, referring to situations in which the party who "requested transport was not a neutral 3rd party or that the air ambulance provider did not act in good faith". He noted the air ambulance provider generally responds to a sending facility's request to transfer the patient, rather than making an independent determination of medical necessity, so it is unclear how this relates to the original medical necessity determination of the requesting party.

Mr. Judge addressed concerns regarding the triage process, citing an example where air ambulance companies, through membership programs, had fire departments call them, potentially leading to overuse or misaligned use of air medical transport. This issue was tied to the triage process and the subsequent discounting of good-faith triage decisions, which can negatively impact access to care.

Mr. Judge highlighted the challenge of establishing a national standard due to varying criteria among third-party payers but pointed out that Medicare provided a national framework through Section 415 of the Medicare Modernization Act of 2003. This framework outlined medically necessary transport criteria, including qualifications for callers and circumstances based on geography, rurality, and hospital systems. He recommended leveraging Medicare's established guidelines as a basis for addressing triage-related issues. Mr. Judge referenced existing resources, including position statements from the American College of Emergency Physicians (ACEP) and National Association of EMS Physicians (NAEMSP), as well as validated national triage scoring mechanisms for trauma and pediatrics, which could inform the development of language for recommendations. He proposed removing the IDR process from the discussion and supported the inclusion of a rebuttable presumption, provided it aligned with Medicare's provisions and allowed triage decisions to be discounted in cases of lack of good faith or other compromising circumstances. Mr. Judge recommended refining the language of the recommendation to incorporate Medicare's established standards and validated triage mechanisms while addressing concerns about misuse and post-transport discounting of triage decisions and shared a proposed revision to the recommendation for consideration:

- "Congress should direct HHS to implement the following AAPB recommendation clarifying that there should be a "rebuttable presumption" that the air ambulance service was medically necessary, if consistent with provisions of Section 415 of the Medicare Modernization Action of 2003, but an insurer can overcome that presumption by presenting evidence that either the third-party first responder/medical professional who requested the transport was not a neutral third party, or that the air ambulance provider did not act in good faith."

Dr. Hinkley acknowledged the complexity of developing triage guidelines, drawing on his diverse experiences as a provider in various roles within the air ambulance system. While recognizing the challenges, he agreed with Mr. Judge that creating a universal triage guideline was feasible.



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Dr. Hinkley expressed concerns about presuming that all air ambulance use is appropriate, noting instances where its use may not be justified. Such misuse can negatively impact patients by diverting resources away from those who may need air transport more urgently. He emphasized the importance of ensuring air ambulances are utilized appropriately to optimize patient outcomes and resource availability.

Commissioner Arnold questioned whether referencing the Medicare Modernization Act as a basis for triage standards might exclude non-Medicare populations, such as children or adults who do not fit the Medicare demographic and suggested adopting a neutral approach to establish a national triage standard for medical necessity determinations, ensuring inclusivity across all patient groups.

Commissioner Arnold highlighted the potential cost implications of a rebuttable presumption, noting while it may ensure insurance coverage for necessary services, it could also increase insurance premiums, potentially making coverage unaffordable. Lack of insurance could lead to broader patient harm and negatively impact the air ambulance industry, and emphasized the importance of balancing patient access to necessary services with affordability and sustainability in the system.

Mr. Judge noted that Medicare's guidelines provide a broad framework for deemed medical necessity, indicating it focuses on who is qualified to request air transport and the various circumstances in which it might be indicated; the guidelines are broad and incorporate considerations such as state protocols.

Mr. Kolbet supported the proposed language, noting it effectively avoids references to diagnosis, clinical conditions, and mechanisms. He expressed concerns about the language ensuring sufficient accountability from insurers, highlighting that as a key question.

Acknowledging the issue's complexity, Mr. Judge noted the importance of ensuring triage decisions were made by qualified first responders operating under physician-approved protocols and the need to balance these decisions while avoiding excessive use of air transport, as such decisions have financial implications. The goal was to ensure the right patient received appropriate care at the right facility, with a focus on access, qualifications, and deemed medical necessity, accounting for diverse geographic and situational factors. He recommended flexibility in refining the language, noting it should remain broad and not tied to specific conditions.

Mr. Richey proposed that the Committee review the revised recommendation language proposed by Mr. Judge as the new version of the recommendation up for the Committee's consideration.



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Mr. Kolbet posed a question related to appropriate utilization of a helicopter request and the likelihood of cancelling the transport after it has been requested by a provider. Such decisions were typically based on factors like availability and locality of ambulances, suggesting the need for consideration of these realities.

Dr. Pritzker asked if the recommendation's focus was fixed-wing or rotary-wing or both. Mr. Kolbet noted the recommendation was primarily for rotary wing, but it could include fixed wing, noting a Subcommittee member would speak later in the meeting about the differences in how air medical was operationalized in Alaska. Mr. Judge agreed the recommendation could include both, but given that the focus is on emergency transport, emergency scene transports were generally done by rotary wing transports. He clarified that focus was not scheduled transports which were often done by fixed-wing aircraft. Dr. Pritzker expressed concern about primarily focusing on rotor-wing transports since this would also be applied to fixed-wing transports.

Mr. Kolbet requested clarification on whether the onus would be on the air medical provider to provide documentation supporting medical necessity, which he noted puts the air medical provider in the position of justifying the transport when generally the decision to transport was made by a different party. That other party's information would not typically accompany the disputed bill from the air medical provider. Dr. Pritzker noted that medical necessity disputes would likely need to bring in information not available from the air medical provider, such as a police report with the site and circumstances of an accident.

Commissioner Arnold emphasized the distinction between the price-focused IDR process and a potential alternative process, such as state medical necessity determinations, which could allow for broader inquiries and additional documentation beyond price concerns. While the bill might not have all information relevant to supporting a medical necessity claim, there are ways to get that information. Mr. Kolbet noted that created administrative burden for the air medical provider and delayed reimbursement. Mr. Richey clarified air ambulance service must submit all information with a claim and when an air ambulance service submitted the bill, oftentimes that documentation was not available at the time of bill submission, so it is done on the backend. Mr. Richey suggested removing references to the IDR in the recommendation.

Mr. Judge supported keeping the AAPB recommendation in the Committee's recommendation as a reference. Mr. Kolbet agreed with Mr. Judge. Dr. Pritzker asked if the Committee had moved away from the original AAPB recommendation with the removal of the IDR references. Mr. Wright noted the specific reason HHS could not implement the original AAPB recommendation was unknown. Commissioner Arnold noted HHS's inability to implement the AAPB recommendation could be that it was not within the IDR process and CMS had indicated that they did not have statutory authority to include it in that process, highlighting two lost court cases regarding rebuttable presumption.



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Ms. Haugen noted the need for inclusivity for rural and frontier communities related to medical necessity and documentation. Mr. Judge confirmed the Medicare manual included special provisions that may exist for rural air ambulance services.

Dr. Gamber sought clarification from Mr. Judge and Commissioner Arnold related to IDR and why they viewed this as a payment rather than a clinical issue. Commissioner Arnold highlighted that the IDR process excluded considerations of medical necessity, focusing on cost. She provided an example in Minnesota where a patient denied coverage due to medical necessity would undergo a multi-step appeals process including internally with their insurer and then externally with the state department. She noted the IDR process addressed financial disputes without evaluating medical necessity. Mr. Kolbet countered that clinical factors do still play a significant role in the IDR process even after a bill is declared medically necessary, as this can affect reimbursement levels for some payers. Commissioner Arnold emphasized the focus for IDR was on reimbursing clinical services, assessing costs at a detailed, line-item level.

Mr. Kolbet explained readiness costs, such as carrying supplies like blood, existed regardless of whether they were used for a specific patient. However, those costs were not accounted for as a reimbursable line item. Mr. Clayton explained the IDR process required extensive documentation to justify clinical care, leading to determinations. Smaller programs experienced challenges as insurers, after losing in IDR, increasingly issued medical denials and shifted the burden to the patient. That process created hesitation among providers to utilize certain services due to the risk of denial, ultimately impacting patient care.

Commissioner Arnold requested clarification on whether the rebuttable presumption, a generic standard often used by Medicare, applied outside the IDR process or if it was still part of the IDR framework. Mr. Judge explained that the proposed recommendation would essentially take the established definition of medical necessity (and how transports are deemed medically necessary) as described in section 415 of the Medicare Modernization Act and give it a stronger stance by establishing it is a rebuttable presumption; this would be independent of the IDR process. Dr. Pritzker asked if the revised Committee recommendation diverged from the AAPB recommendation, which references the IDR process. Mr. Judge, speaking from his experience serving on the AAPB advisory committee, confirmed the Committee's revised recommendation could still appropriately reference AAPB recommendation 12, and the AAQPS Committee's revised language honored the intent behind the original AAPB recommendation – the intent being to focus more broadly on establishing a rebuttable presumption of medical necessity rather than focusing specifically on the IDR process.

