Cause No. 3:24CV379-HTW-LGI

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC.
Plaintiff

VERSUS

MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI
Defendant

BRIEF OF AMICI CURIAE, MISSISSIPPI AMBULANCE ALLIANCE, IN SUPPORT OF DEFENDANT, MIKE CHANEY'S RESPONSE IN OPPOSITION TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

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INTEREST OF AMICI CURIAE[1]

The Mississippi Ambulance Alliance, hereinafter "*MAA*," is an association comprised of emergency medical service providers doing business in the State of Mississippi. In an effort to improve pre-hospital care, MAA was formed to ensure emergency medical service providers across Mississippi are well-informed of industry standards and to assist them with resources that address reimbursement issues, legislative initiatives and lobbying, and clinical standards. MAA also acts as a liaison between its members and the Mississippi Department of Health, Centers for Medicare and Medicaid Services, and the Mississippi Bureau of Emergency Medical Services.

MAA was started in 2019, and its current membership provides emergency medical services to 80% of Mississippi's population. MAA and its members are committed to improving the health of the communities they serve by providing high-quality, efficient, and accessible pre-hospital care. 2024 Miss. House Bill 1489, hereinafter "*HB 1489*", is essential to achieving this goal. HB 1489 mandates health insurance carriers provide, on a prospective basis, coverage for certain treatment-related services offered by ambulance providers that historically were not reimbursable. As such, MAA has a strong interest in the success of Mississippi's legislative efforts to ensure emergency medical service providers are compensated fairly for the services rendered to Mississippi residents.

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[1]Pursuant to Fed. R. App. P. 29(a)(4)(A), Mississippi Ambulance Alliance states that it is a nonprofit organization that has no parent company. No publicly traded company holds ten percent or more interest in the organization.

BACKGROUND FACTS

Emergency medical services are generally the foundation and entry point to healthcare and are known to have the most significant impact on patient outcomes. Providing patients with life-saving and life-sustaining health care during emergencies, transporting patients who require health care during their transport, and providing backup, on-site emergency medical services for community events are the three crucial functions of emergency medical service providers. The assessment, triage, treatment, and transport of critically ill patients to the most appropriate facility have been documented to improve patient outcomes and reduce expenses to the Centers for Medicare and Medicaid Services, hereinafter "*CMS*," Medicaid, or commercial insurance companies.

Historically, commercial insurance companies, CMS, and Medicaid have not been required to pay emergency service providers to respond to calls and provide on-site medical treatment to patients who were ultimately not transported to a medical facility. On March 11, 2021, the American Rescue Plan Act (P.L. 117-2)[2] was signed into law. It allowed "*fire and EMS departments to be reimbursed for ground ambulance services provided during the COVID-19 that did not culminate in transporting a patient to a hospital*." Chiquita Brooks-LaSure, administrator of CMS, when discussing the American Rescue Plan Act[3], noted as follows:

> Normally, ground ambulance services are only eligible for Medicare payment if the beneficiary received medically necessary transport to a covered destination. On May 5, 2021, pursuant to authority granted under section 9832

[2]See September 29, 2021, Letter from Cindy Axne to Chiquita Brooks-LaSure, attached as Exhibit "*A*" and incorporated herein.

[3]See March 2, 2022, Letter from Chiquita Brooks-LaSure to Cindy Axne, attached as Exhibit "*B*" and incorporated herein.

> of the American Rescue Act of 2021, CMS announced a waiver retroactive to March 1, 2020 of the statutory transport requirements if, in response to a 911 call (or equivalent in areas without a 911 call system), such transport did not occur as a result of community-wide EMS protocols due to the COVID-19 PHE. The Ambulance Treatment in Place waiver supports communities in ensuring a strong infrastructure for emergency responses. It also enables EMS providers to receive Medicare payment for emergency services that normally would not have been paid had it not been for the unique circumstances of the PHE resulting in Treatment-in Place protocols.
>
> Between March 1, 2020, and September 30, 2021, 10,378 Medicare Fee-for-Service (FFS) beneficiaries received services under the Ambulance Treatment in Place waiver. CMS paid ambulance providers $3,629,456 for these services.

On January 1, 2021, CMS began its Emergency, Triage, and Transport Model, hereinafter "*ET3 Model*", which was a voluntary, five-year payment model that proposes to test whether paying ambulance providers to transport patients to alternative destinations or providing treatment in place to patients would preserve or enhance the quality of care furnished to patients. Governor Tate Reeves and the Mississippi Legislature, like CMS, determined that there exist substantial benefits to requiring commercial insurance companies to compensate ambulance service providers for transporting patients to alternative destinations and rendering treatment in place to patients. As such, by a unanimous vote, the Mississippi Legislature passed HB 1489 and on May 2, 2024, Governor Tate Reeves signed into law HB 1489[4], which is titled

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[4]The Mississippi Association of Supervisors openly supported HB 1489 and noted, in its Letter to the Mississippi State Senate, that "*[a]s a rural state, timely medical response to healthcare facilities is critical and our counties depend on ambulances services to be available 24/7. Timely medical response and ambulances equipped with advanced medical equipment and trained personnel can provide initial treatment and stabilize patients before reaching a hospital, which is especially important in rural areas with limited medical resources*." See letter from the Mississippi Association of Supervisors to Senator J. Walter Michel, which is attached as Exhibit "*C*" and incorporated herein.

"*Mississippi Triage, Treat and Transport to Alternate Destination Act.*" The purpose of HB 1489 is to provide health insurance coverage and reimbursement requirements for transporting patients to alternative destinations and rendering treatment in place to patients.

HB 1489 reads, in relevant part, as follows

> On and after July 1, 2024, any health benefit plan shall provide coverage for:
>
> (a) An ambulance service to:
>
> (i) Treat or assess an enrollee in place; or
>
> (ii) Triage or triage and transport an enrollee to an alterative destination; or
>
> (b) An encounter between an ambulance service and enrollee that results without transport of the enrollee.

According to HB 1489, ambulance providers shall be compensated at the following rate for the services outlined in the statute:

> (1)(a) The minimum allowable reimbursement rate under any policy of accident and sickness insurance as defined by Section 83-9-1 to an out-of-network ambulance service provider for all covered services shall be the rates contracted between an ambulance service provider and a county, municipality or special purpose district or authority, or otherwise approved or established by ordinance or regulation enacted by any such county, municipality or special purpose district or authority in which the covered healthcare services originated.
>
> (b) In the absence of rates provided in subsection (a), the minimum allowable reimbursement rate to an out-of-network ambulance service provider shall be the greater of:
>
> (i) Three hundred twenty-five percent (325%) of the reimbursement allowed by Medicare for the respective services originating in the respective geographic area; or
>
> (ii) The ambulance service provider's billed charges.

Further, HB 1489 requires reimbursement for ground ambulance services that were previously unpaid or underpaid by insurance providers. Effective July 1, 2024, any new contracts will require these statutory minimums. HB 1489 was adopted to protect access to pre-hospital care for all Mississippians by ensuring state-regulated commercial health insurance companies provide adequate reimbursement for the costs associated with emergency services.

Industry research indicates a direct correlation between treatment in place and alternative transport programs, hereinafter "*TIP/TAD programs*," like that established by HB 1489, and reduced emergency room treatment costs[5]. As such, West Virginia[6] and Arkansas[7] both recently adopted statutes that are nearly identical to HB 1489. Interestingly, Arkansas BlueCross BlueShield did not find the language of its TIP/TAD statute vague or ambiguous but rather sees the value of and cost savings associated with TIP/TAD programs and likewise, have embraced the new law and set up payment and coding policies for TIP/TAD expenditures[8]. Pafford Medical Services, for example, performs TIP services in Arkansas and has had "*no challenges billing TIP to BCBS Arkansas*" using their guidelines[9].

Ironically, the Mississippi Association of Health Plans, Inc.[10] has instituted this litigation seeking declaratory and injunctive relief from the reimbursement and coverage mandates outlined in HB 1489 alleging that the statute's "*allowable*

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[5]See MAA/CMS HB 1489 Resource, which is attached as Exhibit "*D*" and incorporated herein.

[6]See W. Va. Code, § 33-25-8v (Eff. June 6, 2024)

[7]See Arkansas Code Ann. § 23-79-2703 (Eff. August 1, 2023).

[8]See December 28, 2023, letter from BCBS to Nevada County Ambulance Service, which is attached as Exhibit "*E*" and incorporated herein.

[9]See August 13, 2024, letter from Larry Clark. Vice-President of Pafford Medical Services, which is attached as Exhibit "*F*" and incorporated herein.

[10]Blue Cross Blue Shield of Mississippi is a member of the Mississippi Association of Health Plans, Inc. See Declaration of Bryan Lagg [Dkt. 17-1].

reimbursement rate of 325% of the CMS reimbursement rate would be significantly higher than the current allowable under Blue Cross' plans" and would require "*Blue Cross to begin reimbursing out-of-network ambulance service providers at their billed rates on or about July 1, 2024, [which] will result in costs significantly higher than Blue Cross estimated when it filed its 2023 premium rates*." See Declaration of Bryan Lagg [Dkt. 17-1].

The Mississippi Association of Health Plans, Inc., hereinafter "*MAHP*", in essence, is asserting that HB 1489 will create a financial uproar for its members when studies show that the "*ambulance industry makes up less than 1% of the Medicare Budget, and according to Brookings, the ambulance spend for insurance carriers is .33%.*[11]" Furthermore, a study published in the New England Journal of Medicine found that more than 83% of 3,668 patients who received emergency care at home over two years did not require a trip to the hospital, which saved Atrius Health, a division of United Health Group's Optum Health approximately $4.5 million dollars[12].

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[11]See MMA Bulletin on HB1489, which is attached as Exhibit "*G*" and incorporated herein.

[12]https://www.modernhealthcare.com/providers/emergency-room-care-at-home-growth-challenges

Financial analysis from other states that have passed legislation similar to HB 1489 found that the cost increases to insurance companies as a result of paying for TIP/TAD services is minimal if they occur at all[13]. According to the Louisiana Fiscal Note from the Louisiana Legislative Office relating to their TIP/TAD legislation, the Louisiana Department of Insurance opined that "*the proposed legislation is not anticipated to have an impact on health insurance policies issued under the health insurance exchanges/marketplace*[14]." Louisiana law, like HB 1489, awards ambulance providers compensation at a rate of 325% of the current published rate for ambulance services as established by CMS, if no rates have been set or approved by the ambulance provider and the insurance company.

Rep. Stacey Hobgood-Wilkes rejects the validity of the instant lawsuit, and the assertions made by MAHP. When asked about the basis for her position she was clear that "*ambulances shouldn't have to provide services for free*." According to Rep. Hobgood-Wilkes, "*if you provide a service, you should be compensated for it*," and "*without adequate reimbursement for these services, the citizens of Mississippi will not receive the reliable, high-quality care they deserve and pay for.*[15]" Her comment embodies the well-established principle of quantum meruit, which literally means "*as much as he deserves.*" *Redd v. L & A Contracting Co.*, 151 So.2d 205, 207 (Miss. 1963). Under Mississippi law,

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[13]See MAA HB 1489 FAQ Bulletin, which is attached as Exhibit "*H*" and incorporated herein.

[14]See June 5, 2023, Louisiana Legislative Fiscal Note, which is attached as "*I*" and incorporated herein.

