IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Association of Air Medical Services, Plaintiff; v. **U.S. Department of Health and Human Services, et al.,** Defendants.	Civ. No. 1:21-c-v-3031 (RJL)

Brief of Association of Critical Care Transport as *Amicus Curiae* in Partial Support of the Government

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CORPORATE DISCLOSURE STATEMENT

The Internal Revenue Service has determined that the Association of Critical Care Transport (ACCT) is organized and operated exclusively for the promotion of social welfare under Internal Revenue Code § 501(c)(4) and is exempt from income tax. ACCT does not have a parent corporation, nor has it issued shares or securities.

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INTEREST OF AMICUS

Amicus Association of Critical Care Transport (ACCT, pronounced "Act") is a nonprofit grassroots patient advocacy organization committed to ensuring that critically ill and injured patients have access to the safest and highest quality air-transport system possible. ACCT is comprised of air and ground critical-care-transport providers, patients, air operators, business organizations, physicians, and individuals. ACCT is organized as 501(c)(4) organization, like the NAACP or AARP. It is *not* a 501(c)(6) trade association. Its mission is patients, not profits.

ACCT has a critical interest in the proper implementation of the air-ambulance provisions of the No Surprises Act. *See* Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. BB, tit. I (The No Surprises Act), 134 Stat. 1182 (Dec. 27, 2020). ACCT provided lengthy, sophisticated comments on both of the rules at issue in this case and provided additional written materials for the agencies on how to create a pricing methodology for air-ambulance services.[1] Those materials consistently emphasized the need for the agencies to disregard business model and eventually move to a pricing methodology that compensates air-ambulance providers based on clinical and quality factors. However, pricing based on business model is precisely what is advocated by Plaintiff Association of Air Medical Services (AAMS, pronounced "Aims") in a portion of its summary-judgment brief. AAMS's position is wrong on the law and would adversely affect ACCT's interests in encouraging the best patient care, reforming the broken air-ambulance market, and ensuring its members can continue to provide care at reasonable but sustainable prices.[2]

[1] *See* ACCT, Comment Letter on Requirements Related to Surprise Billing; Part I (Sept. 7, 2021), bit.ly/3tfBv7o (ACCT Comment on Part I Rule); ACCT Letter to HHS, DOT, and Treasury (Sept. 9, 2021) (ACCT Letter) (attached as Ex. 5); ACCT, Comment Letter on Requirements Related to Surprise Billing; Part II (Dec. 6, 2021) (ACCT Comment on Part II Rule), bit.ly/3HSRQCQ.

[2] No person or entity other than *amicus* and their counsel assisted in or made a monetary contribution to the preparation or submission of this brief.

INTRODUCTION

The number of air ambulances dotting the night sky has increased dramatically over the last two decades. And yet, just as these aircraft seemingly defy the law of gravity, many of them also defy the law of supply and demand. What goes up must come down; but the prices for most air-ambulance transport, despite a surfeit of aircraft, only go up. And up. And up. Prices for air-ambulance transports performed by independent providers have nearly tripled in the last ten years.

This is due to a confluence of factors—price insensitivity, a limited number of needed flights, lack of consumer choice, and the rise of out-of-network business practices by some private-equity-backed large, national, independent players in the marketplace.

The No Surprises Act creates an opportunity for meaningful reform of the air-ambulance industry's broken market. Yet AAMS argues as part of its summary-judgment brief that the Administrative Procedure Act requires that the agencies implementing the No Surprises Act must, in essence, peg air-ambulance prices to the service provider's business model, even though that variable has no clear connection to patient care, aircraft capability, or any of the other rational factors Congress wanted arbitrators to consider when reviewing price disputes.

This business-model distinction is not required by law. AAMS must get to its conclusion by arguing (among other things) that a medical provider's *specialty*—as in medical specialty, such as cardiology or psychiatry—also includes, in fact must include, the concept of a provider's business model. This is exceedingly doubtful. And just as importantly, AAMS's position ignores the ill consequences that will follow. Some of ACCT's providers may be relegated to even lower rates, with adverse effects on their hospital systems and patients. Investments in what matters most—quality of care and patient safety—will continue to be ignored. And the practices that have led to certain independent providers' bloated rates will be fed rather than tamed.

BACKGROUND

AAMS essentially asks this Court to order the agencies to stratify air-ambulance rates by business model, a result it could not achieve in the No Surprises Act itself nor, so far, in the rule-making process. That result is not legally compelled. It is also a bad idea—it will raise costs and further distort the air-ambulance market. To understand why these things are so, we have to understand the evolution of the air-ambulance industry and its regulation.

I. A (very brief) history of the air-ambulance industry.

In 1980, the United States had 39 air-ambulance helicopters. *See* ACCT Comment on Part I Rule at 6. In 2002, the Medicare reimbursement rates for patient air transport were significantly increased, *see id.* at 7; GAO, *Report GAO-17-637* at 8–9 (July 2017), which one law professor (and licensed helicopter pilot) described as a 434% increase, *see* Henry H. Perritt Jr., *An Arm and a Leg: Paying for Helicopter Air Ambulances*, 2016 J.L. Tech. & Pol'y 317, 317 n.†, 324 (2016). Air ambulances proliferated, growing to 753 helicopters by 2005 and 1115 by 2019. *See* ACCT Comment on Part I Rule at 6; *see also* Ex. 10 (Frazier Decl.) ¶ 5.

Normally, increasing the supply of a service decreases its cost. But not here. Prices have sky-rocketed. This market failure is the result of several features unique to the air-ambulance industry.

First, at least until the passage of the No Surprises Act, there was limited price sensitivity for air-ambulance providers. Patients have little bargaining power. Because of the emergency services involved, they rarely can choose whether to use an air ambulance, much less a preferred provider. And because air-ambulance services are predominantly out-of-network and chosen by hospitals or first responders, neither do health insurers have the choice, leverage or, sometimes, the incentive, to push down costs, because they do not choose whether to use an air ambulance (or which one to use) and costs could often just be passed on to (or threatened to be passed on to) those same patients

as balance bills or to the health insurers' customers through increased premiums. *See* ACCT Comment on Part I Rule at 5, 8; *see also* Frazier Decl. ¶¶ 8–10.

