



Federal Aviation
Administration

Air Ambulance Quality and Patient Safety (AAQPS) Advisory Committee Public Meeting #3 – Meeting Transcript

July 10, 2025

-Good morning, everyone. My name is David Wright. I'm with the Centers for Medicare and Medicaid Services. It's my pleasure today to open this final meeting of the Air Ambulance Quality and Patient Safety Advisory Committee. This meeting is being held pursuant to a notice published in the Federal Register on November 27th, 2024.

The agenda was posted on the AAQPS Committee website. I'm the Designated Federal Officer responsible for compliance with the Federal Advisory Committee Act under which this meeting is being conducted. It's my responsibility to see to it that the agenda's adhered to and that accurate minutes are kept. I also have the responsibility to adjourn the meeting should I find it necessary to do so in the public interest. With that, I'm happy to turn it over now to our Committee Chair, Jeff Richey. Jeff?

-Good morning, everyone. Thanks, David, for that introduction, and I just want to be able to welcome everyone to the final meeting and just say how proud I am of the work that we have done over the last 9 months to be able to come forward with, I believe, is some amazing work and really pioneering some things that we have all been talking about for a long period of time that really encompass both patient safety and aviation safety for the air ambulance work that we do here in the United States.

So, with that, I'd like to go through the roll call. Okay, I'm going to go down.

Committee Member	Response
Dr. Hinckley.	-Good morning, I'm here.
Eileen Fraser.	-Yes, I'm here.
Jason Clark.	-Good morning. Present.
Dr. Gamber.	-Here.



Federal Aviation
Administration

Committee Member	Response
Dr. Pritzker.	-Here.
Commissioner Arnold	-I'm here. Good morning.
Robert Reckert.	-Good morning.
Ben Clayton.	-Good morning. Happy to be here.
Jim Houser.	-Good morning. Present
Tom Judge.	-Good morning.
Paul Julander.	[Not present]
Jason Quisling.	-Good morning. I'm here.
Colonel Coffee.	-Good morning.

Alright, thank you very much. I guess we're going to start with the slides, everyone. Hope everyone has gotten enough coffee for those of you on the west coast and the east coast or in the middle. So here we go. So, next slide.

We're just going to do a quick overview. So, here's the agenda for the day. Introductions and background, we're going to go through the Flight Safety Subcommittee recommendations from that time, flight safety language review, Clinical Standards Subcommittee overview will also happen between there. There will be a break in there at that time, and then lunch will be from 11:45 to 12:45. Everyone will get an hour to do that. And then we will go into Clinical Standards Subcommittee recommendations again at 12:45, a break, and then continue discussion, Clinical Standards Subcommittee. And then review all the recommendations and any other discussion with a break around 4:10 or 4:20, and then public comment, and then at that time we will adjourn our meeting.

Next slide, please. As you can see, this is pictures of everyone that is on our Committee, which we just did our roll call. Let's go to the next panel here. There we go. We've already done that. I was moving ahead slightly from that standpoint, and then we'll go to the next slide.

Okay, so here is where we're at. So, the No Surprises Act calls for the Department of Health and Human Services to establish an Advisory Committee to address the following topics in its



**Federal Aviation
Administration**

deliberation, it's subsequent report to Congress: qualifications for different clinical capability levels and tiering of such levels; patient safety and quality standards; clinical triage criteria for air ambulance; options for improving service reliability during poor weather, night conditions, and or adverse conditions; and then a difference between air ambulance vehicle types, services, and technologies, and other flight capability standards, and the impact of such differences on patient safety. Next slide for the overview, please.

Well, our purpose is to review the options to improve quality, patient safety, and clinical capabilities standards for each clinical capability of air ambulance. The outcome is define innovative approaches to improve quality and accessibility, affordability, and sustainability of air ambulance services for safe, quality health care. Next slide, please.

So, there were two Subcommittees, which all of you have been a part of, most of you. The Clinical Standards looked at the qualifications, the different clinical capabilities and tiering of such levels, patient safety and quality standards, clinical triage criteria for air ambulance. The members, or Committee members were selected from those who applied for the main Committee.

On the Flight Safety side, they looked at options for improving services reliability during poor weather, night conditions, and other adverse conditions, differences between air ambulance vehicle types and services and technologies and other flight capability standards, and the impact of such differences. Those members were appointed by the Department of Transportation and that were also on the AAQPS Committee serving on that same Subcommittee.

So, both Subcommittees provided updates to the Committee, and we have seen those over the last several months, and we look to that Committee for guidance on prioritization and help the Committee members understand the background and nuance of each of these recommendations. Next slide, please.

So, here is the voting process. The Committee Chair, which is me, Jeff Richey, I'll call a vote. The voting choices will be yes, no, or abstain. All Committee members will send a private chat with their vote to a designated team member, yes, no, or abstain, and the Committee Chair will call out each member's name and they will read aloud the voting they submitted via chat and note if they have a conflict of interest. The Committee Chair, which is me, will read the calculated votes aloud. Recommendations will be incorporated into the Report to Congress if the majority of the Committee members voting cast a yes vote. Next slide.



**Federal Aviation
Administration**

Okay. So, a couple other notes that I want to be able to make sure before we go through some things. So, I want to note that members of the public will not be called upon during this meeting and all questions must be entered in the Q&A box and will be answered following this meeting and added to the summary report that will be posted on the Centers for Medicare and Medicaid Services and the AAQPS Committee website. Also note that you can send an email to the AAQPS@cms.hhs.gov, which we'll put into the chat so everyone can be able to, if you have any other questions from that standpoint.

The other piece that I want to say is that this is our final meeting, which both David and I have said twice already. But this is our chance to be able to put forward comments and any sort of discussion. Once we conclude today at close to 5 PM on the east coast that will be it, and so if you have discussion, questions now is the time to be able to do that. Once we are done with this meeting, the MITRE team which has done an incredible job of helping us shepherd through all this entire process, will put forward the report and this will go to the members of this Committee. We will be looking for clarifications on what we discussed but you will not be able to add anything new that wasn't brought forward to the meeting from that standpoint. So, just want to put that out there as we go forward. So, let me go ahead and I'm just going to go into a review of the May 8th meeting.

Okay, AAQPS meeting on May 8th the chairs presented recommendations to us for consideration, we discussed and deliberated on the recommendations, voted on and passed 9 recommendations to be included in a Report to Congress, agreed to discuss one additional flight safety focused recommendation, and 5 clinical standard focused recommendations today. Next slide, please.

Recommendations that were adopted by the Committee. So, AAQPS recommendation 1, 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.

The second recommendation, number 2, Congress should direct HHS to develop a patient safety structure measure, PSSM, adapted for the air ambulance setting and to establish a new quality reporting program for air ambulances, which includes reporting on the PSSM.

AAQPS recommendation 3, HHS should issue guidance to hospitals and air ambulance providers clarifying that HIPAA does not prevent sharing patient clinical data for quality improvement



**Federal Aviation
Administration**

purposes and clarifying the specific limitations and requirements for hospitals to share patient clinical data back to air ambulance providers.

The 4th 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 bi-directional exchange of patient clinical data between air ambulance providers and hospitals.

Number 5, 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 US; increasing access to Terminal Doppler Weather Radar (TDWR) systems; enhancing service detection capabilities, improving forecasting accuracy, and advancing predictive and analysis tools; integrating improved approved weather sources into the National Airspace Data Interchange (NADIM) for Graphical Forecast for Aviation-Low Altitude, which is GFA-LA. Next slide please.

Other recommendations. Number 6, Congress should authorize funding and establish initiatives to modernize and digitize the Airport Data Information Portal 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, marking, and instrument flight rules (IFR) capabilities, compatibility, sorry. This effort should prioritize integrated, updated heliport data into commercially available pilot navigation tools, establishing competitive pilot navigation tools, establishing competitive grants to upgrade substandard helipads and heliports to meet FAA design standards, which is in the Advisory Circular that is there; including maintenance of hospital helipad infrastructure to improve safety, reliability, especially- actually I just skipped a sentence here- including maintenance of hospital, helipad data in the ADIP as a Condition of Participation to be evaluated by hospital accreditation organizations; adding IFR-compatibility infrastructure to improve safety and reliability, especially in rural and underserved areas(non-terminal areas); incorporating locations with medical services into the US Notices to Airmen (NOTAM) system.

Recommendation 7, Congress should direct the FAA to develop low-altitude IFR routes that enhance air traffic control (ATC) capabilities. Congress should increase helicopter air ambulance



**Federal Aviation
Administration**

(HAA) use of the IFR system by funding the required structure and directing the FAA to adopt policies and procedures to support its use by the low altitude aircraft, crewed and uncrewed. Infrastructure needs include adopting additional Automatic Dependent Surveillance-Broadcast transmitters, (ADS-B), radar systems, controller-pilot data link communications (CPDLC), and-- including expansion of low altitude IFR routes and approaches. Again, I think, lots of words, I think I skipped another sentence--And communication equipment and incentivizing hospitals and operators to adopt IFR 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 risk association with the growth of unmanned aircraft systems and advanced air mobility operations.

Number 8, Congress should mandate that new air ambulance helicopters be equipped with stability augmentation systems (SAS) and auto flight control systems 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), and expedite development through industry collaborations.

Number 9, Congress should mandate that the FAA develop performance-based standards and establish standardized policies and procedures across all offices to streamline the certification process to 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 and enhanced emergency medical services to include a dedicated liaison team within the FAA Aircraft Certification Service to improve communication with operators and manufacturers, expedite approvals and provide regulatory guidance. Next slide.

Okay, that was a lot. I apologize if I fumble through a couple of those sentences, but that was a lot of words here this early in the morning. But I hope everyone was able to also read them to hear exactly where we are at.

So, now I'd like to turn it over to the Flight Safety Subcommittee Chair, Jason Quisling, who will lead the discussion around flight safety recommendations that was not voted on during the May 8th meeting.

-Thank you, Jeff. We can go to the next slide. We'll start with just an overview of where we are.



**Federal Aviation
Administration**

So, our recommendation number 6 from the Flight Safety Subcommittee, mandate critical safety standards for air ambulance occupant protection, is what we'll be primarily focused on discussing today. We had a request to do some clarification around the FAA Aviation Rulemaking Advisory Committee, also referred to as the ARAC recommendations, specifically to focus on the details of those ARAC recommendations and clarify the language about what exactly was being proposed with flight safety recommendation number 6. And then, there was additional discussion at the last meeting around recommendations from the Flight Safety Subcommittee 1 through 6 helicopter versus fixed wing language. Requesting clarification of that language to make sure that it was clear and indicating whether each recommendation applies to helicopter or fixed wing ambulances, or both. Next slide, please.

So just as an overview, the Advisory Committee on Air Ambulance Quality and Patient Safety, for the purpose of reviewing options to establish quality patient safety and clinical capability standards for each clinical capability level of air ambulance, the Advisory Committee shall study and make recommendations as appropriate to Congress regarding the following, with respect to air ambulance services. And specifically highlighted here the ones that apply directly to the Flight Safety Subcommittee. And our focus was around options for improving service reliability during poor weather, night conditions or adverse conditions, and the differences between air ambulance vehicle types, services and technologies, and other flight capability standards and the impact of such differences on patient safety. And these recommendations will be used to enhance CMS' approach to air ambulance quality and safety and may be used to help establish an air ambulance quality reporting or value-based purchasing program in future. Go to the next slide.

So just a little background on air ambulance flight safety, quality and patient safety. We've seen increased demand for air ambulance services and tried to discuss and review the need for air ambulance operations has grown significantly, especially in rural and remote areas where access to critical care facilities is limited. These services are vital for rapid patient transport during emergencies. Additionally, safety concerns in adverse weather conditions, air ambulance operations in poor visibility, low ceilings, adverse weather conditions continue to pose significant risks to the patient and crew safety, highlighting a need for improved infrastructure and technology. Then we had specific intervention focus around crash survivability. Despite advancements, crash survivability remains a challenge with ongoing efforts to improve aircraft design such as energy absorbing seats, stronger airframes, and fire-resistant fuel systems.



**Federal Aviation
Administration**

On the technology side, although cost barriers have impeded the adoption of some advanced technologies, such as terrain awareness and warning systems, also referred to as TAWS, autopilot systems, and enhanced GPS Navigation, new technology can improve situational awareness and operational safety for air ambulance crews.

Performance based standards. The development of performance-based standards can help operators and manufacturers design more efficient safety compliant aircraft and aid in streamlining the certification process.

Public and legislative attention. Air ambulance safety has gained attention from policymakers and the public, prompting calls for continued investment in infrastructure, technology and regulatory oversight to ensure patient and crew safety. Next slide, please.

So, there were a total of five meetings held by the Flight Safety Subcommittee from December of 2024 through April of 2025. The first meeting on December 19th focused on understanding the two statutory areas of improving service reliability and enhancing patient safety and identifying key concerns such as infrastructure gaps, human factors, low altitude congestion, and unimplemented National Transportation Safety Board (NTSB) recommendations.

In January, we had further discussion on improving air ambulance safety through better weather reporting, updated infrastructure, unified standards, and enhanced technology and regulations.

February meeting reviewed problem statements developed in January and explored solutions including NTSB recommendations, funding priorities, improved weather sensors, expanded weather cameras and collaboration on helipad safety and patient protection.

In March, we met and prioritized solutions to improve air ambulance service reliability and patient safety. We were informed by subject matter experts who presented insights on vertical flight safety, heliport infrastructure challenges and advancements and weather monitoring, with plans to finalize recommendations at the April meeting.

And in April we reviewed and finalized draft recommendations on improving weather reporting, helipad infrastructure, low altitude instrument flight rule systems and the safety of single pilot operations, while also prioritizing 2 additional recommendations to streamline technology certification and mandate occupant protection standards. Next slide, please.

So, this is an overview of the Flight Safety Subcommittee recommendations, the first being around adverse weather, specifically focused on gaps in reporting in non-terminal areas or areas



**Federal Aviation
Administration**

that are not served by weather reporting stations. Problem statement here, adverse weather creates significant challenges for smaller aircraft, especially helicopters that often take off and land at small private hospital helipad and scene locations, referred to as non-terminal areas, rather than large, well-equipped airports with full weather forecast. Weather information for flights close to the ground below 5,000 feet is often incomplete or unavailable, particularly in these non-terminal areas where there are fewer weather stations and limited access to approved weather sources. FS-1: Enhance weather reporting and infrastructure in non-terminal areas was adopted previously.

Second recommendation focused on facility infrastructure, specifically related to hospital helipad safety and data gaps. The problem statement: many hospital helipads critical for air ambulance operations are not listed in the FAA's ADIP database, leaving over a third unaccounted for. This lack of comprehensive data and combined with voluntary heliport design standards and inconsistent oversight, results in safety risks such as airspace conflicts, substandard facilities and inadequate disaster management capabilities. Additionally, the absence of standardized markings and unclear weight and size limitations further complicated safe operations. Recommendation number 2 was modernize helipad data infrastructure and safety standards and previously adopted.

Instrument flight rules infrastructure, challenges to low altitude IFR operations was involved in number 3, the problem statement being air ambulance operations face significant limitations due to the lack of low altitude instrument flight rules, or IFR infrastructure, including IFR approaches to helipads. This restricts operations during poor weather, delays patient transport, and increases safety risks. The complexity of accessing the IFR system and the absence of mandated standards for helipad design exacerbate these challenges, hindering reliable and timely emergency medical services. Additionally, the rapid growth of low altitude aviation, unmanned aerial systems including drones, and advanced air mobility vehicles, is increasing the air space congestion near hospitals and airports, and potentially delaying critical life-saving missions. So, recommendation to improve low altitude IFR infrastructure, number 3, was adopted. Next slide, please.

On recommendation number 4, we were focused on single pilot operations and addressing safety and airspace challenges and air ambulance operations themselves. The problem statement: air ambulance operations face significant safety challenges due to high pilot workload and demanding conditions like adverse weather, low visibility and night flights, which can impact situational awareness and decision-making. Additionally, the rapid growth of low



**Federal Aviation
Administration**

altitude aviation, including UAS and advanced air mobility vehicles, and increasing airspace congestion and pilot workload near hospitals and airports, potentially interfering with these critical life-saving missions. Recommendation number 4 was to enhance safety and technology in the single pilot operations.

Number 5 was around barriers to innovation. New technology and medical equipment certification. Problem statement for number 5 was current certification requirements restrict timely adoption of new technologies, including advanced aircraft systems, medical equipment and safety technologies, and it limits the ability to enhance patient care and improve operational efficiency in emergency medical services. Recommendation number 5 was to streamline certification and expedite approval pathways for air ambulance technologies and medical equipment.

That brings us to number 6, which we'll be discussing today. And this was around occupant safety standards and addressing NTSB recommendations that currently exist. Problem statement was around a regulatory gap that exists and allows certain helicopters with Type Certificates issued prior to 1994 and those same helicopters have manufacture dates prior to 2020, they are allowed to operate without meeting current safety and certification standards outlined in the Code of Federal Regulations 14 Parts 27 and 29. These certification requirements have been proven to reduce injuries and fatalities for occupants of helicopters. Allowing helicopters with the Type Certificate prior to '94 to continue to operate in the absence of mandatory adherence to updated safety standards- such as crash resistant fuel systems, enhanced document protection, and structural integrity requirements- heightens the likelihood of preventable injuries and fatalities in the event of an accident. Recommendation number 6 is around mandating critical safety standards for air ambulance occupant protection. If we go to the next slide.

So now we'll clarify some language in recommendation 6 and complete a full review before we vote on FS-6. Next slide.

So, the context for flight safety recommendation 6. We, the Flight Safety Subcommittee, leveraged open and outstanding recommendations from the NTSB safety recommendations of previous years as well as FAA working groups. In 2018 Rotorcraft Occupant Protection Working Group, also known as ROPWG, issued final recommendations for Task 5 around crash resistant seats and structures and Task 6, crash resistant fuel systems, and these were subsequently accepted by the FAA Aviation Rulemaking Advisory Committee, also referred to as ARAC. The



**Federal Aviation
Administration**

FAA outlined the implementation process for crash resistant fuel systems in FAA Safety Alert for Operators 19006 and a Special Airworthiness Information Bulletin SW-17-31R2.

Any aircraft with the Type Certification occurring after 1994 must be in compliance with requirements listed in CFR 14 Part 27 and 29 in the following areas: requiring the installation of crash resistant fuel bladders that meet the requirements of a 50 foot fuel cell drop test in or out of the structure, and that demonstrate a minimum of 250 pounds puncture resistance; requiring installation of occupant seats that pass the vertical and horizontal dynamic seat tests; and requiring the restraint of occupants and items of mass in the cabin at g-levels required for newly certified helicopters. Next slide, please.

So, when looking at the differences between air ambulance vehicle types, services, technologies, and other flight capability standards, and the impact of such differences on patient safety, we arrived at the following problem statement around occupant safety standards, which has been previously addressed by NTSB recommendations. But we found that a regulatory gap exists that allows certain helicopters with Type Certificates issued prior to 1994 and manufactured prior to 2020, they are able 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 Type Certificates 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 or fatalities in the event of an accident.

Our rationale involves legislative action being necessary to close this regulatory gap, reduce risks associated with outdated certification standards and ensure the highest level of safety for all air ambulance passengers and crew; implementing proven protective technologies, improve survivability for passengers and crew during accidents and strengthens public confidence in the industry, and; aligning practices with established safety standards reflects a commitment to accountability and continuous improvement, creating a safer operational framework while reducing financial and societal consequences of preventable injuries and fatalities. Next slide, please.

So, the Subcommittee recommendation that we'll be reviewing now is around the mandate for critical safety standards for air ambulance occupant protection. Congress should mandate the implementation of FAA Part 135 ARAC recommendations on helicopter air ambulance occupant



**Federal Aviation
Administration**

protective technologies, including crashworthy fuel systems as referenced in SFO 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 ways.

We went ahead and listed out the individual references in the Code of Federal Regulations. These are the FARs that specifically outline the 3 areas I previously discussed around the crash resistance for the fuel system, as well as the security and structural integrity for seats and objects that are inside the cabin. Enhanced safety for passengers and crew implementing crash worthy and crash resistant technologies significantly reduces the risk of injuries and fatalities during accidents, ensuring greater protection for those board air ambulances. This is also aligning with proven safety standards and adopting these technologies brings industry practices in line with established safety benchmarks, fostering consistency and accountability while promoting a culture of safety.

Some of the challenges around this recommendation being implemented, financial burden: retrofitting aircraft or purchasing compliant models may impose significant costs on operators, particularly smaller ones, potentially impacting service availability. Operational disruptions: upgrading aircraft could temporarily disrupt air medical. Or sorry, air ambulance services, especially in underserved areas. There could be industry resistance: operators and manufacturers may resist due to the cost concerns or perceived regulatory overreach, potentially delaying compliance. And the regulatory complexity: enforcing a mandate will require coordination between Congress, the FAA, and stakeholders, potentially leading to lengthy process and oversight challenges. Next slide, please.

So, Jeff, I think I turn it back over to you here to discuss the vote.

-Yep. Sounds good. So, welcome back all the Committee members and thanks again for that great overview, Jason.

So, this is what we're going to be able to do. So, each Committee member will review what the Flight Safety Subcommittee has recommended, and you should vote yes, no, or abstained for the recommendations. I will also say, is that if you do have any sort of conflicts of interest then please make sure that you note that. The person to be able to submit your vote to is Nicole, so directly do that to her in the chat. Grace?



Federal Aviation
Administration

-This is not for this because I don't have any questions. You did a great job, but we just went through a whole bunch of stuff and there was no opportunity for questions and now we're voting.

-Yeah, sorry. No.

-So, is that going to be the case all day or in what places should we ask questions or where should I save?

-Right now, is the time to ask for discussion. I apologize that I didn't ask for a discussion.

-Okay.

-I was doing the overview of the voting process versus going off of my notes.

-That's totally fine. I just wanted to make sure that I hadn't missed.

-So, but no, it's good because it's in aviation and air medical, please say something if you see something. So that's good for you. So, let's open it up for discussion to the Committee. Is there any questions? Tom, you're raising your hand physically. That's good. Thank you for using the technology.