Ms. Haugen suggested ensuring the language was clear for the reader and covered geographical and resource deficient areas. The Committee's revised recommendation had a heavy emphasis on clinical circumstances, and it was unclear if the reader would understand the intent of section 415 of the Medicare Modernization Act. Mr. Judge clarified several groups, including



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CMS, NAEMSP, and ACEP, have addressed geographical areas. If the geographic circumstance influenced the clinical circumstance, it was a clinical circumstance. If the resource influences the clinical circumstance, was a clinical circumstance. Dr. Pritzker noted as a payer, geographical challenges are a clinical circumstance. Ms. Haugen requested clarification in the final report language for the reader.

Commissioner Arnold agreed with Ms. Haugen's proposal to add language to the report and requested clarifying language to preserve existing state authority and ensure it did not override state medical necessity determinations. Mr. Judge noted medical necessity was determined based on a patient's condition and specific circumstances, with section 415 explicitly referencing state protocols. Section 415 highlighted physicians adhering to state protocols define medical necessity, which was incorporated into the Medicare framework. Commissioner Arnold requested the meeting management team add additional context around this discussion in the report.

Mr. Richey asked if there were any further edits to the language before moving forward with a vote. The Committee made the following edits to the recommendation:

- Mr. Judge recommended adding, "emergency" in front of air ambulance service was medically necessary. Commissioner Arnold agreed with this edit.
- Dr. Pritzker raised concerns related to the phrase, "requested transport was not a neutral third party or that the air ambulance provider did not act in good faith." Mr. Judge clarified including the language, "consistent with section 415 of the Medicare Modernization Act," addresses Dr. Pritzker's comments related to clinical documentation known at the time of transport. This would suffice in explaining why it was medically necessary to move by air. Dr. Pritzker questioned if that would be clear to the end user or if more clarity was needed. He suggested, "documentation at time of transport supported medical necessity for transport." Mr. Judge noted that he agreed if it helped to clarify the language.
- Mr. Houser agreed with the updated language to include, "did not support medical necessity," as it related to insurer denying the claim.
- Mr. Reckert suggested changing "Congress should direct HHS to" to "Congress should implement" as a clearer way of indicating the relevant actor. Mr. Quisling added that the language should include the word, "mandate," rather than implementation. Mr. Judge agreed that this should be, "mandate implementation."
- Mr. Judge noted the removal of the word, "documentation," since there was no documentation at the time. Mr. Richey agreed with that removal stating that providers do not chart in a consistent way.
- Ms. Haugen reminded the Committee about the frontier and rural areas and suggested the inclusion of, "and/or," to provide inclusivity. Mr. Richey explained the recommendation already captures that and offered to expand upon that in the report.



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- Dr. Pritzker noted that, “first presenting” and “first” were superfluous and recommended removing the initial, “first.”
- Commissioner Arnold and Mr. Houser had no further edits to the language.

Voting CS-A

Jeff Richey, RN, MHA, FACHE, Associate Administrator, Airlift Northwest, AAQPS Committee Chair

Mr. Richey reviewed Recommendation CS-A as amended by the Committee.

- ✓ **Recommendation #CS-A:** Congress should mandate implementation of the following AAPB recommendation clarifying that there should be a “rebuttable presumption” that an emergency air ambulance service was medically necessary, if consistent with provisions of Section 415 of the Medicare Modernization Act of 2003, but an insurer can overcome that presumption by presenting evidence that clinical circumstances known at time of transport did not support medical necessity for the transport, third-party first responder/medical professional who requested the transport was not a neutral third party, or that the air ambulance provider did not act in good faith.

AAPB recommendation #12: The AAPB recommends that HHS should issue a regulation addressing medical necessity within the IDR process. Specifically, within the IDR process, there should be a rebuttable presumption that the air ambulance service was medically necessary, but an insurer can overcome that presumption by first presenting evidence that either the third-party first responder/medical professional who requested the transport was not a neutral third party, or that the air ambulance provider did not act in good faith. (See Chapter 5, page 42)

Mr. Richey facilitated the voting process. Recommendation CS-A as amended by the Committee was adopted by the Committee.

Voting Member	CS-A
Com. Arnold	Yes
Mr. Clark	Abstain
Mr. Clayton	Yes
Col. Coffee	Yes
Ms. Frazer	Yes
Dr. Gamber	Abstain
Dr. Hinckley	Yes
Mr. Houser	Yes
Mr. Judge	Yes
Mr. Julander	Not present

Voting Member	CS-A
Dr. Pritzker	Yes
Mr. Quisling	Yes
Mr. Reckert	Abstain
Mr. Richey	Yes
Vote Count	Yes: 10 No: 0 Abstain: 3 Not Present: 1

Overview of Recommendation CS-B: Modernize Medicare payment approach to ensure payment adequacy for specialty care

Kolby Kolbet, MSN, RN, FACHE, CMTE, FAASTN, Chief Innovation Officer, Life Link III, Clinical Standards Subcommittee Co-chair

Mr. Kolbet reviewed the problem statement, goal for addressing the problem statement, and recommendation proposed by the Clinical Standards Subcommittee:

Problem statement:

Clinical capabilities available may not be appropriately matched to the community (may have insufficient or excessive supply of specific clinical services).

Goal: Modernize Medicare payment approach to ensure payment adequacy for specialty care.

- ✓ **Recommendation #CS-B:** Congress should enact legislation to implement the following AAPB recommendation for HHS to evaluate the adequacy of Medicare reimbursement rates for air ambulance. This evaluation should specifically assess whether reimbursement should be differentiated for transports involving specialty care or more intensive procedures to ensure payment is adequate for the diversity of critical services provided in the air ambulance setting, and should consider use of add-on payments, modifier codes, and/or procedure codes commonly used across payors to ensure clarity and efficiency in claims processing. The evaluation should also assess adequacy of reimbursement for aviation operational and training costs in the context of current FAA requirements and advancements in best practices for flight safety.

AAPB recommendation #17: The AAPB recommends that legislation be enacted to require HHS to: (i) study Medicare rates for air ambulance services; and (ii) if warranted, for HHS to take steps to increase the reimbursement rates for air ambulance services upon conclusion of the study. The Advisory Committee also recommends that the study should be based on actual cost data, with “cost” including (1) the definition of cost as set forth in the Balance



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Billing Subcommittee's recommendation; (2) cost elements set forth in Section 106 of the No Surprises Act; and (3) volume of transports. (See Chapter 9, page 60)

Mr. Kolbet noted the financial challenges faced by air ambulance services due to high operational costs, the need for 24/7 readiness, and inadequate Medicare reimbursement that only covers transportation without accounting for advanced clinical capabilities. He described the limitations of available specialized care in communities impacting patient outcomes due to the lack of a financial incentive to offer those specialized clinical capabilities. AAPB Recommendation 17 tied to the Committee's statutory mandate as it included a recommendation for how to categorize clinical capabilities, and also because inadequate reimbursement could be a barrier to adequate availability of clinical capabilities.

The Subcommittee recommended endorsing the AAPB proposal for CMS to conduct a study on Medicare reimbursement suggesting that the study explore differentiated reimbursement for specialty care through add-on payments, modifier codes, or procedure codes, like those used in other critical care settings, to ensure fair compensation and incentivize advanced clinical capabilities. The Subcommittee specifically recommended the use of add-on payments and modifier and procedure codes to characterize and bill for clinical services, rather than a tiering-style approach to characterizing clinical capabilities as used for ground ambulance. The former approach more accurately characterized and enabled the diversity and complexity of clinical capabilities provided by air medical services.

Recommendation CS-B focused solely on Medicare reimbursement, as the Medicare program is the federal government's most direct tool to affect reimbursement, though changes to Medicare could indirectly impact other payers. The Subcommittee did not support a tiered approach to categorizing clinical capabilities due to complexity and potential unintended consequences, such as reduced operator sustainability and increased disparities in access. Mr. Kolbet reminded the Committee that they voted in favor of a recommendation designating air ambulance as a Medicare provider type during the May 8 meeting, and the reimbursement study considered mechanisms to appropriately compensate for the services and capabilities provided.

Discussion CS-B

Clinical Standards Subcommittee Co-Chairs

AAQPS Committee Members

Dr. Pritzker noted that endorsing Recommendation CS-B presumed HHS would conclude there was a need to increase reimbursement rates for air ambulance services rather than finding justification to decrease them following the study. Mr. Richey agreed with Dr. Pritzker.



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Mr. Clayton noted the rates were established decades ago and questioned whether they were based on actual cost data. Mr. Judge clarified the Medicare reimbursement rates for air ambulances were originally established years ago based on outdated cost data from hospital-based, twin-engine helicopters, which did not reflect the broader industry. While air ambulances benefited from the initial fee schedule, annual updates have not kept up with inflation, leading to current rates that failed to cover the actual costs of operating air ambulances. While the NSA mandated a cost study to assess the adequacy of Medicare rates, its implementation had been delayed.