Second, air ambulance costs are primarily fixed. Personnel must be on-site, aircraft must be maintained, and equipment must be ready literally 24/7. Variable costs, like fuel, are a smaller part of the equation. *See* ACCT Comment on Part I Rule at 7. To use a simple example, if a company's air ambulance costs $10,000 per day to maintain, and $1000 per flight, then the company must charge $11,000 per flight if it flies once per day, but only $6000 per flight if it flies twice ([$10,000 + $2,000] ÷ 2 flights), and only $4,333 if thrice ([$10,000 + $3,000] ÷ 3 flights). Bulk goods at the grocery store work on the same principle—greater volume spreads out the fixed costs. Or as stated by the former CEO of one large independent provider, "And if you ask me personally, do we need 900 air medical helicopters to serve this country, I'd say probably not, maybe 500, 600 could do well, but it's an open market, these are—we don't have certificate of need restrictions. And so, therefore, there's going to be the inefficiency of competition." Frazier Decl. ¶ 12.

Third, as the government details in its brief, the air-ambulance market has become increasingly dominated by independent providers owned by private-equity groups. *See* Govt.'s S.J. Br. at 5–6. These large, national, independent providers offer only air ambulances and must satisfy their investors. This means keeping healthy margins through limited network participation despite, or perhaps because of, increasing costs—and even when those firms' practices are a significant cause of those cost increases. *See* Govt.'s S.J. Br. at 5–6; *see also* Frazier Decl. ¶¶ 13, 15–17. In recent years, urban markets in particular have been saturated with independently run air ambulances, leading to fewer flights per aircraft but little incentive to do anything other than charge more. *See* Frazier Dec. Attach. 1 (maps). The result is a broken market in which prices between 2008 and 2017 more than doubled:

Figure 1. Number of Helicopters vs. Patients[3]

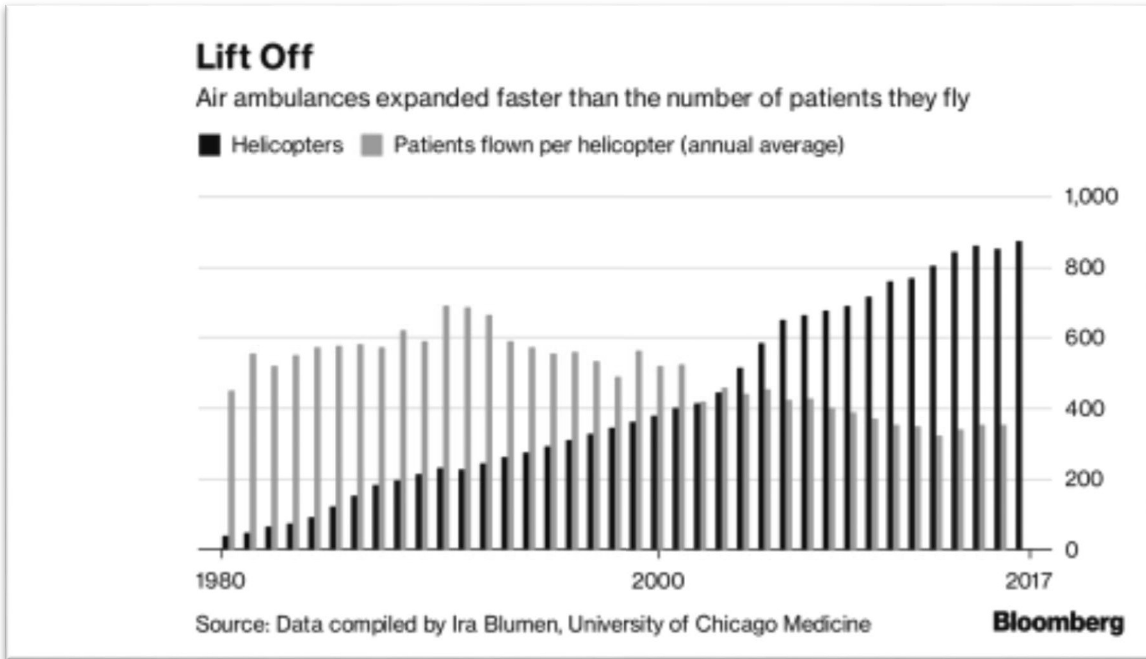
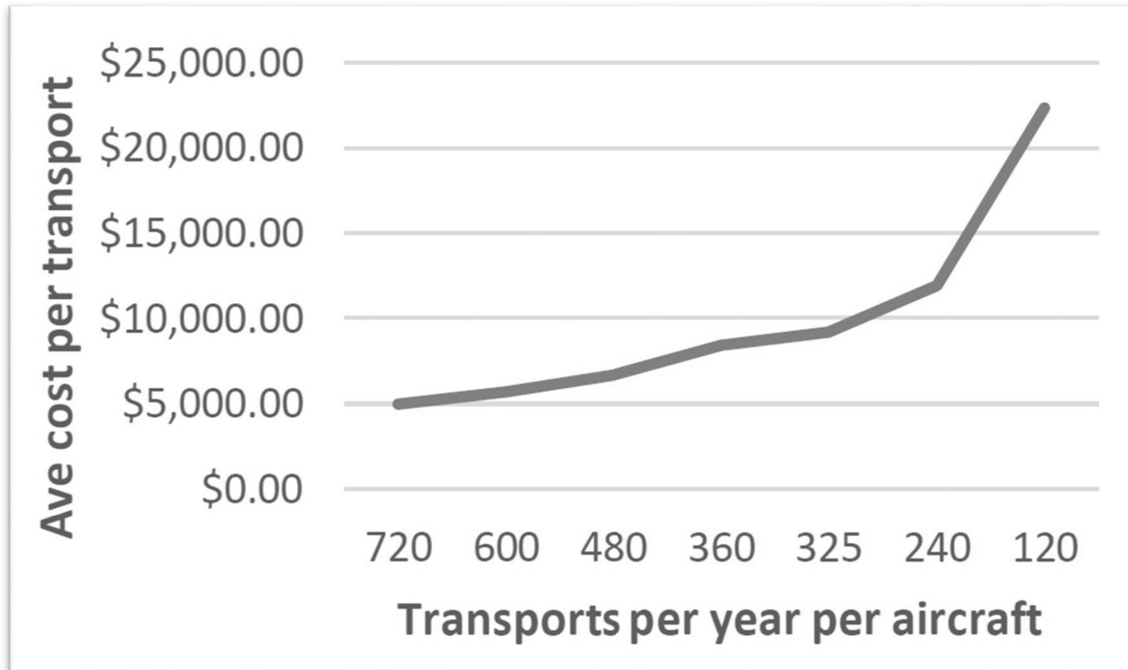