[15]https://www.wlbt.com/2024/07/12/health-insurance-advocacy-group-seeks-block-ambalance-reimbursement-bill/

"*when a person employs another to do work for him, without any agreement as to his compensation, the law implies a promise from the employer to the workman that he will pay him for his services as much as he may deserve or merit.*" *Id.* The Mississippi Legislature, in HB 1489, recognized the value in the services rendered by emergency services providers and likewise, set a reasonable pay scale for those services.

Stacey Hobgood-Wikes' sentiments and the principle of quantum meruit are echoed by Daniel P. Edney, MD, FACP, FASAM, State Health Officer for the State of Mississippi, who asserts that the "*models of reimbursement are not sustainable. The current model is negatively impacting our system of care services by reimbursing as a transportation service. EMS reimbursement must mirror healthcare reimbursement in order to be sustainable.*[16]"

David Grayson, President of Mississippians for Emergency Medical Services, which is the largest association of pre-hospital medical personnel in the state of Mississippi, agrees with the positions taken by Rep. Hobgood-Wilkes and Dr. Edney. According to David Grayson, many rural areas in this state lack a basic emergency room, which creates increased demand and cost to ambulance service providers for services for which they receive no compensation, and "*without adequate reimbursement for our services, our citizens may end up dialing 911 and there not be an ambulance available to come.*[17]"

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[16]See Memorandum to Mississippi Legislature from Daniel P. Edney, which is attached as Exhibit "*J*" and incorporated herein.

[17]See April 3, 2024, letter from David Grayson to the Mississippi Legislature, which is attached as Exhibit "*K*" and incorporated herein.

According to Mark Galtelli, MHA, NRP, Executive Director of the Mississippi Center for Advancement of Prehospital Medicine, HB 1489 "*can alleviate the strain on our emergency services, ensure better patient care, and make significant strides towards a more sustainable healthcare system in Mississippi*.[18]" More specifically, he notes, as follows:

> Our EMS system is under unprecedented strain, with a significant number of 911 calls being made by individuals who do not require emergency ambulance transport. This not only depletes our limited EMS resources but also contributes to the overcrowding of hospital emergency rooms with non-emergency patients. The result is a healthcare system strained to its limits, where those in genuine crisis may not receive timely care.
>
> HB 1489 promotes the adoption of TIP and TAD practices, which have been thoroughly evaluated through the CMS's ET3 model. These practices allow EMS personnel to either treat certain non-emergency patients at the scene or transport them to more appropriate medical facilities rather than emergency departments. Such interventions have demonstrated remarkable benefits including reduction in inpatient admissions, ambulance efficiency, including reduced service time and increased availability, cost savings to patients, private insurers, and Medicaid, and improved patient safety and satisfaction.

Historically, Mississippi ambulance service providers have suffered a substantial economic loss as a result of providing TIP/TAD services to Mississippi residents. Faced with the challenges caused by health insurance companies' unwillingness to reimburse ambulance service providers for TIP/TAD services, the Mississippi Legislature responded by passing HB 1489. MAHP now seeks a preliminary injunction that would ultimately frustrate the Legislature's intent to protect public health and safety.

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[18]See Letter from Mark Galtelli of Mississippi Center for Advancement of Prehospital Medicine to the Mississippi Senate Insurance Committee, attached as Exhibit "*L*" and incorporated herein.

SUMMARY OF THE ARGUMENT

MAHP failed to provide this Honorable Court with credible, empirical data that proves its members would suffer an actual, tangible injury if no preliminary injunction is entered in this matter. At best, MAHP's assertion that it would suffer astronomical financial losses if forced to comply with HB 1489 is based on future events that may not occur as anticipated, or indeed may not occur at all. As such, this matter is not ripe for adjudication. Furthermore, public interest and Mississippians' right to quality pre-hospital care weigh against an injunction. Therefore, this Court should deny the *Motion for Preliminary Injunction*[19] as well as dismiss this action.

ARGUMENT

I. STANDARD OF REVIEW

"*A preliminary injunction is an extraordinary and drastic remedy which should not be granted unless the movant clearly carries the burden of persuasion,"* and *"unequivocally show[s] the need for its issuance." Canal Auth. of State of Fla. v. Callaway*, 489 F.2d 567, 573 (5th Cir. 1974); *Valley v. Rapides Par. Sch. Bd.,* 118 F.3d 1047, 1050 (5th Cir. 1997). The movant must clearly show that the injunction is warranted and the issuance of a preliminary injunction "*is to be treated as the exception rather than the rule*." *Miss. Power & Light Co. v. United Gas Pipe Line*, 760 F.2d 618, 621 (5th Cir. 1985). In order to obtain a preliminary injunction, the movant must establish four elements:

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[19]The *Amici*, MAA, fully adopts and incorporates the arguments set forth in the *Response and Memorandum in Opposition of Preliminary Injunction* filed by defendant, Michael Chaney herein.

> (1) a substantial likelihood that plaintiff will prevail on the merits, (2) a substantial threat that plaintiff will suffer irreparable injury if the injunction is not granted, (3) that the threatened injury to plaintiff outweighs the threatened harm the injunction may do to defendant, and (4) that granting the preliminary injunction will not disserve the public interest.

Canal Auth. of State of Fla. v. Callaway, 489 F.2d 567, 572 (5th Cir. 1974).

The party seeking preliminary injunctive relief must satisfy a cumulative burden of proving each of the aforementioned four elements before a preliminary injunction can be granted. *Clark v. Prichard*, 812 F.2d 991, 993 (5th Cir. 1987). That said, no factor has a "*fixed quantitative value*." *Mock v. Garland*, 75 F.4th 563, 587 (5th Cir. 2023). On the contrary, "*a sliding scale is utilized, which takes into account the intensity of each in a given calculus*." *Id.* In sum, "*the decision to grant or deny a preliminary injunction lies within the sound discretion of the trial court*." *White v. Carlucci*, 862 F.2d 1209, 1211 (5th Cir. 1989). "*In exercising their sound discretion, courts of equity should pay particular regard for the public consequences in employing the extraordinary remedy of injunction*." *Weinberger v. Romero–Barcelo*, 456 U.S. 305, 312, 102 S.Ct. 1798, 72 L.Ed.2d 91 (1982); *Railroad Comm'n of Tex. v. Pullman Co.*, 312 U.S. 496, 500, 61 S.Ct. 643, 85 L.Ed. 971 (1941).

II. THE REQUEST FOR PRELIMINARY INJUNCTION SHOULD BE DENIED AS PLAINTIFF CANNOT PREVAIL ON THE MERITS OF ITS CASE.

At the preliminary injunction stage of litigation, it is proper for the Court to consider whether the underlying claims are subject to dismissal when determining whether those claims are likely to prevail on the merits. *Morlock L.L.C. v. Bank of Am., N.A.,* No. H-14-1678, 2014 U.S. Dist. LEXIS 180005 (S.D. Tex. Oct. 29, 2014)

(dismissing plaintiff's request for injunctive relief because the underlying claims were subject to dismissal).

In the case *sub judice*, plaintiff asserts that HB 1489 violates the Due Process Clause of the Fourteenth Amendment and the Contract Clause. More specifically, plaintiff argues that the coverage mandate in HB 1489 violates the Due Process Clause of Fourteenth Amendment because it is vague and the reimbursement mandate in HB 1489 violates the Contract Clause because it impairs its members' existing contracts.

Before plaintiff can challenge the constitutionality of HB 1489, it must first show that it has standing to pursue this litigation. Defendant, Mike Chaney, in its *Motion for and Memorandum in Support of Dismissal*, makes it clear that plaintiff lacks standing to pursue this action. *See* Dkt. 12 and Dkt. 13. The *Amici*, MAA, fully adopts and incorporates the arguments set forth in the *Motion for and Memorandum in Support of Dismissal* as a basis for its assertion that it is highly unlikely that plaintiff will prevail in this matter. The *Motion for and Memorandum in Support of Dismissal* makes it clear that this action should be dismissed since plaintiff lacks standing to pursue this action.

Even if plaintiff has standing, this alone does not earn it a day in court. Its claims must also be ripe. *Book People, Incorporated v. Wong*, 91 F.4th 318, 333 (5th 2024). In determining whether a claim is ripe, this Court must consider two factors: "*(1) the fitness of the issues for judicial decision and (2) the hardship to the parties of withholding court consideration.*" *Braidwood Management, Incorporated v. Equal Employment Opportunity Commission,* 70 F.4th 914, 930 (5th Cir. 2023). "*A claim*

is fit for judicial decision if it presents a pure question of law that needs no further factual development." *Id.* "*If a claim is 'contingent on future events that may not occur as anticipated, or indeed may not occur at all,' the claim is not ripe.*"

The declaration of Bryan Lagg makes it clear that this matter is not ripe for adjudication when he asserts that "*in future years, a requirement to reimburse certain providers at whatever amount they decide to bill will greatly impact Blue Cross' ability to reasonably estimate premiums*, without any credible proof that establishes the exact nature of any financial deficit that would be suffered by Blue Cross Blue Shield of Mississippi. See Dkt. 17-1. His assertion and MAHP's position that compliance with HB 1489 would cause financial hardship for its members, at best, are contingent on the number of TIP/TAD claims asserted and the costs billed for the services of the ambulance provider. HD 1489 became effective on July 1, 2024, and applies prospectively. As such, there exists no reliable empirical data that shows the financial effect TIP/TAD charges would have on MAHP members.

Tracy Wold, in his declaration[20], acknowledges that "[*b]ecause ambulance service providers were historically not paid for the services covered under HB 1489, which are also called TIP/TAD services, until recently, neither ambulance providers nor MAHP members were gathering billing information on TIP/TAD services, so they, retrospectively, cannot forecast the total number of TIP/TAD claims that would be billed to health insurer*s." Because MAHP does not have any retrospective data on the effect of TIP/TAD charges on its members, it cannot prospectively assert any injury it would suffer if it is required to comply with HD 1489. In sum, without

[20]The declaration of Tracy Wold is attached as Exhibit "*M*" and incorporated herein.

historical data regarding the effect of TIP/TAD payments on the profit margins of MAHP members, this matter is simply not ripe for consideration and should be dismissed.

Ironically, the data from the ET3 Model promulgated by CMS indicates that their payments for TIP/TAD services had minimal financial impact. According to CMS, the ET3 Model[21] was utilized from January 1, 2021, through December 31, 2023, and yielded the following empirical data:

> Total number of participants who have billed for ET3 Model Interventions: 72
>
> Number of unique beneficiaries who have received ET3 Model Interventions (cumulative of Transport to Alternate Destinations [TAD] and Treatment in Place [TIP]): 2,964
>
> Total number of ET3 Interventions (cumulative of TAD and TIP): 3,397
>
> Total number of TIP interventions: 3,144
>
> Total number of TAD interventions: 253

Comparing the ET3 empirical data to the arguments made by MAHP, it becomes abundantly clear that this matter is not ripe for consideration since MAHP has failed to provide any empirical data to support its assertion that HB 1489 will leave its members in a financial crisis. The ET3 empirical data actually suggests that TIP/TAD treatment does not occur at a rate that should create financial hardship for health insurance carriers. The ET3 Model, on the other hand, demonstrates that TIP/TAD services are beneficial to the community as it "*saved them [patients] and their families time waiting in the emergency department and care may have been provided more quickly, hospital costs may have been avoided when appropriate, and ambulance teams may have focused on taking patients with the greatest emergency needs to the hospital*."