Mr. Reckert explained the importance of ensuring the Committee's recommendations were effectively targeted to ensure adoption. He asked a procedural question about how the Medicare fee schedule was established—whether through legislation by Congress or rulemaking by an executive agency like CMS or HHS. Mr. Reckert suggested if the fee schedule is set by legislation, directing the recommendation to Congress is appropriate. However, if it is determined through agency rulemaking or another process, it may be more efficient to recommend HHS evaluate the adequacy of Medicare reimbursement rates. This distinction was crucial for aligning the recommendation with the correct authority. Mr. Richey agreed and requested the Committee review the recommendation language to ensure it's adequacy.

Mr. Reckert noted the circular nature of the recommendation and that the AAPB Committee previously made a similar recommendation to Congress, which has not yet been acted upon. He emphasized the importance of understanding how Medicare reimbursement rates were set and suggested directing the recommendation to the appropriate federal agency responsible for establishing those rates to ensure effectiveness.

Mr. Judge explained the Medicare ambulance fee schedule was established under the Balanced Budget Act, when Congress mandated CMS and HHS create a national fee schedule in 1997 which then went through a five-year rulemaking process. The fee schedule, first implemented in 2003, is updated annually, incorporating an inflation adjustment of less than 1 percent. To change this process, Congress would need to instruct CMS and HHS to revisit the fee schedule, a step they have been reluctant to take due to its complexity and impact on all ambulance services, not just air ambulances.

Dr. Hinkley requested clarification from the Co-Chairs regarding the Subcommittee's definition of "specialty care." Mr. Kolbet explained this could include anything above and beyond whatever was determined the baseline cost of basic air ambulance transport.

Dr. Hinkley requested additional examples of what would meet specialty care similar to neonatal transport. Mr. McMinn listed examples discussed by the Subcommittee including pediatric intensive care and ECMO transport, which required team members with specialty clinical training. Mr. Richey provided additional examples like cardiac assistance devices, blood



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administration, and placing a central line that requires an additional CPT code that can be billed for the services or procedures that the provider performs.

Mr. Clayton asked if evaluation of market impact was part of the scope for CMS when they changed things. Mr. Wright explained notice and comment rulemaking were used for annual updates but was unsure if CMS reviewed market impact when it first established rates.

The Committee made the following edits to the recommendation language:

- Commissioner Arnold requested the addition, “analysis of expected market-wide impacts of change to Medicare payment,” to the AAPB recommendation. The meeting management team recommended not editing the AAPB Committee’s recommendation and instead adding that language to the Subcommittee’s recommendation.
- Commissioner Arnold recommended looking to the AAPB recommendation and leverage the language, “Congress directs HHS to.”
- Mr. Reckert recommended simplifying the first sentence of the recommendation to state, “Congress should enact legislation to evaluate the adequacy of Medicare reimbursement rates for air ambulances.” Since Medicare rates were set by statute, any changes would require legislative action, which would then task the federal agency with implementation.
- Mr. Houser suggested opening the recommendation with, “Consistent with the following AAPB recommendation”. Commissioner Arnold agreed, as did Mr. Reckert. She recommended modifying a sentence to ensure it included evaluation of gaps in services not covered by Medicare, particularly pediatric services.
- Mr. Judge confirmed the language should read, “potential gaps in special services availability evaluation and evaluate the market wide impact.”
- Dr. Pritzker added language should also include, “analysis of potential gaps and reimbursement for specialty services.”

Voting CS-B

Jeff Richey, RN, MHA, FACHE, Associate Administrator, Airlift Northwest, AAQPS Committee Chair

Mr. Richey reviewed Recommendation CS-B as amended by the Committee.

- ✓ **Recommendation #CS-B:** Consistent with the following AAPB recommendation, Congress should enact legislation to evaluate the adequacy of Medicare reimbursement rates for air ambulance. This evaluation should specifically assess whether reimbursement should be differentiated for transports involving specialty care or more intensive procedures to ensure payment is adequate for the diversity of critical services provided in the air ambulance setting, and should consider use of add-on payments, modifier codes, and/or procedure codes commonly used across payors to ensure clarity



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and efficiency in claims processing. The evaluation should also assess adequacy of reimbursement for aviation operational and training costs in the context of current FAA requirements and advancements in best practices for flight safety. The evaluation should also include analysis of potential gaps in reimbursement for specialty services and market-wide impact of any changes to Medicare reimbursement rates.

AAPB recommendation #17: The AAPB recommends that legislation be enacted to require HHS to: (i) study Medicare rates for air ambulance services; and (ii) if warranted, for HHS to take steps to increase the reimbursement rates for air ambulance services upon conclusion of the study. The Advisory Committee also recommends that the study should be based on actual cost data, with “cost” including (1) the definition of cost as set forth in the Balance Billing Subcommittee’s recommendation; (2) cost elements set forth in Section 106 of the No Surprises Act; and (3) volume of transports. (See Chapter 9, page 60)

Mr. Richey facilitated the voting process. Recommendation CS-B as amended by the Committee was adopted by the Committee.

Voting Member	CS-B
Com. Arnold	Yes
Mr. Clark	Yes
Mr. Clayton	Yes
Col. Coffee	Yes
Ms. Frazer	Yes
Dr. Gamber	Yes
Dr. Hinckley	Yes
Mr. Houser	Yes
Mr. Judge	Yes
Mr. Julander	Not present
Dr. Pritzker	Yes
Mr. Quisling	Yes
Mr. Reckert	Abstain
Mr. Richey	Yes
Vote Count	Yes: 12 No: 0 Abstain: 1 Not Present: 1

Overview of Recommendation CS-D: Improve information on geographic availability of capabilities costs associated with providing various capabilities to inform future policy and reimbursement conversations



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Kolby Kolbet, MSN, RN, FACHE, CMTE, FAASTN, Chief Innovation Officer, Life Link III, Clinical Standards Subcommittee Co-chair

Mr. Kolbet reviewed the problem statement, goal for addressing the problem statement, and recommendation proposed by the Clinical Standards Subcommittee:

Problem statement:

Clinical capabilities available may not be appropriately matched to the community (may have insufficient or excessive supply of specific clinical services).

Goal: Improve information on geographic availability of capabilities costs associated with providing various capabilities to inform future policy and reimbursement conversations.

- ✓ **Recommendation #CS-D:** HHS should implement the following AAPB recommendation regarding implementation of data collection requirements authorized under No Surprises Act (section 106) and subsequent Notice of Proposed Rulemaking (CMS-9907-P, Document Number 2021-19797, 86 FR 51730-51779), which would allow CMS to collect operational data on the air ambulance industry for two years and issue a report on the current state of the air ambulance industry.

AAPB recommendation #14: The AAPB recommends that HHS and DOT collect data from air ambulance providers and suppliers regarding: (1) average cost per trip; (2) air ambulance base rates and patient-loaded statute mileage rates; (3) ancillary fees for specialty services; (4) reimbursement data aggregated by payor type and per transport, based on median rate and ZIP code, with data regarding private insurance further identified by provider type; (5) alternate revenue sources (e.g., subsidies or membership programs) broken down per transport for reporting purposes; (6) volume of transports, segregated by aircraft type (fixed wing and rotary wing) and takeoff ZIP code for government purposes, or for public use when aggregated with other data; (7) market share for air transport, obtained from the FAA certificate holder and identifying the certificate holder's parent company; and (8) market share for healthcare, by looking at the program type for the FAA certificate holder. (See Chapter 6, page 51)

Mr. Kolbet provided background on the NSA, which authorized CMS to collect data on air ambulance operators for two years, analyze that data, and issue a report with findings. The AAPB Committee recommended that, in addition to the minimum data elements required by the NSA, CMS should collect specific additional data elements and include analysis of these in the report.

The analysis would be critical for informing reimbursement adequacy discussions by providing more transparency into the costs of providing 24/7 readiness for air ambulance and the



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challenges of covering those costs. This was a critical step to appropriately align financial incentives to provide the best care for each patient.

CMS issued a Notice of Proposed Rulemaking in 2021 to collect the data required under the NSA. That rule was not finalized. Since the proposed rule preceded the issuance of the AAPB report, CMS may wish to revisit the proposed rule considering AAPB's recommendation and any recommendation that comes from the Committee.

Discussion CS-D

Clinical Standards Subcommittee Co-Chairs
AAQPS Committee Members

Commissioner Arnold asked whether the Subcommittee considered recommending the Medicare Payment Advisory Commission (MedPAC), rather than HHS, implement the recommended data collection. Mr. Kolbet responded the Subcommittee had not considered identifying MedPAC in the recommendation. Mr. McMinn added the Subcommittee had discussed the existing precedent for collecting similar information within HHS, specifically through the Medicare Ground Ambulance Data Collection System (GADCS).

Voting CS-D

Jeff Richey, RN, MHA, FACHE, Associate Administrator, Airlift Northwest, AAQPS Committee Chair

Mr. Richey facilitated the voting process. Recommendation CS-D was adopted by the Committee.