Figure 2. Air Medical Cost vs. Volume[4]



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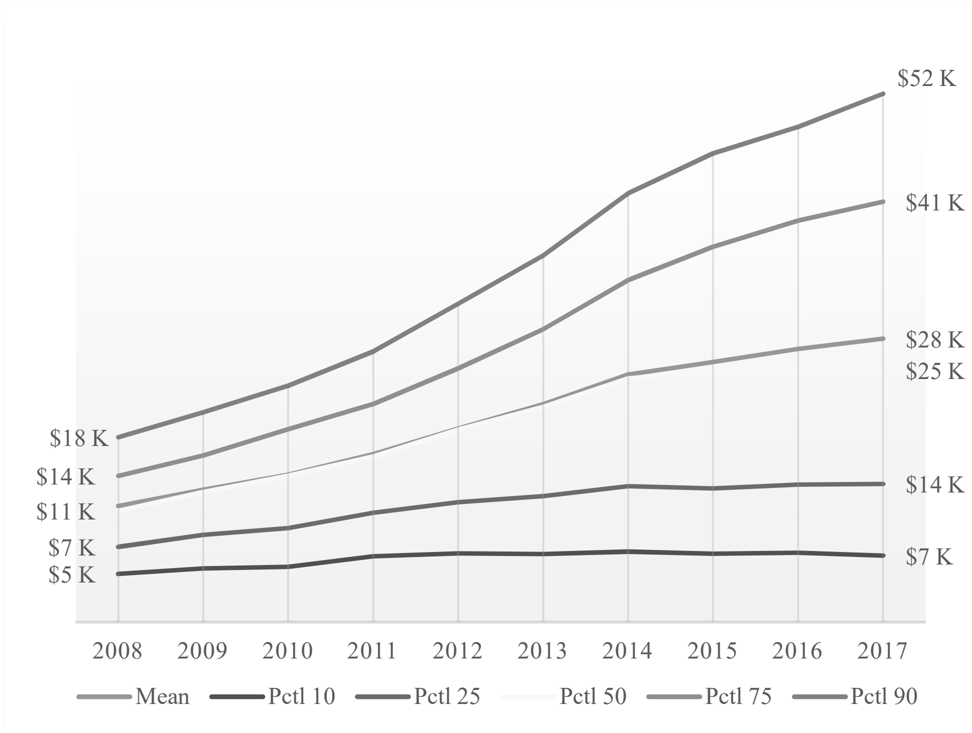
[3] ACCT Comment on Part I Rule at 8.
[4] *Id.* at 7.

Figure 3: Air Ambulance Prices — 10 Year Trends[5]



An irony in this price inflation is that there was—and still is—little relationship between price, territorial coverage, and quality in the air-ambulance industry. Rural providers are indispensable given the distance of their patients from major care centers, so they have a genuine interest in higher payments to compensate for lower flight volume. *See* ACCT Comment on Part I Rule at 5. Prices should also reflect the different capabilities of air ambulances. Air-ambulance helicopters can cost anywhere from $2 million to $16 million depending on capability and mission configuration—things like aircraft range, onboard medical equipment, and number of pilots and medics. Yet the most marked differentiation in commercial payment per transport is not quality, performance, or rural coverage, but business model: as of 2016, five major hospital-affiliated air-ambulance providers charged $13,000 to $31,000 per transport, while the three largest independent providers

[5] From data available at Health Care Cost Inst., *Air Ambulances—10 Year Trends in Costs and Use* (Nov. 7, 2019), bit.ly/3rg4MMt. Air ambulance charges have similarly skyrocketed. *See id.*

reported an average price of over $40,000 per transport. *See id.* at 12 (citing GAO, *Report GAO-17-637* at 14–15 & n.33); *see also* Govt's S.J. Br. at 6 (citing research that "air ambulance operators owned by private equity investors charge almost twice as hospital-owned operators do for the same service").

These perverse incentives are very real to ACCT's members. Dr. William Hinckley, who has trained more civilian flight physicians than anyone else in U.S. history, is the air medical director for UC Health Air Care in Cincinnati, Ohio. *See* Ex. 6 (Hinckley Decl. ¶¶ 2–6). The Air Care program staffs a physician or acute-care nurse-practitioner on every flight; carries a clinical armamentarium that allows definitive care to patients *before* reaching the hospital; and can perform advanced procedures in the air that very few, if any, other U.S. providers can do, including lateral canthotomy for orbital compartment syndrome, field limb amputation, and resuscitative hysterotomy. *See id.* ¶¶ 7–8. Its exclusively dual-engine helicopters have Instrument Flight Rules (IFR) capability, and UC Health has worked with the Federal Aviation Administration to create IFR approaches into 12 hospitals in the Cincinnati area. *See id.* ¶ 9. This program operates without hospital subsidization. *See id.* ¶ 11. Dr. Hinckley is also an emergency physician, so he also sees patients brought in by national, non-hospital-based air-ambulance programs—typically on single-engine helicopters without physicians and without the advanced care capabilities of UC Health. *See id.* ¶ 10. Yet these programs, under AAMS's argument, would be paid more. *See id.* ¶ 10.