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[21] https://www.cms.gov/priorities/innovation/innovation-models/et3

Constant with the findings from the ET3 Model, a study published in the New England Journal of Medicine found that more than 83% of 3,668 patients who received emergency care at home over two years did not require a trip to the hospital, which saved Atrius Health, a division of United Health Group's Optum Health approximately $4.5 million dollars[22].

Considering the tangible savings that Atrius Health attributes to emergency care received outside the hospital setting, it is very probable that the increased costs attributed to TIP/TAD services will be offset by the savings generated from reduced visits to the emergency room, potentially, resulting in an increased profit margin for MAHP members. They can likely save money when their insureds' need to be transported to and treated at the hospital is alleviated by TIP/TAD services. Lastly, the Louisiana Department of Insurance, in its Fiscal Note relating to their TIP/TAD legislation which provides reimbursement rates nearly identical to HB 1489, found that "*the proposed legislation is not anticipated to have an impact on health insurance policies issued under the health insurance exchanges/marketplace.*[23]"

The recorded evidence indicates that MAHP's claims are contingent on future events that may not occur as anticipated, or indeed may not occur at all and as such, are not ripe for adjudication. Therefore, this Court should deny the request for preliminary injunction and ultimately, dismiss this case. *Mazurek v. Armstrong*, 520 U.S. 968, 972, 117 S.Ct. 1865, 138 L.Ed.2d 162 (1997)(issuing a preliminary injunction

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[22]https://www.modernhealthcare.com/providers/emergency-room-care-at-home-growth-challenges

[23]See June 5, 2023, Louisiana Legislative Fiscal Note, which is attached as "*I*" and incorporated herein.

based only on a possibility of irreparable harm is inconsistent with the characterization of injunctive relief as an extraordinary remedy).

III. THE BALANCE OF EQUITIES AND PUBLIC INTEREST SUPPORT DENYING THE PRELIMINARY INJUNCTION.

The award of preliminary relief is never "*strictly a matter of right, even though irreparable injury may otherwise result to the plaintiff*," but is rather *"a matter of sound judicial discretion*" and careful balancing of the interests of and possible injuries to the respective parties. *Yakus v. United States*, 321 U.S. 414, 440, 64 S.Ct. 660, 88 L.Ed. 834 (1944). Thus, a plaintiff must show that it would suffer more harm without the injunction than would defendant if it were granted. *Canal Auth. of Fla. v. Callaway*, 489 F.2d 567, 572 (5th Cir. 1974). Plaintiff must also show that, if granted, a preliminary injunction would not be averse to public interest. *Star Satellite, Inc. v. Biloxi*, 779 F.2d 1074, 1079 (5th Cir. 1986).

"[*T*]*he public is served when the law is followed*." *Daniels Health Scis., L.L.C. v. Vascular Health Scis., L.L.C.*, 710 F.3d 579, 585 (5th Cir. 2013)[24]. See also, *League of Women Voters of United States v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016) ("*There is generally no public interest in the perpetuation of unlawful agency action*.")

HB 1489 seeks to protect public health and safety by ensuring that ambulance service providers have the funding necessary to continue to provide high quality, efficient, and accessible pre-hospital care to Mississippi residents. Considering the

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[24]See declaration of Maria Zito is attached as Exhibit "*N*" and incorporated herein. According to Maria Zito, MAHP members, despite the fact that there exist no preliminary injunction justifying their failure to pay the cost of ambulance services rendered pursuant to HB 1489, obstinate and refuse to pay ambulance service bills at the rate outlined in HB 1489.

legislative intent of HB 1489, it is clear that the preliminary injunction should be denied since the balance of equities and public interest weigh heavily against an injunction. The health of Mississippi's residents is at risk if ambulance service providers are not properly compensated for TIP/TAD services. David Grayson eloquently summarized the dilemma that would be created if a preliminary injunction is granted in this matter: *"without adequate reimbursement for our services, our citizens may end up dialing 911 and there not be an ambulance available to come.*"

Although MAHP members may have a financial interest in avoiding the mandates of HB 1489, its efforts to accomplish that goal cannot be at the expense of providing quality, efficient, and accessible pre-hospital care to the citizens of Mississippi. Mike Cole, Director of Ambulance Services for Covington County Hospital, summed up the public interest crisis created by noncompliance with HB 1489, when he said, the following:

> Public perception is that ambulance transportation is a public service. People think it's free to them. Unfortunately, our collection revenue is less than 30 percent of what is billed. For example – imagine 100 people walk into Walmart and take items home with them, but only 30 of those people pay for what they got. Walmart couldn't survive very long. This is a large part of why ambulance providers are struggling[25].

Like all medical services, in determining their rates, ambulance providers consider many factors that may include but are not limited to distance, urban or rural, in-network or out-of-network, public or private, negotiated or non-negotiated rates. It is the providers' autonomy to do so. MAHP argues that its members will be forced to pay for services without remedy to address any purportedly inflated invoices. This contention

is disingenuous at worst and hyperbole at best. There is no substantiated evidence that ambulance providers will suddenly begin a practice of sending astronomical or inflated bills for their services. The speculative application of this unfair practice would result in either no payment or delayed payment for services rendered. Further, HB 1489 does not limit any provider from denying payment for inappropriate or inaccurate billing, however, it requires payment for services rendered.

The ambulance providers will continue to bill insurance carriers, such as MAHP members, at the usual and customary rates promulgated by industry standards. The significance of HB 1489 is it requires that the insurance companies pay for services rendered, rather than their previous practice of unilaterally opting to pay at a rate it deemed appropriate—whether the rates were negotiated or otherwise. The enactment of HB 1489 allows the ambulance provider to receive equitable payment for quality service provided to patients.

MAHP members' failure to comply with HB 1489 make it difficult for ambulance providers to continue to provide quality, efficient and accessible pre-hospital care to Mississippi citizens. The health of Mississippi citizens is at risk; therefore, the public interest factor weighs heavily against an injunction. In short, the

[25]https://magnoliatribune.com/2021/11/09/cole-perfect-storm-strains-ambulance-providers/

unsubstantiated monetary losses asserted by MAHP simply do not outweigh the benefits of and public interest associated with providing quality pre-hospital care to Mississippi residents who rely on emergency services. Therefore, this Honorable Court should find that the public interests weigh heavily against a preliminary injunction and deny the *Motion for Preliminary Injunction*.

CONCLUSION

As this matter is not ripe for adjudication and MAHP has failed to satisfy the elements for a preliminary injunction, this Court should deny the *Motion for Preliminary Injunction* as well as dismiss this action.

RESPECTFULLY SUBMITTED, this the 22nd day of August, 2024.

MISSISSIPPI AMBULANCE ALLIANCE,
PROPOSED *AMICI*

BY: /s/ Amanda Alexander
AMANDA ALEXANDER, MSB No. 101463
Attorney for Mississippi Ambulance Alliance

OF COUNSEL:
AMANDA G. ALEXANDER
ALEXANDER LAW, P.A.
Post Office Box 1664
Jackson, Mississippi 39215
601-968-8571
aga@alexanderlawpa.com

CERTIFICATE OF SERVICE

I, AMANDA ALEXANDER, counsel for proposed *Amici,* Mississippi Ambulance Alliance, certify that on August 22, 2024, I electronically filed the foregoing with the Clerk of the Court using the *ECF* system which sent notification of such filing to all counsel of record.

/s/ Amanda Alexander
AMANDA ALEXANDER

CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

1. This brief does not comply with the type volume limitations of Fed. R. App. P. 29(a)(5) since it contains 19 pages, rather than 17.5 pages, excluding the parts of the brief exempted by Fed.R.App.P. 32(a)(7)(B)(iii). However, MAA seeks leave to file an oversized brief of 19 pages, which is only 1.5 more pages than allowed by Fed. R. App. 29(a)(5). MAA would otherwise be unable to provide the Court with all of the information MAA believes will be helpful to this Court's deliberations.

2. This brief complies with the typeface requirements of Fed.R.Civ.P. 32(a)(5) and the type style requirements of Fed.R.App.P. 32(a)(6) since this brief has been prepared in the proportionally spaced typeface using WordPerfect X5 in Century Schoolbook, 12 point typeface.

SO CERTIFIED, this the 22nd day of August, 2024.

s/ Amanda Alexander
AMANDA ALEXANDER

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF
MISSISSIPPI
NORTHERN DIVISION

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC. PLAINTIFF

VERSUS CAUSE NO. 3:24CV379-HTW-LGI

MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI DEFENDANT

EXHIBIT LISTING FOR MISSISSIPPI AMBULANCE ALLIANCE'S *AMICUS BRIEF* IN SUPPORT OF DEFENDANT, MIKE CHANEY'S RESPONSE IN OPPOSITION TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Exhibit A	September 29, 2021, Letter from Cindy Axne to Chiquita Brooks-LaSure
Exhibit B	March 2, 2022, Letter from Chiquita Brooks-LaSure to Cindy Axne
Exhibit C	Letter from the Mississippi Association of Supervisors to Senator J. Walter Michel,
Exhibit D	MAA/CMS HB 1489 Resource
Exhibit E	December 28, 2023, letter from BCBS to Nevada County Ambulance Service
Exhibit F	August 13, 2024, letter from Larry Clark, Vice-President of Pafford Medical Services
Exhibit G	MMA Bulletin on HB1489
Exhibit H	MMA Bulletin on HB1489
Exhibit I	June 5, 2023, Louisiana Legislative Fiscal Note
Exhibit J	Memorandum to Mississippi Legislature from Dr. Daniel P. Edney
Exhibit K	April 3, 2024, letter from David Grayson to the Mississippi Legislature,
Exhibit L	Letter from Mark Galtelli to Mississippi Center for Advancement of Prehospital Medicine
Exhibit M	Declaration of Tracy Wold
Exhibit N	Declaration of Maria Zito

Congress of the United States
Washington, DC 20515

September 29, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

Thank you for taking proactive measures to help healthcare providers-including emergency medical services (EMS) practitioners-contain the spread of SARS-CoV-2(COVID-19) and its Delta Variant. EMS personnel have continued responding to their communities and saving lives-despite facing workforce shortages, fatigue, and other challenges. I appreciate your agency exercising regulatory flexibilities as we continue to battle this pandemic.

On March 11 of this year, the American Rescue Plan Act (P.L. 117-2) was signed into law. This legislation granted waiver authority to the Centers for Medicare & Medicaid Services (CMS) to allow fire and EMS departments to be reimbursed for ground ambulance services provided during the COVID-19 Public Health Emergency that did not culminate in transporting a patient to a hospital. As we continue navigating new challenges to healthcare access during this "new normal", I am requesting data about the benefits of this waiver. Specifically, I would like the following information:

1. How many patients have been served under this waiver?
2. How does the quality of care given via Treatment-in-Place compare to treating the patients in the hospital?
3. Has this waiver- or any others- saved CMS any funds? If so, how much?
4. I am also requesting the same data on the other waivers you have granted to allow EMS agencies to facilitate patient treatment through telehealth as well as transport patients to alternative destinations of care. How have these policies helped or hindered EMS agencies to provide care?

I believe the information I've requested will help get us closer to finding legislative solutions to our healthcare system's most pressing issues and ever-changing environment. As our fire and EMS systems continue working tirelessly in the face of this unprecedented pandemic, it is critical that we provide the tools and resources needed to give Americans the highest quality of care.