-Right. One way or another. It's about coffee, right? So, obviously the aviation Subcommittee has put this forward. And you know I'm in strong support. I think that that we know that change is not easy. But we also know that these recommendations go back years and years, and there's been ongoing recommendations about crash survivability. There's been significant work done by the ROPAG group, and we just haven't got there yet. I think if you look at the FAA on their website as a helicopter occupant safety toolkit, and it highlights what aircraft are compliant, what aircraft are not. It doesn't really update fully how many of the new STCs are available to operators. But at the end of the day we're probably spending about 15 to 20 million dollars every single day on air ambulance transport in the United States. And at some point, we have to really make sure, and the idea of this was that to actually mandate that this happened. And certainly there's an opportunity I'm sure that anything that goes to Congress has opportunity for discussion, but if we're really going to represent patients who don't have choice of carriage or carrier, this is a basic safety thing that should definitely be supported. Thanks.

-Thanks, Tom. Any other discussion or questions to Jason and to Nolan, who is an FAA representative? Okay so, given that and after the overview, here is, look down at the voting



Federal Aviation
Administration

options. Please, submit your vote to Nicole, and we will go from there. And then I will then physically call on each member to voice your vote after that process.

Okay, so I think that everyone's votes have been in. So, I'm going to go ahead and go down the list and then we can go from there.

Committee Member	Response
Commissioner Arnold	-Yes.
Jason Clark.	-Yes.
Ben Clayton.	-Yes.
Colonel Coffee.	-Yes.
Eileen Frazier.	-Yes.
Dr. Gamber.	-Yes.
Dr. Hinckley.	-Yes.
Jim Houser.	-Yes.
Tom Judge.	-Yes.
Paul Julander.	[Not present]
Dr. Pritzker.	-Yes.
Jason Quisling.	-Yes.
Robert Reckert.	-Abstain. Conflict of interest.
Jeff Richey	-Yes.

Okay, so it looks like this will go forward with 12 yeses and 1 abstain from this, and so this recommendation will be adopted by the Committee. So, thank you, Jason, for that. So, we'll go move on to the next one.

-Thank you, Jeff. So, the next item that will be reviewing and ultimately bringing to a vote is a discussion from the last meeting. I'm asking for clarifying language on the recommendations



Federal Aviation
Administration

and making sure that it was clear whether the recommendation was referring to helicopter, fixed wing, or all air ambulance operations. We'll go to the next slide.

So, during the May 8th AAQPS Committee meeting there was a request for clarification to language indicating whether each recommendation applies to both helicopter or fixed wing air ambulances, or one type of aircraft.

Proposed language for the Report to Congress. These are the changes that we are looking to make in order to clarify around each recommendation. The report introduction, "Throughout this report and in individual recommendations, air ambulance refers to both fixed wing and helicopter aircraft unless otherwise specified."

Flight safety recommendations 1 and 2, the Committee reviewed and believed that these are clearly indicated as to where they reference either helicopter or fixed wing services.

For flight safety recommendation 3, the recommendation specifies helicopter air ambulance in the Report., and we'd like to include that the problem statement for this recommendation is, "focused on helicopter air ambulance, but fixed wing aircraft will also be impacted by unmanned aerial systems and airspace congestion." The implied benefit there is that this could be a benefit to all air ambulance aircraft, but it is a specific recommendation around the helicopter air ambulance group.

In flight safety recommendation 4, the recommendation specifies air ambulance helicopters. The report should note again, "although this recommendation focuses on air ambulance helicopters, the Committee also recommends exploring opportunities to support new technology for fixed wing air ambulances."

And recommendation 5, the recommendation refers to advanced aircraft systems but does not refer to air ambulances at all. In the report, we would include language that notes, "this recommendation impacts both fixed wing and helicopter air ambulances." Next slide, please.

So, this is a chance to look at the updated report language in full. Helicopter versus fixed wing discussion on the request for clarification language indicating whether each recommendation applies to helicopter or fixed wing air ambulances. Jeff, I think I turn it over to you here for discussion in a vote.

-Yeah, thank you very much. All right, so let's go ahead and welcome back all the Committee members. And let's go ahead and open it up for questions and discussions for the Committee. And if you want to raise your hand, you can physically. I can see most of you. You can raise your



Federal Aviation
Administration

hand if you want. I'll look for you from that standpoint. Any questions or discussion on updates in the language?

Okay so, again, please, each member should vote yes, no or abstain in favor for the report language. Each Committee member should note if they believe they have a conflict of interest from that standpoint. Please send your vote to Nicole, and I will then individually be calling you to adopt this language change.

-Can you please forward the presentation to the final recommendation?

-Is there another slide behind that that puts it all together, or is this the final slide?

-Jeff, I believe that we have a couple of slides here that just show the full recommendation for awareness or review if necessary. I think if we can advance the next slide, I think we might have. FS-1, which we're actually not voting on.

-And if I could jump in, I believe what we're voting on is just the inclusion of that Report language. So, the pieces in the slide previously would just be the Committee voting on the incorporation of this language that is italicized and in blue into the Report, rather than going through each recommendation.

-Rob, is that helpful for you? Or do you want to see it?

-That's not. It may just be me, but I think seeing the recommendation and its final language would help my decision. I don't know if others feel the same or not.

-As I understood, Jeff, this is the final language, with what's up on the presented right now. And then as Michelle has said, there were some optional things of how this played into FS 1 through 5, if it did it all, and 1 and 2 it didn't. And then when you sort of looked at FS-3 there was a highlight the word all, well, to aircraft. And so, I think that that was the pieces of this that Rob's referring to, that how it plays out in the recommendation. So, this was the report. And the other things were just how it applied to the recommendations we had previously voted in.

-So, if I could make a recommendation, maybe? Because I fully understand Rob's concern here around confusion about what we're talking about.

-Yeah, go ahead, Jason.

-Perhaps we start with the report introduction language itself. This would be in the final report that's issued around the actions of this entire group. I think that specific sentence would go into



**Federal Aviation
Administration**

the report as a broad statement, to kind of anchor people to whether or not we're referring to fixed wing or helicopter air ambulance. So perhaps we start with that as the first item, to consider if people are comfortable with that language, and then we can actually advance some slides after that to get to recommendations 3, 4, and 5. And I believe we can see the revised language inside of those recommendations and could vote on them independently in that manner.

-That's totally fine with me. Michelle and the MITRE team, can we get to that report piece to be able to see that in that report. And then the previous, the next slide.

-Yes, I believe if we move forward, w. We have included each recommendation.

-Okay, so let's go ahead and do that and then we can just come back to this slide for the voting piece. And we'll just go, so, let's do each one. So, let's go to the report language. Look at that incorporated language in there and then we'll just go back to that slide. Okay. But where that is, I want to be able to make sure, so that's where this, just so that I'm making sure that.

-Yeah.

-Yes. Go ahead, Jason.

-Yeah, go Jason. Cause I'm looking for it and I'm not seeing it. So, there you go.

-Okay. Yeah, I will do my best here to try and connect the dots. So, and the MITRE team, please correct me if I'm wrong in anything or misstate the reference, but we have the recommendations that we're voting on and they're the specific language that's on the screen right now.

The report language and that specific sentence there will be a broad written report detailing our activities and how we arrived at our recommendations as a summary of the Committee's efforts. That's where that that language will go, but I don't believe that that report is fully written yet because we haven't concluded activities as a Committee. I'll reference Michelle or the MITRE team just to see if that's the correct statement.

-Yes, Jason, that's correct. The introductory language from the previous slide is going to go in that introduction, but we don't have the surrounding language available for the Committee to look at, at the moment.

-So, if I can take that then and say, really, I believe it's 4 asks here. Does anyone see conflict or have concerns about that type of statement being included in a summary report that will be



Federal Aviation
Administration

written. And then we have flight safety recommendations 3, 4, and 5, I believe that we'll look at the specific slides, and we can see the actual change.

-Yeah. I think that we could go back to that previous slide, and do it individually as opposed to probably just doing it as a bundle, if that would be okay with everyone. I'm asking Rob, does that help you from that standpoint, to understand each one?

-For the report introduction, completely on board. I think that sentence is very straightforward. My understanding is that we're to vote on recommendations 3, 4, and 5 today, I think it's helpful, at least for me, to see recommendation 3 on a slide in its entirety. Then we vote on 4, and then we vote on 5.

-Okay.

-I think that's how we've done it in the past, versus just a snip of the recommendation.

-Okay.

-Okay. Sorry, Jason. Jeff, if I could just clarify. So, the language on this slide in blue is language that we would incorporate in the problem statement, and so it wouldn't be modifying the recommendation itself. Like for example for FS-3, we would not be suggesting, or the slide doesn't suggest that we modify the recommendation for FS-3, FS-4 or FS-5. It's really about the language that's included around the recommendation in the report. Not the recommendation itself. So, I hope that helps to clarify.

-Yeah, I think. I want to make sure that everybody on the Committee has a chance to see the full context, because I think that's Rob's point. Could we advance to, I think it's slide 30 which shows FS-3?

So, in this particular case what Michelle is talking about, we don't actually have modification to the language. Sorry, I'm going between slides here. The sentence that would change inside of the problem statement specifies, focused on helicopter air ambulance, but fixed wing aircraft will also be impacted by UAS and air space congestion. That's in the problem statement for this recommendation. But this particular recommendation doesn't have a change in language. So, it's clarification only in the sub-content.

-Actually, it does have one. It put it the word "all". You see the word "all" is now bolded there.

-That's a new word. That's how the problem language flows through and that's why FS-3, so it's not a substantive change, but it's just the clarification that says "all" low altitude aircraft now.



**Federal Aviation
Administration**

-Great catch, Tom. Thank you.

-So then, just focusing on FS-3 right now, is that the one that we will vote on right now with that change of adding the word all into the recommendation? That's what we're going voting on.

-And for the Committee, I am just clarifying with our flight safety team. They have indicated that that is actually not a new word. It is part of. There is no change to this. They just highlighted it for emphasis that all aircraft are included, but that actually was the language that was approved during the May 8th meeting.

-Okay. So then going back up to what we're trying to be able to do. So, from what Jason has said, it's really in the problem statement is what we're adding the fixed wing aircraft into the problem statement. So, my question is, I think that Rob, we're not going to see it, right, in the language to be able to go the context of it. And so, it's really just modifying the problem statement. I'm sorry for the confusion on this. Nolan, do you want to add anything?

-Yes, sir, if I could, please. The whole reason for this coming back in is Eileen had asked some questions last time whether it referred to helicopter or fixed-wing. So, as Jason has been explaining here, that was corrected inside of the problem statement and not the recommendation. So, the recommendations remain the same. It's just a clarification within the problem statement, if we were talking about helicopter air ambulance or air ambulance in general, if that helps.

-So, I guess here is my question. Is that from a voting standpoint, we were voting on the recommendation, not necessarily the problem statement. So, here's where I need a little bit of help from the MITRE team and anyone else that wants to opine on this. Is that something that we should be voting on, modifications to the problem statement? If the recommendations have already been put forward with and we're not making any modifications to the recommendation.

-That's correct, Jeff. We do not have to vote to change anything at this point, in terms of the actual recommendation. I think the thought had been to share what the report language would include to address the concerns voiced during the May 8th meeting.

And so therefore it would really just be to ensure that the Committee members are okay with that updated report language, since the actual recommendation will not change. So, no voting on the problem statement necessarily but maybe voting on the language that would be included in the report.

-Okay.



Federal Aviation
Administration

-And Jeff, if I might.

-Yeah, go ahead.

-So, I think there may not be a vote required on recommendation 3 then. But I think we do have, if we can go to the next slide, I think we'll see for FS-4 and FS-5, I thought we had language that had been added to these, but I'm not seeing anything in red on here. Michelle, am I wrong in thinking that?

-And give us one second. We will refresh the slides.

-Okay.

-Jason, this is Claudia. That little sentence or that little wording that said includes both HAA and fixed wing air ambulance. That was if the Committee thought that adding language in the report was not enough and they wanted to change the actual recommendation, which would then require voting on the recommendations again. So, if including language in the report is sufficient and clears it up for everybody, then we can just vote on that and get a thumbs up or down. If people aren't happy with that, then we can insert language into the recommendation and change it, and then that will require voting on the recommendations again.

-Okay.

-Okay, so I guess, going back to, can we look at FS-5 to see what that looks like to everyone before I do go back?

-Again, that's the old one. It doesn't have the little HAA and fixed wing air ambulances which are on the, just to move it along. I think we're making this more confusing than it needs to be. I would say that I'm not certain if we add the language in the problem statements to clarify. I'm not certain that we need to change the actual recommendations that we already adopted. But you know, if other people feel that we do, I would just sort of make a motion to adopt the language as presented and to modify any of the recommendations previously voted in to include those clarifying pieces if necessary. Just so that we can not get more confused.

-Yeah, okay.

-I totally concur with that.

-Okay, thank you, Colonel Coffee. What I would also, so, Eileen, I'm going to just call you out and ask, because this was something that you had brought forward, which I think was something



Federal Aviation
Administration

really good for us to be able to discuss. I'm going to ask you, because you brought it forward, what are your thoughts on this before we take Tom's motion to do that.

-Yeah, I think the clarifying language that was in there is just fine. My concern was that whoever reads this may say, oh, well, we don't have to do it because it doesn't say that fixed wing is included in this, and it felt like the whole thing was written just for helicopters. And I just wanted to make sure that we were clear on the recommendations. I'm sorry to cause such a discussion. I didn't think it would be that difficult.

-I think it was a great call out, Eileen. I guess I would put in front of the Committee members that it should be clear what we're recommending for Congress or the FAA, to try and move forward as actionable items. But this language itself won't be that item that sets the requirement. So, I think as long as it's clear in the minds of this going to Congress or to the FAA on where they're going to drive action or legislative change, then I think we're meeting the intent with those language additions to the problem statements and the report summary.

-Okay, so with that then, I think then what we're doing then is just modifying, what we would do is modify a motion, and I believe we can do this Michelle and the MITRE team, that we can have Tom restate his motion, and we can discuss and then vote on that. Is that a correct statement?

-Yes.

-Okay, so Tom, can you restate the motion for the Committee, please.

-Yeah, my motion to Committee would be to adopt the modifications to the report language as presented to the Committee and incorporate by reference those modifications to the problem statements. If there's any needed piece in a recommendation the recommendations aren't changing but incorporate them by referencing to the recommendations we already voted on.

-Okay.

-Second.

- Alright, thanks. Any discussion?

-Okay, so I'm going to go to our normal rules that we go. Please place your vote to Nicole, and then I will call everyone out individually from that side. And again, if you have a conflict of interest please state that as we go forward. Okay, thank you everyone. Alright, I'm going to go down in alphabetical order here:



Federal Aviation
Administration

Committee Member	Response
Commissioner Arnold	-Yes.
Jason Clark.	-Yes.
Ben Clayton.	-Yes.
Colonel Coffee.	-Yes.
Eileen Frazier.	-Yes.
Dr. Gamber.	-Yes.
Dr. Hinckley.	-Yes.
Jim Houser.	-Yes.
Tom Judge.	-Yes.
Paul Julander.	[Not present]
Dr. Pritzker.	-Yes.
Jason Quisling.	-Yes.
Robert Reckert.	-Yes.
Jeff Richey	-Yes.

Okay, so that has passed with that. Thank you for the discussion. Thank you for everyone that has helped guide us there. Tom, thanks for summarizing that. I appreciate that from that side, and Eileen, thanks again for bringing this up. It was very, very good.

All right, so right now I'm just going to do a time check here. We're ahead of schedule, I believe, and I'm going to ask my MITRE team, do we want to take a break to get us back on schedule or do we want to move forward?

-Let's go ahead and move forward to the CS overview.

-Go ahead. Okay, so we're going to go, and we're ahead of time and we will move forward and maybe we can get done early for the day, everyone. Always that gift of time. So, I would like to



**Federal Aviation
Administration**

actually personally think Jason and the Flight Safety Subcommittee for extensive work on this topic area. We have now completed that work from there and just incredible work. And I'll tell you that I've learned a lot from there, but thank you very much for your work on that.

So now I'm going to turn the meeting over to Kolby and Keith to provide an overview of the Clinical Standard recommendation and alignment to the AAQPS statutory mandate.

Keith McMinn is the director of Penn State Health Life Lion and an instructor at the Public Health Sciences at Penn State Health Milton S. Hershey Medical Center and College of Medicine. He serves as a member of the senior management team, the Children's Hospital leadership council and sits on the board of directors for the Pennsylvania Emergency Health Services Council.

Kolby Kolbet is a nationally recognized innovator and thought leader in critical care transport, currently serving as the Chief Innovation Officer at Life Link III, one of the largest nonprofit air medical programs in the United States. A nurse by training and flight nurse by experience, Kolby spent over 20 years at the bedside, from the emergency department, PICU, NICU, and as a flight nurse with the last 12 years as Chief Clinical Officer at Life Link III, before stepping into the enterprise-wide innovation role focused on transforming operations far beyond the clinical domain.

So, I would like to turn it over to both Kolby and Keith. You have the floor.

-Well, good morning, everyone, and we'll advance to the next slide.

So, we'll begin our discussion today spending a bit more time reviewing the statutory mandate and how the Clinical Standards Subcommittee arrived at our set of recommendations in response to that mandate. We will then discuss and vote on AAPB recommendation endorsements that we did not have time to get into during the May 8th meeting. Finally, we'll circle back to the discussion on recommendations on CS-1B, which was started at the May 8th meeting and deferred to this meeting for further discussion. Next slide, please.

As a reminder, here are the 3 topic areas the Clinical Standards Subcommittee was charged with studying and making recommendations as appropriate. I do want to highlight the language in this mandate that we shall study and make recommendations as appropriate. Our interpretation of this mandate was to focus on those recommendations in these topic areas that we feel would have the most meaningful and positive impact on the air medical industry.



**Federal Aviation
Administration**

Next slide, please. To review the work by the Clinical Standards Subcommittee to this point, we've had 4 half day working meetings between January and April, as well as a meeting in June to debrief the May 8th AAQPS Committee meeting.

We started by brainstorming key issues and challenges for each of the topics defined in the statute for the Report to Congress and refined these into specific problem statements. We then identified potential solutions for the problems statements. As part of the work, we reviewed the recommendations of the Advisory Committee on Air Ambulance Patient Billing and determined which CS problem statements might be aligned or addressed as a whole in the AAPB recommendations.

Finally, the Subcommittee focused its remaining time performing options analysis and developing new recommendations for the remaining problem statements to address those gaps. Next slide, please.

Here are the 5 problem statements developed by the Clinical Standards Subcommittee. The topics include claim denials related to medical necessity, market availability of the appropriate clinical capability, lack of clinical national standards, promoting a just culture framework for patient safety in the air medical environment, availability of follow-up patient clinical information to inform quality improvement and to drive quality improvement.

We determined for the first 2 problem statements, full implementation of 3 outstanding AAPB recommendations would likely result in significant progress in these areas. For the remaining 3 problem statements we developed new recommendations for the Committee's consideration. We reviewed these in our May meeting but want to spend a bit more time discussing why we chose these problem statements and associated recommendations to address the questions in the statute. Next slide, please.

For clinical triage criteria, the single most important issue we identified was claim denials from medical necessity and clarifying medical necessity criteria and process in order to avoid a chilling effect on providers ordering medically necessary air transports.

The AAPB offered a recommendation for this that focused on the process for medical necessity, specifically indicating the conditions under which a physician ordering an air transport should be presumed to be medically necessary, rather than defining a specific clinical criteria for medical necessity, which makes sense to us because it's a complex decision, requiring clinical and operational judgment and there is not a one-size fits all approach for all communities. While that recommendation is focused on out-of-network claims, these do represent a



Federal Aviation
Administration

significant share of where we see denials in the industry and there's a clear federal mechanism that can be used. The Subcommittee did not in its limited time identify a federal mechanism of action to address in the work claim denials, but are open to the Committee's thoughts on that issue. Next slide, please.

-Keith, I think Grace Arnold has a question. Do you want to go back up to that next slide, and Grace, do you want to go ahead and ask your question, please?

-Yeah, so Keith, this is probably something for all of the ones that are the AAPB recommendations. The AAPB has 4 per bucket that you guys have selected. If you could speak a little bit to why you didn't bring in others, I think that would be helpful in understanding, and then can you explain to me how medical necessity denials are related to patient safety and quality?

-So, Grace, I think the first question that you asked, I'll be turning it over to Kolby a little bit later to more in detail cover the AAPB recommendations.

-Okay.

-And I would ask that we hold that thought until later.

-That's totally fine. I'm just curious about which there are 4 in each of them. So, I'm curious how you guys landed at each of the ones that you're pulling out. That's a general big picture.

-Yeah, I will chime in. Why the certain ones were picked is that from patient billing and from a clinical aspect, some of the AAPB pertain to clinical and some do not. And our Committee, obviously being the Clinical Subcommittee, focused on clinical care and the triage one, which we'll talk about later, is specifically around that triage gets judged after the fact by payers, typically. And what we find is that the decision, when it's made to request an air ambulance, is often made due to resources available at the time and the complexities that are outside the scope or the capabilities of the local EMS and that's not taken into consideration when you do a blanket. Yeah, that's why.

-I totally get that. I'm asking the question of how it pertains to patient safety. Like the billing stuff I totally get. It's a whole thing, right? It's much of why we're here. I'm not disputing that it's an issue.

-Right. This isn't just about patient safety, this is about triage criteria for air ambulances -that's one of the asks as a statutory mandate.



Federal Aviation
Administration

-Is to look at triage criteria.

-Correct. Yep. Number 5 is clinical triage criteria for air ambulances.

-Okay.

-So yeah, if you recall, our Committee is charged with 3 of the 5 and one.

-Yeah, I get that. But this isn't looking at triage criteria either, right? It's looking at the back-end process and an evaluation of the triage criteria, but it's not looking at whether or not the triage criteria are appropriate. It's looking at the payment part of it, but it's not looking at the part that is getting the person to where they need to be. Right?

-Right, the one size fits all approach was mentioned that does not work. And if we took a list of clinical conditions, or traumatic injuries, or mechanisms of injury, there may be some that ground is completely appropriate for based on geography and available resources at the time and there's others that are not. And we have a presentation later on which will further illustrate that.

-Okay, I'll hold. I think, I'd like to dive into this a little bit more later, but I think I have what I need for now.

-Yeah, I would just echo that. I'd like to hear Kolby and Keith go through the whole thing, but I think this warrants discussion, as Grace has noted.

-Keith, you might need to scoot like closer, I think you leaned back a little bit and now it's really hard to hear you.

-Okay. So. Are we okay to continue and then circle back?

-Much better. Yeah, thank you.

-Alright, next slide please. For clinical capability levels, the Subcommittee focused on 2 problem statements. The first of these problem statements had 2 outstanding recommendations from the AAPB that we felt, if implemented, would make important improvements and collect critical data to support future policy refinement in the future.