Voting Member	CS-D
Com. Arnold	Yes
Mr. Clark	Yes
Mr. Clayton	Yes
Col. Coffee	Abstain
Ms. Frazer	Yes
Dr. Gamber	Yes
Dr. Hinckley	Yes
Mr. Houser	Yes
Mr. Judge	Yes
Mr. Julander	Not present
Dr. Pritzker	Yes
Mr. Quisling	Yes
Mr. Reckert	Abstain



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Voting Member	CS-D
Mr. Richey	Yes
Vote Count	Yes: 11 No: 0 Abstain: 2 Not Present: 1

Other Topics

Clinical Standards Subcommittee Co-Chairs
AAQPS Committee Members

Mr. Judge raised concerns that the Clinical Standards Subcommittee elected not to put forward Recommendation CS-C. He believed that the recommendation was critically important and should be on the Committee's agenda.

Mr. Richey shared the Subcommittee had considerable discussions after the May 8 meeting about Recommendation CS-C, including a consult with the FAA. He requested Mr. Reckert provide his perspective on Recommendation CS-C. Mr. Reckert said that there was concern about the wording of Recommendation CS-C and the FAA did not have authority to implement the recommendation as written. Mr. Reckert asked Mr. Jonathan Cross, a representative from the FAA's Office of the Chief Counsel, to provide input. Mr. Cross stated the Subcommittee made the decision to withdraw Recommendation CS-C and directed Committee members to the Subcommittee Chairs for additional information. Mr. Judge noted withdrawing a recommendation was the Committee's jurisdiction, not the Subcommittee's jurisdiction.

The Subcommittee still felt conflicting standards across state lines was a valid issue, and that ambiguity in how the ADA was interpreted by states was a challenge. However, Mr. Kolbet stated the Subcommittee ultimately felt Recommendation CS-C was not necessary given the Committee adopted a recommendation to recognize air ambulances as a provider type in Medicare (Recommendation CS-1a), which began to address the challenge of standardization across state lines. Mr. Richey agreed with the Subcommittee and supported their decision not to put forward Recommendation CS-C.

Mr. Judge stated Recommendation CS-C did not mention the FAA, referring to the recommendation language proposed in the May 8 meeting. He further noted that the FAA did not have a role in evaluating the ADA but had field preemption to oversee aviation safety. Mr. Judge said the recommendation was about prices, routes, and services, not aviation safety, and the ADA had a major effect on economic conditions. In 2000, there were 377 air ambulances in the United States and about 400,000 transports. At the implementation of the fee schedule, there were 545 air ambulances and helicopters and about 400,000 patients. Today, there are



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about 400,000 patients and 1,315 helicopters – a large increase in vehicles without a corresponding increase in volume of patient transports. Mr. Judge noted that the ADA has had a dramatic effect on prices but did not believe there had been an increase in availability given the volume of patient transports has not changed. Mr. Judge stated the NSA included air ambulances because of the ADA, and Congress should evaluate the implications of the ADA.

Mr. Houser asked whether the decision to move air ambulances to provider status would correct any inconsistencies, as it related to clinical quality standards and reimbursement, which were two of the Committee's charges. Mr. Houser also asked whether evaluating the ADA would move in the direction of creating an opportunity for more inconsistency from state to state.

Mr. Judge clarified that the recommendation would evaluate the impact of the ADA but not necessarily change it. While not everyone was happy with the AAPB Committee's recommendation on evaluating the ADA, it was overwhelmingly supported and the state insurance commissioners testified in favor of the AAPB recommendation. Any change to air medicine would have to be narrow and carefully considered.

Mr. Houser asked whether the move to provider status would account for the issues Mr. Judge just described, from the perspective of quality, safety, and reimbursement. Mr. Judge agreed moving to provider status answers the original question. During the first Committee meeting in December, the doctor from CMS noted that ambulance reimbursement from CMS was a transportation, not a clinical benefit. Mr. Judge also agreed that moving to provider status would improve all the issues already identified but noted it would not deal with the impact of the ADA and how the entire system was organized.

Commissioner Arnold stated provider status was Medicare only and flights reimbursed through Minnesota's state regulations would have a different ability to take action. Her colleagues, who oversaw safety and quality at the state level, similarly, only cover a portion of the market. While helpful, the move to provider status created a series of gaps. The evaluation would help to understand the gaps. That would likely mean there are still cases where there is not a recourse for patients or air ambulances are unable to resolve a dispute. Commissioner Arnold asked if the ADA was the appropriate venue for addressing those gaps and noted that having that discussion would be helpful. She further noted that taking action in Medicare rarely solves all the downstream issues that can occur.

Mr. Houser asked Commissioner Arnold if she could share examples of gaps. Commissioner Arnold said Minnesota did not have the issues that other states have and was not aware of specific examples of gaps. Most of Minnesota's hospital systems sit on the board of Life Link, which does a lot of the state's transport. There were cases where there were either non-health care entities financing transport or specialty providers with subscription-based services. There could also be niche areas, for example mountain transports or subscriptions. The nexus of



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clinical quality and insurance can be complicated and different in every state and that markets that existed in one state may not exist elsewhere. Pediatric care may be another example where there was a gap, particularly in situations where there was no ability to have critical care and very sick pediatric patients are getting transported.

Mr. Houser appreciated both perspectives and asked the Committee to consider the risks and benefits of this discussion. If moving the Medicare provider status adjusts for the quality concerns that the Committee is charged with discussing, then that is a step forward. He recognized that with the ADA, it was not an option to clarify and that it was either a revision or guidance, and he was considering taking one step at a time. There was a natural alignment where the ADA related to aviation operations and Medicare provider status gave some oversight for quality and clinical capabilities, putting a natural segue and segregation to two things. Commissioner Arnold agreed splitting those two concepts was a step.

Dr. Hinkley noted if Mr. Judge's growth statistics over the past few decades were correct, then nobody can be as good as they used to be. Air ambulances could not take care of as many patients as they did 20 years ago. That would impact flight nurses, paramedics, pilots and patient safety. If the Committee believed the ADA partially affected that growth, it impacted safety and quality.

Mr. Kolbet added there was a significant amount of hospital closures and loss of services such as OB that air ambulances did not face in the past. Access to brick-and-mortar providers was becoming a significant issue, and since air ambulance helped to bridge those gaps in access by transporting patients longer distances to get the care they need, there was likely a push-pull relationship.

Mr. Richey suggested pausing the discussion to ensure the Committee had adequate time to cover the Subcommittee's last recommendation. He suggested returning to this discussion around Recommendation CS-C later in the meeting.

Clinical Standards Subcommittee: CS-1b Recommendation

Overview of Recommendation CS-1b: Establish Minimum National Clinical Standards

Keith A. McMinn, Director, Life Lion, Penn State Health Milton S. Hershey Medical Center,
Clinical Standards Subcommittee Co-chair

Mr. McMinn reviewed the problem statement, goal for addressing the problem statement, and recommendations proposed by the Clinical Standards Subcommittee:

Problem statement: Variability in the equipment and clinical capabilities available on air ambulances can present a clinical risk to patient safety when the available equipment, personnel, and training are not adequately matched to the needs of the patient; this presents



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particular risks for specialty populations and low frequency/high risk patients (e.g., neonatal/pediatric, high-risk OB, patients in rural areas).

Goal: Establish minimum national clinical standards

- ✓ **Recommendation #CS-1a** (approved by AAQPS at the May 8, 2025 meeting): Congress should pass legislation to establish air ambulance as a provider type regulated by Medicare so that CMS may establish Conditions of Participation and enforce basic clinical safety standards.

Recommendation CS-1b (for discussion today): Congress should pass legislation to require compulsory accreditation for Medicare air ambulance providers. The minimum standards assessed by the accrediting organization(s) should include specific standards for safe transport of specialty populations. The process must include periodic reassessment of compliance and must include exceptions or waivers for operators in rural/frontier areas where certain standards may not be feasible to implement without creating barriers to access (e.g., due to shortage of specialists). Accreditation standards should be reassessed on a periodic basis, soliciting industry input on proposed changes.

Mr. McMinn explained that the Committee discussed Recommendation 1b during the Committee meeting held on May 8 and deferred a decision or a vote until this meeting in order to gather more information to address questions raised by the Committee at the May 8 meeting.

Mr. McMinn stated when a provider requests an air ambulance, they should expect that air ambulance meets a minimum standard for equipment and personnel to support the patient. But since states regulate the scope of practice for EMS, there is significant variability in the minimum equipment and personnel required from state to state. When the equipment and personnel are not adequately matched to the needs of the patient, this presents a risk, particularly for specialty populations.

He explained the Subcommittee had two recommendations for this problem statement. The first was to establish air ambulance as a provider type in the Medicare program, with their own Conditions of Participation (CoPs). The Committee adopted this recommendation in the May 8 meeting.

The second, for discussion in this meeting, was to require compulsory accreditation for Medicare air ambulance providers, which would establish a more rigorous standard than the CoPs. Accreditation as discussed in the context of this recommendation would not necessarily look exactly the way it currently does today. CMS would approve accrediting organizations, and the standards each organization uses could meet different use cases, as long as they met CMS standards. Given the significant uptake of the existing accrediting organizations in the air ambulance industry, the Subcommittee expected those organizations would play a pivotal role



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in informing and implementing accreditation standards set by CMS. However, this recommendation was not about existing accrediting organizations per se, but rather establishing an accreditation requirement, which would likely include those organizations and could potentially include accreditation options that do not exist today.