Thank you for your continued commitment to the health and safety of the American people. I request this information to sent to my office within 60 days and can be sent via email to Denise.Fleming@mail.house.gov. I appreciate your attention to this important matter.

Sincerely,

Cindy Axne
Member of Congress

Exhibit A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

March 2, 2022

The Honorable Cindy Axne
U.S. House of Representatives
Washington, DC 20515

Dear Representative Axne:

Thank you for your letter and interest in the waiver authority for payment of ground ambulance services during the COVID-19 public health emergency (PHE) that did not result in transporting the patient to a covered destination ("Treatment in Place"). You asked a number of questions about the benefits of the Ambulance Treatment in Place waiver during the PHE as well as other emergency medical service (EMS)-related flexibilities.

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring that health care providers have the necessary tools and information to respond to the COVID-19 PHE. Normally, ground ambulance services are only eligible for Medicare payment if the beneficiary received a medically necessary transport to a covered destination. On May 5, 2021, pursuant to authority granted under section 9832 of the American Rescue Plan Act of 2021, CMS announced a waiver retroactive to March 1, 2020 of the statutory transport requirements if, in response to a 911 call (or the equivalent in areas without a 911 call system), such transport did not occur as a result of community-wide EMS protocols due to the COVID-19 PHE. The Ambulance Treatment in Place waiver supports communities in ensuring a strong infrastructure for emergency responses. It also enables EMS providers to receive Medicare payment for emergency services that normally would not have been paid had it not been for the unique circumstances of the PHE resulting in Treatment-in Place protocols.

Between March 1, 2020, and September 30, 2021, 10,378 Medicare Fee-for-Service (FFS) beneficiaries received services under the Ambulance Treatment in Place waiver. CMS paid ambulance providers $3,629,456 for these services.[1] Ambulance providers were not required to report quality of care data under this waiver. Additional utilization data should be available in the future.

We note that the CMS Center for Medicare and Medicaid Innovation (Innovation Center) began the Emergency, Triage, Treat, and Transport (ET3) Model test on January 1, 2021.[2] The ET3 Model is a voluntary, five-year payment model that provides greater flexibility to ambulance

[1] Claims received by CMS as of October 22, 2021, with dates of service between March 1, 2020, and September 30, 2021. For services provided under this waiver from March 1, 2020 – May 5, 2021, the deadline to submit claims is May 5, 2022. For services provided under this waiver after May 5, 2021, providers must file claims within one calendar year after the date of service. As a result, this count may not reflect all services during this window.
[2] CMS established the ET3 Model pursuant to section 1115A of the Social Security Act and waivers issued thereunder.

EXHIBIT B

service suppliers and ambulance providers to address emergency health care needs of Medicare FFS beneficiaries following a 911 call. The purpose of the Model is to test whether paying for two model-specific interventions will improve quality and lower costs by reducing avoidable transports of Medicare FFS beneficiaries to emergency departments and/or unnecessary utilization of other Medicare covered services. Under the ET3 Model, Medicare will pay participating ambulance service suppliers and ambulance providers to: (1) transport a beneficiary to an Alternative Destination Partner, such as a primary care office or an urgent care clinic (Transport to an Alternative Destination); and (2) initiate and facilitate beneficiary receipt of a medically necessary covered service by a Qualified Health Care Partner at the scene of a 911 response, either in-person on the scene or via telehealth (Treatment in Place).

The ET3 Model intends to preserve or enhance the quality of care furnished to beneficiaries. To that effect, the Innovation Center is using utilization and other measures to track experience and quality of care, identify gaps in care, and focus quality improvement activities. An independent evaluator is conducting the Model evaluation. The Model evaluation will include an analysis of the quality of care furnished under the Model, including the measurement of patient-level outcomes and patient-centeredness criteria, and the changes in spending under the applicable titles by reason of the model. Evaluation results of the Model are not yet available.

Thank you again for your letter. We hope that this additional information will be helpful as we work together to protect the health and safety of the American people and to ensure the provision of high-quality care. As more data become available, we will reach out to your office with such information. If you have any additional questions, please contact the CMS Office of Legislation at (202) 690-8220.

Sincerely,

Chiquita Brooks-LaSure

Mississippi Association of Supervisors

793 N. President Street, Jackson, Mississippi 39202
Office (601) 353-2741 | Fax (601) 353-2749
www.mssupervisors.org

Honorable Senator J. Walter Michel
Mississippi State Senate
Room: 212-C
P. O. Box 1018
Jackson, MS 39215

Dear Chairman Michel,

The Mississippi Association of Supervisors (MAS) would like to thank you for advancing legislation that will improve ambulance service throughout our 82 member counties. As a rural state, timely medical response to healthcare facilities is critical and our counties depend on ambulances services to be available 24/7. Timely medical response and ambulances equipped with advanced medical equipment and trained personnel can provide initial treatment and stabilize patients before reaching a hospital, which is especially important in rural areas with limited medical resources.

To maintain community development and growth throughout our State, the Mississippi Association of Supervisors stands collectively with the advocates of quality ambulance services. We appreciate your assistance, and we ask that legislation that will improve ambulance service be passed from the Senate.

Sincerely,

Derrick Surrette
Executive Director
Mississippi Association of Supervisors

EXHIBIT C

HB 1489- TO USE AMBULANCE & HOSPITAL EMERGENCY RESOURCES TO GREATER COMMUNITY BENEFIT

CMS STUDY SHOWS MAJOR BENEFITS FOR PATIENTS, AMBULANCE SERVICES & HOSPITALS FROM "TREATMENT IN PLACE" (TIP) & TRANSPORTING PATIENTS TO ALTERNATE DESTINATIONS (TAD) OTHER THAN EMERGENCY ROOM

THE PROBLEM: Many patients who call 911 for EMS are low acuity and have no medical need for an ambulance transport. Ambulance services nationwide are severely short on personnel. 911 callers suffering no medical emergency often delays service to patients who are in a medical crisis. Further, hospital emergency rooms are saturated with non-emergency patients which causes a delay for EMS to unload the patient and return to service.

SOLUTIONS EXAMINED & VALIDATED: CMS has field tested allowing ambulance crews to **(A)** treat certain non-emergency patients at the scene but not transport them (a practice called "treatment in place" or "TIP") and **(B)** take certain other patients to medical facilities other than hospital emergency departments (a practice called "alternative destinations" or "TAD"). The field test program is known as "ET3" (Triage, treatment & transport). Dozens of sites across the US participated.

REDUCTION IN INPATIENT ADMISSIONS

- In a pilot focused on frequent EMS utilizers that tested transport to alternative destinations coupled with case management, one hospital experienced a **28% reduction in ED visits**, along with a **9% reduction in hospitalizations**.[1]
- The Innovation Center conducted additional analyses of the literature as well as analysis of 2017 Medicare FFS claims and determined an **estimated range of potentially avoidable admissions of 7.5% to 12% if patients were transported to alternative destinations**.

IMPROVEMENTS IN AMBULANCE EFFICIENCY

- Evidence from stakeholder feedback and pilots similar to ET3 interventions suggests the time from ambulance initiation to being back in service after treatment in place **is less than half the time** required for transport to an ED **(39 minutes vs. 84 minutes, respectively).**[2]
- Stakeholders estimate that transport to an alternative destination is somewhere in between these two estimates, but less than the transfer time at an ED.

Source Document: Department of Health and Human Services, Centers for Medicare and Medicaid Services Joint Informational Bulletin, August 8, 2019

1 Tadrops AS, Castillo EM, Chan TC, Jensen AM, Watts K, Dunford JD. (2012) Effects of an Emergency Medical Services–based Resource Access Program on Frequent Users of Health Services, Prehospital Emergency Care, 16:4, 541-547
2 Langabeer JR, Gonzalez M, Alqusairi D, et al. Telehealth-Enabled Emergency Medical Services Program Reduces Ambulance Transport to Urban Emergency Departments. West J Emerg Med. /2016;17(6):713-720.

EXHIBIT D

OPPORTUNITIES IN THE EMERGENCY ASSESS, TRIAGE, TREAT AND TRANSPORT PROGRAM AND TRANSPORT TO ALTERNATE DESTINATIONS MODEL EVIDENCE BASED

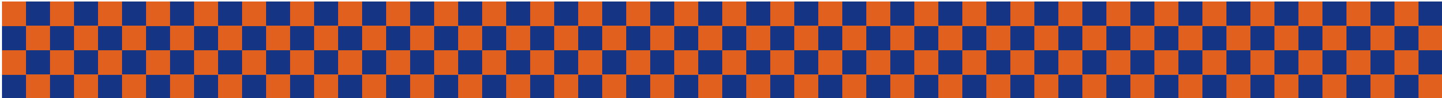
TREATMENT IN PLACE PROGRAMS AND OUTCOMES

Program Title or Study Author	Program Description	Available Outcomes
Willings, JG (2018)[3]	• Provided treatment in place after falls among assisted living facility residents. • Applying a non-transport protocol resulted in a **66% non-transport rate.**	99% of those not transported received the appropriate level of care.
Krumperman, K et. al.[4]	• Treatment in place initiative implemented in a rural area • 1,512 treatments in place and 6,100 EMS transports occurred, corresponding to a treatment in place **use rate of roughly 20%.**	N/A

Source Document: Department of Health and Human Services, Centers for Medicare and Medicaid Services, Joint Informational Bulletin, August 8, 2019

3 Williams, JG., Bachman, MW., Lyons, ZD., Currie, BB., Brown, AW., Cabanas, JG., Kronhaus, AK., Myers, J.B.. (2018). Improving decisions about transport to the emergency department for assisted living residents who fall. Annals of internal medicine, 168(3), 179-186.

4 Krumperman, K., Weiss, S., & Fullerton, L. (2015). Two types of prehospital systems interventions that triage low-acuity patients to alternative sites of care. South Med J, 108(7), 381-386.