The first of these 2 recommendations was related to the adequacy of Medicare reimbursement. We endorse the existing AAPB recommendation that specifically asked the Congress and HHS explore whether reimbursement should be differentiated for specialty care and offer a suggested approach to categorizing clinical capabilities for that purpose. We believe that one of



**Federal Aviation
Administration**

the biggest drivers of inadequate supply of specialty clinical services is a lack of appropriate reimbursement. It is difficult to provide all of the necessary equipment, specialty staff, and training necessary to treat more complex and specialty populations when there's no payment differential at all, just a flat transport fee. It does not incentivize or adequately cover costs for more intensive transports that simply cost more to run.

We think this cost study will reinforce this point and suggest that HHS consider the use of add-on payments, modifier codes, or other procedural codes commonly used across payers to ensure clarity and efficiency.

The statutory mandate specifically asked about levels of tiering capabilities. The Subcommittee discussed this in detail and felt strongly that tiering is not the most practical way to characterize air ambulance services and capabilities. The Subcommittee agrees with the intent behind tiering, which is to recognize there is greater expenses and expertise associated with more complex clinical care. Next slide, please.

Finally, the Subcommittee had 2 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 8th AAQPS 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 is around improving access to patient clinical data in order to enable quality improvement activities. I'm happy to answer further questions. Otherwise, I'll turn it back to the Committee Chair.

-Okay. Dr. Hinckley.

-Keith, a moment ago. I believe I heard you say that the Subcommittee strongly disagrees with the concept of tiering as being the best way to incentivize clinical quality, or something to that effect. Could you just clarify what you said?

-We as a Subcommittee did not recommend tiering as the best way forward. We understand the intent behind tiering but felt that it was extremely difficult in the industry to operationalize a tiering approach.

-And I'll just add to that. In the May meeting we voted forward the Medicare provider type. And the proposed tiering structure was really aligned with EMS type levels, and what lacks right now is a current baseline for, if anyone is to receive an air ambulance to a car accident in the 50



Federal Aviation
Administration

different states, there is an expectation from the general public that everyone would have the same baseline capabilities.

And that lacks currently, and some of that's because of state influence. So, the Medicare provider type was proposed to overcome that, as a provider type and Conditions of Participation. And then the proposed add-on modifiers to really meet the same expectation and intent of those different proposed tiers. So everyone will be recognized and would receive appropriate reimbursement for that different level of investment everyone has in the in the capabilities that need to be provided in their local area.

-Grace.

-I have a few questions. So, one of them is a process one because the goals here are ultimately what we're going to vote on and there are a couple, particularly on the data collection, where I think the recommendation is too narrow because it's only focused on Medicare. I think that's not going to provide enough information and it will not allow for conversation about potential cross-subsidization, which is what I hear a lot about. So, I guess I have a process question, which is, where is the appropriate place to raise that? Because I think data collection is great. I just think we should not focus only on Medicare.

-Well, I'll address that because this is a recommendation and an ask from Congress. So, from congressional authority, it really is with Medicare. Medicare serves as kind of the baseline or the reference point for all payers. And we have to make the recommendation there, since Medicare doesn't have the authority or Congress wouldn't have the authority.

-CMS wouldn't, but between the three, if you do a tri-agency thing, like ERISA, like DOL could collect information from ERISA plans. I mean, there's some state kind of space that we could collect, or there's information that could be collected, some of it's already collected I think through the IDR process. So, making that public. And then Medicaid rates are in most cases statutory, or if they're not statutory they're at a very minimum public.

-Yeah, this is a reimbursement. It's more cost study. So, what does it cost for us to provide that service?

-Right.

-So, regardless of the payer our obligation is to the government and through this.

-It's phrased as Medicare focused. And so, costs should be neutral of that, right?



Federal Aviation
Administration

-Right, but Medicare is the government payer that we're responding to, so cost is cost. And that's what the proposal is for a cost study.

-I will take this one up with when we have the actual language up. I, when I read through it, it didn't seem like it was-It seemed like it was too narrow. Can we go back to the first one? So, I think, a couple of comments on this. Well, actually, so first is a question. The recommendation is that this is put through the IDR process. The IDR manual explicitly says that medical necessity isn't part of the process. So, is there any discussion of that?

-I don't know if I understand the question.

-The IDR process is a cost process, not a medical necessity determination process. And if you look at that, I can send the link. If you look at the manual for the IDR process, it explicitly says, we don't do medical necessity discrimination, and part of that is because medical necessity determinations have already have processes-sometimes at the state level, sometimes at the federal level for review.

-Right, but, medical necessity creates it, as it doesn't make it available for IDR if it's denied for medical necessity. So that's a whole...

-I know that and what I'm saying is the IDR process as currently conceived explicitly says they're not doing medical necessity. I appreciate your trying to get it in here. And I'm pointing out that it's a square peg round whole thing.

-Yeah.

-Like if you have a bunch of people who care about cost and who are providers, or a process that's designed to do a cost adjudication and not a medical necessity adjudication, I'm really worried that that would be, like. I hear the point on medical necessity. I'm not trying to argue the point on that medical necessity. This is a process thing as much as anything else. So, if you have a process that's designed to adjudicate costs, and then you're asking that process to adjudicate medical necessity, I think you're inevitably going to have problems because you're trying to do something that the process isn't designed for.

-I don't think we're trying to adjudicate costs. We're trying to demonstrate what cost to provide the service, before the billing even takes place. Like in general study the cost of a 24/7

-I'm on the first one. The medical necessity one.



Federal Aviation
Administration

-Right, but the after the fact becomes the medical necessity. The medical necessity is determined days after the transport took place.

-I know, I know, I know all of that. What I am saying is that you're asking what the recommendation here is, and I'm wondering if you thought through this. Is to have there be a presumption that the services are medically necessary through the IDR process, and that the IDR process is the thing that that handles that. The IDR process currently does not deal, explicitly does not deal with medical necessity. And a medical necessity determination is a fully different determination than a cost determination.

-Right.

-And my point is that if you're asking a process that is designed to deal with cost, to do medical necessity, I think you're inevitably going to have problems because the process is not designed to do what you want.

-I don't think we have cost of medical necessity. They're two separate ones, right? Here reduce claim denials.

-That's my point. You're asking the IDR process to do medical necessity in this recommendation.

-So, here's what I'm going to say. Sorry to interrupt you, Grace. I think that we need to get to the recommendations so we can have a robust conversation so that we can understand this.

-Yeah.

-I think there's a lot more to discuss on this and I think that to be able to answer your questions and then also to be able to have both Keith and Kolby to be able to respond to those questions as we discuss individual recommendations from that standpoint.

-That's, yeah, that's totally fine.

-I do think the discussion is robust and I'm glad you're asking those types of questions. So, Tom, I see you had your hand up. Is there anything else you want to add?

-Totally agree. I'd really like to get Kolby and Keith so that we could understand their entire framework and then I think, again, this is a very important discussion, but let's do it when we get to the actual recommendation.

-Yeah, totally fine.



**Federal Aviation
Administration**

-Yeah. So, let's do this. Keith and Kolby, let's move forward with the rest because we are coming up close to a break, but I want to be able to make sure that we're not, there's more to be able to go within the slides for the overview.

-Yeah, understood. Under the original schedule, I believe we are at a break point.

-Alright, so, what we're going to do is, we're going to take a pause. And we're going to give our lunch break to be able to do this in the next segment of our recommendation will be not recommendation, but our next section will go over the recommendations and then we can further have those discussions that we are just having from that standpoint. Okay?

-So, we'll take an hour for lunch. It's 11:35. So, if we could see everyone back at 12:35 that would be great. Thanks, everyone.

-Thank you.

-Okay, everyone I hope you had a good lunch. Appreciate the discussion this morning and we will continue discussion with the Clinical Standards Subcommittee. And Jeff, turn it back over to you.

-Alright, thanks everyone. Yeah, thanks for the discussion and the overview by Keith and Kolby.

So just a couple pieces as we're going to be able to get into the recommendations. What I would like to be able to put forward to all of our Committee members is that in order to be able to help us move things along and really just take this opportunity to be able to make some changes, during the discussion I would like to be able to have people add in suggestions for changes into any recommendation language that would get this over the line that we can all agree to. So please keep that in mind during the discussion. I think that will be really, really good moving forward. So, with that, I'm going to hand it over to both Keith and Kolby for the next segment.

-Alright, thanks, Jeff. So, we'll go to the next slide. And let's talk about the background of the Air Ambulance and Patient Billing Advisory Committee. And part of the process of our Committee, the Clinical Standard Subcommittee, in assessing potential solutions to the various problem statements was to review whether or not there were federal initiatives in progress or recent outstanding recommendations from federal advisory committees that were relevant to our charge. Particularly, we did not want to duplicate the effort put forward recently by the Air Ambulance Advisory Patient Billing Committee as they pertain to clinical quality and safety.



**Federal Aviation
Administration**

We recommend that the report to Congress should include this Committee's endorsement of 3 AAPB recommendations, highlighting the importance of those recommendations for advancing clinical capabilities and patient safety. This will also allow time for recommendations to be fully implemented and see their complete impact. Next slide.

Alright, got the right slide. Here's an overview of the topic areas for the 3 AAPB recommendations that the Subcommittee recommends for endorsement. These address 2 of the problem statements developed by the Clinical Standards Subcommittee. Recommendation CS-A is related to medical necessity determinations. Recommendation CS-B is related to the adequacy of Medicare reimbursement. And recommendation CS-D is related to collecting data and performing analysis of our air ambulance industry, which can inform future policy and reimbursement conversations.

You may recall that on May 8th the AAQPS meeting materials also included recommendation CS-C, which was related to the ADA preemption of state authority. Upon further discussion among the Clinical Standards Subcommittee and with the Chair of the AAQPS Committee, we have chosen not to put that recommendation forward for discussion among the Committee. This Subcommittee feels that other recommendations under consideration by this Committee will do more to achieve the intent behind recommendation CS-C and the Subcommittee wants to ensure there's adequate time today for discussion of those critical topics. Next slide.

Our first recommendation is related to the medical necessity determinations. Many of us are familiar with the Monday morning quarterback phenomenon, in which claims can be denied on the grounds of medical necessity based on information available after the encounter, information that was not available at the time a decision was made that transport was medically necessary. This is a problem for both the financial viability of the air ambulance service, but more importantly because it can cause a chilling effect leading to referring providers both on the ground and referral providers to second guess ordering an air ambulance which may be medically indicated due to fear of a catastrophic medical bill for the patient. I'm sure that several of us have specific instances of this occurring. The No Surprises Act created an independent dispute resolution process which creates recourse for providers negotiating these claim denials for out-of-network claims.

The AAPB recommended that if a physician certified the patient for air transport at the time of the call and the claim was later denied on the grounds of medical necessity, the IDR process should include a rebuttable presumption of medical necessity, essentially putting the burden on



Federal Aviation
Administration

the insurer to prove that the transport was not medically necessary. The Subcommittee recommends this recommendation for endorsement.

We did add a nuance beyond the AAPB's recommendation that is important to note. HHS determined it was not within their statutory authority to implement AAPB's recommendation number 12, which is why it has not been implemented. Therefore, we recommend that Congress enact necessary legislation for AAPB recommendation to be implemented.

The Subcommittee also recognizes that the issue of claim denials is not limited to out-of-network claims. But these claims do represent a substantial proportion of where we encounter these issues as providers. There's clear federal mechanism of action authorized under the No Surprises Act and a specific recommendation from the AAPB on this topic.

The Subcommittee noted that it might be helpful to explore whether there should also be a recommendation around in-network medical necessity denials, but this would require a separate analysis to determine what would be the federal mechanism of that action, given that the No Surprises Act would not apply in those cases of in-network. Next slide.

Turn it over to you, Jeff.

-Alrighty, so this is our discussion point. So, I'd like to invite all the Committee members back up and we can start our discussion about the recommendation that Congress should direct HHS to implement the following AAPB recommendation. So, you can read that and so, I'd like to leave little bit enough for discussion. Please raise your hands. Tom.

-Yeah, thanks, Jeff, and thanks, Keith and Kolby for all of your work. I'd just like to follow up on a couple of things and I think that Commissioner Arnold brought up, which really pertain to this.

So, the charge from Congress was about developing triage criteria. And what this recommendation in the AAPB, I was on that Committee, and I was on the Subcommittee that that actually wrote this. What it was really dealing with was a separate issue. So, triage is an upfront decision. And I totally agree and understand, and we experience what happens when post-transport the triage decision is nullified by what may be not completely clear pieces of medical denial. So, I think the problem statement is correct. And that the ability to presumptively negate something in, post the triage decision is a problem and it discounts the triage process.

That said, I think that having this, we're not talking about triage anymore. We're talking about payment issues. The AAPB recommendation had a significant piece at the end of it that the



Federal Aviation
Administration

insurer can overcome presumption by first presenting evidence that either third party responder in question was not a neutral third party or the responders were not in good faith that is actually a very important piece of this puzzle as well.

So I certainly would like to hear what other people think but I think as presented this recommendation needs some significant modification and I would be prepared to present what is at least my theory of that. But, would like to hear what other people are thinking first. But I don't think this is triage.

-Ben.

-Thanks. I'll start by saying I am not a clinician. So, this is just I'm a pilot by training. But I was also in the Marines, and I'm bringing that up because in the Marines we do a lot of things that's very decentralized, as opposed to having a big overarching rule that may be very complicated. And I wasn't involved in the Clinical Subcommittee, I was part of the Flight Subcommittee, but to make a national triage rule that then applies to all physicians and all EMS providers seems extremely complicated, whereas physicians are trained in triage. They know when they need to write an order, and for me, just thinking about systemically for us as a Committee to come up with what the national triage and then try to train everyone, beyond what they've already been trained for in medical school seems very, very complicated. And I would argue decentralizing that, relying on the physicians and the first responders seems to make more sense. And with the work that's already been done by the AAPB and us endorsing that, I think that to me that makes sense, but I'll stop there.

-Grace.

-Alright, so I'll just, I think I got most of what I had to say out earlier. So, appreciate the comment and appreciate the work and I want to be clear, we end up with the patient complaints here on a lot of these cases. So, I'm not in any way saying that that's not a problem. What I was trying to point out is that the IDR process is not one for medical necessity. And I think there are a couple things here that we should be mindful of, just to get to the specific recommendations.

One is that the rebuttable presumption has been struck down by courts a couple times now. Even a softer version has. So, I think that is problematic from a, like, recommending something that's been struck down by courts is not great. The second thing is, I think the medical necessity determination is, like, there are already processes to dispute that. And they already kind of take into account all the things that we've talked about. They take into account what was the



**Federal Aviation
Administration**

evidence at the time? How did they know? What this does is say that there was always medical necessity, no matter what the facts are. And now you have to kind of undo that. But it's putting that conversation into a process that's made for a cost conversation, not is this necessary or not.

So, I'm not sure that I can get to a place where this is salvageable. If we were to move something into more clearly focused on triage, or at least make a recommendation, I don't know if this is where you were going, of there should be. Like Ben, I hear I hear your point about not having national standards but it is unreasonable to have a kid who is really sick go on an eight-hour ambulance ride even though that's technically more costly, right? Because that's just worse for the patient.

And if we were to recommend that maybe there be some general principles of the way that triaging can work, that I as a state regulator could then look at and as we're looking at our own medical necessity determinations through the process that already exists or doing enforcement actions on insurance companies if there are any issues, then that is a much more actionable standard in the scope of how disputes on medical necessity particularly, between insurers and patients, already happen. That would be a much more actionable thing for me, if I get the complaint on medical necessity. So, I would be in favor of kind of modifying it to direct HHS to come up with maybe some criteria or guidelines, or maybe there's another working group like this that could do that to look at the triage guidelines, so there's something to look at when you're doing the medical necessity determinations. I think just like fundamentally we have a process challenge here.

-Okay, thanks. Jim.

-Two comments. First, I would echo Ben's statement regarding coming up with a national standard for triage. You have so many things and we're fortunate that we have a few physicians on this Committee so they could speak better than I could to the nuance and the art of practicing medicine in certain regions of the country. Then you layer on top of that geographical challenges, resource challenges, distribution of health care access and the list goes on of the things that would make it extremely complex and cumbersome at best to try to come up with a way to put a triage criteria on the front end. So, I'll just add my belaboring to that point.

As far as Grace in her comments, I think that's fair. I think having either a mechanism to ensure, no pun intended, that there is an accountability method for medical denials could be an alternate pathway, but I do want to be clear that, and I think this has been said and the group should recognize, that medical necessity then negates the need for the IDR process in these



Federal Aviation
Administration

scenarios. And so, while they're parallel processes, one could negate the other which is a real challenge that the industry is experiencing right now as it relates to the current IDR process.

-Thanks. Jason.

-Thanks, Jeff. I would echo some of the comments. I guess the piece here that's giving me a little bit of trouble is understanding the triage aspect of this. And maybe this is an oversimplification but when I think about the mandate for the Committee, to me it's about how do we ensure that there's easy access for people that need air medical transport, that we ensure that that's appropriate and high quality, and then most importantly how do we increase the safety level around those transports. And this piece for me is happening well after the decision was made to provide air ambulance service. So, is there a piece I'm missing here in how this particular language is preventing people from receiving air medical transport today, or is this truly in fact all happening on the backside? If there's a clarification to be made there, that might help me understand.

-Okay, I would just ask from the Committee, maybe from Kolby, to answer Jason's question to be able to see. I've got a little bit of an opinion on what that is I think from what, but go ahead, Kolby, or Keith.

-Yeah, it seems to be more on the back end, you know. I think that Tom addressed that the triage is meant to be on the front end and could the triage criteria limit or prevent individuals from getting air medical? If I phrased that right, Jason, absolutely. And you know, I've had experiences in our own area where we've had emergency physicians and as well as EMS providers that were hesitant to request an air ambulance because of not having the knowledge about the patient being subjected to a large bill or whatever.

And that's a challenge. But we also had the same discussion regarding triage criteria, where it ends up damaging us as the air ambulance provider, if they're not specifically met. Perfect example, someone with an abdominal aortic aneurysm. It's a surgical emergency. They can be stable, they can be unstable. And oftentimes we fly those patients and they are almost denied medical necessity every single time when they're stable because of lack of intervention required. And making triage criteria, if we want to propose criteria it could be as simple as at the discretion of EMS providers, given the local resources, and their assessment and their direction from the states. If we all had air, ground, and all levels of ground services available in our area and we got to make the decision for triage, it would make a lot more sense. But yeah, this is on the back end where the triage criteria lack of acuity, and really what the word is acuity,



Federal Aviation
Administration

like are they sick enough or injured enough to be on an air ambulance, very subjective and dynamic. Does that answer Jason?

-It does, Kolby. I think that helps me a lot. And I would probably just close my comments with I probably am more aligned with where Tom was, in terms of if we're going to move forward with this, I would probably want to see some language that ties it into how are we increasing access to air ambulance transport for the patient when that's medically necessary, versus this piece, for me, I'm having a hard time seeing how that's preventing people from receiving the air medical transport and care on the front side. So, I think that's the place where I'm just trying to get to.

-The triage criteria, Jason, could actually limit if we get specific with items that must be met. That could be a challenge based on the geography. If those specific criteria are not met perfectly it may prevent someone from activating an air ambulance.

-I'm absolutely in agreement with that statement, Kolby. I think it's just. I'm trying to tie that statement into the language inside the recommendation and that's where they're not quite matching for me but thank you for that clarification.

-Okay. Yeah.

-Dr. Pritzker.

-So, I support both Grace and Kolby's comments, in toto. I have concerns about the last sentence of the recommendation. Requested transport was not a neutral third party or that the air ambulance provider did not act in good faith. If we're talking about medical necessity, how would we be pulling that into that statement? Is that the air ambulance provider not acting in good faith of the medical necessity? The air ambulance provider is responding to the sending facility's request to transfer the patient. It doesn't seem to account for the question about the medical necessity in the first place for the transport of that patient.

-I think that's a good point. I think if you have language, if you have any sort of language changes into this, I think that would be helpful for the discussion to be able to account for that, from that standpoint. And I think right now, if we want to, we could go ahead and put some things into the chat, either to Michelle, as we're trying to be able to do things to be able to see how we could be able to modify this. Would be great to be able to make sure that we're doing that. I do agree that the air ambulance service is being called. And then the reality is if they get on scene or get to the hospital and they say, well, this isn't, this doesn't meet medical necessity, do they turn around and go back home? Right? You know, which I think is a little bit tough



Federal Aviation
Administration

because we're relying on EMS providers or referring physician that's already made arrangements with a receiving physician to be able to accept that patient, right? And so, you'd be overstepping as the air ambulance service to say, I'll just use Dr. Hinckley because you're on my screen right now, we don't believe you, right, in your medical judgment. So, I'm just throwing that out there as part of it.

Tom Judge.

-Yeah, so thank you. So, to Dr. Pritzker's comment, part of that language got put in. Probably not really necessarily about inner facility requests where a physician is making the request, although that is also a challenge. But there are when an air ambulance company, especially with membership programs, that give free or discounted memberships to fire departments who call them, then I think there is an issue with the triage process that there's going to be the potential for overuse or misaligned use that starts from the triage process. So that's why that language is there. And I actually have sent some language to Michelle. I think there are ways to do this.

So, one of the other big challenges is when we talk about a national standard, and that's difficult for the reasons that Jim just shared with us and totally understand. The other piece is that every third-party carrier, every payer has somewhat different criteria. So, what happens with one patient may be very different with the next patient and sort of very similar clinical circumstances. But there is a national standard, which is Medicare. And they actually have published a lot of work on this. So, if you go back to the Section 415 of the Medicare Modernization Act of 2003, it talks about the deemed medically necessary transport. Who are the qualifications of the people that can call for that? What are the circumstances under which they could call for that, which take into account geography, take into account rurality, hospital systems, all of those things are actually in account if you look at the Medicare manual.

I think the problem that the Subcommittee has correctly identified is that nationally we are seeing this after the fact where the triage process, which was made in good faith, is then completely discounted. And that is a problem and I agree that that can lead to a problem with access.

The other piece that I sent around to the Committee, and I don't know if people looked at it over the weekend, but ACEP has published on this, they have a position statement on this.