Mr. McMinn reviewed relevant context before discussing the Subcommittee's options analysis. Currently, ambulance providers must demonstrate some basic requirements to be reimbursed for Medicare supplier claims, but these are very basic (for example, being equipped with a stretcher and "emergency medical supplies"), and they are not differentiated between air vs ground ambulance. Other types of Medicare providers are subject to certification requirements, known as CoPs, which includes minimum health and safety standards. These providers must be periodically certified by CMS to remain in the Medicare program. These certifications are conducted by state survey agencies or accreditation organizations approved by CMS. While these are somewhat more specific than the supplier requirements, they are very high-level. The Subcommittee provided links in the meeting slide deck to an example of CoPs for reference. In the May 8 meeting, the Committee approved the recommendation to establish air ambulance as a provider type with high-level CoPs like these.

Clinical aspects of air ambulance are regulated by the states, like other healthcare providers. However, this is complicated by the ADA, which has in some cases caused some ambiguity around what states can and cannot regulate with respect to clinical services. For this reason, the Subcommittee felt it was important to establish a national minimum standard to ensure a shared understanding across the industry and reduce the mismatch of requirements across state lines.

A large majority of air ambulance operators already participate in voluntary accreditation programs. There are accreditation standards in use today that are generally well respected across the industry, with processes in place to ensure these are regularly reviewed and updated with expert input. There is a strong foundation to build upon.

The Subcommittee considered four options:

1. Update existing Medicare supplier requirements for ambulance services.
2. Establish a new Medicare provider type.
3. Compulsory accreditation for air ambulances seeking reimbursement as Medicare suppliers of ambulance services.
4. Compulsory national accreditation for all air ambulance providers, regardless of Medicare participation.

Mr. McMinn explained the Subcommittee's final recommendation reflected options 2 and 3 and that he would focus on the third option today—compulsory accreditation for air ambulance providers participating in the Medicare program.



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Mr. McMinn reviewed Recommendation CS-1a, which was adopted during the May 8 meeting, and its connection to Recommendation CS-1b. Establishing a new provider type with CoPs would come with some additional basic standards above what was required as a supplier, but these standards would still be very basic. However, it would establish a more robust process for assessing compliance and establishing air ambulances as a Medicare provider would likely be a platform for a number of other Subcommittee recommendations, such as implementing a quality program or requiring reporting of a patient safety structural measure (both recommendations that the Committee also adopted at the May 8 meeting).

Because CoPs would be very basic standards, and the Subcommittee believed there was a compelling need for more meaningful shared standards at a national level, the Subcommittee also recommended requiring accreditation for providers participating in the Medicare program (Recommendation CS-1b). Under this process, CMS would approve accrediting organizations that meet certain minimum standards. This new accreditation requirement could leverage existing accreditation organizations, which would make the transition smooth for air ambulance providers already accredited.

Mr. McMinn also shared some challenges that would need to be addressed in standing up such a requirement. If the standard was too low, then the recommendation would add an administrative burden without meaningful improvement in safety and quality. If the standard was too high, the recommendation would risk putting operators out of business and reducing access. While the Subcommittee did not want to say that a lower standard of care was acceptable in some communities versus others, the reality was that there were parts of the country where it simply was not feasible to meet higher standards, and patients would be at risk of not being able to access transportation at all, which was not a desired outcome.

Operational Challenges in Frontier Areas

Todd McDowell, Director of EMS, State of Alaska

The Committee heard a presentation on Operational Challenges in Frontier Areas by Todd McDowell, Director of EMS, State of Alaska, which informed the Subcommittee's decision on Recommendation CS-1b.

Mr. McDowell shared with the Committee operational challenges air ambulances encounter in Alaska's frontier areas, and how these might make it difficult to comply with one-size-fits-all triage criteria, or accreditation requirements such as staffing minimums that are not feasible to implement in Alaska. Mr. McDowell noted Alaska is the largest U.S. state with less roads than Rhode Island and spans almost the entire country from the east to west coast. Alaska has a large population off the roads system and challenging transport times. For example, the closest Level



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1 Trauma Center to Anchorage is 1,500 miles away, and depending on where a patient is in Alaska, their transport to a Level 1 Trauma Center can be up to 2,500 miles.

In the lower 48 states, most air medical services staff transports with a flight nurse and paramedic, but Alaska has bases that use a double paramedic staffing model. Some rural services rely on any available volunteer EMT, and those services may use non-pressurized aircraft, single engine aircraft, and sometimes a transporter of last resort (where an air medical service may not be able to get in to an area to pick up a patient, but another non-medical aircraft can get the patient out of the area and closer to the care they need).

Putting these services at risk does not improve patient care and instead decreases availability of medical resources in these communities. In some communities, there are no hospitals, and patients need to be transported out of clinics with very basic capabilities. Poor weather can trap critically ill patients into a small community clinic for days. Some communities have a community health aide with one year of primary care education and then utilize telemedicine with a doctor to provide care. Alaska has one specialty team (a neonate specialty team out of Alaska) whose availability depends on call volume. This creates situations where they have had the option of waiting up to 12 hours for a special transport team or sending a neonate with non-specialty transport teams.

Alaska operates mostly fixed wing air ambulances and only has three rotor air ambulances. Air ambulances sometimes transport patients with a simple arm or ankle fracture; these patients would typically use ground ambulances in the lower 48 states. Due to the availability of ground ambulances in Alaska, many ground ambulances are staffed at the basic life support (BLS) level and can be hours from a hospital. When making a triage decision, the choice is often whether a patient is transported via a non-medical aircraft (such as Alaska Airlines) or air medical – unlike in the lower 48 states, where the choice is often between ground or air transport. Some communities are three to five hours away from the closest hospital by ground under good weather conditions, and these local volunteer ground ambulance services are often not willing or able to send volunteers on a 12-hour round trip transport. Many patients who would be transported by ground in the lower 48 states take air transport because of pure logistics.

Mr. McDowell emphasized areas facing these operational challenges may not be able to meet accreditation or triage standards and would need a waiver process or broad enough standards to fit these operational realities.

Discussion CS-1b

Clinical Standards Subcommittee Co-Chairs

AAQPS Committee Members



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Mr. McMinn noted Mr. McDowell offered the Subcommittee an important perspective on the operational realities of frontier areas, and as a result, Recommendation CS-1b included exceptions or waivers for air ambulances in rural or frontier areas, so that these providers would not be excluded from the Medicare program. Because the recommendation tied compulsory accreditation to Medicare provider status, rather than as a requirement to operate in the United States at all, it would be possible for some providers to forgo accreditation if they did not wish to be Medicare providers and were financially viable without Medicare reimbursement.

Ms. Frazer asked what criteria CMS would use to approve an accrediting agenda and whether CMS had a history of approving accreditations for hospitals. Mr. Wright shared CMS would first determine the standards the accrediting organization would have to meet. If there were existing Medicare standards, for example, then it would be incumbent on the accrediting organization to meet those standards. If there were not, then CMS would define those standards through public notice and comment rulemaking. Once those standards were established, CMS would hold an open call for any accrediting organization that believed they met or exceeded those standards to apply to CMS for approval.

Ms. Frazer noted she is confused about the time frame and raised concerns the Committee is voting on the recommendation without knowing how the process will work. Mr. Wright clarified the process would be the same, but the standards are not known yet. CMS had a well-established process for both determining accreditation standards and reviewing and approving the accreditation organizations for compliance with those standards. He deferred to Mr. Kolbet and Mr. McMinn to explain the intent of the recommendation.

Ms. Frazer noted the Subcommittee referenced Commission on Accreditation of Medical Transport Systems (CAMTS) and National Accreditation Alliance of Medical Transport Applications (NAAMTA) but not European Aero-Medical Institute (EURAMI). She is aware of three accrediting organizations in the world. While EURAMI is not based in the United States, they do accredit services in the United States. Mr. Richey clarified part of the recommendation would be to establish it, and the steps Ms. Frazer was discussing would be part of the process initiated after the recommendation's adoption. Mr. Wright confirmed Mr. Richey was correct.

Mr. Clayton raised concerns about the recommendation's potential unintended consequences and asked how compulsory accreditation for air ambulances would impact smaller operators in rural communities with a need for air ambulance services. He also asked if there was a timeframe to receive accreditation and raised concerns about the time and resources that would be required to obtain that accreditation, noting that larger organizations would likely find this process easier to complete compared to smaller organizations. Mr. Clayton also asked whether large organizations would need to obtain accreditation for each base or site by site.



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Regarding Mr. Clayton's question about obtaining accreditation for each base or site by site, Mr. Wright clarified accreditation was based on the unit of reimbursement (i.e. certification). For example, hospitals certified under one CMS compliance number could share one accrediting agreement. Accreditation was both a decision on the part of the operator and the unit of certification put in place.