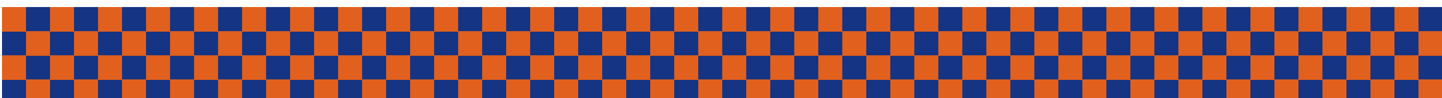
OPPORTUNITIES IN THE EMERGENCY ASSESS, TRIAGE, TREAT AND TRANSPORT PROGRAM AND TRANSPORT TO ALTERNATE DESTINATIONS MODEL EVIDENCE BASED

TRIAGE LEVEL BY AGE

Program Title or Study Author	Program Description
Richmond, N. J. and MedStar Mobile Healthcare (Louisville, Kentucky and Fort Worth, Texas) [5, 6]	• Among medical triage calls from individuals over age 64: 68% were classified as needing emergency care as soon as possible, but not warranting emergency transport. Of those, 8% were advised to seek care within 1 to 4 hours. 8% triaged as only needing self or home-based care. The remainder were primarily classified as either needing care within a day or more or needing only routine care. • Despite these numbers, across all age groups, only slight more than a third of calls were safely triaged to lower acuity settings; the remainder were sent an ambulance. • Another analysis of these two programs over different periods of operations indicated that **25% of participating callers to the medical triage line ultimately pursued care in settings other than the ED with $1,700 in savings per avoided ED visit.** [7] • The Fort Worth program indicates that since June 2012, of the 9,836 low-acuity callers referred to this program, roughly **one third did not use an ambulance to the emergency department, resulting in $3.8 million savings from avoided ambulance transport and emergency department expenditures ($1,165 per enrolled patient).** [8]

Source Document: Department of Health and Human Services, Centers for Medicare and Medicaid Services Joint Informational Bulletin, August 8, 2019

5 Both programs directly connected patients to care and provided non-ambulance transport. For more information on the Louisville program see: Richmond, N. J. (2014, August 21). The Front Door to Care: EMS in Louisville Grows Beyond Simple 9-1-1 Response. *EMS World*. or more information on the Ft. Worth program see: Fact Sheet
6 Fivaz, M. C., McQueen, J., Barron, T., Clawson, J., Scott, G., & Gardett, M. I. (2015). The distribution of recommended care levels by age, gender, and trauma vs medical classification within the emergency communication nurse system. Ann Emerg Dispatch Response, 3(1), 14-20.
7 Gardett, I., Scott, et al. (2015). 911 Emergency communication nurse triage reduces EMS patient costs and directs patients to high-satisfaction alternative point of care. Ann Emerg Dispatch Response, 3, 8-13.
8 Mobile Healthcare Programs – Overview. Medstar911. http://www.medstar911.org/mobile-healthcare-programs



OPPORTUNITIES IN THE EMERGENCY ASSESS, TRIAGE, TREAT AND TRANSPORT PROGRAM
TRANSPORT TO ALTERNATE DESTINATIONS
MODEL EVIDENCE BASED

MEASURING ACCURACY OF TRANSPORT

Program Title or Study Author	Program Description
Scott, G et. al. [9]	• Evaluated whether medical dispatchers could accurately identify low acuity cases appropriate for medical triage (as opposed to requiring ambulance transport). • Examined medical-related 911 calls and compared the triage level assigned by the dispatchers to the individuals' severity level defined by vital signs taken by the EMS crew. Of roughly 20,000 cases identified by the medical dispatchers as the lowest severity, **89% did not have a single unstable vital sign and only 1% were transported with lights and siren (a proxy for severity).**

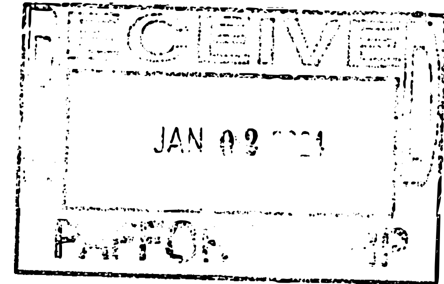
Source Document: Department of Health and Human Services, Centers for Medicare and Medicaid Services Joint Informational Bulletin, August 8, 2019

9 Scott G, et al. Using on-scene EMS responders' Assessment and Electronic Patient Care Records to Evaluate the Suitability of EMD-Triaged, Low-acuity Calls for Secondary Nurse Triage in 911 Centers. (Feb 2016). Prehospital and Disaster Medicine. Vol 31 Issue 1. Pp 46-57.

Provider Network Operations

P.O. Box 2181
Little Rock, AR 72203-2181

December 28, 2023



Nevada County Ambulance Servic
PO Box 267
Prescott, AR 71857-0267

Dear Provider:

Arkansas Act 480 that enacts "triage, treat and transport to an alternative destination" is effective January 1, 2024. This communication is notify medical transport providers about the coverage policy and the claims filing policy Arkansas Blue Cross and Blue Shield, Blue Advantage Administrators and Health Advantage will be implementing January 1, 2024 in conjunction with Act 480. As a reminder, the Act does not apply to self-funded ERISA Plans administered by Blue Advantage Administrators, therefore each of these employers have the choice whether or not to follow Act 480's guidelines.

Enclosed is the coverage policy. In addition, here are some highlights to emphasize related to claims submission and payment.

FOR MEDICAL TRANPSORT PROVIDERS:

If you engage with a medical professional (e.g. a Physician via telehealth), do not bill on behalf of the medical professional. He/she should bill us for their own services. The medical professional should be a participating network provider; that is, should participate in the Preferred Payment Plan, Arkansas' First Source PPO, True Blue PPO, or Health Advantage HMO networks ("the Networks").

All claims from a medical transport provider should be submitted in an electronic 837P format.

If a behavioral health professional is needed, please utilize one of the provider types listed in this policy as these are the specialties participating in our provider networks.

For treat in place, claims will require code A0998 and a run sheet/medical record. Claims for treat in place should be billed with the same origin/destination modifier in both the origin and destination modifier place.

If transporting to an alternative destination, claims should include only service codes A0425 and A0427. Claims should be billed with ambulance origin/destination modifier P in the "destination" position of the origin/destination modifier combination signifying transport was made to an alternate destination allowed per the policy.

EXHIBIT E

Medical transport providers who are participating in the Networks will be reimbursed per the terms of those agreements. Non-participating providers will be reimbursed per the terms of Act 480.

FOR MEDICAL PROFESSIONALS

As was mentioned above, submit claims on behalf of your services, and not any of the transport service codes. Services must meet the telehealth coverage policy #2015034 found at https://arkansasbluecross.com/providers/coverage_policy.aspx

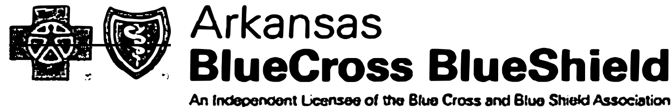
The medical professional should be a participating provider as mentioned above and will be reimbursed per the terms of his/her participating provider agreement.

Arkansas Blue Cross is delighted to work with medical transport providers to offer these additional services that will benefit Arkansas residents.

If you have any questions, please contact the Network Development Representative for your area (see enclosed map).

Sincerely,

Dan Stevens, MHSA, FAHM
Director, Provider Network Operations



Payment and Coding Policy		
Subject: Ambulance Triage, Treat and Transport to Alternate Destination		
Policy Number: AR-0000006	Category: Transportation	
Initiated: 01/01/2024	Last Revision:	Last Review:

Disclaimer

These policies serve as a guide to assist in the submission of accurate claims and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, product, or any other item submitted in a claim is covered under a member's benefit plan is not a determination of reimbursement. Services must meet authorization and primary coverage criteria or medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Proper billing and submission guidelines must be followed. Industry standard, compliant codes on all claim submissions are required. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes.

Unless otherwise noted within the policy, our policies apply to both participating and non-participating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, claims may be rejected or denied and there may be recoupment of payment.

As determined by Arkansas Blue Cross and Blue Shield, these policies may be superseded by applicable provider or state contract language, by applicable state or federal laws and regulations, or by other applicable state or federal requirements or mandates. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Policies will be reviewed and revised periodically when necessary. When there is an update, the most current policy will be published to the website. Notification of policy revisions will be published as an alert on the Availity Portal and quarterly in Providers News.

Description

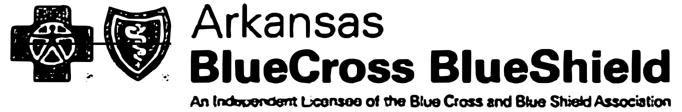
This policy addresses claims processing and payment policy for ambulance services to triage, treat in place and transport to an alternate destination. An alternate destination means a lower acuity facility that provides medical services which includes federally qualified health centers (FQHC), urgent care centers, physician offices or medical clinics and behavioral or mental healthcare facilities including crisis stabilization units.

Claims processing and payment policy for general air and ground ambulance transport is addressed in Payment and Coding Policy AR-0000002.

Policy

In accordance with Act 480 of 2023 of the Arkansas legislature for all contracts subject to this law, coverage is provided for an ambulance service to treat in place or triage and transport to an alternative destination. For contracts subject to Arkansas Act 480, the following payment policy applies.

CPT Codes Copyright @ 2023 American Medical Association



1. **The following general guidelines apply:**
    a. The service must have been initiated in response to a 911 call that is documented in the run sheet or ambulance service records.
    b. The service is subject to the member's health benefit plan's deductible and copay for both the ambulance service and the treat in place service performed by the physician or behavioral health specialist.
    c. Services provided are subject to all applicable Medical Coverage Policy and plan benefits.
    d. The coverage for this service does not diminish or limit benefits otherwise allowable under the member's benefit plan, even if the claims for medical or behavioral health services overlap in time that is billed by the ambulance service also providing care.
    e. Claims must be submitted on an 837P with the appropriate origin/destination modifiers as indicated in this policy. A complete list of origin/destination modifiers can be found in the Modifier section of this policy.
    f. If the Ambulance Provider is a hospital owned affiliated company, claims cannot be submitted under the hospital's NPI. A separate NPI for ambulance services is required.
    g. Certain items and services are not separately reimbursed as they are included in the base rate. Refer to Payment and Coding Policy AR-0000002 for a list of items and services that will be denied as included in the base rate if billed separately.
    h. Mileage beyond the nearest appropriate facility as reported with HCPCS A0888 is not reimbursable.

2. **Treat in Place**- Claims must include the Ambulance Provider NPI and HCPCS A0427 [Ambulance service, advanced life support, emergency transport, level 1 (als 1 emergency)].
    a. The ambulance provider can bill for one Advanced Life Support Emergency (ALS-E) rate for each treat in place intervention, regardless of whether it was performed in-person or via telehealth.
    b. HCPCS Q3014 Telehealth originating site facility fee is not reimbursable to the ambulance service provider. The facilitation of the telehealth services is considered a part of the base rate for the Treat in Place intervention.
    c. The physician or behavioral health specialist must submit the claims for any health services rendered during the Treat in Place service. Services provided via Telehealth will be subject to the Telehealth Coverage Policy #2015034.
    d. Claims for Treat in Place will require the addition of HCPCS A0998 signifying there was no transport. A run sheet will be required to verify policy criteria was met.
    e. Claims for Treat in Place should be billed with the same origin/destination modifier in both the origin and destination modifier place. *Example: if the ambulance service responds to the member's home for the Treat in Place service and no transport was required, the origin/destination modifier combination would be RR.*
    f. The coordination of care via real time audiovisual telehealth must be performed by an in-network, contracted physician performing services within the scope of licensure for a medical-based complaint and in-network, contracted behavioral health specialist (Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Psychiatric Examiner and Psychiatric Certified Advance Practice Registered Nurse) for a behavioral health-based complaint.

3. **Transport to Alternate Destination**- Claims must include the Ambulance Provider NPI and HCPCS code A0427 [Ambulance service, advanced life support, emergency transport, level 1 (als 1 emergency)] and HCPCS code A0425 (Ground mileage, per statute mile) and no other claim lines.
    a. The receiving provider/facility should bill as usual for services rendered.
    b. The alternative destination must be one of the following:
        i. federally qualified health center (FQHC)

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

ii. urgent care center
iii. physician office or medical clinic,
iv. behavioral or mental healthcare facility including without limitation a crisis stabilization unit.

c. The alternative destination must not be one of the following:
   i. critical access hospital
   ii. dialysis center
   iii. hospital
   iv. private residence
   v. skilled nursing facility
d. Claims for Transportation to an alternate destination should be billed with ambulance origin/destination modifier P in the "destination" position of the origin/destination modifier combination signifying transport was made to an alternate destination of either a FQHC, urgent care center, physician office or medical clinic or a behavioral or mental healthcare facility or a crisis stabilization unit. *Example: if the ambulance service responds to the scene of an accident and a transport to an urgent care center or other alternate destination is required, the origin/destination modifier combination would be SP.*
e. If a transport to an alternate destination is recommended by the provider coordinating the care and the patient refuses to transport, the ambulance service is eligible for reimbursement for services performed billed by HCPCS code A0427. The claim should be billed with the addition of HCPCS A0998 signifying there was no transport. A run sheet will be required to verify policy criteria was met.