NAEMSP has published an extensive piece about very particular issues and how to deal with them. being put in a helicopter is a medical decision. It's a medical therapy in and of itself which is ordered by physicians, to do things. There are validated national triage again. So, actually



Federal Aviation
Administration

some of Jim Houser's colleagues at Pitt have published what is a validated, especially for trauma, triage scoring mechanism to look at. There's other validated ones for pediatrics. So, these things do exist. And I think we could get to some language. So, I think we, in my opinion, we would take the IDR processes out. But if the idea of a rebuttable presumption, despite what Grace has shared, I think that is a reasonable piece of language to put in there. And just add in if it's consistent with the provisions of the section 415 of the Medicare Modernization Act of 2003, which go into these pieces of detail. But also, to still have that this triage decision can in fact be discounted if there was some lack of good faith or some other circumstance that tarnished the way that triage decision was made. So, I sent some language to Michelle and it's hard to it makes it easier to see if they can put it up.

-Thanks, Tom. So, what I would like to do is maybe Michelle, you could put that to the group to the entire chat for people to be able to do that, to be able to see that, and I'm going to keep us moving. Dr. Hinckley, I'd like to move to you next as, I'm trying to, as I'll go through everyone and then maybe we can come to looking at a revision of the language.

-Thanks. I sympathize with the charge that the Subcommittee was given here because this is incredibly complex. Sometimes I'm the guy on the helicopter. Sometimes I'm the guy calling for a helicopter at a referring hospital. Sometimes I'm the receiving doc at the receiving hospital and sometimes I'm the guy telling my fire department when to call for a helicopter. So, I really do see all sides of this. It is incredibly complex and challenging to write a triage guideline that would apply everywhere. But I agree with Tom that it probably can be done.

And I do have concerns about basically laying out a presumption that everything is appropriate, that every use of an air ambulance is appropriate because I do see, fairly often, instances in where it probably was not appropriate. And that can also have negative effects on patients. If a helicopter is, or any air ambulance is being used for a patient where it's really not needed and then is not available for another patient where it really would be needed. So, I'll just leave it there, but thanks.

-Alright, thanks, Rob.

-Good afternoon, everybody. I don't want to venture into parts of this that are not something I'm familiar with, the clinical triage piece. I would just like to highlight a concern I have just from a perspective of how government works, etc. for the Committee to consider. And I would just offer that there is a little bit of, the best way I can describe it is, circular language in the recommendation. And what I mean by that is the language specifically says Congress should



**Federal Aviation
Administration**

direct HHS. The recommendation is referring to another recommendation from the AAPB in which that committee recommended to Congress to take action. Congress didn't take action and now we're recommending that Congress direct an executive branch agency to take action. So, I would just offer that circular piece of a recommendation to Congress that was not acted on, now we're potentially recommending that Congress direct an executive branch agency. I would offer that it may be a little bit of a cleaner recommendation, because of the Committee charter to instead of saying Congress should direct HHS, that Congress should implement or somehow the language reinforce the other recommendation. But it is, from a procedural standpoint, very difficult to say to an executive branch agency, "Hey, do something that Congress didn't do themselves." If that makes sense. So not necessarily the content that I'm commenting on, just how it's worded.

-Okay, thank you. Grace, and then we will go to the Word document that we have in the background.

-This is maybe a question for Tom. I'm wondering if. I think I'm going to knock it off my IDR process being wrong, but I don't think anyone else cares about that, so that's fine. But, if we point to Medicare Modernization, is that going to leave a gap with folks who are not on Medicare? I'm thinking specifically kids, but you know, other adults who are like you know, not as frail as a Medicare population or something like that. I think that's the main question I have about that standard because I think that, I mean, my preference would be to be processed neutral and just say, like, there should be a triage standard when they're doing medical necessity determinations. Or we should like have, like you can't know every single thing, but we should be moving toward there being, like, something to point to on medical necessity determinations. So that would be my question to Tom.

And then the only other comment that I'll just make as a broad statement is we're talking a lot about the specific patient harm that happens in a particular instance. I think it's important to remember that in this case, a rebuttable presumption likely will increase costs for patients across the board because you pay more in insurance premiums because there are more of these that get paid for, which is fine. I think people should be getting. Insurers should be paying for the services that people need and generally speaking, like, unless there are you know, other arrangements as Tom pointed out, we should be relying on the medical judgment.

There is also patient harm when people don't have insurance because it gets too expensive. And that harms everyone, including the air ambulance industry, because there are emergency flights that no one can pay for. And so, I think we should just be mindful of that as like an overarching



Federal Aviation
Administration

thing. But Tom, I think my question for you is if we point to Medicare, are we going to leave out groups of people?

-Yeah, if Michelle can put the language up. I'm not saying that Medicare is a standard. I think the language says if it's consistent with that because the Medicare language is about deemed medical necessity. Who's qualified to request that, and then has a series of circumstance of why you would use an air ambulance in a certain situation. So, it doesn't, it's not age specific, it's not clinical condition specific, it's a very broad piece and they've actually done a lot of work with this. And it comes back to state protocols and those kinds of things as well. So, if Michelle put that language up, it would make it a lot easier.

-It's in the chat, Tom. I think that language is good. What we need to avoid is diagnosis, clinical conditions, mechanisms, and I think that this accomplishes that. Whether or not there will be accountability on the insurance side is the fear. You know, is that going to be enough? And I think that's the question.

-Yeah, so. I think it's, this is complex. And I don't think it's going to. There's always going to be some tension in here. I think what we want as a goal is to make sure that triage decisions made by first responders who are qualified, they've had some medical training in how this gets done and they're operating under protocols from physicians and the physicians at hospitals that their triage decisions are honored and at the same time, to make certain that that doesn't, as Commissioner Arnold has shared, doesn't just open up the door that everything is okay. You know, to put everybody in the helicopter is also not okay. And, and that just ends up being these decisions do have financial consequences. And getting the right patient into the right way to get to the right doctor at the right hospital is important. So, if you're okay with that, I hear Rob's comment that that it's a little bit circular. But you could take the AAPB piece out of it or you could just leave it as it is. And then as the contractors get to this final bit of clean up you know, that if there's some pieces of wordsmithing in there. But I think if people look at that, this is broad, it's not about specific conditions, it's about access. It's about who's qualified and the fact that things, that a good decision is deemed medically necessary and takes into account the broad geographies and the circumstances around the country.

-Okay, so here's what we're going to do. Thanks, Tom. I appreciate that. So, we're going to put up what Tom has sent as another, as a recommendation there. And please just kind of highlight what Tom has put forward as a language recommendation there.



Federal Aviation
Administration

And then I think I just saw Dr. Gamber. I don't know if you were able to fix your technology pieces and Krista, I do, I'm going to recognize you here in a minute, but I just want to be able to make sure we've got everything. So, if we can put that back up so that we can take a look at that and then I will take comments on that or tweaks to that as we're going forward. And, Kolby, thanks. I appreciate that, as reading that. So, can you just highlight what the recommendation is just so everyone's looking at the right one there just, or put your cursor on it.

-It's the bottom one. Right.

-Yeah. Yep. Okay, so this is the one that

-The one from Tom Judge is this. And Rob Reckert had also recommended a minor tweak to the beginning of it.

-Okay.

-Kellen, are you able to like, zoom in just a teeny bit? If you can, thank you.

-Yeah, just give me one moment.

-Okay, so once we are able to be able to read that language, what I'd like to be able to do is everyone read it. And then Krista, I'll recognize you for any comments there, and then I think we're just to be able to, just, this has been a great discussion.

I'd like to be able to see if we want to be able to make any sort of tweaks and I am going to lean on my two co-chairs for the Clinical Subcommittee to be able to help us represent what we are trying to be able to do. Okay.

-I just want to pose a question, just out of reality, about appropriate utilization of a helicopter when we're requested. Other than being canceled by the referring provider, what's the occurrence, or the reality, that someone's going to say this person doesn't meet criteria when that decision was made by third party EMS provider or a health care provider in a referring facility and without being canceled or mutually agreed upon. Because that decision was made on, based on availability, locality of ambulance and that type of thing. I think that's something we have to be really honest about.

-To be clear, we're focusing on fixed wing or rotary wing or both for the statement?

-I would say rotary wing for this and that's probably something to call out specifically on here. Because of the.



Federal Aviation
Administration

-I think it's primarily rotor wing. It's an emergency transport. There are emergency transports that are done by fixed wing. Emergency scene transports that are done by fixed wing.

-Right.

-So, it is both. I think this is about emergency transports, not schedule transports that which is often fixed wing, which is a bit different.

-And again, you'll hear that from Todd when he presents from the Alaska point of view, how this is going to not be a carte blanche solution for all 50 states.

-So, I'm concerned that this being primarily focused on rotary wing will also be applied to fixed wing transport. Do we need to bifurcate in any way?

-Yeah, I think some of my. Like, there's a lot more discretion in a non-emergency setting. In an emergency setting, it's a pretty fundamentally different set of actions. And if we're only talking about emergency transport here, I think we should be super clear about that and add that into the language. So, I would suggest, I can throw some language in, but my suggestion would be that we, if the intention is to be narrow, which it sounds like it was, then the language should reflect that.

-So, I would recommend, yeah, so Grace, if you want to put some sort of verbiage or articulate that that maybe, Kellen, if you're the one that's in control of this document, then maybe we could put that into that right now in real-time. That would be great.

-Yep, happy to do that. I'm putting that on top of Tom Judge's edit version, right?

-I think that's the baseline right now. Is that something that everyone can agree to, that we're changing the, using what Tom has put forward as a recommendation for a language change to CS-A?

Is that a good baseline right now? I can't see everyone so I don't know if you're agreeing or you're thinking that it's not a good baseline.

-I think it's just adding the word in front of that the air ambulance, that the emergency air ambulance service was medically necessary.

-Okay, is that good with you, Grace?

-Yeah, I did. Yep, I think that makes sense. I think, yeah.



Federal Aviation
Administration

-And to Dr. Pritzker's other comments, I think that the doctor, the clinical documentation known at the time of transport. That is, when you say it's consistent with section 415, that's exactly the kind of thing that's there. It's not very, it's not hugely specific, but it's broad categories of why this should be why this is medically necessary to move by air.

-Is that going to be clear to the end user or should we add a little more clarity? Documentation at time of transport as listed in MMA.

-You could, I mean, I'm certainly, if that helped clarify it for people. You know, I have no pride in language. I want to just get to the best result here.

-So should we put the second row under my edits, documentation on at time of transfer supported medical necessity for the transport, into your document. Consistent.

-Sure.

-If you're talking about the air.

-Yeah.

-Even just below, just below the word, it just kind of and paste it.

-Well, if you're talking about the air provider's documentation, again, that puts us in the position of justification of the transport.

-Whatever is known in general. The police report, it puts the site of an accident.

-It just doesn't accompany, that does not accompany the bill.

-But at the time of like, but at the time of IDR it makes sense. No?

-We don't have that information.

-Well, but Kolby, if you, if the point is to have. I think this is again back to the point that we've kind of been going a little bit back and forth on that. I think there's a back-end portion, which is the bill, and then there's the front-end portion, right. And so like, I think that you're focused on that because we're going into the IDR process, which is only about the billing part. If there were another process like the state medical necessity determinations, then you can ask all kinds of things and you could, like, there is a process that can request additional documentation and is not so focused on the bill and is more focused on the medical necessity.

-And supported the medical. In the middle.



Federal Aviation
Administration

-I think nobody's going to get there. That's fine. But I think that is like, of course the bill is not going to have that information, but there are ways to get that information.

-But the thing about it is the administrative burden on the air ambulance providers and it delays reimbursement unnecessarily.

-Okay.

-It doesn't necessarily mean like, you're asking for the documentation, right?

-What I'd say is to support that, Grace, that what the air ambulance service is asked to be able to get all of that information to then submit it with your claim. And the reality is that when an air ambulance service submits a bill, we can't submit that documentation at the time of the bill. It's all in the back end. Just for clarification.

-Okay. Right. Yeah, okay. I see the distinction that you're talking about there.

-Yeah.

-And I'm thinking about in terms of fixed wing then rotary when it gets to the IDR, rebuttable assumptions are there.

-Yeah, I think we're trying to get that out.

-Yeah, I think the IDR piece is going to be, I think we're vacating that statement, correct? For everyone?

-Yeah.

-Is that's not going to be there? So, I think IDR piece is going to go away. I think this is now more of a broader statement.

-Okay, just a couple of clarifying questions if that's okay. So, what this still says, implement the following AAPB recommendation and that recommendation refers to the IDR process. Did you want to remove the reference to that AAPB recommendation? Like, is this a new recommendation?

-Firstly, I think the AAPB recommendation should still be in there because we do want, we'd want people to look at those.

-I agree.



Federal Aviation
Administration

-Okay, great. And then here, the insurer can overcome the presumption by first presenting evidence that clinical documentation known at the time of transport supported medical necessity. Should that say did not support medical necessity because this is about the insurer denying the claim?

-I think you're correct.

-And then finally, I did want to circle back to Rob Reckert's suggested edit of beginning this with Congress should implement rather than Congress should direct HHS to and get consensus on that.

-Toss it to David on that one.

-Yeah, David. Yeah, okay.

-I agree.

-Okay.

-Have we moved enough away from the AAPB recommendation that we're not really following an AAPB recommendation, but we've got more language.

-Yeah, I didn't know the, I couldn't speak to what was the original inability to implement that before. So, I don't really, I don't really know to be honest, sorry.

-I think there are 2 things. I think it's 1 that it's not within the IDR process and CMS has said they don't have statutory authority and they've lost on 2 court cases for something similar. But not for air ambulance, on something else. But on that idea of a rebuttable presumption. So, I would assume that it's that.

-Okay.

-So, I think, just because I want to get some other people that I've also been doing, so, Tom, if you want to hold your thought for just a second, and then we'll go from there. And I think Grace, from that standpoint, if it's been struck down, I think also, and I'm going to lean on David and my MITRE team to be able to say that, in this report it's going to be a report that we can reference back to as we work through our own pieces.

But I do want to call out for Krista. Thanks for your patience as we're working through this language. You have the floor and then I'm going to go on to Dr. Hinckley and then Rob I will go to you next, okay?



Federal Aviation
Administration

-Thanks, Jeff. I just want to make sure we're not tying the hands of folks in the rural and frontier communities and maybe, Tom, this is covered in the Medicare Modernization Act from 2003 when we talk about what is medically necessary and documentation on the clinical picture. I'm thinking about our colleague Todd up in Alaska who will be presenting later, and it may not be necessarily from a medical perspective, clinically emergent, but it is from a resource, a local resource perspective. So, I just want to make sure that we're including language that covers folks in those sorts of territories.

-One of the specific things is other considerations, is rural versus urban areas. Special provisions may exist for rural air ambulance services. That's in the Medicare manual.

-Perfect. Thank you.

-Okay, Dr. Hinckley, I know you're having some technology problems. So maybe you can come off of mute. And then I'll go to you, Rob.

-If my hand is raised, I did not intend that.

-Oh, sorry, Dr. Hinckley. Oh, I'm sorry. Dr. Gamber. Sorry, I was getting my physicians all mixed up. Sorry.

-No, I'm good. I think he answered part of it for me when you mentioned that the IDR piece was removed. I don't pretend to be an IDR expert, but if we're referring to AAPB and the rebuttal presumption, is that in essence still referring to IDR as well? And here's my simple understanding. Maybe somebody can clarify it for me. If a case makes it to IDR, it's essentially, it's now just a payment issue. It's not a clinical issue. And I'm still kind of working through that there's a clinical piece here for IDR. And Tom or Grace, maybe able to help me with that.

-Just to be clear when this recommendation, when the AAPB wrote this, the NSA had not been passed.

-Okay.

-And this had no reference to the IDR process at all. It is an AAPB recommendation that stands on its own. The IDR stuff is all later.

-And I think, I think because of exactly what you're saying, Mark, there. The IDR process has been, has tried to exclude medical necessity as even a thing they look at because it's such a different process. And so if you are a patient in Minnesota who has a medical necessity determination that's denied for any reason across any kind of thing, you first go to your insurer,



Federal Aviation
Administration

there's an internal appeals process within the insurer, then there's an external appeals process that comes to our department. It works a little bit differently on Medicaid and Medicare. So there's like, the complexities of how you get your insurance are baked into that. So, it's not the most consumer-friendly process, but there is a process that exists for everyone who has insurance to go through a process with their insurer and then to go through a process externally to review them the medical necessity part. The IDR process is just looking at charges and costs and isn't looking at whether or not there are, explicitly excluded medical necessity as a part of that process and are only looking at the back end. I think what with the

-But was a very significant portion of the IDR.

-Sorry, would you say Kolby?

-Clinical plays a significant role in the IDR process after even after it's declared medically necessary. It is a reimbursement issue, but it is very much one of the 6 criteria are clinical.

-Right, so it's, but it's more like, are you reimbursing for clinical services that are like actually delivered to the patient and are those, kind of at a line item level, like what are the costs of those, right?

-What we see.

-It's a cost of readiness and the cost of, I mean, whether or not it's used in that patient, we can all argue that it costs to carry things like blood, whether or not we give it to that patient or not. But it's all about, I mean, there is no line item for our reimbursement. 3:26

-I'm not disputing anything.

-What we see frequently is, yeah, I mean, it's a 30 or 40 page packet that you're submitting, documenting all the clinical care that occurred in order to prove that it was necessary and then they make the IDR determination. What we're seeing, particularly smaller programs, and this is where that impact to patient care comes in, is as insurers get beat in IDR, then they start increasing their medical denials. And so, they say, okay, we're going to lose in IDR. So then we'll just deny. Therefore, it goes all back on to the patient, which then the physicians and the sending people are, we don't want to use it because we think they might get denied. So, I think that's where that nuance comes in on the IDR process.

-Okay.

-So, Dr. Gamber, did that answer your questions from that standpoint?



Federal Aviation
Administration

-Yes, that was helpful. I appreciate everybody.

-Or did it? Okay so I'd like to, and I see Tom that your hand is up. But I'd like to be able to kind of focus back as, we still, we've got, I'd like to be able to see if we are at a point where we can be able to move this forward.

-I sent some new language to Kellen and added that I think brought all of those things into it. But just once again, the IDR process is about out-of-network claims and we're not talking about out-of-network claims. We're talking about all air ambulance services here. That's what the AAPB was dealing with.

-I added that an emergency air ambulance service here. So, is there any other edit that I didn't capture here that you wanted me to add?

-Yep. It was, I think it's the medical necessity. Was it the emergency was medically necessary that brought in Dr. Pritzker's comments from below? And that at the time of, the clinician's decision-making was it consistent with the provisions of section 415. And I think you've got it.

-Okay, great.

-And I would take the word documentation out as the clinical the clinical circumstances known at the time because there isn't any documentation at the time.

-I would, I think that's great. I like that language because not everybody charts at the same level, right? Everybody charts differently and I think that that would be better. Its circumstances is a good piece. What else in that language, Tom? And then I think what I'd like to be able to see is one final look at this and then we can kind of move forward.

-Yes, we can pull it back into the slide now. I think it'll be a little easier to read.

-Do we capture everything that Tom had put in there, Kellen?

-I think so, but Tom, but please speak up if I'm missing something in this version here.

-I think you got it here. No.

-Okay, great.

-Okay, so can you pull that into the other slide?

-Yep.



Federal Aviation
Administration

-I'm just wondering if there should be an and, or and/or between those two clauses? Thinking about people in the frontier of rural areas that it's not necessarily the clinical condition, but it's the resources. Just to make sure that that is captured in the statement. Does that make sense, Tom? You being more familiar with the Medicare Modernization Act. I just want to make sure that we're not hog tying our folks in the rural community.

-Where are you putting the and the or?

-So it would be, if consistent with provisions of section, okay, wait. That an emergency air ambulance service was medically necessary or if consistent with provisions of section 415, because that covers the geographical and resource challenges, right Tom?

-Yeah. No, I suppose and/or. I don't know, I think it's, I think it just necessary if. That's, I would just leave it as it is, but I'm not opposed to changing it, but I think we have it as it is, of what we're trying to get to.

-I think that captures it. I think what I would say is that again, going back to the report out, we can reference back to it when we tried to be able to drive legislative changes, okay. But Krista thanks for the suggestion. I appreciate that. Okay, so I think we're at a point where we can be able to, I guess my question is with the language that has been proposed, is there any further discussion? Grace.

-We covered this, I just want to make. The rebuttable presumption is a generic one that I guess Medicare would use since it doesn't really have a locus that it's tied to since we're out of the IDR process, is, can I just clarify that part? Or are we still in the IDR process?

-The Congress should implement. What this is doing is it's making the deemed medically necessary in section 415, giving it a stronger stance.

-Okay.

-That if those conditions are met, it's a rebuttable presumption. So, it's not really anything to do with the IDR process and that Congress should implement that recommendation.

-Okay.

-Okay.

-So, is this still the AAPB recommendation? Or did our language diverge enough from AAPB that we should say implement AAPB recommendations.



Federal Aviation
Administration

-I think that the AAPB recommendation is below, it's the number 12 recommendation. I think we've honored what's in the AAP recommendation and probably made it a little bit better.

-Okay. Thank you.

-Jason.

-Yeah, Jeff, it's kind of a little bit of a ticky tack thing, but I think the word implement probably needs to be changed to mandate. I don't think that Congress is the implementation group.

-Good call out. Thank you. Can we make that change?

-To mandate implementation.

-Krista, while we're making that change.

-Yeah, I don't want to beat the dead horse. I'm just not certain that it's clear in the language that this is also covering for geographical and resource deficiencies, because there's a heavy emphasis on clinical circumstances. So, presenting evidence that clinical circumstances known at the time. I mean, I would defer to the group, but I'm just asking for another look to ensure that it's very clear to the reader. And especially if they don't necessarily go back and refer to section 415 of the Medicare Modernization Act to understand what the intent of that was, that we are very clear that it's not just the clinical presentation that's driving the ask for the air asset, that there's also geographic and resource restrictions that make it necessary. I mean, honestly, issues with the term medically necessary in some cases.

-So, could it be a language that says presenting evidence that clinical and or geographic circumstances known to the time of transport did not support air ambulance, and I just lost everybody. Is that the right language? Help me out here. So, is that it? Do we need to be able to put on top of clinical circumstances geographical?

-So, NAEMSP addresses this a lot as does CMS, as does ACEP. So, it isn't just a geographic circumstance. If the geographic circumstance has an effect on the clinical circumstance, then it's a clinical circumstance. If the resource has an effect on the clinical circumstance, it's a clinical circumstance.

-Okay.

-Yeah, yeah, for me as a payer, geographical challenges are a clinical circumstance.