This is the experience too for Dr. Christopher Wuerker, the recent executive director of MedSTAR Transport, the air-transport service for MedStar Health, the largest healthcare provider in the Mid-Atlantic Region. *See* Ex. 7 (Wuerker Decl.) ¶¶ 2–4. MedSTAR Transport uses twin-engine IFR helicopters and flies over 2000 patients per year, who are typically "much sicker than the average patient transported by non-hospital-based programs." *See id.* ¶¶ 7–8. Dr. Wuerker states

that while "cost shifting . . . was historically a common business practice for hospitals, it is no longer sustainable," and while MedSTAR Transport does "operate[] at a *slight* loss," it is "working with the insurance payers for fair reimbursement to cover the cost of transport." *Id.* ¶ 10 (emphasis added). But even so, says Dr. Wuerker, "from my experience, independent providers providing less sophisticated care and operating less expensive aircraft have charged patients two to three times what we do." *Id.* ¶ 10.

Certified Flight Registered Nurse Matthew Heffelfinger has a similar story. His program flies for a two-hospital consortium in Michigan. *See* Ex. 9 (Heffelfinger Decl.) ¶¶ 4–5. His helicopter is a dual-engine, IFR helicopter with two certified flight nurses and specialized capabilities, including being the first in Michigan to carry whole blood. *See id.* ¶ 8. His program's rates are below the FAIR Health median rate of $18,668. *See id.* ¶ 16. Yet he sees certain independent providers with inferior safety and clinical capability charging far more. *See id.* ¶ 14.

The same is true for former Coast Guard aviator Jeff Frazier. He now works for an ACCT member organization that helps primarily ERISA plans with air-ambulance charges. *See* Frazier Decl. ¶¶ 1–3. He describes a hospital-based operation with "gold standard" quality and aviation safety that charges on average less than $23,000 per flight, yet it operates in the black because of high flight volume. *See id.* ¶ 16. A nearby independent competitor has a single-engine helicopter with one pilot, nurse, and paramedic, yet its billed charges start at $53,484 plus $378 per mile. *See id.* ¶ 17. Mr. Frazier also describes as another example a recent claim from a private-equity-owned provider for a flight on a single-engine Bell 206, manufactured in 1979. The bill? $67,000. *See id.*

II. Key aspects of the No Surprises Act.

After various legislative iterations over the last several years, Congress passed the No Surprises Act as part of the Consolidated Appropriations Act, 2021. ACCT strongly supported the air-ambulance provisions of the No Surprises Act. *See* ACCT Comment on Part I Rule at 1.

A principal aim of the No Surprises Act is to ensure that insured patients no longer receive crippling "surprise" bills from out-of-network providers in emergency situations where they have little choice over their source of care. The Act accomplishes this salutary purpose through a two-part process that determines how much the patient needs to pay, and then how much his "group health plan or health insurance issuer"—what we simply call a "health insurer"—needs to pay. There is one process for emergency services generally, *see generally* Public Health Service Act § 2799A-1,[6] and another for air ambulances specifically, *see generally id.* § 2799A-2. The processes are mostly the same, and we highlight differences that matter for this case.

First, for emergency services, the process establishes that a patient's "cost-sharing requirement" (his out-of-pocket cost) cannot exceed the cost were the service performed by a "participating provider," i.e., a provider with "a contractual relationship with" the health insurer, i.e., typically an in-network provider. *See id.* §§ 2799A-1(a)(1)(C)(ii), (a)(3)(G); *see also id.* § 2799B-1. The cost itself is calculated by determining a figure called the "recognized amount." *See id.* § 2799A-1(a)(1)(C)(iii). The "recognized amount" is either the amount set by state law (or an All-Payer Model Agreement) or a figure called the "qualifying payment amount." *See id.* § 2799A-1(a)(1)(H). In turn, the "qualifying payment amount" is "the median of the contracted rates recognized by the [health insurer] . . . as the total maximum payments . . . for the same or a similar item

[6] We cite only to the provisions of the Public Health Service Act and not to the parallel provisions in ERISA and the Internal Revenue Code. Generally the provisions we cite have been codified at 42 U.S.C. §§ 300gg-111 to 300gg-120.

or service that is provided by a provider in the same or similar specialty . . . in the geographic region . . . ." *Id.* § 2799A-1(a)(1)(E)(i)(II). So in short, a patient cannot be made to pay an out-of-network emergency provider more than the median rate his health insurer would charge for that same service in the area. The cost-sharing process is similar but simpler for air-ambulance patients. A patient's "cost-sharing requirement" (his out-of-pocket cost) is simply the same amount "that would apply if such services were provided by . . . a participating provider." *Id.* § 2799A-2(a)(1); *see also id.* § 2799B-5.

Second, for both emergency and air-ambulance providers, after the patient is removed from the equation, the No Surprises Act leaves it to the health insurer and the out-of-network provider to decide whether and how much to pay of the remainder of the provider's bill. *See id.* §§ 2799A-1(a)(1)(iv), 2799A-2(a)(3). That remainder is called the "out of network rate." *See id.* §§ 2799A-1(a)(1)(iv)(II). The "out of network rate" is determined by state law, or if inapplicable, by open negotiation between the parties, or if that fails, by resort to dispute resolution. *See id.* §§ 2799A-1(a)(3)(K), 2799A-2(b)(1). The parties each submit an offer to an "independent dispute resolution entity," essentially an arbitrator, that chooses one of the offers. *See id.* §§ 2799A-1(c)(5)(A)–(B), 2799A-2(b)(5)(A)–(B).

In deciding, the arbitrator must consider the "qualifying payment amount"—meaning, again, essentially the health insurer's median contracted rate for the item or service at issue. *See id.* §§ 2799A-1(c)(5)(C)(i)(I), 2799A-2(b)(5)(C)(i)(I). The arbitrator must also consider certain circumstances enumerated in the statute if requested by or offered to the arbitrator. *See id.* §§ 2799A-1(c)(5)(C)(i)(II), 2799A-2(b)(5)(C)(i)(II). These factors are similar but not identical for emergency providers and air-ambulance providers. *Compare id.* § 2799A-1(c)(5)(C)(ii), *with id.* § 2799A-2(b)(5)(C)(ii). For both, the arbitrator must consider the provider's training and experience and

quality and outcome measurements, the patient's acuity or the complexity of treatment provided, and the provider's good-faith efforts (or lack thereof) to enter into network agreements and contracted rates with the health insurer. Solely for air ambulances, the arbitrator must also consider the ambulance vehicle type and its clinical capability, as well as the population density of the pick-up location. "ACCT advocated directly with the relevant Committees of jurisdiction" for these factors, while other groups "advocated vociferously against some of them." ACCT Comment on Part II Rule at 4. Finally, for both types of providers, the arbitrator must *not* consider certain things: "usual and customary charges"; "the amount that would have been billed" absent the No Surprises Act's prohibition on surprise billing of insured patients; and the reimbursement rates for the service from government programs including Medicare and Medicaid. *See id.* §§ 2799A-1(c)(5)(D), 2799A-2(b)(5)(C)(iii).