CPT/HCPCS

A0425 Ground mileage, per statute mile
A0427 Ambulance service, advanced life support, emergency transport, level 1 (als 1 emergency)
A0888 Mileage Beyond the Nearest Facility
A0998 Ambulance response and treatment, no transport

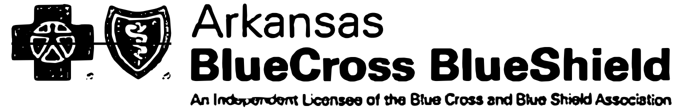
ICD-10 Diagnosis Codes

Modifiers

D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;
E = Residential, domiciliary, custodial facility (other than 1819 facility);
G = Hospital based ESRD facility;
H = Hospital; I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;
J = Freestanding ESRD facility;
N = Skilled nursing facility;
P = Physician's office;
R = Residence;
S = Scene of accident or acute event;
X = Intermediate stop at physician's office on way to hospital (destination code only)

References

Alternative destination- means a lower-acuity facility that provides medical services, including without limitation: a federally qualified health center (FQHC), an urgent care center, a physician office or medical



clinic, as selected by the patient and a behavioral or mental healthcare facility including without limitation a crisis stabilization unit. Alternative destination does not include the following: critical access hospital, dialysis center, hospital, private residence or skilled nursing facility.

Telemedicine (Telehealth)- Telemedicine means the use of audio-visual electronic information and communication technology to deliver healthcare services, including without limitation, the assessment, diagnosis consultation, treatment education, care management, and self-management of a patient. Telemedicine includes store-and-forward technology and remote patient monitoring. Telemedicine does not include the use of audio-only electronic technology.

Policy History

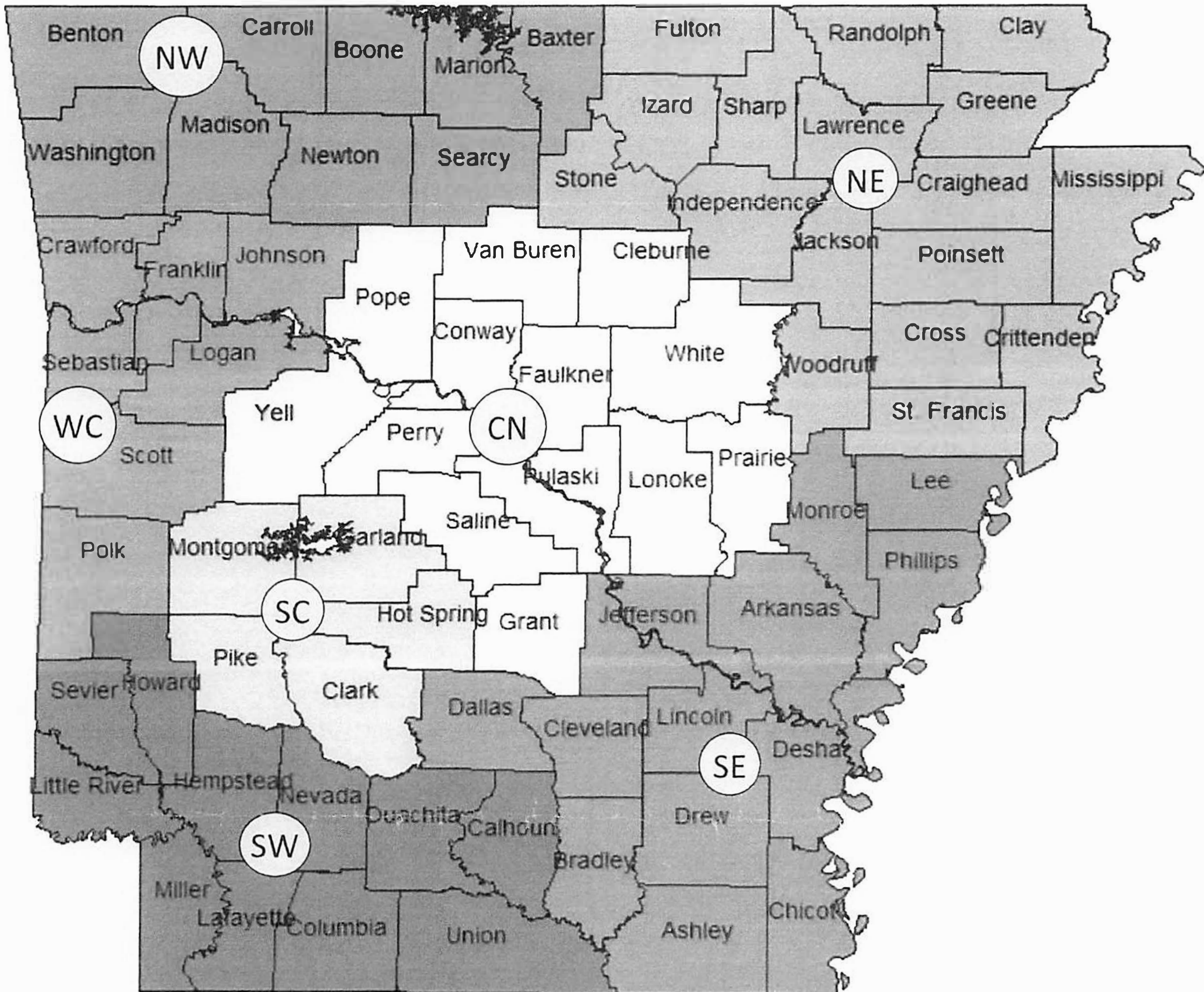
Arkansas Blue Cross and Blue Shield Regional Map with NDR and Support Staff

Northwest Region & West Central Region

NDR: **Terry Rhoads** (479) 527-2359
tarhoads@arkbluecross.com
Support Staff: Melody Spence - *Credentialing*
(479) 527-2320 mtspence@arkbluecross.com
Kimberly Carpenter - *Claims* (479) 527-2389
kacarpenter@arkbluecross.com

Northeast Region

NDR: **Alison Morrison** (870) 974-5740
apmorrison@arkbluecross.com
Support Staff: Pam Moore (870) 974-5754
providerrelationsne@arkbluecross.com



Southwest Region & South Central Region

NDR: **Renay Turner** (870) 779-9109
prturner@arkbluecross.com
Support Staff: Diana Wolfe (501) 620-2644
dlwolfe@arkbluecross.com

Southeast Region

NDR: **Jason Aud** (870)543-2945
jsaud@arkbluecross.com
Support Staff: Bambi Wilson (870) 543-2910
SEarkproviders@arkbluecross.com

Central Region

NDR: **Tina Baggett** (501) 378-3036
trbaggett@arkbluecross.com
Counties: Cleburne, Perry, Pope, Van Buren, White, Yell, Pulaski

NDR: **Joaly Velasquez** (501) 378-3049
jmvelasquez@arkbluecross.com
Counties: Conway, Faulkner, Grant, Lonoke, Prairie, Saline, Pulaski

Support Staff: Asiah Scribner (501) 378-3035
centralregionnetworkmanagement@arkbluecross.com

August 13, 2024

To Whom It May Concern:

Pafford Medical Services currently performs Treatment in Place (TIP) in Arkansas. We have no challenges billing TIP to BCBS Arkansas using the attached billing guidelines. Please feel free to contact me if I can be of further assistance.

Sincerely,

Larry Clark
Vice President - Revenue Cycle Management
Pafford Medical Billing Services
PO Box 1120
Hope, AR 71802
800-451-8036 x 232 - Office
870-703-8152 - Cell

EXHIBIT F

MISSISSIPPI AMBULANCE ALLIANCE

HB1489 HB1629

Amidst the chaos of saving lives, a frustrating reality often emerges: ambulance providers are seldom adequately compensated for services provided. Despite the critical role these services play in stabilizing patients and providing vital care en route to hospitals, the financial burden of these overlooked expenses falls squarely on the shoulders of the providers and, ultimately, the patients themselves. This discrepancy not only undermines the sustainability of ambulance services but also places an undue strain on healthcare systems and individuals. It's time to bridge this gap in coverage and ensure that ambulance providers receive the fair compensation they deserve for their crucial, life-saving efforts.

HB 1489

Treatment in Place/Alternative Destination TIP

HB1489 is focused solely on 911 responses. Even though nearly 25% of ambulance responses result in no transport of the patient, ambulance providers routinely respond to a call and, after a full assessment, find that the patient will not go to the hospital. Treatment is often provided on-scene during this encounter, improving the patient's condition. Currently, there is no mechanism requiring payment to the provider for this because reimbursements are based on transport, not treatment.

This legislation allows an assessment and treatment in place and even the option of an alternative destination, such as a mental health facility or doctor's office, for a patient who does not require an ER visit. It also allows the patient to be transported to an alternative destination if required, reducing the strain on overflowing ER situations.

Passage of this bill ensures patients are properly cared for and the provider is properly reimbursed for the evaluation and treatment in place.

HB1629

Ambulance Minimum Payments

This bill intends to protect both the patient and provider while ensuring equitable insurance rates for the services provided. The current Mississippi Balance billing law has crippled the ambulance industry by forcing providers to accept a below-cost reimbursement from the carriers without a method to protect vital services. It is to be noted that the Federal No Surprises Act carved out ground ambulance providers due to the unique requirements placed on providers to respond to all emergencies regardless of a patient's ability to pay. This legislation follows national guidelines from the American Ambulance Association of setting the payment to be either 1) 100% of locally mandated rates developed by local officials knowing their EMS systems and community or 2) set the payment to 325% of Medicare. *The ambulance industry makes up **less than 1% of the Medicare Budget**, and according to Brookings, the ambulance spend for **insurance carriers is .33%.***

EXHIBIT G

MAA
MISSISSIPPI
AMBULANCE
ALLIANCE

HB1489

Frequently Asked Questions

Who will the provisions of the bill cover?
The provisions of HB 1489 will apply to all private and public EMS agencies in Mississippi who are REQUIRED to respond to 9-1-1 emergency medical calls. Currently, these agencies are mandated by law to provide services however are not adequately reimbursed for the cost of providing life-saving services . The bill will protect access to care for all Mississippians by ensuring state-regulated (non-ERISA) commercial insurance plans are providing adequate reimbursement for the cost of emergency services.

What is considered an emergency transport?
Any ambulance transport that occurs in response to a 911 call is an emergency transport. There are a few other instances (e.g., if an on-duty ambulance crew witnesses a car wreck, if a critically ill patient at a rural hospital needs to be transferred immediately to an acute care facility, etc.) that could trigger an emergency transport.

Does this cover non-emergency transports?
No. Non-emergency transports often occur when a hospitalized patient is being discharged to home, nursing center, or rehab but cannot sit upright, or when a patient is being transported between facilities for testing or specialized care but has not been discharged. These transports are for post-stabilization where the patient, hospital or insurance carrier can make appropriate transportation arrangements.

Will this bill increase the costs for insurance carriers?
Financial analysis from three states that passed similar legislation last year suggests that cost increases will be infinitesimal – if they occur at all. Additionally, we believe HB 1489 will help carriers save time and money they currently expend working to resolve payment disputes and address complaints raised by patients and EMS agencies.