-Okay. Thank you. Krista, does that help you?



Federal Aviation
Administration

-Would that be spelled out in the. It does. Would that be spelled out in the final report then? So that it's clear to the reader? Because not everybody knows that. I really appreciate the point. So, I just, I think we need to make sure it's spelled out so that everybody who has exposure to this report understands how we're all kind of working out the same sheet of music.

-Or if there's a new Medicare Modernization Act of 2027.

-The act goes back to 2003.

-I know.

-I would agree and, like, separate point from Krista's, but I think like some language clarifying that this is not, like, usurping state's medical necessity determinations? Like I can get on board with that, but I can't get on board with it if we aren't clarifying, like if that's not clarified. So just, I think we've discussed all of that here and I have no doubt the MITRE team has the skills to be able to, like, weave all of that into the report in an artful way. But that I would add, like my ability to vote yes is kind of dependent on like, not having an infringement of the places that we already have authority.

-Look at the language. Medical necessity is and specific criteria is related to patient's condition and the circumstances of the situation. And the language, the section 415 specifically calls out state protocols. Right? That is if people are following state protocols. That's what this is about, right? Because physicians in the state have said this is medically necessary. So that's included in the in the in the Medicare piece. The idea of state protocols.

-A way to resolve that would be to have a parenthetical e.g., but I would not support that. The e.g. would be huge.

-Yeah, and to your point, Tom, I think that's referring to, like, state medical things and I think this is totally fine. I just I would ask that the that the MITRE team just kind of like, have a little bit of that additional context around the discussion.

-So, I think that the MITRE team will have documentation of what the discussion was that's in the report from there. I want to get to is the recommendation as written in a way that would then get support? As that's kind of where I kind of want to go to right now. Because we still have several other ones to go on, and I know this is a great discussion.

-Are you trying to finish this meeting, Jeff?



Federal Aviation
Administration

-Just a smidge, just to try to keep us on time. The ICU nurse is starting to come out in me a little bit. So, I guess are we in a spot where, is there any other tweaks, I guess? I mean Grace, I think you kind of said it, to get my buy in, right? Is it as written, is that where we need to be?

-And I'll send, I've gathered lots of the stuff and I'll send it to Michelle and her team for they can sort of look at how this fits in the report.

-So, I'm looking at, so, Jim, Grace, anybody else for the comments on this because I'd like to be able to see if we have to go back to making a change to it. Let's make the change and then if I'd like to be able to put it out for some.

-I'm fine voting on this one.

-Yeah, No more comments. I was just trying to help with some context for Krista with regard to what it currently states.

-Okay, and then I will say too, and I mentioned this the beginning, which was early, is that when we're all done with this, we'll be able to review and edit. So, all this discussion is going to be documented. So, we'll be able to say, did we capture everything that we needed to be able to do, which will then go into the report to Congress. Okay. Alright. So, I'm going to go ahead and I'm going to put this forward as a vote.

I'm going to read it so that everyone has this, Congress should mandate implementation of the following AAPB recommendation clarifying that there should be 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 first presenting evidence that clinical circumstances known at the time of the transport did not support medical necessity for the transport, third party first responders slash medical professional who request the transport was not a neutral third party, or that the air ambulance provider did not act in good faith.

So, I'm going to ask that everyone goes through the voting process, which is a yes, no, or abstain. And then the Committee members should note if they believe that they have a conflict of interest and please send that to Nicole. And I'll give us a couple of minutes to be able to do that.

-Sorry, Jeff, is it act or action? Medical Modernization Act of 2003? Or action of 2003.

-Good question. I might have said it wrong.



Federal Aviation
Administration

-I think it's written as action, but I think it's actually act.

-Okay, can we make that change then? Sorry, good call. Thank you.

-Yep.

-I know we're voting but the word first and first presenting is probably superfluous.

-So, you're suggesting taking out that first.

-Yes. It would not impact voting.

-Okay. Got it. Thank you.

Okay. Okay, I'm going to go ahead so we've got where we're at right now. So, I'm going to go ahead and call everyone by their name.

Committee Member	Response
Commissioner Arnold	-Yes.
Jason Clark.	-Abstain.
Ben Clayton.	-Yes.
Colonel Coffee.	-Yes.
Eileen Frazier.	-Yes
Dr. Gamber.	-Abstain.
Dr. Hinckley.	-Yes.
Jim Houser.	-Yes.
Tom Judge.	-Yes.
Paul Julander.	[Not present]
Dr. Pritzker.	-Yes.
Jason Quisling.	-Yes.
Robert Reckert.	-Abstain. Conflict of interest.



Federal Aviation
Administration

Committee Member	Response
Jeff Richey	-Yes.

Okay, thank you. This was a great discussion. Okay. Let's move on to the next one. Kolby and Keith.

-Alright, so moving along. Our next recommendation is related to the adequacy of Medicare reimbursement. I think we're all very familiar with the challenges faced with keeping an air ambulance business financially viable on a 24/7 operation given the high fixed costs of that readiness and the unpredictable nature of our revenue streams.

Reimbursement adequacy has been a particular challenge in Medicare, which reimburses transfer transportation only, as there is no supplies and expertise considered. The lack of financial incentives to provide those advanced capabilities is a huge barrier to ensuring these capabilities are adequately available in the communities that they serve and that every patient gets the care that they need in route where delays in clinical care can have dramatic difference in the patient's outcome.

The Subcommittee recommends endorsing the AAPB recommendation for CMS to conduct a study of current reimbursement adequacy. The Subcommittee's recommendation then builds upon the original AAPB recommendation by recommending a specific approach that this study consider whether reimbursement should be differentiated for specialty care using add on payments, modifier codes, and/or procedure codes commonly used in other critical care settings to ensure adequate compensation and incentives to provide the clinical capabilities needed to meet the patient's needs.

We believe this will more accurately characterize and enable the diversity of clinical capabilities provided by air medical programs, which is why we have included it as a recommendation under the statutory area specific to our mandate.

We do want to note that only that this would apply only to Medicare reimbursement because this is a report to Congress. Medicare is the federal government's most direct tool to affect reimbursement. That is where we focused our recommendation. It is difficult to say exactly how any changes proposed by Medicare might impact other payers, though it is not uncommon for Medicare billing and reimbursement practices to be a reference point to other payers.



Federal Aviation
Administration

As discussed earlier, the Subcommittee discussed the potential benefits and challenges of a tiered approach to categorizing clinical capabilities but does not recommend this as a foundation to reimbursement. The Committee felt the complexity is too great to be effectively operationalized and that there would likely be unintended consequences that could negatively impact operator's sustainability and increase disparities and access to these critical services.

The Subcommittee instead recommends that air ambulance be designated as a provider type. This was a recommendation adopted in the May 8th meeting and that the reimbursement study in this recommendation consider the use of add on payments modifier codes and/or procedure codes to adequately reimburse for the services and capabilities provided. I'll turn it over to Jeff for questions and discussion.

-Okay, discussion. I think we could probably leave it, right. I mean, we can move to what the recommendation is on the next slide, but I think we can open it up for discussion, please.

-I'm wondering if there's openness to adding a number 4 after at the end that says analysis? I can put it in the chat. That says analysis of expected market-wide impacts of changes to Medicare payment

-Okay. Kellen, can you do your word magic in the back? Maybe.

-Yes, so I think we can't edit the AAPB's recommendation, but we can add that addendum to the Subcommittee's recommendation.

-Yeah.

-And I will put that in the chat as soon as I can. Make it want to send to the channel.

-Okay, okay. Thank you.

-I assume we're making the presumption that HHS will find that there is a need to increase reimbursement rates for air ambulance as opposed to finding a reason to decrease reimbursement rates for air ambulance, in the conclusion of their study?

-I would. Yeah, I think that would be a presumption. I would look to other experts in the room.

-I would say the rates were established many, many decades ago based on no data, so.

-I mean. Okay.

-Okay. Mr. Judge.



Federal Aviation
Administration

-Yeah, I would actually say the rates were established many years ago under the Medicare fee schedule. It was based on a lot of data and the Medicare fee schedule single biggest winner was medical helicopters. The single biggest loser was ground critical care. The next biggest winner was ALS 2. And the reason for that was that the cost data that was used in the Medicare piece scheduled negotiations was hospital-based twin engine high-end helicopters because that's the cost data that AIMS had at the time, and they had the best cost data. So, it wasn't based on anything.

Now, that said, the Medicare fee schedule was an annual update less 1%. So, over a long period of time, the Medicare rates have not kept up with inflation. And so, there is certainly a general perception among all the providers of air ambulances that Medicare rates, current Medicare rates don't begin to address the actual cost of running an air ambulance. Part of the No Surprises Act requires a cost study. That cost study has not been implemented yet. Many of us have worked with the contractors working for CMS on the cost data, what that should look like and how they would do it. It's a little disappointing that it's been a black hole for over a year now with trying to implement that. I'm sure the elections and HHS interrupted things. It's both that cost study is supposed to be done and the cost study will determine if the Medicare fee schedule is sufficient.

-Thanks. Rob.

-With the interest in my mind above of these recommendations coming out of the Committee being as effective as possible, right? The highest chance of them being adopted. The question I would just ask, and this is not my area of expertise, is how is the Medicare fee schedule established? And the reason why I say that's important is if the Medicare fee schedule is established through legislation, then the recommendation is written appropriately Congress should enact legislation. If the Medicare fee schedule is set by CMS, the Health and Human Services or another or an executive branch agency through rulemaking or some other process, that directing Congress to enact legislation may not be the most efficient way to get there versus recommending that HHS simply evaluate the adequacy of the Medicare reimbursement rates. I don't know where they come from. Not my area of expertise but just from a how government works perspective, if it's legislation then the recommendation being directed to Congress seems really appropriate, but if it's something else, whether it's rulemaking or another process directing the recommendation to the agency that controls that process may be a more efficient way of communicating what the Committee's interests are for change. Just something I wanted to share. Okay.



Federal Aviation
Administration

-And thanks, Rob. I think probably what, as I'm reading this, because I think that was, and please the other members please correct me, when we say the statement Congress should enact legislation to implement the following AAPB recommendation for HHS, is that significant? Because Congress has to tell HHS to do something. Is that an adequate language or should it be something different?

-That would go back to my previous point of, with referring to the AAPB recommendations that have already been made to Congress, it's kind of getting back to that circular argument of the recommendation was made to Congress. Congress didn't do anything with the recommendation. Now you're asking Congress to direct somebody else to do it. That's a little bit of that circular piece and that's similar comment to before, I would just offer that, if the meat and potatoes is the right recommendation for the Medicare reimbursement rates, I would just ask how are those set? And I would direct the recommendation to the folks that are responsible for setting those rates.

-Okay.

-I think, and Commissioner Arnold may remember from her days here, I think they're set. I'm not health and safety guys. Sorry. I think they're set through regulation through rulemaking every year. So, it'd be the agency.

-So, okay, I think if there's changes that somewhat, if there's any sort of tweaks to this language, if you could put them in the chat and then we can put them into a Word document and then I'll call it to you next, Tom.

-Yeah, just to go back. So, this is all from the Balance Budget Act. So, Congress did enact that legislation, required CMS and HHS to create a national ambulance fee schedule which then was a 5 year rule making process, which then gets updated every year. So, they started in 1997, the first year of the fee schedule was 2003 and then every year HHS publishes a rule updating the fee schedule with the continuing mandate that it's the inflation update less 1%. So, to change that, Congress would have to instruct CMS and HHS to open the door, which they've been reluctant to do, because it's a lot of things. It's all ambulances. It isn't just air ambulances.

-And Jeff, I was just going to say, I think, a lot of the way that, particularly CMS, I mean you know this Jeff, that CMS HHS legislation is at Congress directing. I think that the first sentence is a little circular if you look at the AAPB recommendation. It's just enact legislation to require HHS to, and I hear the point about two different things but if you're saying a must, then the agency then you have recourse if agency isn't doing it. So, if we change anything, maybe just using the



Federal Aviation
Administration

recommend the legislation be enacted to require HHS to is just, copy that up so it's a little less floofy, for using a real technical term. But I think it's fine because it's rough. I don't feel like I need it, but if we feel like we need it. The AAPB recommendation is Congress directs HHS to.

-Yeah, I guess what I would say is, I like the should. Because shall gives you a choice, right?

-Yeah, that's it's like the art of must/may, should/shall. Yeah.

-Yes. So, I guess what I will say to the group is that as written right now, is there any tweaks to this as written before I would take it to a vote? Or a discussion. Further discussion. Dr. Hinckley.

-I would I guess like to ask Kolby and Keith in writing this, what did the Subcommittee mean specifically by specialty care? I have a pretty good idea, but is that, I guess, is that something that needs to be spelled out any more in the recommendation?

-Right. So, anything that is determined when Medicare does provider type. It would be those add-on payments would be special care, things above and beyond what's determined to be a baseline air ambulance. So that's what we talked about. With the tiering with the states having different limitations across different states about who can do what. That has to be cleared out first and then special care would be anything above that base that established baseline. Alright.

-So, as a guy who focuses almost entirely on the clinical side and not on the billing side, like beyond neonatal transport, what else, what other examples would there be that would meet that?

-Pediatric intensive care, ECMO transports where specialty team members are used, things like that. We talked about that in in the Subcommittee.

-Cardiac assist devices, blood administration, those type of things? All kind of going back to, Dr. Hinckley, what you can do when you're practicing? If you put in a central line, that could be that's an additional code, CPT code that could be billed for the services or the procedure that you performed.

-Roger, thank you.

-Okay, so Rob, next and then Grace and then I'd like to be able to see if this language is good, as again, I'm going into ICU nurse mode trying to be able to keep us on track.

-I'll try and keep it on point Jeff. Highlighting my other points. I would recommend striking some of the first sentence to where the first sentence just reads Congress should enact legislation to



Federal Aviation
Administration

evaluate the adequacy of Medicare reimbursement rates for air ambulances. Directing HHS to do something that Congress didn't do on a previous recommendation, it's a little strange and I think Tom Judge, you shared that those rates are set by statute. So, the only way to do something different or recommend something different than the model that you highlighted would be through the legislation, right? So, if Congress enacts the legislation to evaluate the adequacy, then through that legislation executive branch agency would be tasked with that. I think it's just a cleaner way of saying the same thing.

-What is, so how is that, so I think, Kellen, you just, thank you for doing it in real time. So, let's read that right there. Is that captured, Rob?

-I think it meets the concerns I shared, and I think it's a cleaner or a more clear recommendation.

-Okay.

-I like what James has consistent with the AAPB recommendation X, Congress should. Rob, are you okay with that?

-Yes, ma'am.

-Alright, I think that one just because then it references HHS rulemaking. Because I think if we leave out the HHS rulemaking, which is setting the things then we'll, like, miss a bunch of it. So, to the point about the specialty services being like ECMO and central line and those kinds of things, like that would get covered under Medicare. If we're talking about a lot of pediatric services those aren't going to get covered in any Medicare analysis likely.

So, I would maybe make a quick modification to the sentence. I added to say the evaluation should also include analysis of any gaps in services related to non-Medicare covered services or something like that. I don't know what the right way to say it is for Medicare, so I would look to my more Medicare-focused folks on here, and analysis of market-wide impact. Because I mean, peds stuff is, when there's something wrong with a kid, it's often super expensive. And so, I think I would, just think that calling out that would be helpful. So, Kellen.

-Yeah, can you repeat the language you suggested?

-Yup. The evaluation should also include analysis of potential gaps in, which part was that specialty service? What was the part that we were, what was the language we were talking



Federal Aviation
Administration

about in that spot? I lost it, sorry. Potential gaps in specialty services evaluated and market-wide impact of any changes to Medicare reimbursement rates.

-That's potential gaps in special services availability evaluation. And evaluate the market wide impact.

-Yeah, thank you.

-Did you get that, Kellen?

-So, specialty services. Yep. And market. Yep, I think that looks good.

-Okay. Ben. Robert, do you have anything else to say or do you just need to take- Are you good because your hand is?

-Sorry, forgot to lower my hand.

- Okay, Ben.

-Sorry, just forgive my ignorance. I'm just curious. Does CMS normally, or like other government agencies normally evaluate market impact when they change things. I don't know the answer to that, and so, would that be outside their normal scope?

-David, do you know?

-I don't know. You know, in terms of the annual updates, those are through notice and comment rulemaking. So, there is input, but I honestly don't know if we look at market impact when we first establish or as we continue to update the rates. Sorry, I don't have that answer.

-Okay, Dr. Pritzker, do you have a comment? Question?

-Yeah, well, a couple of words to add. We just added the evaluation should also include analysis of potential gaps and reimbursement for specialty services.

-Okay. Good call out. Thanks.

-So, analysis of potential gaps in reimbursement for specialty services, removing the word availability. Is that right?

-Agree.

-Okay. Alright, so as it is written right now, are we ready for a vote? Or any further discussion before I put it to a vote?



Federal Aviation
Administration

-Just to include that when the team is looking at this, they can make any little wordsmithing without changing intent to just clean up how it fits together.

-Yeah, I think that's fair. Okay, so I'm going to read it and then I'm going to call for a vote.

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 specially care or more intensive procedures to ensure payment is adequate for the diversity of clinical services provided in the air ambulance setting and should consider the 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 adequacies of reimbursement for aviation operation, operational, and training costs in the context of current FAA requirements and advancements in best practice for flight safety. The evaluation should also include analysis of potential gaps in reimbursement for specialty services and market-wide impact of any changes for Medicare reimbursement rates.

Okay, so, voting is a yes, no or abstain, and if you have a conflict of interest, please cite that and please send your vote to Nicole. Okay, going down our roll call:

Committee Member	Response
Commissioner Arnold	-Yes.
Jason Clark.	-Yes.
Ben Clayton.	-Yes.
Colonel Coffee.	-Yes.
Eileen Frazier.	-Yes.
Dr. Gamber.	-Yes.
Dr. Hinckley.	-Yes.
Jim Houser.	-Yes.
Tom Judge.	-Yes.
Paul Julander.	[Not present]



Federal Aviation
Administration

Committee Member	Response
Dr. Pritzker.	-Yes.
Jason Quisling.	-Yes.
Robert Reckert.	-Abstain. Conflict of interest.
Jeff Richey	-Yes.

Okay, I think that we have got until 2:30 until our break. So, I think we'll move on to our next one then. Over to you.

-Alright. Final recommendation is related to data collection and analysis. The No Surprises Act authorizes CMS to collect data on air ambulance operators for 2 years, analyze that data and issue a report with the findings. AAPB recommended specific data elements that should be collected to support the report, in addition to the minimum data elements required by the No Surprises Act. This analysis will be critical to inform discussion on reimbursement adequacy because it will give more transparency into the cost required to provide 24/7 readiness for air ambulances and the challenges of covering those costs given the variability and volume of services provided and in reimbursement.

The Subcommittee believes that this is 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 No Surprises Act. That rule was not finalized. It's worth noting that the proposed rule preceded the issuance of the AAPB report, so did not incorporate AAPB's recommendations. CMS may wish to revisit the proposed rule in light of AAPB's recommendation of any recommendation that comes from this Committee.

So, I will read the recommendation itself. HHS should implement the following AAPB recommendation regarding implementation of data collection requirements regarding implementation of data collection requirements authorized by the No Surprises Act section 106 and subsequent notice of proposed rulemaking which would allow CMS to collect operational data on the air ambulance industry for 2 years and issue a report on the current state of the air ambulance industry. The AAPB recommendation number 14 recommends that the HHS and the DOT collect data from air ambulance providers and suppliers regarding average cost per trip; air ambulance base rates, patient loaded statute mile rates; ancillary fees for specialty services;



Federal Aviation
Administration

reimbursement data aggregated by payer type and per transport based on median rate and zip code with data regarding private insurance further identified by provided type; alternate revenue sources such as subsidies or membership programs broken down per transport for reporting purposes; 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; market share for air transport obtained by the FAA certificate holder and identifying certificate holder parent company; and market share for health care by looking at the program type for the FAA certificate holder.

And I'll turn it over to you, Jeff, for discussion and questions.

-Thanks. Okay, let's go to the slide for the recommendation. I would like to open it up for discussions, any discussion or questions. Grace.

-Did you guys think about asking, I know the AAPB recommendation is asking HHS to do this, but is there a reason to have HHS do it versus MedPAC? I guess it's No Surprises, so it's more expansive probably, but I just, like, Congress can directly ask MedPAC to do something, to Rob's point. Congress can directly ask HHS to do something which will then come into a list of things that they may or may not get too. If you didn't that's fine. It was, it's like in some ways an intellectual question of, like where you would do that.

-No.

-But I think it looks fine as is.

-Okay, any other discussion? Questions? Oh, you got to get closer to your mic there.

-There was some discussion about. Yeah, sorry. Can you hear me?

-Yep.

-There was some discussion in Committee about the fact that there was already a similar precedence of collecting this information in HHS through the ground ambulance data collection process that's already in progress, most of like items 1 through 6 under the AAPB recommendation 14, or is similar data being collected for ground ambulance.

-Okay, that's super helpful. Thank you.



Federal Aviation
Administration

-Okay, any other questions from the Committee? Okay, we can go ahead and vote on this. I think Kolby did a good job of repeating the recommendation. So I'm not going to read through it because there's no changes to the language.

So, you should vote yes, no or abstain, and then just please note if you have a conflict of interest, and please send your votes to Nicole. Okay, I will go down and do a roll call.

Committee Member	Response
Commissioner Arnold.	-Yes.
Jason Clark.	-Yes.
Ben Clayton.	-Yes.
Colonel Coffee.	-Abstain.
Eileen Frazier.	-Yes.
Dr. Gamber.	-Yes.
Dr. Hinckley.	-Yes.
Jim Houser.	-Yes.
Tom Judge.	-Yes.
Paul Julander.	[Not present]
Dr. Pritzker.	-Yes.
Jason Quisling.	-Yes.
Robert Reckert.	-Abstain. Conflict of interest.
Jeff Richey	-Yes.

Okay, all right. I think we've gotten through this. Is there another slide? As I'm trying to remember. Okay, recommendation CS-1b establish minimum national clinical standards. So, I'll turn it over to Kolby and Keith again.



Federal Aviation
Administration

-Jeff, just as a quick reminder, our plan is to cover that after the break at 2:40 since we have a couple of guest speakers that we are waiting on.

-Perfect. Alright.

-But we do have a few moments if you wanted to cover anything else.