The No Surprises Act lays the groundwork for future improvement of the air-ambulance industry by directing additional study on the issues that are most important to ACCT: patient safety, quality care, and a payment system that rewards those critical metrics rather than business model. *See* ACCT Comment on Part I Rule at 1, 16–22; ACCT Letter (Ex. 1) at 5–7; ACCT Comment on Part II Rule at 4–7. The Act does so through a series of measures to collect claims and other data; to issue a comprehensive public report on the economics of the air-ambulance industry; and to establish an Advisory Committee on Air Ambulance Quality and Patient Safety for reviewing options to establish quality, patient safety, and clinical capability standards. *See id.* § 2799A-8(b), note.

III. The agencies' rulemaking and ACCT's comments.

The agencies have issued two interim final rules implementing parts of the No Surprises Act. *See* Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36,872 (July 13, 2021); Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021). As noted above, the price charged by an air-ambulance provider to the patient and to the health insurer is, or is influenced by, the "qualifying payment amount," defined generally in the No Surprises Act as "the median of the contracted rates recognized by the [health insurer] . . . as the total maximum payments . . . for the same or a similar item or service that is provided by a provider in the same or similar specialty . . . in the geographic region . . . ." Public Health Service Act § 2799A-1(a)(1)(E)(i)(II).

In the agencies' first interim rule they defined the phrase *provider in the same or similar specialty* as "the practice specialty of a provider, as identified by the [health insurer] consistent with [its] usual business practice, except that, with respect to air ambulance services, all providers of air ambulance services are considered to be a single provider specialty." 45 C.F.R. § 149.140(a)(12).[7] The agencies explained that the definition provides health insurers "the flexibility necessary to calculate the median contracted rate, relying on their contracting practices with participating providers." 86 Fed. Reg. 38,672, 36,891. The agencies thus instructed that health insurers should "use the method of identifying the practice specialty it uses for contracting purposes." *Id.* The agencies decided against a more elaborate methodology requiring different median rates "for every provider specialty" because it would unnecessarily fracture the rates—some health insurers do not vary their rates for services by the specialty of the provider providing them, and

[7] Like the parties, we cite the HHS regulations only, and not the corresponding regulations promulgated by the Departments of Labor and the Treasury.

for others it may lead to too little information to be able to calculate a meaningful median rate. *See id.*

The agencies also explained their proviso treating all air-ambulance providers as a single specialty. The agencies explained that there was no need to vary the rates by rotary- or fixed-wing, since those are coded as different services in the first place. *See id.* The agencies also acknowledged the concern raised by AAMS in this lawsuit, that hospital-based providers sometimes charge less than independent providers. *See id.* However, said the agencies, patients frequently cannot choose their air-ambulance provider, so they should not pay a cost-sharing amount simply because of the provider's higher costs or revenue model. *See id.*

ACCT commented on this provision. In line with the agencies' conclusion, ACCT agreed that "business (revenue) model is irrelevant to establishing a QPA; we do not support distinguishing between hospital, hybrid or community based business models, which are entirely of the provider's choosing and irrelevant in establishing the QPA." ACCT Comment on Part I Rule at 19. ACCT urged the agencies in further rulemaking to establish three qualifying payment amounts based on three tiers of vehicle type and clinical capability, to encourage better patient care and safer aircraft. *See id.* at 20–21. ACCT thereafter shared with the agencies a sophisticated framework for how to do so as part of a more lengthy regulatory project. *See* ACCT Letter (Ex. 1).

IV. AAMS's lawsuit and this amicus brief.

AAMS has now challenged various provisions of the agencies' two interim final rules, including the proviso in the agencies' definition of *provider in the same or similar specialty* in the first interim final rule that all air-ambulance providers are a single provider specialty. According to AAMS, the agencies should have distinguished between hospital-based and independent air-ambulance providers, and in failing to do so violated the Administrative Procedure Act (APA). *See* AAMS's S.J. Mot. Br. at 27–29. That argument is the subject of this amicus brief.

ARGUMENT

The agencies complied with law and exercised their discretion appropriately when they opted to treat all air-ambulance providers as a single provider specialty for purposes of calculating the median contracted rate. Their decision comports with the text and structure of the No Surprises Act and furthers its purpose of protecting patients from surprise bills. The agencies acted consistently—not capriciously—when they permitted distinctions among emergency providers: the No Surprises Act defines them differently, and the agencies recognized that provider type can serve as a proxy for the level of patient care provided. Neither is the case for air-ambulance providers.

The No Surprises Act and its implementation reflect more broadly an effort to rationalize the air-ambulance industry over time. The Act requires data disclosure, a comprehensive public report, and a new advisory committee to review matters of cost, safety, quality, and coverage. Given the multiplicity of factors involved and the data yet to come, the agencies acted reasonably by regulating incrementally, rather than making the specific distinctions urged by AAMS.

Finally, AAMS's preferred distinction would harm ACCT's members and stymie improvements to the air-ambulance industry. If the qualifying payment amount for air-ambulance services were stratified as urged, the new rates would harm certain ACCT members and perpetuate the problems in the air-ambulance market that ACCT seeks to solve.

I. ACCT is concerned solely with AAMS's argument that independent and hospital-based providers should be treated as different practice specialties.