Regarding Mr. Clayton's question about exemptions for operators facing specific geographic or operational challenges, Ms. Kianna Banks, a representative of CMS, noted CMS could incorporate exemptions as appropriate.

Regarding Mr. Clayton's question about timeframe, Mr. Wright explained that as part of the process of establishing the accreditation requirement, CMS would include a timeframe for those providers to work with and obtain approval from an accrediting organization, and an effective date for when providers would need to obtain accreditation.

Regarding Mr. Clayton's question about resources required to obtain accreditation (with cost being a potential barrier for smaller organizations), Mr. Wright noted CMS did not have the ability to prescribe or recommend specific costs to accrediting organizations. If a provider was not accredited, the state survey agency would survey that provider to determine whether the provider met the requirements.

Mr. Clayton asked whether there was a mechanism by which a new base could receive Medicare reimbursement funding prior to obtaining accreditation. It would be untenable for a new base to operate for two years without Medicare funding. Mr. Wright clarified a new base would not have to wait to get accredited. As they are building their base or starting operations, they would concurrently seek accreditation so that when they are ready to begin operations, their accreditation is in place and they can start billing Medicare.

Mr. Richey clarified if a hospital was already accredited by CMS through a joint commission or another accrediting body and they acquired another hospital, they would still be able to bill Medicare. If Mr. Clayton were to open another base and was already accredited, the new base would be covered under Life Flight Network as the biller. Mr. Wright confirmed Mr. Richey's understanding and noted it would depend on the unit of analysis and whether the unit of analysis was the corporation or a single base. He noted those details could be fleshed out in rulemaking. Each single base could be accredited or the whole organization could be accredited and then any bases built within that organization would automatically fall under the organization's accreditation.

Mr. Clayton asked Ms. Frazer how Mr. Wright's explanation comports with CAMTS's accreditation process. Ms. Frazer explained CAMTS conducts a supplemental visit for new bases and confirms the new base has met all standards. CAMTS encountered problems when states



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created new accreditation programs: because CAMTS requires operators be in business for a year before receiving accreditation, this can be a challenge for timely accreditation of new and extra bases.

Mr. Clayton raised concerns about the recommendation's impact on new market entrants because they cannot start a business in the air ambulance industry without receiving Medicare funding immediately. Mr. Richey noted new entrants could be certified as part of a corporation such as Life Flight Network. Mr. Clayton agreed, noting new entrants would need to be affiliated with another organization and receive funding elsewhere.

Mr. Judge noted the recommendation was proposed by the Subcommittee on the premise of qualifications of different clinical capabilities and establishment of a national standard. The Committee already agreed to create the air ambulance provider type so that CoPs could then be developed for air ambulances, which would create a national minimum standard. With accreditation, the Subcommittee did not present state-imposed clinical requirements, and the ADA complicated the situation for air ambulances. CMS does not generally require accreditation in other settings; in settings which allow for accreditation, accreditation is voluntary but gives the provider "deemed status" with CMS to demonstrate compliance with CoPs (i.e., they do not need to go through a separate survey process from CMS state surveyors). Accreditation and external measurement of quality and safety performance were important. Mr. Judge emphasized deemed status, voluntary accreditation, and CoPs would establish a national minimum standard.

Mr. Clayton agreed with Mr. Judge on his point about CoPs but not the ADA and agreed establishing air ambulances as a provider type was a good step. Mr. Clayton expressed concern about voluntary accreditation.

Ms. Frazer added states requiring CAMTS accreditation did not perform inspections on organizations that had that accreditation (referred to as deemed status), similar to what Mr. Judge described for Medicare oversight in other clinical settings.

Mr. Quisling agreed with Mr. Judge's statements around CoPs and was hesitant to support having another government agency essentially create a new set of regulatory standards for an industry that already had voluntarily set up minimum standards to ensure quality. He emphasized this was more about ensuring minimum standard can be pulled in than in rewriting the book of how operators were accredited. Mr. Quisling cautioned the Committee against changing the ADA or current divisions between CMS, FAA, and other government organizations like the Department of Defense.

Dr. Hinkley asked Ms. Frazer if she supported the recommendation. Ms. Frazer stated that naming CAMTS specifically as one of the accrediting organizations would open up CAMTS to



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lawsuits. However, not naming a specific accrediting organization would also be a problem; there is no national standard for accrediting organizations. Ms. Frazer asked if CMS had criteria for whether a hospital accreditation was acceptable or not. Mr. Wright clarified any entity that wanted to become an accrediting organization can. They must meet certain criteria including being national in scope and submit their standards to CMS. CMS evaluates those standards to ensure they meet or exceed Medicare's standards and determines whether the entity can survey to ensure compliance with those standards.

Ms. Frazer noted CAMTS developed its standards over 35 years and did not want an accrediting agency to be sued. She was not sure if naming the accrediting agency would make a difference in a lawsuit. Mr. Wright clarified CMS does not identify specific entities in its credential programs and CMS regulation do not refer to a specific accrediting organization.

Mr. Judge recommended Congress pass legislation to require CoPs for air ambulance providers and suggested the following recommendation language for the Committee's consideration:

- "Congress should pass legislation to require Conditions of Participant (CoPs) for air ambulance providers. Voluntary accreditation by CMS approved accrediting agencies should provide deemed status for meeting Medicare Conditions of Participation (CoPs). The minimum standards assessed by the accrediting organization(s) should include specific standards for safe transport of specialty populations. The process to develop CoPs and accreditation standards must include periodic reassessment of compliance and must include exceptions or waivers for operators in frontier areas where certain standards may not be feasible to implement without creating barriers to access (e.g., due to shortage of specialists). Accreditation standards should be reassessed on a periodic basis, soliciting industry input on proposed changes."

Mr. Judge noted voluntary accreditation by CMS approved accrediting agencies will provide deemed status for meeting CoPs. The process to develop CoPs and accreditation standards along with the Committee's language about periodic reassessment compliance would get to this a little better than compulsory accreditation. Mr. Houser agreed with Mr. Judge and his suggested language, noting accreditation was potentially duplicative of CoPs. Mr. Judge further noted it was important for the Committee to identify that any accreditation standard and the CoPs needed to think about the entire United States.

Mr. Clayton questioned whether the recommendation was needed at all, noting that making air ambulances a provider type with CoPs might be good enough. He was supportive of Mr. Judge's suggested language but raised concerns about unintended consequences the Committee had not thought of yet.

Mr. Judge asked Mr. Wright if moving from a supplier to a provider required CoPs. If so, Mr. Clayton's point about whether this recommendation is necessary was valid. If not, this



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additional piece, which set a national standard of CoPs, would be needed. Mr. Wright stated, and Ms. Banks confirmed, establishing air ambulances as a certified provider types under Medicare would include establishing CoPs. The Subcommittee Chairs also noted the recommendation adopted by the Committee in the May 8 meeting regarding establishing air ambulance as a Medicare provider type included a recommendation to establish CoPs, though it did not reference voluntary accreditation.

Mr. Kolbet asked Mr. Wright if the CoPs would be inclusive versus voluntary accreditation being comprehensive across the organization. Mr. Wright clarified for CoPs with a deeming option through accreditation, providers must meet those CoPs whether through the accrediting organization or the state. The accrediting organization can have additional (complimentary or tangential) standards beyond CoPs. CMS does not have a say in those additional standards. CMS confirms whether the accrediting organization's standards meet Medicare's basic standards. For example, the Joint Commission has reporting requirements, certain Centers of Excellence, and other programs they might give a separate accreditation for. Those additional requirements are beyond the Medicare CoPs; CMS does not oversee those requirements.

Mr. Richey asked whether Committee members preferred to vote on the Subcommittee's or Mr. Judge's suggested recommendation language. Ms. Frazer expressed support for the latter. Committee members suggested the following edits to Mr. Judge's proposed recommendation language:

- Mr. Judge suggested removing the first sentence.
- Dr. Hinkley suggested removing the word "rural."
- Mr. Houser suggested using existing CMS language for rural and frontier.
- Dr. Pritzker suggested deleting the word "frontier" because there may be urban areas with a shortage of specialists.
- Dr. Pritzker suggested deleting the word "voluntary" from "voluntary accreditation" because the recommendation to establish air ambulances as a provider type will include a process for developing CoPs and accreditation, including period assessment and exclude exceptions or waivers for operators in areas where certain standards may not be feasible.

Mr. Quisling asked whether the process for establishing an air ambulance provider type would allow voluntary accreditation to occur organically, without the Committee trying to wordsmith Recommendation 1b. He suggested striking the recommendation because Recommendation 1a covered the intent of Recommendation 1b. Mr. Clayton was supportive of moving forward with a vote and noted he would vote against Recommendation 1b due to his concerns about unintended consequences. Mr. Judge agreed with Mr. Quisling and Mr. Clayton that Recommendation 1b may be moot. If air ambulances were a provider type and had CoPs, that



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process could potentially incorporate voluntary accreditation that provided deemed status, without making accreditation compulsory for all Medicare providers.