-Yeah, no, that's perfect. Okay, thank you for keeping me on track on that. I guess after our discussion, I think this was great. It's amazing to bring everyone together and have this really good robust discussion.

What I'd like to be able to ask before we go to our break is, have we missed anything from the Committee members? So, it's a little bit of a loaded question, but I do want to be able to make sure that this is an opportunity to be able to say is there anything else that we should get on record that we did not address? Tom.

-Yes, absolutely. I think both these recommendations were helpful. But we eliminated, as they said, they eliminated the recommendation from CS-C from the May 8th piece. I think that is a very, very major shortcoming and that that recommendation over evaluating how the impact of the ADA and how it affects all of this, which is these last 2 recommendations, is actually critically important and I believe that should be back on our agenda to deal with that recommendation.

-So, I will say I appreciate that. I think that we've had a lot of discussion from the Subcommittee on that. I think there were some other items that we consulted with the FAA on. And so I think that probably Tom, to your question, I would look to if, I believe that we have another FAA representative. Rob, I know you're here, but we can just talk through that. And MITRE please help me out because I'm not seeing everybody.

-Well, if they're trying to jump on, I would just concur with that.

-Okay, appreciate that. Rob, do you want to pinch hit for our discussions that we had that brought us to not putting that one forward with the Clinical Subcommittee.

-Okay. Couple of things, I would share is first, the concern around the way the recommendation was worded with Congress. Congress directing FAA for which the FAA does not have authority to implement the recommendation as it was written. Otherwise, with respect to the other topics around the ADA. I have another person from our office who's come on screen, Jonathan Cross, from our chief counsel's office. Otherwise, I would offer that our opinion, and Jonathan, correct me if I'm wrong, has been documented previously in recommendations.



Federal Aviation
Administration

-If I may, could I just say a word?

-Yes, the floor is yours, sir.

-Yes, I'm sorry. The decision to withdraw CS-C recommendation was made by the Subcommittee and I would just direct you to the co-chairs of the Subcommittee. They decided to withdraw it and that's really all I'm able to say.

-Anything to add from what Rob had just said, Jonathan? Appreciate that. I think he was throwing you a line. Yeah.

-I appreciate it. It's the Committee's jurisdiction, not the Subcommittee's jurisdiction, to withdraw something.

-Yeah, I would say that, so Tom, I was just going to say that I was just asking for some FAA piece and then we will go back to, back to the Subcommittee, but I didn't know if Jonathan wanted to add anything from that standpoint, from what Rob had said.

-Not at this time. Thank you.

-Okay, all right, now.

-Yeah, I just want to speak up, Jeff, because I feel like I heard the truck beeping backing up. We were advised by the FAA that like Rob said, that there is no jurisdiction for them to be able to provide that clarity around the ADA. And one of the parts about the ADA component is looking for, when we talked about asking for clarification about what the ADA did and did not do in air ambulance for us. And one of the discussions that we talked about was, rates, routes and services and what is the service defined as? Is it the air ambulance or is it the services rendered in the air ambulance? And was that going to be a vehicle to allow for universal services provided across all states. With the Medicare provider type that kind of negated that necessity. And outside of the ADA determining if it regulates services or not, it doesn't have a necessity from the Clinical Subcommittee. It doesn't fit within our scope.

-And I would also as the Chair also agreed with the Subcommittee on that piece because of our recommendation that we approved back in our Committee meeting in May that provider status elevates the clinical standard. So, from the Chair standpoint, I supported that decision. Tom.

-With all due respect, so, let's be very clear that the recommendation said nothing about the FAA. The FAA does not have a role to evaluate the ADA. There is a field preemption for the FAA to oversee aviation safety. No one in the world has ever agreed with anything saying that the



**Federal Aviation
Administration**

FAA should not have the field preemption to oversee aviation safety. So, there's nothing in this. This is about prices, routes and services. It's not about aviation safety. It's about economic conditions and that's where the ADA has had a major effect including how we got to the last 2 recommendations on the air ambulance industry. In 2000, there were 377 air ambulances in the United States. There's about 400,000 transports. At the implementation of the fee schedule, there were 545 air ambulances, helicopters, and there was about 400,000 patients. At year today, there's about 400,000 patients and there's 1,315 helicopters. So it's had a dramatic effect, and that's how a dramatic effect on prices. It hasn't really changed availability because it's the same number of patients in a way, but it's had a dramatic effect on prices. And part of how we got to this point and how we got the air ambulances in the NSA was because of the ADA. So, to not have the ADA be evaluated, not changed, and it said Congress should evaluate the implications of the ADA. I believe that should happen.

-Okay, thank you, Tom. Jim.

-Just, just want to clarify though, and I understand what you're saying about growth as it relates to the ADA, but wouldn't the decision to move to the provider status correct any inconsistencies, as it both relates to clinical quality standards as well as reimbursement, which are the 2 charges I think that we were focusing on from the Committee.

And then also I'm sensitive to, while I don't disagree with the risks that you presented with the current state of the ADA, wouldn't it also create an opportunity for inconsistency state to state if we move the direction that is being indicated from your vantage point now.

-Again, this is about evaluating the impact of the ADA, not necessarily changing it, not necessarily changing anything that has to do with the states but understand that impact.

The Air Ambulance Patient Billing Advisory Committee took that on and not everyone at DOT was happy with that, but that was an important feature, and it was overwhelmingly supported that the ADA really needed to be evaluated. I think that that continues to be the case. There are very good reasons for the ADA. If there was a change for air medicine it would have to be very narrow, it would have to be carefully thought out for doing things. But to not evaluate the impact is, I think and the state insurance commissioners certainly testified in favor, of how important that was. All the state EMS directors testified how important that was. It is important to evaluate the impact and I think we are remiss in our charge by Congress if we don't get that done and don't encourage Congress to actually get that done.



Federal Aviation
Administration

-But I still want to make sure that we get the answer to the question on the record here. Does the move to provider status not account for everything you just described, from the perspective of quality, safety and reimbursement?

-Moving to provider status answers the original question. That you have to remember, got to go back to in our first presentation in December. The doctor from CMS did agree that the ambulance reimbursement from CMS was a transportation, not a clinical benefit. Absolutely going to the provider status will improve all of those things. But that does nothing to deal with the impact of the ADA in how the entire system is organized. And if we're going to analyze data, that needs to be part of the conversation. Not negating anything about the provider. We've been advocating for provider status for 20 years.

-Understood.

-Jim, I think the distinction may be that the provider status is Medicare only. And so if I have a flight that's fully reimbursed just by something that is under my regulation, I would have a lot different ability to do something if there were an issue on the insurance side in particular. But my colleagues who oversee safety and quality similarly at the state level, it only covers a portion of the market. So it's helpful, but I think it is likely to create a series of gaps that we don't necessarily know, and I think that's a little bit like the evaluation from my perspective. Where the evaluation should be helpful is to understand the gaps. Figure out where they are. I think that that would likely mean that there are still cases where there isn't a recourse for patients or that the air ambulance providers get in some dispute that I can't do anything, I can foresee a variety of circumstances because these are all really complicated. And so from my perspective, that's where the understanding would be. That's where I would want to understand what the gaps are. If there are any gaps. I suspect there are. If there are then, should we look at whether the ADA is the appropriate venue for addressing those? Is there a different venue? Having that discussion, being able to have it in a fulsome way, I think is, from my perspective, where evaluation is helpful. Because It's rarely the case where if you do something within Medicare, it solves all of the downstream issues that can occur.

-So, Grace, do you see this now in looking at it from the perspective, as you are the commissioner, from the perspective of the ADA and how it impacts you? You mentioned gaps, do you have any examples?

-I think so I'll say and Kolby, as one of our large air ambulance providers here, is we don't have some of the particular issues that other states have had. So I'm a little bit of a unique. Because



Federal Aviation
Administration

most of our hospital systems sit on the board of Life Link, which is doing a lot of our transport, I think the cases where there are either other entities that are financing that aren't health care entities or that are in some of those spaces where there's maybe specialty providers that have subscription-based services or something like that. I could imagine that the cases where they're a little bit niche areas, like mountain transports or something, or if you have like a subscription because you're out a lot or particularly companies are contracting. I can imagine there might be still some gaps there. I will say that, because the nexus of clinical quality and insurance can be complicated and is different in every state, I appreciate the folks who want some uniformity across. And then sometimes they're just particular markets that exist in the state that may not exist elsewhere. So, the answer to your question, Rich, is I don't know, or Jeff, is that I don't know because there are some complexities. I would be very surprised if there aren't some gaps that are left over and I can imagine it's in some of these more nuanced, pediatric maybe is a good other one where there's no ability to have critical care for like these little things that are getting transported around that are very sick. So that's the other place where I could see there being a little bit of a challenge just because Medicare doesn't deal with neonate transport.

-I only asked because I was hoping you had some examples because I'm sensitive and I totally appreciate both perspectives. Just my comment as a single person on this Committee would be considering the risk benefit of this discussion and if moving the Medicare provider status adjusts for the quality concerns that we're charged with discussing, looking at it as one step forward. Recognizing that with the ADA, it's not an option to clarify, it is either revision or guidance. So, taking it one step at a time is just what's in my mind. And maybe I'm ignorant in making this statement, that there is a natural alignment where you have the Airline Deregulation Act as it relates to our aviation operations and then the Medicare provider status giving some oversight as it relates to quality and clinical capabilities and putting a natural segue and segregating those two things out. But that's just my thoughts going into this discussion.

-Yeah, I think for sure helping to at least like start to split those two concepts is a step.

-Okay, so we're at time, or at least a break, for all of us. I think.

-Okay. Thank you. I see you ICU nurse Jeff.

-Dr. Hinckley. Comments, but I think that we have some other things that we want to go forward with on the next meeting or at least, I think we can discuss after this, but Dr. Hinckley, do you want to add anything before we just take a break?



Federal Aviation
Administration

-Yeah, real quick on the ADA question. If Tom's numbers of growth over the past several decades are correct, and I'm quite certain they are, you got to keep in mind that if you've got roughly the same number of patients with three times the number of helicopters then nobody has the opportunity to be as good, because you can't take care of near as many patients as you did 20 years ago. And that's going to impact flight nurses, paramedics and pilots, just in terms of how good they get to be at their job and that is going to impact patient safety. And so, if we believe that the ADA has had a part of the effect on that growth and I think it does impact patient safety and quality.

-I would just add too real quick before break is that there also is a significant amount of hospital closures and loss of services such as OB that we didn't face in the past. And access is becoming a significant issue. So, there's likely a push pull relationship there. And, but that's just my response.

-Okay. Thanks, Kolby. Thanks, Dr. Hinckley. So, let's take a break. How much time do we have?

-It'll be 10 minutes, Jeff. Okay, thanks everybody. 10 minutes.

-10 minutes. Alright, take us to break.

-2:42 or whatever time zone you're in.

Okay, this is David again, let me see if we have Jeff back and once we do, we'll go ahead and continue that discussion. Thanks, Jeff.

-Alright, welcome back everyone. Okay, I'm going to turn it over. I did forget the last time to be able to make sure that everyone knew that, as another reminder, just making sure that if you do have any questions from the public, we will not be calling on you as a member of the public, but, if you have any questions, please put in the Q&A box and then we'll answer it and add that to the summary report that will be posted on the Centers for Medicare and Medicaid Services and the AAQPS website that is also in the chat that everyone will see. So, I'm going to go ahead and turn it over to Kolby and Keith again. Thank you.

-Good afternoon. This is Keith. Can everyone hear me?

-Yes, Keith, thanks.

-Okay, great. So, we will now move on to the final pending recommendation around establishing minimum national standards. The Committee discussed this recommendation on May 8th and



**Federal Aviation
Administration**

deferred a decision or a vote until this meeting in order to address the Committee's questions. Next slide, please.

When a provider requests an air ambulance, they should expect that the air ambulance meets a minimum standard for equipment and personnel to support the patient. But due to the fact that the states regulate the scope of practice for EMS, there are significant variability in the equipment and personnel on board. When these are not matched to the needs of the patient, it presents a risk, particularly for specialty populations.

The Committee had two recommendations for this problem. One was to establish the air ambulance as a provider type in the Medicare program. This recommendation was adopted during the May 8th meeting. The second for discussion today is to require compulsory accreditation for Medicare air ambulance providers, which would establish a more rigorous standard than the conditions of participation. I want to note upfront that accreditation as we discuss here would not necessarily look exactly the same as it does today. CMS would approve accrediting organizations and the standards each organization uses could meet different use cases as long as they meet a CMS standard. That being said, given the significant uptake of the existing accrediting organizations in our industry, we expect those would play a pivotal role in developing this recommendation. We just want to be clear upfront that this recommendation is not about existing accrediting organizations. Next slide, please.

We'll review some important context before we discuss our options analysis. Number 1, currently air ambulance providers do have to demonstrate some basic requirements to be reimbursed for Medicare supplier claims. Number 2, other types of Medicare providers are subject to certificate requirements known as conditions of participation, which includes minimum health and safety standards. These providers must be periodically certified by CMS to remain in good standing. These certifications are conducted by state survey agencies or accreditation organizations provided by CMS. While these are somewhat more specific than the supplier requirements, they're still very high level. We have provided links to this in the slide as an example of conditions of participation.

During the May 8th meeting this Committee approved recommendations to establish air ambulance as a provider type with of conditions of employment. Next slide, please.

Clinical aspects of air ambulances are regulated by the states like other health care providers. However, as we know, this is complicated by the ADA, which in some cases causes some ambiguity around what states can or cannot regulate. For this reason, the Subcommittee felt it



**Federal Aviation
Administration**

was important to establish some kind of national minimum standard to ensure a shared understanding across the industry and reduce the mismatch across state lines.

Finally, 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 that they're regularly reviewed and updated with expert input. There's a strong foundation to build on here. Next slide, please.

Here are the 4 options the Subcommittee considered for Committee awareness the final recommendation reflects options 2 and 3 in this table. For today's discussion, we will focus on that third item, compulsory accreditation for air ambulance providers participating in Medicare program. Analysis of the benefits and challenges of each of these 4 approaches is provided in reference at the end of this session. Next slide, please.

Here are the Subcommittee's recommendations. CS-1A was approved at the May 8th meeting, establishing a new provider type. With COPs would come with some additional basic standards above what is required as a supplier, but these standards would still be very basic. However, it would establish a more robust process for accessing compliance and establishing air ambulances as a provider would likely be a platform for a number of other recommendations, such as implementing quality for programs or requiring the patient safety structural measure already discussed during these meetings. There will be likely very basic standards as we think there is a compelling need for more meaningful shared standards at a national level.

The Subcommittee also recommends 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 accrediting organizations, which would make the transition fairly smooth. However, there are some challenges that need to be addressed in standing up such a requirement.

I apologize. I'm having a technology problem here. Some of the challenges that need to be addressed in standing up such a requirement. If the standard is too low then we've added administrative burden without meaningful improvement and safety and quality. If the standard is too high, we risk putting operators out of business and reducing access. While we don't want to say that a lower standard of care is acceptable in some communities versus other, the reality is that there are parts of the country where this simply may not be feasible. Next slide, please.



**Federal Aviation
Administration**

At this point, I'd like to turn the presentation over to Todd if he's on to discuss some of those exact challenges that areas like frontier areas where Todd works, where need to be considered.

-Good morning or good afternoon depending on your time zone. I'm Todd McDowell. I'm the director of EMS for the state of Alaska. I would be on camera, but we are having some issues with our internet and my video has been glitchy this morning, so I will just be on audio. Next slide, please.

So to start, I wanted to kind of point out some of our geographical challenges, especially in Alaska. A lot of times when we look at maps, Alaska is the small state down the corner. When the reality is, Alaska is the largest state with less roads than Rhode Island. And we span almost the entire our state spans almost the entire country from east coast to the west coast.

We have a large population off the road system, with very long transports to our main hub in Anchorage. And as you can see some of the mileages on the left side, and with the challenging transport times we have, our closest Level 1 trauma center to Anchorage is just 1,500 miles. Depending on where you're at in the state of Alaska, that could be up to a 2,500 mile transport to a level one trauma center. Next slide, please.

Some of the challenges when we look at mandatory accreditation and staffing standards and also triage for air medical. We have bases where we have double paramedics. Whereas the lower 48, the majority of air medical services use a combination of paramedic nurse we have bases that use the double paramedic staffing model. We also have some small rural services that may rely on any available volunteer EMT. Those services may also use non-pressurized aircraft, single engine aircraft and a lot of, sometimes they're also what we like to call the transporter of last resort. Where an air medical service may not be able to get in, but can get off, but they can get out.

And so potentially putting these services at risk, we're not improving patient care in those areas. We're actually decreasing the availability of medical resources because in these communities we're not even transporting from, there's no hospitals in these communities. Their patients are being transported out of clinics with very basic capabilities. And so the need to get them out. The weather can come in and last potentially for days and potentially trapping, essentially trapping some of these critical patients in a very small community clinic for 4 days, and we have actually seen that in some areas where there were no aircraft available on the ground and we've had patients trapped with what we had. We have community health aids with



Federal Aviation
Administration

practitioners, which are very specific to Alaska. They essentially have a year's worth of education and primary care and then utilize telemedicine with a doc to provide care.

As far as specialty teams, we have one specialty team in Alaska, a neonate specialty team out of Anchorage. And the availability is obviously dependent on the call volume. But I know what I've been flying up here, we've either had the option of waiting up to 12 hours for a special transport team or a day or we've sent neonates with non-specialty transport teams.

We also operate mostly fixed wings. We only have 3 rotors operating in Alaska. But even with those 3 rotors when we're talking about triage, they can still, potentially be transporting simple arm or ankle fracture or something of that nature, something that typically would definitely go by ground in the lower 48.

Because the availability of the ground ambulances here, a lot of them are staffed at the BLS level. They don't carry pain medications and things of that nature. And they're potentially hours from a hospital. Our lack of road systems up here, it's not necessarily an issue of do we triage? Is it do they go by ground versus air? It's a triage decision of do they go by Alaska Airlines or do they go by air medical?

Also, we have communities that are 3 to 5 hours in good weather away from the closest hospital. Our volunteer services a lot of times are not willing and just don't have the ability to send volunteers on a 12-hour round trip transport and to a hospital. And so again, we send many patients that would go by ground in lower 48 and they end up going by air just because of pure logistics. So, I think due to all these reasons, there does need to be some sort of waver process in place for these areas and for these services in these areas that may not be able to meet accreditation standards, or triage standards may not fit the operational realities of the areas. Or the standards need to be broad enough that that these agencies in these areas can be fit into this equation. I'm happy to take questions.

-Alright, thank you very much.

-Hey, Keith, you get a little bit closer. We're having a hard time hearing you.

-Yeah, I'm sorry. You're very muffled.

-Thank you. Okay.

-Barely. There you go.

-Yep, there you go.



**Federal Aviation
Administration**

-Okay, so, Todd really gave our Subcommittee a perspective through a different lens, which was really important. And because of his work with the Committee, the recommendations that the Subcommittee came forward with are that first, there should also be exceptions or waivers for air ambulances in rural or frontier areas. It is also possible for providers to opt out of Medicare programs if they do not wish to become accredited or financially viable without Medicare reimbursement.

The Subcommittee recommends proceeding with both these options. The Committee may adopt both, one or neither. If the Committee chooses to adopt B, the compulsory accreditation but not A, establish a new provider type, the language for B should be updated to refer to Medicare air ambulance suppliers rather than providers.

With that said at this point, I'll turn it over to Jeff, but certainly open to any questions or concerns.

-Yes, so let's go ahead and just discuss. Thanks for advancing those slides there so we can kind of see those, basically from the discussion standpoint. So, I'll open it up to the group.

-Okay, Jeff Keith, I also wanted to flag that we had brought a representative from CMS and compiled some questions for the last meeting. If folks feel that they've been answered, then, okay, but wanted to let you know they're on the line to speak to these topics.

- Okay, great. Thanks, Kellen.

-Jeff.

-Okay. Yeah, go ahead, Eileen.

-Yeah, what criteria would CMS use to approve of an accrediting agency, and do they have such history right now with approving accreditation for hospitals?

-Yeah, thanks, Eileen. This is David. A couple of things. What CMS would do is first determine what standards the accrediting organization would have to meet.

And so, if there are existing Medicare standards, for example, then it would be incumbent on the accrediting organization to meet those standards. If there aren't, then CMS would define those standards through public notice and comment rulemaking. And once those standards were established, then it's an open call at any time for any accrediting organization that believes they meet or exceed those standards to apply to CMS for approval. Does that answer your question?



Federal Aviation
Administration

-Yeah, I'm just confused about timeframe because if you don't have that yet, then we're voting for this without knowing how the process is going to work.

-I think it'll just clarify the process is going to be the same, I think. We don't know yet what the standards would be. But I think it, and I'll let Kolby and Keith speak to again what the intent of the recommendation is, but there is a well-established process for us to both determine accreditation standards and also review and approve the accrediting organizations for compliance for those standards.

-And if I may, I saw that you mentioned CAMTS and also NAAMPTA. I did not see your EURAMI listed there. There's all, as far as I'm aware, there's only 3 accrediting agencies in the whole world. And EURAMI is not based in the United States, but they do accredit services in the United States.

-I think just for point of clarification too, Eileen, is that a part of the recommendation would be to establish this and then it would have to be established post-recommendation and adopted.

-Okay.

-So we would have to build it. We would say, yes, we want to, and then we would build all the things that you're talking about of how we do that.

-Okay.

-Right. And so just I wish that we had the authority just to say, yes, go ahead and do it and tomorrow we're enacting it, right? We would have to be able to walk through that.

-Okay.

-Correct me if I'm wrong, David, if I miss that.

-That's exactly right. Thanks.

-Any other questions? Any questions for our CMS? Ben? Go ahead.

-Yeah, thanks. I'm just curious. I'm just trying to think of unintended consequences on the accreditation side part of it. And this is somebody coming from an organization where we have multiple accreditations and think that's really valuable. But, smaller operators that want to establish something in a rural area where there's a community need, how does that work? Is there a timeframe to get the accreditation? Also resources, I mean it takes a lot of time and energy to do these accreditations and larger organizations maybe can do that easier than a



Federal Aviation
Administration

smaller organization. And then the other key is, going into larger stacking questions so I apologize, but if you're a large organization, does every single base get accredited or, you know like if you're across 10 states, or is it site by site? So those are some of the things that are coming to my mind when I look, think about this.