In Louisiana, the fiscal note attached to SB 109 (2023) stated, "The LA Department of Insurance reports the proposed legislation is not anticipated to have an impact on health insurance policies issued under the health insurance exchanges/marketplace." In addition, the Office of Group Benefits (OGB) in Louisiana did not anticipate the proposed law to require premium increases.

In Texas, the fiscal note for SB 2476 (2023) referenced a potential fiscal impact of $5.1M over the biennium for the Teachers Retirement System (TRS). This reflects a 0.06% annual increase in health care claim costs. Additionally, the Texas Employees Retirement System, Texas Department of Insurance, Texas Health and Human Services Commission, Texas A&M University, and the University of Texas all concluded no additional resources were needed to implement SB 2476.

In California, AB 716 (2023) is expected to increase net annual expenditures for health plans regulated by the Department of Managed Health Care and the California Department of Insurance by 0.05%.

EMS agencies are the friends of insurance companies. Our early access and early treatment helps their members for better healthcare outcomes. We assess the patient to make sure they

EXHIBIT H

are transported to the most appropriate hospital the first time that reduces the likelihood of the patient being transferred to another hospital and get them in front of a specialists quickly that can provide the best outcome. This is beneficial to the patient's health and the insurance carriers saving on costs of additional transports plus keeping their members healthy.

How will we contain costs within this proposal?
Tying reimbursement to a rate that is both set by local public officials through contract negotiations with their ambulance provider, provides accountability and transparency that will deliver cost containment. Where locally set rates don't exist, a reimbursement cap tied to the Medicare rate is the containment tool.

Won't this bill result in ambulance agencies no longer going in network with insurance companies?
Ambulance agencies are rarely in network as it is. Most of Mississippi's ground ambulance agencies are very small and under-resourced. Most simply do not have the expertise or capacity to engage in sophisticated contracting with multiple insurance carriers. A *Health Affairs* report from 2020 found that 79% of all ground ambulance transports were provided out-of-network.

How many other states have passed similar legislation?
Nearly a dozen other states have laws protecting ambulance patients from balance billing. The laws passed in California, Texas, and Louisiana in 2023 all have similar elements to the Colorado bill, including directives that carriers pay locally set rates where they exist.

State / Jurisdiction	Statute	Notes
Colorado	3 CCR 702-4 "Carriers shall reimburse a non-contracted service agency that provides emergency ambulance services to a covered person at **three hundred twenty-five percent (325%) of the Medicare reimbursement rate for the same service provided in the same geographic area, including mileage**."	Regulatory
Louisiana	Act 453 – "the minimum allowable rate of reimbursement under any health benefit plan issued by any healthcare insurer shall be **three hundred twenty-five percent** of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same service provided in the same geographic area"	Enacted
Indiana	HB 1385 – "(1) at a rate set or approved, by contract or ordinance, by the county or municipality in which the ambulance service originated; (2) at the rate of **four hundred percent (400%)** of the current published rate for ambulance service as established by the Centers for Medicare and Medicaid Services under Title	Enacted

	XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.) for the same ambulance service provided in the same geographic area; or (3) according to the nonparticipating ambulance service provider's billed charges; whichever is less."	
Texas	SB2476 – "if the political subdivision has not submitted the rate to the department, the lesser of: (A) the provider's billed charge; or (B) **325 percent of the current Medicare rate, including any applicable extenders and modifiers**."	Enacted
Washington	"If a rate has not been established under (a) of this subsection, the lesser of: (i) **325 percent of the current published rate for ambulance services as established by the federal centers for medicare and medicaid services under Title XVIII** of the social security act for the same service provided in the same geographic area; or (ii) The ground ambulance services organization's billed charges."	Enacted
Wisconsin	**400% of Super Rural Rate**	In Progress – 495% of Medicare allowable

What other states are considering similar legislation currently?
Georgia, Minnesota, Florida, New Hampshire, New York, Ohio, Missouri, Montana, Nevada Oklahoma, Massachusetts, Michigan, Maine, Illinois, and Wisconsin are all considering bills that would prohibit balance billing for ground ambulance transports, direct health plans to pay locally set rates where they exist, and create reimbursement caps (ranging between 325-500% of the Medicare rate) where locally set rates don't exist. These states are in all different stages of enacting their bill.

Why does the bill set 325% of Medicare as the payment for transports when there is not a locally set rate?
Insurance carriers utilize Medicare guidelines to set their coverage guidelines and payment structure. Medicare is a national standard and is utilized for this purpose often to set a floor for rates. In MS Medicare has one set of rates for the entire state. In some larger states Medicare does have states broken into areas for different rates. For example, Medicare for Louisiana has rates for Parishes around New Orleans and then rates for the remainder of the state.

Medicare uses an annual Ambulance Inflation Factor (AIF) that considers CPI, inflation, etc. While the base rates are low, Medicare does recognize different rates for locality so there is respect for areas of urban, rural, and super rural. It's more of a science.

The County rate that's in the bill is from the County and their local ambulance provider agreeing on a rate that considers costs and desired service levels for their particular county needs.

What would the 325% rates look like in MS for Urban Areas?

Level of Service	Mississippi Urban Medicare Rate	Rate: 325% Medicare	Ambulance Co. "A" Local Rate	Ambulance Co. "B" Local Rate	Ambulance Co. "C" Local Rate
Basic Life Support Emergency	$398.56	$1,295.32	$988	$1,650	$1,224.82
Advanced Life Support Emergency	$473.29	$1,538.19	$1,250	$1,650	$1,408.55

Why is there such a variation in the local rates the ambulance companies charge?
Each ambulance company bases their charges off a pro forma for their expenses and revenues for that area and the subsidy that is received. Expenses for companies may very widely in cost for equipment, insurance, medications, and personnel. Also, the volume of transports in a county will impact the amount of revenue that is generated off transports. This is all considered when rates are being set for an area.
The ambulance companies backed by tax dollars and public utility models may have lower rates since they are not completely relying on reimbursements from their transports for funding.

LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **SB 109** SLS 23RS 353
Bill Text Version: **REENGROSSED**
Opp. Chamb. Action: **w/ HSE FLOOR AMD**
Proposed Amd.:
Sub. Bill For.:

Date: June 5, 2023 6:24 PM **Author:** TALBOT
Dept./Agy.: Insurance and Office of Group Benefits
Subject: Balance Billing - Non-Network Ambulance Ground Services **Analyst:** Patrice Thomas

INSURANCE POLICIES REF INCREASE SG EX See Note

Provides for balance billing by and reimbursement of covered health services provided by out-of-network emergency ambulance services. (8/1/23)

Proposed law requires the minimum allowable reimbursement rate under any healthcare plan issued by a healthcare insurer to an out-of-network ambulance provider is one of the following: (1) at the rates set or approved, whether in contract or ordinance, by a local governmental entity in the jurisdiction in which the covered health care services originate, or as provided by proposed law; and (2) requires if no rates have been set or approved, the minimum allowable rate of reimbursement under any health benefit plan issued by any health care insurer is 325% of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services (CMS) for the same service provided in the same geographic area or the ambulance provider's billed charges, whichever is less.

EXPENDITURES	2023-24	2024-25	2025-26	2026-27	2027-28	5 -YEAR TOTAL
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	$0	$0	$0	$0	$0	**$0**
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total						

REVENUES	2023-24	2024-25	2025-26	2026-27	2027-28	5 -YEAR TOTAL
State Gen. Fd.	$0	$0	$0	$0	$0	**$0**
Agy. Self-Gen.	$0	$0	$0	$0	$0	**$0**
Ded./Other	$0	$0	$0	$0	$0	**$0**
Federal Funds	$0	$0	$0	$0	$0	**$0**
Local Funds	$0	$0	$0	$0	$0	**$0**
Annual Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

EXPENDITURE EXPLANATION

Proposed law will increase Self-Generated Revenue expenditures within the Office of Group Benefits (OGB) beginning in FY 24. The LA Department of Insurance reports the proposed legislation is not anticipated to have an impact on health insurance policies issued under the health insurance exchanges/marketplace.

Office of Group Benefits Impact (Self-Generated Revenue Impact)

Proposed law increases expenditures within the Office of Group Benefits (OGB). The proposed law requires OGB to provide a minimum allowable rate of reimbursement for ground ambulance at 325% of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services (CMS). Based upon the assumptions listed below, the expenditures to cover this benefit are as follows:

	FY 23-24*	FY 24-25	FY 25-26	FY 26-27	FY 27-28	Total
Low (Non-Network Providers)	$84,053	$95,363	$99,177	$103,144	$107,270	$489,007
High (In-Network and Non-Network Providers)	$651,790	$739,486	$769,065	$799,828	$831,821	$3,791,989

*FY 23-24 represent 11 months of estimated claims expenditures. Unless OGB Fund Balance is utilized, SGF appropriation will be required to cover the state portion of the increase in premium costs, which is approximately 41%. As of February 2023, OGB reports a $434 M fund balance.

The expenditure estimate is based upon the following assumptions: (1) As of 4/01/2023, the current OGB member population in the five self-funded health plans is 165,015 (excluding 43,515 Medicare primary members, total members of 208,530). Membership will remain constant. (2) The coverage will become effective on 8/01/2023. (3) No change in OGB self-funded health plan membership in future fiscal years from current levels. (4) The third-party administrator (TPA), Blue Cross Blue Shield of LA (BCBSLA), estimates medical claims between $88,168 (low) and $683,696 (high) annually based on non-participating ground ambulance provider claims in Plan Year 2022 with point-of-pickup zip codes corresponding to jurisdictions without rates established by local governments. (5) **Low Estimate - Non-participating (non-network) ambulance providers -** The re-pricing of claims includes only the following Current Procedural Terminology (CPT) billing codes: A0427 (ambulance service, advanced life support, emergency transport, level 1) and A0429 (ambulance service, basic life support, emergency transport). **High Estimate - Both participating (in-network) and non-participating (non-network) ambulance providers -** The re-pricing of claims includes two additional CPT billing codes: A0433 (advanced life support, level 2) and A0434 (specialty care transport). (6) In future fiscal years, a medical inflation factor of 4%.

See EXPENDITURE EXPLANATION on Page 2

REVENUE EXPLANATION

The Office of Group Benefits (OGB) does not anticipate the proposed law to require premium increases, therefore there is no impact self-generated revenues collected from premiums. OGB has indicated the estimated costs associated with minimum allowable reimbursement rate for ground ambulance services be absorbed by the existing fund balance reserve. However, to the extent other legislative instruments that are enacted expand covered medical and pharmacy benefits, the cumulative impact may be material and require OGB to increase premiums to maintain an actuarially sound fund balance of $250 M.