Voting CS-1b

Jeff Richey, RN, MHA, FACHE, Associate Administrator, Airlift Northwest, AAQPS Committee Chair

Mr. Richey reviewed Recommendation CS-1b as amended by the Committee.

- ✓ **Recommendation #CS-1b:** Voluntary accreditation by CMS approved accrediting agencies should provide deemed status for meeting Medicare Conditions of Participation (CoPs). The minimum standards assessed by the accrediting organization(s) should include specific standards for safe transport of specialty populations. The process to develop CoPs and accreditation standards must include periodic reassessment of compliance and must include exceptions or waivers for operators in frontier areas where certain standards may not be feasible to implement without creating barriers to access (e.g., due to shortage of specialists). Accreditation standards should be reassessed on a periodic basis, soliciting industry input on proposed changes.

Upon further discussion, Committee consensus appeared to be not in favor of the recommendation; therefore, Mr. Richey determined that the Committee would vote on whether to strike recommendation CS-1b as suggested by Mr. Quisling. Mr. Richey facilitated the voting process. The Committee voted in favor of striking Recommendation CS-1b as amended by the Committee.

Voting Member	Vote to Strike CS-1b
Com. Arnold	Yes
Mr. Clark	Yes
Mr. Clayton	Yes
Col. Coffee	Yes
Ms. Frazer	Yes
Dr. Gamber	Yes
Dr. Hinckley	No
Mr. Houser	Abstain
Mr. Judge	Yes
Mr. Julander	Not present
Dr. Pritzker	Yes
Mr. Quisling	Yes
Mr. Reckert	Abstain
Mr. Richey	Yes



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Voting Member	Vote to Strike CS-1b
Vote Count	Yes: 10 No: 1 Abstain: 2 Not Present: 1

Other Topics

Clinical Standards Subcommittee Co-Chairs
AAQPS Committee Members

Mr. Richey asked Committee members if they wanted to continue the discussion on Recommendation CS-C, which the Clinical Standards Subcommittee elected not to put forward to the Committee but was the subject of some Committee discussion following votes on the other AAPB-related recommendations. Mr. Judge requested to continue that discussion, noting that this was a very important discussion for state insurance commissioners and EMS state directors. He proposed the following suggested language for Recommendation CS-C, which largely mirrored the language put forward by the Subcommittee in the May 8 AAQPS meeting:

- “Congress should implement AAPB recommendation seeking clarification regarding how Airline Deregulation Act (ADA) preemption over states’ ability to regulate price, routes, and services applies or does not apply to states’ ability to regulate clinical aspects of air ambulance, such as use of Certificate of Need or regulating clinical scope of practice to ensure appropriate access to clinical services needed in a community.”

Mr. Judge noted if the Committee was looking for a data driven design for a system, this recommendation was part of understanding the data and how the system is designed.

Mr. Quisling noted if he had a patchwork of aviation regulations and oversight around those operations, it would be extremely dangerous in terms of unintended consequences. The suggested recommendation language was essentially a ruling on what the ADA does and does not do and raised concerns the suggested language was outside of the Committee’s scope because it is moving into states versus the federal government. Mr. Quisling was not supportive of the suggested language. Mr. Clayton agreed with Mr. Quisling, noting he could not support going down the path of looking at ADA preemption because it would have a detrimental impact on ability to transport and get to patients and would have a lot of unintended consequences. Mr. Judge clarified the suggested language did not include anything about aviation and instead focused on the clinical aspects of air ambulances.

Ms. Haugen asked whether it was possible to create a corollary to the ADA that was specific to clinical, to capture the intent of Mr. Judge’s concern.



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Mr. Richey noted the recommendation was already put forward by the AAPB Committee and asked whether that was enough and whether the AAQPS Committee needed to recommend it again. Mr. Judge clarified the AAPB recommendations modified the ADA and this proposed language did not do that – it instead focused on clarifying the ADA.

Mr. Clayton was not supportive of modifying the ADA and especially the certificate of need. He raised concerns that states would regulate rates, routes, and services and this might restrict where he could fly if a state did not have a certificate of need. This would have a detrimental impact on patients.

Mr. Houser noted from the standpoint of understanding air ambulances have too much regulation at the state level for clinical care, the logic behind clarifying the role of the ADA was clear. However, CoPs provide guidance for clinical care and the ADA provided guidance for aviation operations.

Ms. Haugen agreed transportation should be kept separate from healthcare and medicine and asked whether the language could be reworked to reflect the need to study the impact of the ADA on the clinical aspects of operations. Mr. Judge noted the language could be simplified, but there was a lot of gray area around what was considered medicine under the ADA and that state insurance commissioners had testified to this. Court cases had ruled that clinical aspects of medicine were preempted by the ADA because of economic regulation. As an example, it took four years to convince DOT that cabin temperature regulation was a clinical requirement, not an aviation standard. States had testified to the fact that there were a number of these gray areas.

Dr. Hinkley noted the current landscape had led to a lot of unintended consequences, specifically around volume. Patient outcomes were better when they were treated by people who did those things at higher volumes. This applied to air ambulance patients, and the per provider volume of air ambulance patients was much lower than it was 20 to 30 years ago. He also agreed that considering this question should be the purview of the Committee, not the Subcommittee.

Mr. Houser agreed with Dr. Hinkley that repetitive experience increased the prowess of a provider and their ability to do care at an exceptional level. The challenge was that mortality decreased with proximity to an air medical resource or trauma center, particularly in the case of a trauma patient. Defining the balance where those two intersect appropriately still must be the answer. Furthermore, looking at the ADA's application to regulations, for example, from a licensing perspective, air ambulance organizations located in an area bordering more than one state already meet multiple requirements from a medicine perspective. Organizations that are geographically close to multiple states already meet the requirements of each state. The suggested language increased state oversight, which would limit resources and detrimentally affect patients.



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Mr. Quisling agreed with Mr. Houser, noting his organization must meet multiple regulations and adding to those regulations increased the complexity of the operation and left fewer options to provide service. The intent of the Committee was to provide more services options in a safe manner at a high quality. Repetition could improve expertise and quality outcomes, but the research, quality assurance that happens with current providers, and training undergone with the current providers, covered a lot of these potential gaps. The suggested language involved tremendous risk, and the Committee has alternative solutions that address the intent of driving better patient outcomes in an aircraft.

Mr. Richey asked Committee members if they wanted to vote on a recommendation or if the discussion was sufficient. Mr. Reckert asked if the Committee was being procedurally correct with its Charter because the Subcommittee elected not to bring forward the recommendation and the Committee was discussing that recommendation. Mr. Wright clarified there was no procedural limitation with regard to the Charter or the scope of the Committee for the Committee to take on a discussion that might not have been completed by the Subcommittee or to pursue their own path. There was no requirement that the Subcommittee approve a recommendation prior to Committee deliberation.

Mr. Reckert noted recommendations from federal advisory committees tended to gain more traction when there was consensus within the Committee around the recommendation and that it sounded like the Committee did not have consensus around the recommendation. He suggested taking the recommendation back to the Subcommittee for further discussion or leaving the recommendation off entirely.

Mr. Reckert also recommended the Committee determine whether the suggested language fell within the Committee's scope since there was a lot of comments from Committee members about the suggested language being out of scope. Mr. Wright noted he was not certain who made the ultimate determination of what was out of scope. The Agencies that charter the Committee could accept the recommendations or not. Mr. Wright was willing to explore that topic more. The question of a recommendation being out of scope would need to be determined in terms of what goes into the final report.

Mr. Reckert noted the final option under consideration was whether to send the suggested language back to the Subcommittee for further discussion. Mr. Richey clarified the suggested language could not go back to the Subcommittee because the Committee was out of time. He also clarified the Subcommittee withdrew the recommendation, which was why it was not included in the package distributed to Committee members prior to the meeting.

Mr. Judge noted the path of least resistance was to state in the report that the Committee discussed this issue, identified gray areas, discussed the ADA's impact on states' ability to



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oversee clinical care, and was not able to reach a consensus on the topic. Mr. Richey agreed, noting the record would reflect the Committee had a robust discussion on this topic and that Committee members would have an opportunity to review and add appropriate clarifications to the report.

Review of Clinical Standards Recommendations Adopted May 8, 2025

Keith A. McMinn, Director, Life Lion, Penn State Health Milton S. Hershey Medical Center,
Clinical Standards Subcommittee Co-chair

Mr. McMinn reviewed the voting results from the recommendations voted on and adopted during the Committee meeting held on May 8, 2025.