-Yeah, I'll answer some of the questions. Thank you. I'll do the last one first and then maybe you may have to remind me of some of the other ones. The accreditation is based on whatever unit of reimbursement there is. So, in other words, it'd be based on the certification. So, if we certify, for example, we accredit hospitals and hospitals have the ability to be certified under one CMS compliance number. So, there might be 5 hospitals under that same number. And those hospitals could also have one accrediting agreement for those 5 hospitals. So, it's both a decision on the part of the operator as well as the unit of certification that is put into place with this.

And again, I don't know necessarily what that would look like. In terms of cost, we don't have the ability to prescribe or recommend specific cost. There can be options where if they're not accredited, they're surveyed, again as we talked about, by the state survey agency to see if they still meet those requirements. I don't know and I know my colleague Kianna is online. I don't know if we've made any other provisions in terms of accreditation exemptions or any other way that we've dealt with some of the other mandatory accreditation programs we have. Kianna, do you have any thoughts on that?

-Hi, no, I'm not aware of any such exemptions that we make, for any of the providers as far as their accreditation is concerned.

-Yeah, so in terms of timeline, Ben, so a couple of things. One is that again, as Jeff kind of pointed out, there's a process to get all this stood up and put into place. Then there would be if it was a mandatory accreditation program that in order to receive Medicare reimbursement you had to be accredited, there would be an effective date for that. And so there would be a timeframe for providers who wanted to get the Medicare reimbursement to be able to get on with the accrediting organization, be approved and be able to get reimbursed that way. But we don't have the ability again to do anything about the cost specifically.

- Somebody puts a base somewhere. During that time where they're working on getting their accreditations, of course they couldn't get their accreditation before they're up and running. Is there a mechanism by which they could still get CMS funding during that time because that



Federal Aviation
Administration

would be untenable for almost anyone to establish a base, run it for 2 years without getting CMS funding.

-Yeah, well, it would be the existing funding. Whatever existing funding, model is in place. And then once the accreditation, if this was approved and put in place, if we had a mandatory accreditation program, there's not a timeline that they have to wait in order to get accredited. In other words, as they're building their base or starting their operations, they're concurrently seeking accreditation, so when they're ready to go I assume that they'd be accredited and be able to start billing Medicare at the same time. Does that?

-And just point of clarification to just on that is that when, I'm going to put my hospital hat back on this one, is that if say said hospital already is accredited by CMS through Joint Commission or the other accrediting body and they acquire another hospital, they are still able to be able to bill Medicare, correct? For that work. They're not waiting in the wings because it's basically another branch of said hospital.

I'm just trying to equate apples and apples. Ben, to your point, if you were to open another base and you're already accredited to be able to in the conditions of participation, that it's under Life Flight Network as the biller. And correct me if I'm wrong on that.

-No, I think that's correct. It just depends again on, unit of analysis we're looking at and if it's corporations or if it's single bases or you know, and that's something again that can be fleshed out in the rulemaking. In terms of the unit that, the governing body and organization and, what level of discreet distinction I guess we make to each one. So it could be, I'm not advocating this each single base would have to be accredited, or it could be again that the organization itself is accredited and then any bases that they build within that organization are automatically fall within that fold.

So those are some things that kind of get into the regulatory sausage making, but to Jeff's point, the other way to think about it for hospitals, if a new hospital is being built from dirt, again, they're working with their accrediting organization while they're building the hospital so that as soon as that hospital is operational they're going to be accredited and then be certified by Medicare.

-Eileen, how does that comport with how you do the accreditations?

- Yeah, what we in the CAMTS situation we've required that we go out and do a supplemental visit for a new base. And that base is not accredited, per se, until we see it and have eyes on and



**Federal Aviation
Administration**

see that all the standards are met. We ran into this a lot when states were requiring CAMTS accreditation, not only lawsuits, but we ran into a lot of problems with new programs coming up. The state was saying you have to be accredited. We require a year of being in business before you can even start to be accredited because you have to get that all set up first before we come out and do a site visit. So, there's the time lapse there. It could be very tricky for new and extra bases.

-My concern would be for a new market entrant, right? Somebody that has a passion, they want to put something in an area and now are not eligible for that. There's no way that you could start a business in our industry without CMS funding immediately.

-No.

-Unless you use the hospital piece, right, or you certify it as a corporation, right? Or the hospital piece, right, Ben?

-Yeah, you'd have to be affiliated with someone else and get funding elsewhere.

-Yeah, it would be. Yeah, it would have to be a Life Flight Network base. And so as part of the Life Flight Network that you already have that accreditation, right? To be able to do that.

-So, I think it's interesting. So, we're doing this under the premise of qualifications of different clinical capabilities, establishment of a national standard. So, the first one we agreed to in past said to create a provider type so that conditions of participation could be then developed for air ambulances. That creates the national minimum standard. Now we're talking about accreditation and the Committee noted that states imposed clinical requirements were not presented, the Committee noted that the ADA complicates all of this. So, if you're a hospital, you have conditions of participation. But accreditation is actually voluntary and what accreditation gives you is it gives you deemed status with CMS to meet your conditions of participation. So, it's not a requirement. In any other setting for CMS doesn't have requirements for accreditation. What accreditation is voluntary, but it gives you deemed status. So, I think that what we're maybe trying to get here, and we're very, very big believers in accreditation, I think that external measurement of all of the things that quality, safety performance, all those things are incredibly important. We're big believers in it. But I think we're trying to push this because of a national minimum standard because of the problems with the ADA. So, I just would offer that that that deemed status and voluntary accreditation conditions of participation, if you get those, give you the national standard. Not accreditation.



**Federal Aviation
Administration**

-And Tom, I think I'm aligned with you on the conditions of participation. Not the ADA piece. I think we differ there as the root cause, but I agree with you that the conditions of participation, and in establishing as a provider type is the good step. I'm concerned about voluntary accreditation.

-And if I may add some of the states who required CAMTS accreditation, that's what they did. If they had the program that had CAMTS accreditation, they didn't have to go out and do inspections. They provided a thing where they call it deemed status, as Tom just talked about. And those that didn't then had to go through accreditation separately.

-Jason.

-Yeah, I would just, I mean, I think probably a little bit of what Ben said. I would say that I agree with Tom's statements around the conditions of participation. I am extremely hesitant to say that we want to have another government agency essentially create a new set of regulatory standards for an industry that already has, in a lot of places, voluntarily set up minimum standards to ensure quality in the way that we conduct our business. So, I think it's more about ensuring that that minimum standard can be pulled in than it is rewriting the book of how we accredit the various operations. And I want to just say I think we also have to be extremely careful about messing with things like the ADA or the current division that exists between CMS, FAA, some of these government organizations. We haven't even mentioned the DoD, which has a whole other set of standards. So, if our job here is to ensure that we're able to deliver care to as many patients as possible under the right circumstances, I think we just have to be very careful that we don't make a landscape that's difficult to do that in.

-Okay, thank you, Jason. Any other discussion? Can we put up the recommendation? Please. So, this is what the recommendation has been as written. Congress should pass legislation and require compulsory accreditation for Medicare air ambulance providers to the minimum standard assessed by the accrediting organizations. It 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. Accreditation standards should be reassessed on a periodic basis, soliciting industry input on proposed changes. So, that's how I read it. Dr. Hinckley, for discussion.

-I guess I just want to ask, Eileen is probably the world's greatest expert on accreditation of air ambulance providers. Do you think this is a good idea? Do you want this to pass?



**Federal Aviation
Administration**

-It resulted in us in 2003 having a lawsuit where our E&O insurance went from 3,000 a year premium to 30,000 a year since that time. And that would be my fear. If you name CAMTS specifically that would really be a problem. If you say an accreditation agency, there's a vast difference between what CAMTS does and maybe another accreditation agency. The qualifications of the Board of Directors, even if there is a board of directors, there's no really national or any kind of standard. Anybody can get into the accreditation business. That's the problem. And the way we've designed it, most of the experts in every discipline that's involved in air ambulance, that's not true of the other 2 accreditation agencies. So, it's apples and oranges but I don't like the word compulsory accreditation. And if you don't say who the accreditation agency is, I guess we would be less liable, but I really don't know how you do this. I know joint commission used to be the only accredited agency for hospitals. There are others now. So how does CMS deal with that? As far as discrepancies and types. Do they have criteria to look at as far as which hospital accreditation is or isn't acceptable?

-Yes, so again, we have the Medicare conditions and participation for a hospital. So, any entity that wants to become an accrediting organization can. They have to meet certain criteria including being national in scope, things like that, but they provide to us their standards. And then we do an evaluation to ensure that their standards meet or exceed those of Medicare. Some accrediting organizations, for example, just take our standards and say, here's our accreditation standards. And that's perfectly appropriate. But they have to demonstrate that they meet our standards and that they can then survey to ensure compliance with them as well. Does that help Eileen?

-Yeah. I certainly think, we already have developed all these standards over 35 years and have a lot of history so certainly it's a good way to look at this. But I just don't want accrediting agencies to be put into a litigation type of situation. And I don't know if this would do it or not, if they don't specifically say who the accreditation agency is or if that would make a difference, I don't know.

-And just to be clear for all of our credential programs, we don't identify specific entities. It's open to anyone and then we just approve that. But none of our regulations speak to a specific accrediting organization.

-Okay.

-Rob, you had your hand up or did you get your question answered?

-Question was answered.



Federal Aviation
Administration

-And is there any recommendation for changes in the language or is everyone ready to be able to vote on this? Tom.

-Yeah, I would love to get to yes here, but I think there are some pretty significant pieces of this. So, I would recommend, and I sent it to Kellen, that Congress should pass legislation to require conditions of participation for air ambulance providers. Voluntary accreditation by CMS approved accrediting agencies will provide deemed status for meeting COPs.

And then the minimum standards assessed for COPs and accreditation should have the process to develop these COPs and accreditation standards with the rest of the language the Committee developed about periodic reassessment compliance and such. So, I think that would get to this little bit better than the compulsory accreditation. This is out of CMS or what they do. It's yeah, so that might be still a little bit of things that need to do this, but that might be a better way to get to this.

-Jim.

-Tom said it well. I would lean towards looking at the language you see presented regarding conditions of participation.

-Yeah.

-I see the accreditation as duplicative. If we're going to outline expectations for conditions of participation.

-I think it is important that the Committee identify that any accreditation standard and the COPs need to really think about all of the United States.

-Yeah, and I actually clarified this for Eileen, duplicative from the requirement of participation. I'm also, like many on this call, a big advocate for voluntary accreditation as an additional quality effort but I think those 2 things are segregated.

-Yeah, I'm just wondering if we need this recommendation at all, if we're saying a provider type is good, then is that good enough? And then I like your wording a lot better, Tom. But is there going to be an unintended consequence that we're not thinking of in this Committee right now if we vote to recommend this?

-I think the question will go back to David. Does being a provider, that is moving to a provider from supplier. If you're a provider, does that require conditions of participation? And if it does,



Federal Aviation
Administration

then I think with Ben this may be moot. If it doesn't, then I think you would need that additional piece, which sets a national standard of conditions of participation.

-Yeah, and Kianna you can fact check me, but if. If the recommendation is that air ambulance becomes one of the certified provider types under Medicare then that conveys conditions or participation as well.

-Okay, so.

-Correct.

-Would that also?

-Yes, since that language was included in recommendation CS-1A, which was adopted.

-And Kianna, are you, do you agree with that?

-Yes, I do. That's correct.

-Would that be inclusive, those conditions of participation as far as, versus voluntary accreditation being comprehensive across the entire organization?

- For COPs with a deeming option through accreditation, again, everyone has to meet those COPs, whether through the accrediting organization or through the state. The accrediting organization can then have additional standards that can do with a wide range of things above and beyond the COPs, or complimentary or tangential to. So, we don't have any say in those. We're really just looking to see that they meet, in terms of their basic standards, what we put out for Medicare. And otherwise they're free to do anything they want after that. Does that help Kolby?

-Yeah, it does. And then, so I think that, just so I understand it right, it would be COPs or deemed by accreditation.

-Yeah, and just to again put a quick example on it. So Joint Commission again, which everyone recognizes, has certain reporting requirements. They can have certain centers of excellence that they can accredit or certain, like cardio stents or things like that, programs that they might give a separate accreditation to or a separate focus on. They could do all that, which is just in addition to the Medicare COPs. We don't do those things, but they have the ability to add those things as expectations for accreditation by their members.



Federal Aviation
Administration

-Okay, with that information I guess here there's two questions on the floor, right? Is should we have it and I'm still not, and are we being repetitive, right?

It sounds like we're not, or we are. I just want to be able to see, can we adopt the current language as is and take it as a vote from that standpoint and go from there. And MITRE please check me on this one. Is that kind of how we would go for it? On that side.

-Yeah, you can vote on either one of these versions, whatever the Committee prefers, or not.

-Alright, so given that and any discussion. Is there more consensus on looking at the one that's highlighted as one that we would take to a vote for the Committee for a recommendation?

-Definitely the one that's highlighted that Tom brought forward.

-Okay. Anybody else besides Eileen want to comment on this? Kolby, Keith?

-To David's point, you might be able to get rid of the first sentence.

-Right, because of our vote. Last.

-Yeah.

-So, just, basically it would be voluntary. Yeah. Thanks, Kellen.

-And again, the MITRE people might clean it up a little bit.

-So with that latest change. Are we good, are we comfortable with saying let's vote on that highlighted amount for that statement for CS-1B? Okay. Alright. Oh, Dr. Hinckley.

-Sorry. Rural slash frontier areas. I'm wondering if that could just be frontier because I think almost everybody in the continental US operates at times in a rural setting and I think most of us don't need or deserve an exception. Fully understand the situation in a true frontier area like Alaska. But I'm just wondering about that language.

-So take the rural out but leave in frontier areas. Is that what I'm hearing you say?

-I guess. Yeah, that's what I'm wondering. But I'm interested in others' thoughts.

- You guys talk and I'll listen, how's that? For the first time in my life. How's that? Jim?

-I was just going to say, I think there's already precedent for the type of language and what's defined. So I would suggest if CMS already has that in place for rural frontier that we would align it in the language.



Federal Aviation
Administration

-Jason.

-Yeah, Jeff. I guess I'm getting hung up on maybe a couple of things here. I'm not clear on if we have, I think it's CS-1A, that's going to set provider status and conditions of participation. Wouldn't the process of all of that allow for this to happen organically? And moving a recommendation forward that says voluntary accreditation when it's a recommendation that essentially is being mandated, is that voluntary? I just feel like this is tripping me up because if we already have the condition on one side of the fence, won't that process get us here without kind of trying to account for every wordsmith option.

-So what I'm hearing you say is there's the highlighted yellow as one option for this and then the other option which is B is to recommend that we strike this. Is that what I'm hearing you say? Jason? Strike this recommendation.

-Based on the fact that we've already passed a recommendation that I think covers what we're trying to get to here by intent.

- Okay, so probably what I'm saying is that we would, and again I'll ask for MITRE, is we propose the recommendation and everyone votes on it like we would do and that's how we would accomplish that. Correct?

-Yes, I think you could hold the vote even if you think the outcome will be to strike the recommendation.

-Okay.

-Or you could vote to strike the recommendation. The other thing we could suggest is if you wanted for clarity, you could append some of this language onto recommendation 1A, which also references the conditions of participation, just so it's all in one place.

-But wouldn't we have to vote again if we added this language on to the recommendation?

-I think you would be voting to append, like not to remove 1A, but to just modify it and if you choose not to modify it, 1A still stands as is.

-Got it.

-Up to you, there's a few options.

-Okay. Ben.



Federal Aviation
Administration

-Yeah, I'm processing. I would be fine going forward with a vote. I think I'm still a no, just because I think there's some unintended consequences, but we can, happy to vote on it, but just my opinion, because I think we're covered in 1A. I really do.

-Okay. Dr. Pritzker.

-So, do we even need the word frontier? Waivers and operators in areas where certain standards may not be feasible, so there may be even urban areas where there's a shortage of specialists. So, should we delete the word frontier?

And a second thought is do we delete the word voluntary? The first word. Because we have the process to develop COPs and accreditation, include periodic assessment and include exceptions or waivers for operators in areas where certain standards may not be feasible. So does that qualifying statement 3 lines down allow for deletion of the word voluntary? Ideally, we want everybody to be accredited, but we understand there's going to be areas, rural, frontier, urban with specialist shortages, that won't be able to be accredited.

-I think it's the same that you don't have to be accredited. To get paid by Medicare, you have to meet conditions of participation. To be accredited just deems that the possibility, but I would go back and I think that Jason and Ben may be right that if in fact the whole process as David laid out, that if we have that you're a provider and you have conditions of participation and that process already includes that voluntary accreditation will give you deemed status for those COPs, then then maybe this whole thing is actually moot.

-Okay. Any other comments? Cause I feel probably what we need to do, I think we should have vote. Vote what you want to be able to do on this, given all the discussion. My guess is that I'm not quite sure that even changing the language is going to get us to where we need to be able to be. But I am open to be able to voting on the highlighted area right there. To be able to highlight the discussion and then take it to a vote.

-Actually, having made up that language, I'd be happy to make a motion to strike the whole thing. And, as David said, most of this is actually moot.

-Okay. Alright, thanks, Tom. Okay, so the motion on the table right now is to strike the recommendation for CS-1B. Do I have a second and then I will go to the votes?

-Second

-Second.



Federal Aviation
Administration

-Okay, alright, okay, so Committee members should vote yes, no, or abstain. Please ping Nicole on this and if you believe you have a conflict of interest, please do so.

-And we're voting, just to clarify, we are voting to strike. Putting down this language. Okay.

-Yes. We are voting to strike it. Yeah, we are voting just so that we were voting to strike recommendations CS-1B.

-Because it's already incorporated.

-Okay, alright, so I am going to call everyone again. Thank you.

Committee Member	Response
Commissioner Arnold.	-Yes.
Jason Clark.	-Yes.
Ben Clayton.	-Yes.
Colonel Coffee.	-Yes.
Eileen Frazier.	-Yes.
Dr. Gamber.	-Yes.
Dr. Hinckley.	-No.
Jim Houser.	-Abstain. Conflict of interest.
Tom Judge.	-Yes.
Paul Julander.	[Not present]
Dr. Pritzker.	-Yes.
Jason Quisling.	-Yes.
Robert Reckert.	-Abstain.
Jeff Richey	-Yes.



Federal Aviation
Administration

Okay. Moving on to the next. I think that we've got a little bit more time here. So, this is review of recommendation and discussion. So, remind me, my MITRE team, how much more time do we have? I know that there's a break coming up right between 4:10 and 4:20. Just to be able to make sure. And then the last part is just closing for the last 10 minutes. So obviously we can continue to be able to work through everything and then give everyone the gift of time. I do think that, given that we did end the last discussion point on the other recommendation that was not brought forward from the Clinical Standards Subcommittee, and we didn't get to finish that out, and then also discussing that with the team and with David that we can also continue to be able to have that discussion. Yeah, Michelle.

-Yes, why don't we go to at least 4:20 and reassess where we are.

-Okay.

-And then we can navigate from there. If that works for you, Jeff.

-That sounds good. Yep.

-Okay, perfect.

-Okay, so we're going to continue on. I guess is there anything more that everyone wants to be able to discuss about that? And I'll just leave it there and then I can go over the review of the recommendations if there's no other further discussion on that topic. Tom? And you're on mute.

-I put the language that I think actually was pretty much the original language from May and sent that to Kellen. I would like people to take a look at that, and then just go on record about this because I think that it was a very, very important discussion at the AAPB. It's a very important discussion for the insurance commissioners from the states, it's a very important discussion for all of the EMS state directors. And I again, believe we're remiss if we don't at least evaluate. We're not saying change. So, I'd love to see that language put up so people can actually look at it.

-I think that's a great plan. Okay.

-Yep, just give us one moment. And the language you put is the highlighted version here.

-Right. If we're looking for a data driven design for a system, and we've done lots of work on data, this to me is part of the data to understand how the system's designed.



Federal Aviation
Administration

-Okay, so I would open this up for discussion then from the group. Jason?

-Thanks, Jeff. So first, I mean, Tom, I agree with you. It's definitely a very important discussion and I appreciate your passion around it. I'll say that, from where I sit, I see decades of court rulings and committee work that have referenced the ADA and talked about it and I think can't really imagine a world where I could effectively service the states that I service today across the country if I had a patchwork of aviation regulations and a patchwork of oversight around those operations. And I think, it's extremely dangerous in terms of unintended consequences if we go to the point where we're going to clarify, and that's what the language says, is seeking clarification, which is essentially a ruling on what the ADA does and doesn't do. And I think we're just getting way outside of the scope of the Committee here, because we're essentially moving into states versus federal government. So, I'm not supportive of going down this path.

-Ben.

-Yeah, I'll just say I agree with Jason there. The states in which I operate, there's no world in which I could be supportive of going down the path of looking at ADA preemption. It's just, when you're talking about patient safety, I do think going down that road on interstate air ambulances, it would have a detrimental impact on ability to transport, ability to get to the patients that you need. I think there's a lot of unintended consequences.

-Nothing about aviation in there. Clinical aspects of air ambulances.

-Krista.

-We've talked in previous meetings about the air medical transport industry evolving from transport and I should say not into health care but adding that health care component to the transportation piece. Is there an opportunity here to create something that's sort of the corollary to the ADA that is specifically clinical? To kind of capture what the intent of your concern here, Tom, would be. I think what we're looking for doesn't exist and is this something that can be created?

-I also want to just ask the question just with the AAPB recommendation already submitted to Congress in a report, has it already been recommended from that report? And is it already out there? And why would we do that again, I guess? And I think also, on the things that we just talked about with being a Medicare provider I believe sets the clinical standards that we're trying to achieve. So, I think two questions is, and I'm just throwing this out as discussion point, is it already out there as a standalone AAPB that people can reference back as a



**Federal Aviation
Administration**

recommendation. Is that enough from that standpoint? And do we even need to address it in this Committee?

-If you look specifically at what the AAPB did, all the AAPB recommendations were to actually carve out parts of it or to change the Airline Deregulation Act. This does not do any of that. This is saying, look at how this works and does it or does it not apply to states' ability to regulate clinical practices. So, this is, I would say, in line with the AAPB, but it's pretty substantially different because every one of the 4 recommendations from the AAPB did some actual modification to the ADA.

-I guess what I'm saying is, I'm not supportive of modifying the ADA, particularly the problematic here is the certificate of need. I mean, so now all the states are going to regulate rates, routes and services because we can no longer put what if my aircraft needs to go to Washington, but they don't have a certificate of need up there? It's just, this will have a detrimental impact to patients.