The APA permits the Court to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory jurisdiction, authority, or limitations." 5 U.S.C. §§ 706(2)(A), (2)(C). AAMS's summary-judgment brief argues that the agencies violated these provisions of the APA, first, by impermissibly over-weighting the qualifying payment amount as a factor for the

arbitrator to consider when choosing between the health insurer's and the air-ambulance provider's offers on a disputed bill amount. *See* AAMS's S.J. Mot. Br. at 15–21. The brief then argues, second, that the agencies impermissibly deflated the qualifying payment amount by excluding certain contracted rates, defining air-ambulance providers as a single provider specialty for qualifying-payment-amount purposes, and using overbroad geographic regions. *See id.* at 21–33.

ACCT's concern is solely with the argument regarding provider specialties. *See id.* at 27–29. As written by AAMS, the argument is an invitation to the Court to *de facto* order the agencies to rewrite the first interim rule to treat hospital-based and independent air-ambulance providers differently for that purpose: AAMS's filings present its view of the reasons for differing prices between hospital-based and independent providers and argues that it violated the APA for the agencies to *not* recognize those differences, *see* Compl. ¶¶ 15, 49–50, 114–115; AAMS's S.J. Mot. Br. at 6, 27–29; AAMS states that "[t]he Court should reject the treatment of hospitals and independent air ambulance providers as a single specialty because it is contrary to law and arbitrary under the Departments' own reasoning elsewhere in IFR Part I," *id.* at 29; and AAMS seeks to vacate the air-ambulance proviso from the definition of *provider in the same or similar specialty*: "except that, with respect to air ambulance services, all providers of air ambulance services are considered to be a single provider specialty." 45 C.F.R. § 149.140(a)(12); *see* Compl. at 40; AAMS's S.J. Mot. at 4; AAMS's S.J. Br. at 43. ACCT disagrees with that position.

II. The agencies complied with the APA when they opted to treat all air-ambulance providers as within "the same or similar specialty."

A. The agencies acted in accordance with law and exercised their discretion appropriately to further the purposes of the No Surprises Act.

As explained by the government, the agencies comported with the text, structure, and purpose of the No Surprises Act when defining *provider in the same or similar specialty*. *See* Govt.'s S.J. Br. at 30–31. Regarding the text, there is no basis for AAMS to insert a business-model distinction

into these medical terms. We start with the word *provider*. The Act defines both "[n]onparticipating providers" and "participating providers." Both are described as "a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law . . . ." Public Health Service Act § 2799A-1(a)(3)(G). It is telling that the definition expressly differentiates providers on the basis of their participation or not in a "contractual relationship with the [health insurer]." *Id.* The Act similarly defines and differentiates between hospital-based and freestanding emergency departments (more on that later). *See id.* § 2799A-1(a)(3)(A), (D). Congress could have similarly differentiated air-ambulance providers on the basis of such economic considerations, but did not. "The absence of such a term . . . may properly be understood as purposeful." *Am. Fuel & Petrochem. Mfrs. v. EPA*, 3 F.4th 373, 381–82 (D.C. Cir. 2021); *see, e.g.*, *Council for Urological Interests v. Burwell*, 790 F.3d 212, 221 (D.C. Cir. 2015) ("Congress knew how to permit per-click payments explicitly, suggesting that the omission in this particular context was deliberate.").

Nor does the second part of the definition, *same or similar specialty*, easily yield a distinction by business model. In the medical sense, a *specialty* is "a branch of medicine or surgery, such as cardiology or neurosurgery, in which a physician specializes; the field or practice of a specialist." *American Heritage Dictionary of the English Language* (5th ed. 2022), bit.ly/33ysUlz; *see also Oxford English Dictionary* ") (3d ed. 2015) ("A special subject of study or research; the branch of scholarly, scientific, or professional work in which one is a specialist; *spec.* the branch of medicine or surgery in which a physician practices. The Public Health Service Act uses the word that way repeatedly. *See, e.g.*, Public Health Service Act § 330(b)(1)(A)(ii) ("referrals to providers of medical services (including specialty referral when medically indicated)"); *id.* § 330N(b) ("chronic diseases and conditions, infectious diseases, mental health, substance use disorders, prenatal and

maternal health, pediatric care, pain management, palliative care, and other specialty care"). So does the No Surprises Act. It requires provider directories listing "name, addresses, specialty," and so on. *Id.* §2799B-9(d). The Secretary of HHS must publish quarterly certain information about the independent dispute resolution process for emergency providers, including "the category and *practice specialty* of each such provider or facility involved in furnishing such items or services." *Id.* § 2799A-1(c)(7)(B)(v) (emphasis added). Again, tellingly, this particular reporting category is not included in the independent dispute resolution process for air-ambulance providers. *See id.* § 2799A-2(b)(7). Under the text, *provider in the same or similar speciality* is not business model.

The structure of the No Surprises Act offers AAMS no help either. The Act establishes an arbitration process for billing disputes between health insurers and out-of-network air-ambulance providers. The arbitrator is instructed to consider certain economic considerations—the qualifying payment amount, the provider's efforts to enter network agreements, and population density—as well as quality and care factors—quality and outcome measurements, patient acuity, and vehicle capability. *See id.* § 2799A-2(b)(5)(C). Business model is nowhere to be found in these factors. Indeed, the No Surprises Act if anything *discourages* consideration of business model. The arbitrator "shall not consider usual and customary charges, the amount that would have been billed had the provisions of section 2799B-5 not applied"—the section prohibiting balance-billing insured air-ambulance patients—"or the payment or reimbursement rate" furnished by public payors. *Id.* § 2799A-2(b)(5)(C)(iii).

The agencies followed these considerations in defining *same or similar specialty*. They instructed that a provider's specialty is the one that is "identified by the plan or issuer consistent with the plan's or issuer's usual business practice." 86 Fed. Reg. 36872, 36889. Nothing in that instruction suggests that specialty turns on business model itself, rather than the basic understanding that

practitioners of medicine (as of law) charge different rates depending on their particular field and experience, and billing practices reflect that fact. But business model is not a medical specialty, no matter how loosely characterized, and the agencies had no obligation to pretend that it is.