- **Recommendation #CS-1a:** Congress should pass legislation to establish air ambulance as a provider type regulated by Medicare so that CMS may establish Conditions of Participation and enforce basic clinical safety standards.
 - **Voting Results: 9 Yes; 2 No; 3 Abstain**
- **Recommendation #CS-2:** Congress should direct HHS to develop a Patient Safety Structural Measure (PSSM) adapted for the air ambulance setting, and to establish a new quality reporting program for air ambulance which includes reporting on the PSSM.
 - **Voting Results: 14 Yes; 0 No; 0 Abstain**
- **Recommendation #CS-3a:** HHS should issue guidance to hospitals and air ambulance providers clarifying that HIPAA does not prevent sharing patient clinical data for quality improvement purposes and clarifying the specific limitations and requirements for hospitals to share patient clinical data back to air ambulance providers.
 - **Voting Results: 13 Yes; 0 No; 1 Abstain**
- **Recommendation #CS-3b:** Congress should provide additional funding to bolster existing state and federal efforts to develop and promote health information exchange. This funding should specifically support improving the bidirectional exchange of patient clinical data between air ambulance providers and hospitals.
 - **Voting Results: 12 Yes; 0 No; 2 Abstain**

Public Comments

The public was offered an opportunity to provide comments to the Committee. No members of the public requested to comment during the meeting.

Closing

Final Reflections

AAQPS Committee Members



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Mr. Richey expressed his gratitude for the Committee members, Subcommittee members, and public commenters and their contributions in developing these recommendations. He called on Committee members to share their closing reflections.

Committee members expressed their appreciation for the leadership of Mr. Richey and Mr. Wright, as well as for the hard work and dedication of the Committee and Subcommittee members. Several Committee members highlighted the complexity of the topics addressed and commended the group's commitment to patient-centeredness, quality, and safety. Mr. Houser shared a personal story that underscored the real-world impact of the Committee's efforts. Committee members noted the work accomplished by the Committee represented important progress for the air ambulance industry, and challenges and areas for further improvement remained. Committee members also acknowledged the significance of this federal effort and the value of collaboration between government and industry.

Next Steps

Jeff Richey, RN, MHA, FACHE, AAQPS Committee Chair

Mr. Richey explained the Committee would work over the summer to complete the Report to Congress and Committee members would receive information regarding the report timeline and review process following this meeting.

He noted that the public may submit written comments until July 30th by emailing CMS at AAQPS@cms.hhs.gov, and all questions from the meeting would be answered and included in the summary report posted on the CMS AAQPS website.

The meeting was adjourned by David Wright at approximately 4:30 PM EST.

Questions and Answers

The public was offered an opportunity to submit questions to the Committee. No members of the public submitted questions during the meeting.



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AIR AMBULANCE QUALITY AND PATIENT SAFETY (AAQPS)

Federal Advisory Committee Meeting 3

Meeting Date: July 10, 2025

Note: This Advisory Committee is governed by the provisions of the Federal Advisory Committee Act (FACA), P.L. 92-463 (Oct. 6, 1972), as amended, 5 U.S.C. App. 2.

This is a public meeting that is being watched live by members of the public and is being recorded. By staying in this meeting, you are consenting to being recorded and for the transcript of this meeting to be posted publicly.

Committee Purpose

The Advisory Committee will advise the Secretary of Health and Human Services and the Secretary of Transportation on options to establish quality, patient safety, and clinical capability standards for each clinical capability level of air ambulances. The Advisory Committee shall study and make recommendations, as appropriate, to Congress regarding the following with respect to air ambulance services:

1. Qualifications of different clinical capability levels and tiering of such levels.
2. Patient safety and quality standards.
3. Options for improving service reliability during poor weather, night conditions, or other adverse conditions.
4. Differences between air ambulance vehicle types, services, and technologies, and other flight capability standards, and the impact of such differences on patient safety.
5. Clinical triage criteria for air ambulances.

The recommendations will be collated into a report to Congress.

Committee Structure

The Advisory Committee will hold three public meetings. In addition, there will be two subcommittees: a Flight Safety subcommittee and a Clinical Standards subcommittee. Each subcommittee will hold nonpublic meetings and report their recommendations to the main committee during the public meetings.

Meetings will be announced through the Federal Register and registration will be posted at:
<https://www.cms.gov/es/node/1974466>.



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Committee Members

Chair:

Jeff Richey, RN, MHA

Members:

William Hinckley, MD

Eileen Frazer, RN

Jason Clark

Mark Gamber, MD

Jordan Pritzker, MD

Commissioner Grace Arnold

Col. Steven Coffee

Ben Clayton

Jim Houser, MSN, APRN

Thomas Judge

Paul Julander

Jason Quisling

Robert Reckert

Reference Documents

Please see the CMS Air Ambulance Quality and Patient Safety Committee website for reference and pre-reading materials here: <https://www.cms.gov/es/node/1974466>.

Agenda: Third Full Committee Meeting

Overall Meeting Objectives:

- Review the findings and clarification from the subcommittees on recommendations that were not resolved during the May 8 AAQPS Committee meeting.
- Hear from Committee members and other subject matter experts, as needed, to provide additional context around subcommittee recommendations.
- Come to consensus and vote on remaining subcommittee recommendations.

(See next page for agenda)



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Agenda: Third Full AAQPS Committee Meeting

All Times are EST		Introduction and Background	
10:00 – 10:30 AM	Welcome	David Wright (DFO)	
	Meeting objectives	Jeff Richey (Chair)	
	Recap of May 8 Meeting	Jeff Richey	
Flight Safety Subcommittee: Recommendation			
10:30 – 11:10 AM	Recommendation FS-6 <ul style="list-style-type: none">BackgroundProblemJustificationBenefits and challenges	Jason Quisling	
	AAQPS discussion and questions	AAQPS Committee Members	
	AAQPS consensus and voting	Jeff Richey	
Flight Safety Subcommittee: Language Update and Review			
11:10 – 11:30 AM	Language update, voting, and additional discussion	Jason Quisling AAQPS Committee Members	
	Clinical Standards Subcommittee: Statutory Overview		
11:30 – 11:45 AM	Overview of clinical standards recommendations and alignment to AAQPS statutory mandate	Kolby Kolbet Keith McMinn	
11:45 AM – 12:45 PM	Lunch		
Clinical Standards Subcommittee: AAPB Recommendations			



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12:45 – 2:30 PM	Recommendations <ul style="list-style-type: none"> • Background • Problem • Justification • Benefits and challenges 	Kolby Kolbet Keith McMinn
	AAQPS discussion and questions	AAQPS Committee Members
	AAQPS consensus and voting	Jeff Richey
2:30 – 2:40 PM Break		
Clinical Standards Subcommittee: Recommendation		
2:40 – 3:40 PM	Recommendation CS-1B <ul style="list-style-type: none"> • Background • Problem • Justification • Benefits and challenges 	Kolby Kolbet Keith McMinn
	AAQPS discussion and questions	AAQPS Committee Members
	AAQPS consensus and voting	Jeff Richey
3:40 – 4:10 PM	Recap of recommendations and additional discussion	Jeff Richey
4:10 – 4:20 PM Break		
Public Comments		
4:20 – 4:30 PM		Public
Closing		
4:30 – 5:00 PM	Final Reflections <ul style="list-style-type: none"> • Committee final reflections • Next steps for the Report to Congress • Email/procedure for providing additional comments 	Jeff Richey



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Acronyms

Acronym	Definition
AAPB	Air Ambulance Patient Billing
AAQPS	Air Ambulance Quality and Patient Safety
ACEP	American College of Emergency Physicians
ADA	Airline Deregulation Act
ADIP	Airport Data Information Portal
ADS-B	Automatic Dependent Surveillance–Broadcast
AFCS	Auto Flight Control Systems
ARAC	Aviation Rulemaking Advisory Committee
ATC	Air traffic control
BLS	Basic life support
CAMTS	Commission on Accreditation of Medical Transport Systems
CCSQ	Center for Clinical Standards and Quality
CMS	Centers for Medicare & Medicaid Services
CoP	Condition of Participation
CPDLC	Controller–pilot data link communications
CPT	Current Procedural Terminology
CRFS	Crash Resistant Fuel Systems
CRSS	Crash Resistant Seats and Structures
DOT	Department of Transportation
ECMO	Extracorporeal membrane oxygenation
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
EURAMI	European Aero-Medical Institute
FAA	Federal Aviation Administration
FACA	Federal Advisory Committee Act
GADCS	Ground Ambulance Data Collection System
GFA-LA	Graphical Forecasts for Aviation – Low Altitude
HAA	Helicopter Air Ambulance
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IDR	Independent Dispute Resolution
IFR	Instrument Flight Rules
MedPAC	Medicare Payment Advisory Commission



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Acronym	Definition
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NAAMTA	National Accreditation Alliance of Medical Transport Applications
NADIN	National Airspace Data Interchange
NAEMSP	National Association of EMS Physicians
NOTAM	Notices to Airmen
NSA	No Surprises Act
NTSB	National Transportation Safety Board
OB	Obstetric
PSSM	Patient Safety Structural Measure
ROPWG	Rotorcraft Occupant Protection Working Group
SAFOs	Safety Alerts for Operators
SAS	Stability Augmentation Systems
TAWS	terrain awareness and warning systems
TDWR	Terminal Doppler Weather Radar
UAS	Unmanned aircraft system
VWOS	Visual Weather Observation Systems