-Jim.

-I continue to try to get understanding around. I initially looked at it from the vantage point of understanding that we have too much regulation at a state level when you look at our industry, as it relates to clinical care and clinical standardization. Coming from that angle, initially I could see the logic behind clarifying the role of the ADA in this. But as our conversations continue to progress towards certificate of participation, while I understand that that's just for Medicare, similar to a hospital that builds a building, the regulation is around the medicine fall under the certificate of participation. Whereas the ADA is speaking to our aviation operations. And I'm all in favor of trying to simplify this. And I certainly understand some of the challenges and complexities that the ADA brings. With everything there is a risk and there is a benefit and certainly, and it's been clearly noted the risks of the ADA and the implications to growth in our community. And that could be argued the good or the bad depending on access and depending on your perspective. But I'm fearful that if we go into a clarification mode on the operations around aviation and those who have to manage a certificate and ensure aviation safety, the risks of what that opens outside of medicine and I understand the context of this discussion is focusing on medicine. That looking at the requirements for participation with Medicare to help us with the medicine and keep the two segregated to me. This seems like a natural progression to moving forward with our quality and safety expectations on patient care and allowing this to be the vessel, to allowing our rules of participation. My mind is blanking. I've said it 3 different ways now, so forgive me. The conditions of participation allowing us the guidance for clinical



**Federal Aviation
Administration**

care and the ADA allowing us the guidance for our aviation operations. And that's, maybe I'm looking at that too simplistically and I'm not seeing it correctly, Tom, but that's from my perspective where I see this as a win that we can use. One is the vessel for our clinical needs and the others are vessel for aviation operations.

-Krista.

-So, it seems clear that we need to keep the transportation aspect of the industry separate from the healthcare and medicine aspect. Are you, Tom, is it fair to say that the intent of this is to study the ADA's impact on the health care aspect of the work that we do, and if so, can this just be reworked to reflect that need to study the impact of the ADA on the clinical aspect of operations?

-It could be simplified to that. There is a lot of gray areas of what's clinical medicine under the ADA because people have gone in under clinical medicine requirements and said that's economic regulation. So, there's been court cases that clinical aspects of medicine are preempted by the ADA because of economic regulation.

It took us 4 years to get the DOT to agree that temperature control in a helicopter was actually a clinical piece. It took 4 years of arguments with the DOT to say that the temperature regulation was actually a clinical requirement, not an aviation standard. So, there are tremendous number of gray areas with where the states go, and I think that's exactly what the states testified and the insurance commissioners testified to, and the AAPB was there and that's how those recommendations. They're like, we can't fully. Leave aside aviation safety. The FAA controls aviation safety. No one has any issue or argument or question about that. But all of them testified that they couldn't fully deal with situations at hand because of the issues around the ADA.

-Dr. Hinkley.

-A couple people have mentioned unintended consequences, but I feel like the current state of play has led to a lot of unintended consequences. Specifically around the volume piece. There may be nothing in all of clinical medicine that is known with greater scientific certainty than the fact that when you're talking about critically ill patients and procedures or things that need to be done to optimize those critically ill patient's outcomes are done better by people that do those things at higher volumes. That's been true every time that it's been studied. Whether you're talking about ECMO or cardiac cath. And clearly it applies to people that take care of critically ill patients on a helicopter. And the per provider volume of patients taken care of now



Federal Aviation
Administration

compared to 20 or 30 years ago is way less. And that is having a bigger impact on patients than I think people realize or are willing to admit.

And I would second what Tom brought up before that. I do think that at least considering this question should be in the purview of this Committee, and not just the Subcommittee.

-Jim.

-I'd start first with response to Dr. Hinckley, as I mentioned in the chat. We've been fortunate academically to do research both on the consequence of experience and as Dr. Hinckley points out, certainly repetitive experience increases the prowess of a provider and their ability to do care at an exceptional level. There's no argument from me there. The challenge is we've also published this research that shows your mortality decreases with proximity to an air medical resource or a trauma center, particularly in the case of a trauma patient. So, defining the balance in the intersection of where those two intersect appropriately still has to be answered.

So, I think to just make the arbitrary statement we'd be better off with less resources is not a fair statement for any of us without additional information. Furthermore, when we look at the ADA and how it applies to regulations, Dr. Hinckley, I'll just go to you again since you spoke last. You serve a neighboring state routinely. If we look at this differently, we talk about unintended consequences, there is a risk that there could be neighboring state requirements that are put into play that negate you from being able to serve in that state without additional measures, perhaps additional requirements, which by the way, clinically we all now know anyone who has more than one state that they serve, from a licensure perspective if you live in a neighborhood where you border more than one state, you already have to meet multiple requirements from a medicine perspective.

The organization that I work in today has licensure in several states. Not because of size or scale, but because of geographical proximity to multiple states in the corners in which we serve. We have to meet the requirements of each of those states, even though the ADA is in place today the way that it is. So that's where I started with if it were to limit the oversight of the state, but the way we're writing this is actually to increase the oversight of the state, which I think would only impact patients in a detrimental way because it would limit resources, which I hear loud and clear seems to be in favor for some, but again, I don't know that we can simply place horses provides more experience, which then is better for patients, only up until we get into the situation where we have patients that have to wait where we also have research that shows lack



**Federal Aviation
Administration**

of access is detrimental to our patients as well. And that's where it becomes a somewhat circular argument. Thus, my concern with the unintended consequences is it relates to the ADA.

-Jason.

-Yeah, I think Jim said that very well and I think at the heart of this for me is the fact that when we have multiple regulations coming into play and we add to that bucket, we increase the complexity of the operation, and the more we increase the complexity of the operation, the fewer options there are to provide service.

I think it's that simple of a math equation for me and I think that ends up, regardless of which area it might fall into, I think that ends up preventing us from achieving what the overall intent of this group was, and that's really how do we provide more service options in a safe manner at a higher quality. I do think that repetition certainly can improve expertise and quality outcomes, but I also think that the research, the quality assurance that happens with current providers, the training that's undergone with the current providers, covers off on a lot of these potential gaps.

And I think we have a pathway to patient quality and standards that exist today, which we just debated around the accreditation piece of this and using the temperature inside the aircraft as the example. We have accreditation standards out there today that set that minimum. So even if the state doesn't require it or it's not required by an aviation regulatory body, we still have that representation for the patient available and we're talking about standardizing that now in a broader way. So. I just think that there's tremendous risk on the side of upsetting the cart in going down this path. And I think we have other alternative solutions that get us to the intent of driving better patient outcomes, better patient quality of care in an aircraft.

-Alright, thank you, Jason. So, we have 20 min left since it's 4 o'clock Eastern Standard Time. Is there any further discussion? What do we want to do with this? So I guess I'm bringing that forward. There could be recommendations, or there could be anything from that side or is this discussion good enough? I'm opening that up to the Committee for the next 20 minutes.

-Just a clarify, Jeff and Tom is, is the highlighted portion on the screen new language presented today or was this the original recommendation?

-The original recommendation is up in the top there, the non-highlighted spot. Tom provided additional language to change the language for the discussion.

-Yeah, so, Jeff, I'll just chime in briefly. So, the language that Tom pulled, I think was from the May 8th meeting. So that is an older version that was put forth by the Subcommittee. The



**Federal Aviation
Administration**

version up top here that is not highlighted is one that we discussed with the FAA since that meeting. They felt this version of it was more actionable. So, if you feel that either one of them meets the intent, they had indicated that the first version was preferred from a government process perspective.

-So, with both of those there, I guess I'm open to what does the Committee want to be able to do for a next step? Is the discussion that we have just gone through, which is going to be in the record? Or do we need to formally look at this or formally vote on something? So, Rob, I'll let you chime in.

-Thanks, Jeff. I have a question and then I have some thoughts. I guess the question is mostly toward MITRE or the Subcommittee Chairs about are we being procedurally correct with the charter, where the Subcommittee wouldn't bring the recommendation forward and the Committee is now discussing it. I understand the conversation both ways but I would like to understand if we are being procedurally correct with the charter.

And then the second side of this is, there's an obvious amount of interest, if you will, and thoughts about this recommendation. It seems a bit complex to make a quick decision about. I think in committees and these types of federal advisory committees when there's consensus with the group around recommendations they tend to get the most traction. It most definitely doesn't sound like we have consensus around this recommendation in the background. And so, I would offer that it should be discussed, about should this go back to the Subcommittee and be discussed, or should it be left off because it's so much opinion still around it and I don't think it's necessarily.

-Yeah, this is David. I don't think there's a procedural limitation with regard to the charter or the scope of the Committee for the full Committee to either take on a discussion that maybe wasn't completed in the Subcommittee or to pursue their own path. It's not required that anything the full Committee discusses has to have been approved by the Subcommittee.

-Yeah, the other thing I think I've heard, David, as the conversation matured, is there was a lot of comments about this recommendation being out of scope to the Committee so I think that is something that probably needs to be landed before the recommendation or any type of recommendations.

-Yeah, I don't know who makes the ultimate determination about whether it's out of scope or not. And also again, the agencies that have chartered the Committee have the ability to accept the recommendations or not. So, I don't know necessarily that, given the charter of the



**Federal Aviation
Administration**

Committee, that this recommendation is necessarily out of scope. And again, I don't know the process for determining that and happy to explore that more. But I don't know that we can preclude further discussion based on scope at this point. I think that's something that we'd have to determine in terms of what goes into the final report.

-I think the final option out of that conversation between not land it today, and go back to the Subcommittee for further discussion.

-I think the issue too is that this is it. So, we can't take it back to the Subcommittee. I think that we're out of running out of time, but also just for point of clarification so everyone knows, is that the Clinical Subcommittee did withdraw this recommendation. So everyone's clear on that. That's why it didn't get into the packet that everyone received on Wednesday. So, I think Rob to your point, it's just time right now and I don't think we have any more time unless MITRE and David tell us that we're asking for more time.

-Perhaps, Jeff, the path of least resistance is to say that the Committee discussed this in detail. And there is need to at least look at this in the future and could certainly work on the language of what that might look like. But the Committee identified that there were gray areas and they put it in their report today that the ADA has an impact on states' ability to oversee clinical care. It's in the report today. And so, if we can't resolve it, we can't resolve it. It certainly doesn't sound like it's going to be completely resolvable, certainly not to any great consensus among this group. So, maybe the thing to do is just to put it in the report as language that there was extensive discussion around this issue. And then to work from there.

-Yeah, I think that's probably the best pathway forward, Tom, is that we've had a robust discussion about it. And it's in the record that we talked about it.

-And you could say there's points on either side, I don't know. It needs to probably be a little bit more than robust discussion. There needs to be some detail about what the issues are but it couldn't be resolved.

-Yeah, I think that's me kind of paraphrasing at the end of the day, right? So, I think that there was a discussion, and I believe that we'll get the record from what MITRE has done to be able to bring it forward and you'll be able to review what we discussed and making sure that there's any sort of clarifications when that goes out, that will highlight exactly what you just said.



Federal Aviation
Administration

Okay, so I'm going to move on to the next section here. We're going to review the recommendations and then get to the to the break here, or get to 4:20 and then we'll see where we're at.

Okay, next slide. So, recommendations that will go into this report is FS-6. Mandate critical safety standards for air ambulance occupant protection. That is what we voted on and that recommendation passed. Fight safety update report language, that passed with 13 yeses and so that would also be adopted. Recommendation CS-A, medical necessity, with the changes that passed there. Recommendation CS-B, reimbursement adequacy, that recommendation passed with 12 yeses from there. Recommendation CS-D, data collection, also passed with 11 yeses and you can see we did strike the recommendation of CS-1B to establish minimum national clinical standards and that is there.

So, next slide please. Okay, so anything else for the next 10 minutes and then we will go into the last 30 minutes of our conversation. Rob.

-Motion to forego the break and press on with getting the meeting completed.

-Second.

-You got it. Alright. Thanks everyone, let's keep on going. So, let's go to the next slide. Okay, so this is public comments. So, I will look to the MITRE team to see if there has been any public comments. I've been checking my box here to see if I saw anything.

-I can speak up. So, we have not received any public comments as of today. So, we know that HHS offered to accept oral comments and, at this time we can move forward. We'll just remind everyone that any type of question that the public might have can be entered in the Q&A box that's found in this meeting and those will be answered following the meeting and added to the summary report and you can access that on the CMS website. And then if any member of the public would like to submit a written comment for consideration for the Committee, you can email it to AAQPS@CMS.HHS.Gov and comments will be accepted until July 30th, 2025.

-Okay, I think this is the end from the formal Committee and then I have a section after, mostly on a reflection from the Committee group. I will hand it over to David.

-Sorry, I think Jeff I'm the Rep-wrap.

-Okay, alright, so I'm just going on the run of show here, I got to flip these things together probably. What I would say is a couple of things and then David could do the Rep-wrap. I think



Federal Aviation
Administration

what I guess I would ask for. So, I'll give a context of what's next and then I'll ask for any sort of reflection.

So, regarding the Report to Congress, the Committee will make recommendations to the Secretary of Health and Human Services and the Secretary of Transportation on options to establish quality patient safety, clinical capability standards for each clinical capability level. Following this meeting, the Committee will receive information regarding the report timeline and review process. Should you have any questions, the meeting management team will support in fielding these for myself and the DFO, David Wright.

I want to thank everyone on this Committee, and anybody that produced public commentary, those that are on every Subcommittee for the time and the effort that you spent on coming up with these recommendations. I think it was it was pretty amazing, and I was very happy that I got the privilege to be able to sit in on a lot of these Committees.

So, as we're working with a tight timeline for completing the report, we're going to work with Committee members to write the report to Congress over the summer. The public can continue to send feedback on what they have heard in the meeting. So, members of the public may submit written comments for consideration by the Committee at any time via the email aaqps@cms.hhs.gov. Comments will be received until July 30th, which is the end of this month. As a reminder, we want to note that all questions entered in the Q&A will be answered following the meeting and added in the summary report as we post on the Centers for Medicare and Medicaid Services AAQPS website.

So, I guess what I would like to do is just go back to just kind of the reflection and I can call on everyone individually or I can just open it up for people to be able to see how things kind of went. So just go ahead and put your hand up, and we can go from there.

-I can start since I'm listed first. First of all, I want to thank the MITRE team and everyone who has pulled all this together. It's really great work, and I know it's a lot to come together. I think these are a lot of really tricky topics it gets into. I think we've covered a lot of the borders of policy and systems, which is always really challenging to do when you're bumping up against payments when we're about quality, and those kinds of things, and this group has really tried to navigate that as best as possible. So, I appreciate all the work, and David and Jeff for shepherding us through. I really appreciate the ICU nurse in you, Jeff.

-Thanks. The OCD nurse. I'll just go down the list. Jason.



Federal Aviation
Administration

-Yeah, great work by the Subcommittees and all those involved. This has been really informative, and looking forward to seeing how this better impacts our industry and those that we serve moving forward. So, thank you.

-Ben?

-Yes, thank everybody for all the time and input. I think this group, there's been some impassioned conversations, and I think it just shows that everyone here really, truly does care about the patients that we're serving, and I'm hopeful that this report to Congress will actually go somewhere and will have an impact.

-Colonel Coffee.

-First of all as a guy who writes policy here in the Department of Defense for the Air Force, I understand the challenges, and I will say that everyone on this Committee and the Subcommittees have masterfully worked through the challenges of writing policy. As the patient advocate and activist that is here, it is so refreshing to know not only that my well-being and my son's well-being and all those that are served by this community, that it was really still at the forefront of the minds of everyone here, and it really came across. It was very evident, all the work and the recommendations that were put forth, that we did things with patient-centeredness and quality and safety in mind. Certainly appreciate the very comprehensive review and look across the many domains to ensure that we had a very complete product. And so, I'm just very thankful to be on the Committee and for the work that everyone's done.

-Thank you. Eileen?

-Yes. It's been a pleasure and an honor to work with all of you as kind of a culmination of my retirement. I just recently retired. But I was happy to serve on this Committee in whatever capacity I could do. Jeff and David, you did a great job keeping everybody together. And thank you for all, for all your hard work.

-Thank you. Dr. Gamber.

-Awesome discussion. I'm a better physician for having been surrounded by amazing nurses and medics throughout my career and I'm excited about where this could take us. For them to be recognized through air ambulance as providers, I'm excited about that discussion for the industry, and I just congratulate everybody on a fascinating discussion.

-Dr. Hinckley.



**Federal Aviation
Administration**

-As Eileen said, truly an honor and a pleasure being a part of this. I mean, all of us have poured our heart and soul into air ambulance in the United States, and I think that this Committee has worked hard to do some things that will make things better. I would love to see the US considered the world leaders in air ambulance. I don't know that we're there. We definitely did some things to move in that direction. I think there's some things we could have done more, and I'd be happy to be a part of that work in the future, but I have learned a lot from each of you. So, thank you everybody.

-Okay, Jim.

-Thanks, Jeff. As everybody has said, I really appreciate the leadership, Jeff, that you provided to this group and a shout out to the Subcommittee chairs as well. I know they didn't have an easy task. And as Eileen said, really a pleasure and honor. It's been great to get to know the folks on this Committee and certainly I've benefited and I've learned. I certainly can appreciate Tom Judge, Chat GPT Tom and his tremendous knowledge as it relates to the industry and the contributions that everyone's made and I really appreciate it.

And I say that because, we all know life doesn't stop. Things get hectic. I know mine's been particularly hectic. Some of you may know, some of you may not know, we just welcomed our first grandchild into our family. He and I got to go on a helicopter ride on his birthday. He developed respiratory distress from an airway issue. Something that couldn't be treated at the community hospital where my daughter delivered him that morning. The team was amazing. The work they did was amazing. After 40 plus days in a NICU, several surgeries later, he's home, he's doing well. And I share that quickly because he is the story. Like many of you here have experience, he's why we are all here. I just want to reinforce all of our passion here. This isn't a health care transport problem. We, as a community, are a solution to access. Our teams get help, they get the care to those who need them in a circumstance where maybe they aren't getting the care that they need. Maybe there aren't the right teams there, whatever the case may be, we provide that bridge. We are the access to our patients getting definitive care. We're not just a mechanism of transport. I'm really proud of the work that we've all done here today. I hope that Congress listens to us, and I would echo Dr. Hinckley that the work is not done. We still have much work to do and again I just thank you all for the opportunity.

-Thanks, Jim. That's great. That just brings it around to the why we're here and bringing us back to purpose. So, thank you for sharing that. Tom.

-You're muted, Tom.



**Federal Aviation
Administration**

-Yeah, thanks. I agree. You know, great leadership and the team from MITRE, and appreciate everyone's work in the Subcommittees. You know, if this, as Ben says if this has an effect, then I think we've made some incremental, important good steps. This is the first time, the first time that the federal government has ever looked at policy around air ambulances. The first time, right? So, we have 50 years of history, and we finally had a chance to do it. So, we made some important work here. But we also made a lot of misses. And I think there's a lot of work to still be done, as Bill and Jim said. We did not sufficiently address the clinical triage issue. We did not sufficiently address the tiering issue. We did not sufficiently address the different capabilities of air ambulances. All of those were in the specific charges by Congress. Not enough time, perhaps, to do that, but those become misses and the organization of the system remains a real challenge. So, lot of great work, hopefully it takes, and if it does, it's an important first steps. But it did not get us there, after 50 years. And I think the glass is always technically full. But I think there's a tremendous amount of more work that still needs to be done.

-Thanks, Tom. I appreciate that. Okay. I don't know if Paul ever joined us. So, Dr. Pritzker.

-So, I reiterate all reflections as stated by our esteemed colleagues here, and I look forward to improved air ambulance quality and patient safety for all of us stakeholders. Thank you all.

-Jason.

-Well, Jeff and David, thank you very much for your efforts and guiding us through this entire process. You know, huge thank you to the MITRE team, and all of the behind the scenes work to keep us organized and getting us here. I think one of the greatest things about this experience for me was just the opportunity, inside a couple of larger industries, to be in a subgroup of people with incredible passion, knowledge and expertise and have the chance to engage in discourse and have a varied group of opinions discussion and really debate these things down to their core. I feel it just makes me a better person and one of the reasons I'm extremely happy to be in this industry. In addition to the fact that this core group of people supports an industry that is moving nearly half a million people a year that really need that help. So. Really appreciate the opportunity and the chance to be around everyone here, and I would say that we have become a learning industry, and we never reach the finish line. There's always something for us to be working on improving and doing better and I think we took some steps in that even if we didn't maybe meet all the marks for everybody on the team. But, appreciate it. Thank you.

-Thanks. Rob.



**Federal Aviation
Administration**

-Just like to share a thank you to David, Jeff, and the MITRE team. Great job, David and Jeff, having been in those roles before myself, I understand how much work there is and the MITRE team for their support. On behalf of the Department of Transportation and the Federal Aviation Administration, just like to say thank you to everybody on this Committee, this is a volunteer Committee. The best work comes from government when government is able to partner with industry and make recommendations together. There's a lot of rules about how we do that, federal advisory committees and other laws and rules about how we have to do that. And yeah, it's a little bit administrative, but in the end, once that gets moving, this is the products that those partnerships produce. And it's a great opportunity to influence both the executive branch through different government agencies participating and our congressional leadership. So, I just want to say thanks to everybody, and the Department of Transportation and the Federal Aviation Administration recognize and thank everybody for their time and effort and understand that all of you are here as volunteers. Really appreciate that.

-Thanks, Rob. Okay, so we're at the end. David, I'm going to turn it over to you.

-Well, thanks, Jeff. I have to say thank you first, again, to you. I am, it's embarrassing to be thanked in the same sentence with you because I am the break and lunch captain. You do everything else and also in between meetings have done so much work. So, thank you, Jeff. Thank you to the Subcommittee chairs. Rightly folks have identified the outstanding work of MITRE, which is the machinery running this whole process. And to really echo what Rob said, thank all of you on behalf of CMS and HHS. This is a civic duty. This is like doing jury duty, except you don't get the extra \$6 a day. But it is really a high responsibility to be able to speak directly to federal policies. It's something that not many people get a chance to do, and you all executed it with incredible expertise, engagement and confidence, and I am just proud to know that there are people out there looking out for folks with the passion and commitment you all have. And so, it really is heartwarming and reaffirming in terms of the power of our citizens to help shape and continue to mold good government. So, thank you for that.

And with that I will do my final duty as the Designated Federal Officer here, which is to thank you all for joining our final AAQPS Committee meeting, and I'm happy now to adjourn this discussion. Thank you all.

-Thanks everyone.