Likewise, the agencies did not violate the APA by purportedly treating emergency providers differently from air-ambulance providers. The agencies considered precisely the factors given them by Congress, and that accounts for the differences, such as they are. The No Surprises Act separately defines freestanding and hospital emergency departments, *see* Public Health Services Act §§ 2799A-1(a)(3)(A), (D), and treats them as facilities, not providers, *see id.* §§ 2799A-1(a)(3)(F)–(G). This matters for rulemaking purposes. The agencies' rulemaking grant for establishing "the methodology the [health insurer] . . . shall use to determine the qualifying payment amount" "may account for relevant payment adjustments that take into account [1] *quality* or [2] *facility type* (including higher acuity settings and the case mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities." *Id.* § 2799A-1(a)(2)(B) (emphasis added)). In contrast, nowhere in the No Surprises Act did Congress expressly differentiate independent and hospital-based air-ambulance providers, other than in provisions for further study of the industry. *See id.* § 2799A-8(b) & note. (And as we discuss *infra*, those provisions support the agencies' treatment of air-ambulance providers.)

In defining *provider in the same or similar specialty*, the agencies generally allowed the median rate to vary by provider specialty when recognized as such in contract agreements. For instance, a board-certified cosmetic surgeon may be paid more than a general-practice resident for sewing up a wound, and for good reason. The agencies, acting consistently, did not permit different charges for air ambulances on grounds that patients should not pay more solely because of (to the

patient) the happenstance of its provider's business model or costs, which alone have no bearing on *quality* of care. *See* 86 Fed. Reg. 36,872, 36,891.

The agencies followed the same approach when defining *facility of the same or similar facility type.* They acknowledged the difference between freestanding and hospital emergency departments—as does the No Surprises Act by defining them separately and repeatedly mentioning both in the Act's text—and tentatively permitted median contract rates to be calculated differently between them—as does the No Surprises Act's rulemaking grant. *See id.* at 36,891–92. The agencies explained that they did so because, again echoing the No Surprises Act itself, "there may be appreciable differences in the case-mix and level of patient acuity between these types of facilities." *Id.* at 36,892. That is to say, median rates can differ because the services rendered differ. Consistent with their treatment of air-ambulance providers, the agencies otherwise declined to allow a different median rate for a facility based on other characteristics "that may have a bearing on its contracted rate with [health insurers], but which are unrelated to or incidental to the facility's role as a provider of emergency services." *Id.* Thus the definition for *facility of the same or similar facility type* is simply "with respect to emergency services, either . . . [a]n emergency department of a hospital; or . . . [a]n independent freestanding emergency department." 45 C.F.R. § 149.140(a)(4). This definition permits no other distinctions by business model other than this one, but this one distinction made in the definition is both expressly blessed by the No Surprises Act and can serve as a proxy for the level of patient care. Neither holds true for a distinction between independent and hospital-based air ambulances.

B. AAMS's proposed distinction need not be immediately implemented in the No Surprises Act.

AAMS's proposal would impose through judicial action a distinction in the treatment of air-ambulance payments that neither Congress nor the agencies so far have been willing to make. The

air-ambulance industry has grown and changed rapidly over the last two decades. *See supra* A (very brief) history of the air-ambulance industry. So it is natural that the No Surprises Act evidences congressional interest in further study of the industry. *See supra* Consolidated Appropriations Act, 2021.

The No Surprises Act contains a plethora of reporting, data-gathering, and advising measures. The Act requires health insurers to submit claims data for air ambulances to the Secretaries of HHS, Labor, and the Treasury, disaggregated by five factors: whether the services (1) were emergency-based or not, (2) originated in a rural or urban area, and (3) were provided under a contract with the health insurer; (4) the type of aircraft used; and (5) "[w]hether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska." *See* Public Health Service Act § 2799A-8(b). Meanwhile, air-ambulance providers are to provide key information to the Secretaries of HHS and Transportation: cost data; numbers of bases; numbers and types of aircraft; numbers of transports disaggregated by payor mix, base, and type of aircraft; and claims denied. *See id.* § 2799A-8 note. The Secretary of HHS, in consultation with the Secretary of Transportation, is to use that data to produce a comprehensive public report on the economics of the air-ambulance industry, including a breakdown of providers by business model and network participation, the extent of competition on the basis of price and services offered, average charges and amounts paid by health insurers and patients, and rural coverage. *See id.* § 2799A-8 note. The Act also establishes an Advisory Committee on Air Ambulance Quality and Patient Safety for "reviewing options to establish quality, patient safety, and clinical capability standards." *Id.* The Committee is to study many of the measures that ACCT and its members advocated before Congress and in its rule comments and letter to the agencies as eventual goals for

the industry: tiering air ambulances by their capability; establishing patient safety and quality standards; reforming the air-ambulance market; and improving aircraft reliability in bad weather and at night. *See id.*; Frazier Decl. ¶ 20.

The agencies opted, for now, to treat all air-ambulance providers as a single provider specialty for purposes of calculating a median contract rate. It was permissible for them to decide against racing ahead with distinctions in an industry that Congress has indicated needs further study. This is normal and prudent: "Agencies, like legislatures, do not generally resolve massive problems in one fell regulatory swoop. They instead whittle away at them over time, refining their preferred approach as circumstances change and as they develop a more nuanced understanding of how best to proceed." *Massachusetts v. EPA*, 549 U.S. 497, 524 (2007) (citations omitted). This strategy of "moving in an incremental manner," *FCC v. Fox TV Stations, Inc.*, 556 U.S. 502, 522 (2009), is all the more sound when an agency is pioneering the implementation of a new statute rather than updating a longstanding law with which it has decades of experience. The agencies may consider the action that AAMS desires—or the one that ACCT desires, for that matter—in the future, and it will be much better equipped to do so given the data and recommendations it will receive under the information-gathering provisions of the No Surprises Act. *See Ctr. for Biological Diversity v. EPA*, 722 F.3d 401, 410 (D.C. Cir. 2013) ("incremental regulation is especially appropriate in response to evolving economic and technological conditions" (citation omitted)).

The rejoinder to this point is that if indeed the agencies were concerned about regulatory missteps in a new area, then they should have afforded greater flexibility by permitting health insurers to calculate median rates based on air-ambulance provider type, rather than less by treating all air-ambulance providers as the same specialty. This argument presupposes that the agencies *had to* credit the business model of the air-ambulance provider above all else. Creating that requirement

via judicial decision would be a coup for AAMS's independent providers. But as explained above, it is not a result compelled by the No Surprises Act. The agencies exercised their discretion properly.

III. AAMS's proposed division of air-ambulance providers by business model would cause substantial harm to ACCT.

A. AAMS's business-model distinction would harm the patients and operations of ACCT's hospital-based air-ambulance providers.

AAMS argues that by treating all air-ambulance providers as the same or similar specialty, the agencies will cause the median contract rates for independent air-ambulance providers to be dragged down by hospital contracts in which air-ambulance services are an afterthought or a loss-leader, *see* AAMS's S.J. Mot. Br. at 5–6, 27–28, including apparently what AAMS described in one of its regulatory comments as "below-market, phantom rates that are accepted by hospital systems because they will never be charged to plans or issuers." *See id.* Ex. 4 at 3. And so, the argument continues, the agencies need to reconsider their action because those median rates do not reflect the prices that independent providers need to recoup their expenses. *See* AAMS's S.J. Mot. Br. at 5–6, 27–28.

Even crediting AAMS's statements about the effect of the current rule on their independent providers, the purported solution of essentially stratifying rates by business model has problems of its own. To be sure, the new median contract rate for certain independent providers would be higher than before. But the new median rate contract rate for other providers, especially hospital-based providers could be even lower. This is both because the higher contract rates for independent providers would no longer be in the mix, and also because hospital-based providers alone would bear the full sinking weight of the so-called "phantom rates."

These lower rates would result in considerable harm to the patients and operations of ACCT's hospital-based providers. Dr. Hinckley from UC Health explains that a lower median contracted

rate could lessen UC Health's coverage, reduce its helicopters from three to two, cause it to release employees, and eliminate the resources for "maximal, world-class clinical and aviation capability on each flight mission." Hinckley Decl. ¶ 18. UC Health recently made the financial commitment to upgrade two aging aircraft; but "a lower median contracted rate could, over time, prevent the advancement of clinical care in the transport setting or safe operations that have proven to benefit patients." *Id.* ¶ 19. Likewise, John Visokay, director of Aeromed Transport for Tampa General Hospital, warns of "perpetuat[ing] the problem of flight payments being based on business model with little relationship to actual clinical capability, patient outcomes, aircraft safety, and other measures that actually benefit patients." Ex. 8 (Visokay Decl.) ¶ 16. Dr. Wuerker adds, "It provides incentives to operate unnecessary air-transport programs that significantly increase health expense with only marginal benefit." Wuerker Decl. ¶ 17. Finally, Mr. Heffelfinger is concerned that if payments derive from business model rather than patient-care metrics, the incentives will be toward "purchasing more aircraft, but not better aircraft." Heffelfinger Decl. ¶ 15. He states that if his median contract rate decreased, his hospitals could withdraw their support and close the program, "effectively eliminating air medical services for a large section of rural Southwest Michigan." Heffelfinger Decl. ¶ 16.

When defining specialties for purposes of the median contracting rate, the agencies already understood "that hospital-based air ambulance providers sometimes have lower contracted rates than independent, non-hospital-based air ambulance providers." 86 Fed. Reg. 36,872, 36,891. However, they opted for a definition treating air-ambulance providers the same because that would further the purposes of the No Surprises Act of protecting patients from expensive out-of-network medical bills. Implicit in the agencies' reasoning is their understanding of the effects of differing

median contract rates for hospital-based and independent providers. They understood that separating the rates would result in higher rates for independent providers (and for patients), which is exactly why they employed the definition that they did; and as a natural corollary, the agencies had to have understood that separating the rates could result in lower rates for hospital-based providers. They then decided to treat providers the same to further a legitimate statutory purpose. This is a classic example of an agency weighing various courses of action and exercising its sound discretion to choose among them. "[A] court is not to substitute its judgment for that of the agency," *Motor Vehicle Mfrs. Ass'n of U.S., v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 30 (1983), which is "especially true when the agency is called upon to weigh the costs and benefits of alternative policies." *Consumer Elecs. Ass'n v. FCC*, 347 F.3d 291, 303 (D.C. Cir. 2003) (quoting *Ctr. for Auto Safety v. Peck*, 751 F.2d 1336, 1342 (D.C. Cir. 1985) (Scalia, J.)). That judgment should remain undisturbed here, especially when considering the damage that could befall patients and certain ACCT members otherwise.

B. AAMS's business-model distinction would harm ACCT's interests in aligning economic incentives with investments in aircraft safety and patient care.

As described earlier, the cost of air ambulances is increasing at an unsustainable pace, and yet there is still "wide variation in the clinical and aviation capabilities of air ambulances" and "no agreed upon benchmarks in the industry or commercial marketplace to distinguish between higher clinical and aviation capabilities." ACCT Comment on Part I Rule at 9, 12. That is where ACCT comes in. "ACCT's members have a shared commitment to re-making the critical care transport system into one that is accountable, patient-centered and characterized by quality, safety, and value." ACCT Comment on Part I Rule at 1. This is reflected in ACCT's communications with the agencies, *see id.* at 1, 16–22; ACCT Letter at 5–7; ACCT Comment on Part II Rule at 4–7, and what it advocated to Congress, *see* ACCT Comment on Part II Rule at 4–5, which center on the

need to reorient economic incentives in the air-ambulance industry away from market oversaturation and toward a rational system that distinguishes price based on clinical and aircraft capability, rural coverage, and investments in quality and safety.

However, if AAMS is successful in installing a provider's business model as the fulcrum for pricing methodology, that could jeopardize these reform efforts. There will be little incentive to invest in quality and safety, much less efficiency, when payment is driven instead and foremost by business model. And there will be even less incentive for reflection as to why the very costs that AAMS allegedly struggles to cover are rising so rapidly in the first place.

CONCLUSION

For the foregoing reasons, the Court should reject AAMS's arguments on pages 27–29 of its summary-judgment brief that the agencies' definition of *provider in the same or similar specialty* at 45 C.F.R. § 149.140(a)(12) should be vacated in part.

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States District Court for the District of Columbia by using the Court's CM/ECF system on January 26, 2022. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the Court's CM/ECF system.

Dated: January 26, 2022

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