Senate	Dual Referral Rules	House
[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S & H}		[x] 6.8(F)(1) >= $100,000 SGF Fiscal Cost {H & S}
[ ] 13.5.2 >= $500,000 Annual Tax or Fee Change {S & H}		[ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

Evan Brasseaux
Evan Brasseaux
Interim Deputy Fiscal Officer

EXHIBIT I

LEGISLATIVE FISCAL OFFICE
Fiscal Note

Fiscal Note On: **SB 109** SLS 23RS 353
Bill Text Version: **REENGROSSED**
Opp. Chamb. Action: **w/ HSE FLOOR AMD**
Proposed Amd.:
Sub. Bill For.:

Date: June 5, 2023 6:24 PM **Author:** TALBOT
Dept./Agy.: Insurance and Office of Group Benefits
Subject: Balance Billing - Non-Network Ambulance Ground Services **Analyst:** Patrice Thomas

CONTINUED EXPLANATION from page one:

EXPENDITURE EXPLANATION Continued from Page 1

Based on the aforementioned methodology on page one, expenditure estimates are between $88,168 (low) and $683,696 (high) annually based on establishing minimum allowable reimbursement rate for non-network ground ambulance provider claims in Plan Year 2022, and a medical inflation (MI) factor of 4% compounding annually. Below are expenditure calculations utilized to project the cost within OGB utilizing the assumptions listed on page one.

Expenditure Calculations listed below reflect 12 months of claims expenditures:
Base Cost (Low) = $88,168
Base Cost (High) = $683,696

FY 24 (Low) = $ 91,695 = $88,168 x 4% MI ($37,822 SGF)
FY 24 (High) = $711,044 = $683,696 x 4% MI ($293,291 SGF)

FY 25 (Low) = $ 95,363 = $ 91,695 x 4% MI ($39,335 SGF)
FY 25 (High) = $739,486 = $711,044 x 4% MI ($305,022 SGF)

FY 26 (Low) = $ 99,177 = $ 95,363 x 4% MI ($40,908 SGF)
FY 26 (High) = $769,065 = $739,486 x 4% MI ($317,223 SGF)

FY 27 (Low) = $103,144 = $ 99,177 x 4% MI ($42,545 SGF)
FY 27 (High) = $799,828 = $769,065 x 4% MI ($329,912 SGF)

FY 28 (Low) = $107,270 = $103,144 x 4% MI ($44,247 SGF)
FY 28 (High) = $831,821 = $799,828 x 4% MI ($343,109 SGF)

Total (Low) = $ 496,648 ($204,857 SGF)
Total (High) = $3,851,243 ($1,588,557 SGF)

Insurance Exchanges Impact (State General Fund Impact)
The LA Department of Insurance reports the proposed legislation is not anticipated to have an impact on health insurance policies issued under the health insurance exchanges/marketplace.

Senate	Dual Referral Rules	House
[x] 13.5.1 >= $100,000 Annual Fiscal Cost {S & H}		[x] 6.8(F)(1) >= $100,000 SGF Fiscal Cost {H & S}
[ ] 13.5.2 >= $500,000 Annual Tax or Fee Change {S & H}		[ ] 6.8(G) >= $500,000 Tax or Fee Increase or a Net Fee Decrease {S}

Evan Brasseaux
Evan Brasseaux
Interim Deputy Fiscal Officer

MISSISSIPPI STATE DEPARTMENT OF HEALTH

To: Esteemed Members of the Mississippi Legislature

From: Daniel P. Edney, MD, FACP, FASAM
State Health Officer

Emergency Medical Services (EMS) play a vital role in communities by providing immediate medical assistance during emergencies. Here are several reasons highlighting their importance:

1. Saving Lives: EMS personnel are trained to provide life-saving interventions on scene and during transport to medical facilities. Their rapid response can significantly improve outcomes for patients experiencing medical emergencies, such as heart attacks, strokes, traumatic injuries, or respiratory distress.

2. Critical Care: EMS professionals are equipped to administer critical care procedures, such as CPR, defibrillation, airway management, and stabilization of patients before they reach a hospital. These interventions are often time-sensitive and can make a crucial difference in patient survival and recovery.

3. Public Safety: EMS agencies often collaborate with other emergency responders, such as fire departments and law enforcement, to ensure public safety during accidents, natural disasters, and other emergencies. They provide support and assistance in managing and mitigating various types of emergencies.

4. Accessibility: EMS services provide accessible medical care to individuals in remote or underserved areas, where access to hospitals or primary care facilities may be limited. They bridge the gap in healthcare access by bringing medical expertise directly to the community.

5. Community Health Education: EMS personnel often engage in community outreach and education programs to promote public health and safety. They provide training in CPR, first aid, injury prevention, and disaster preparedness, empowering community members to respond effectively to emergencies.

6. Coordination of Care: EMS agencies collaborate with hospitals and other healthcare providers to ensure seamless transitions of care for patients. They play a critical role in coordinating medical resources and facilitating communication between different healthcare entities to optimize patient outcomes.

While providing these services are critical for Mississippians, EMS services are facing unprecedented challenges.

1. Models of reimbursement are not sustainable. The current model is negatively impacting our system of care services by reimbursing as a transportation service. EMS reimbursement must mirror healthcare reimbursement in order to be sustainable.

2. The EMS workforce is dangerously thin with EMS training programs struggling to enroll students each year. Less workforce equates to longer response times in our rural communities. Many of these citizens face disparate healthcare challenges which often result in poor outcomes due to the lack of services.

EMS services are the entrance into healthcare and an integral component of the healthcare system, providing essential medical care, promoting public safety, and improving the overall health and well-being of communities.

MEMS

Mississippians For Emergency Medical Services

April 3, 2024

The Honorable J. Walter Michel
Mississippi Senate
Insurance Committee Chair
Mississippi State Capital – Room 212-C
P O Box 1018
Jackson, MS 39215

Dear Senator Michel:

Mississippians for Emergency Medical Services is the largest association of pre-hospital medical personnel in the state. On behalf of our membership and our board of directors, I am writing today to ask for your support in **HB 1489**. Your support of this bill is vital to assure continued availability of ambulances in the state of Mississippi.

With many rural areas of this state lacking a basic emergency room, the increased demand and cost to provide services to the citizens is threatening the availability of these critical services. Without adequate reimbursement for our services, our citizens may end up dialing 911 and there not be an ambulance available to come.

Ambulance providers throughout the state need your help to pass this bill that would benefit every citizen in the state.

On behalf of our membership, I would like to thank you for all your efforts to ensure that Mississippians have access to the services that they deserve.

Please do not hesitate to contact me if you would like to discuss further or need additional information.

Sincerely,

David Grayson
President
david@caremedems.com
769-223-4169

EXHIBIT K

CC: Insurance Committee
The Honorable Michael McLendon, Vice-Chairman
The Honorable Bradford Blackmon
The Honorable Scott Delano
The Honorable Hillman Frazier
The Honorable Chris Johnson
The Honorable Dean Kirby
The Honorable Chad McMahan
The Honorable Brian Rhodes
The Honorable Benjamin Suber
The Honorable Joseph Thomas
The Honorable Neil Whaley
The Honorable Chick Younger

MEMS Board of Directors

President
David Grayson, CEO
AmeriPro EMS
Oxford, MS

Vice-President
Stan Alford,
Pafford EMS
Ridgeland, MS

Secretary-Treasurer
Jody Phillips
National EMT Association
Clinton, MS

District I – Director
Raymond Liberto
Holmes Community College
Grenada, MS

District II – Director
Ben Richards
North MS Medical Center
Tupelo, MS

District III – Director
Bridget Watkins
Lifecare EMS
Carthage, MS

District IV – Director
Howard Elkins
Metro Ambulance
Meridian, MS

District V – Director
Kevin Heurtin
AAA Ambulance
Hattiesburg, MS

District VI – Director
Earnest Hollingsworth
ASAP Ambulance
Laurel, MS

District VII – Director
Kevin Smith
ASAP Ambulance
Laurel, MS

Mississippi Senate Insurance Committee
Chairman Senator Walter Michel
CC: Senator Michael McLendon, Senator Bradford Blackmon, Senator Scott Delano,
Senator Hillman Frazier, Senator Chris Johnson, Senator Dean Kirby, Senator Chad McMahan, Senator Brian Rhodes, Senator Benjamin Suber, Senator Joseph Thomas, Senator Neil Whaley, Senator Chuck Younger

Dear Chairman Michel,

I am writing to express my strong support for House Bill 1489 and to urge your affirmative committee vote on this critical legislation. As someone intimately involved in the delivery of Emergency Medical Services (EMS), I am deeply concerned about the health of EMS in our state. There is compelling evidence that demonstrates the immediate need for action to help stabilize and enhance the EMS industry which is central to every aspect of healthcare in Mississippi. The implementation of "Treatment in Place" (TIP) and "Transport to Alternate Destinations" (TAD) models, as endorsed by the Centers for Medicare and Medicaid Services (CMS), presents a transformative opportunity for our EMS systems, benefiting patients, ambulance services, and hospitals alike.

Our EMS system is under unprecedented strain, with a significant number of 911 calls being made by individuals who do not require emergency ambulance transport. This not only depletes our limited EMS resources but also contributes to the overcrowding of hospital emergency rooms with non-emergency patients. The result is a healthcare system strained to its limits, where those in genuine crisis may not receive timely care.

HB 1489 promotes the adoption of TIP and TAD practices, which have been thoroughly evaluated through the CMS's ET3 model. These practices allow EMS personnel to either treat certain non-emergency patients at the scene or transport them to more appropriate medical facilities rather than emergency departments. Such interventions have demonstrated remarkable benefits including reduction in inpatient admissions, ambulance efficiency, including reduces out of service time and increased availability, cost savings to patients, private insurers, and Medicaid, and improved patient safety and satisfaction.

The evidence is clear: HB 1489 is not just a bill but a pathway to a more efficient, effective, and patient-centered EMS system. By supporting this legislation, we can alleviate the strain on our emergency services, ensure better patient care, and make significant strides towards a more sustainable healthcare system in Mississippi.

I respectfully urge you to vote in favor of HB 1489. Your leadership can bring about a pivotal change in our state's approach to emergency medical care, one that promises substantial benefits for all Mississippians.

Sincerely,

Mark Galtelli, MHA, NRP
Executive Director
Mississippi Center for Advancement of Prehospital Medicine

EXHIBIT L

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC. PLAINTIFF

VERSUS CAUSE NO. 3:24CV379-HTW-LGI

MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI DEFENDANT

DECLARATION OF TRACY WOLD

Pursuant to 28 U.S.C. Section 1746, Tracy Wold declares as follows:

1. My name is Tracy Wold. I am over the age of eighteen (18) and have personal knowledge of the matters set forth in this declaration. I am the owner and operator of ITG Strategies, LLC.

2. I have extensive knowledge, training and experience in emergency medical services operations in urban, rural and super-rural areas. I have managed and consulted with private ambulance services, public ambulance districts, fire-based ambulance services, and hospital-based ambulance services regarding billing audits, cost reporting, finances and operations. I have negotiated in-network commercial contract rates for various ambulance service providers in Mississippi.

3. Emergency medical services are the foundation and entry point of healthcare for communities and it has the most significant impact on patient outcomes, and reduced morbidity.

4. I am familiar with House Bill 1489. By an unanimous vote, the Mississippi Legislature passed HB 1489 and on May 2, 2024, Governor Tate Reeves signed into law HB 1489, which is titled "*Mississippi Triage, Treat and Transport to Alternate Destination Act*." The purpose of HB 1489 is to provide commercial insurance coverage and reimbursement requirements for transporting patients to alternative destinations and rendering treatment in place to patients.

5. On March 5, 2024, the Mississippi Legislative held its insurance committee hearing on HB 1489, which was open to the public. I was present at the committee hearing. During the hearing, no health insurance companies

advanced any objections to or concerns about the bill in the open debate regarding the bill.

6. Most commercial health insurance companies submit their premium rates in late spring or early summer to the Mississippi Department of Insurance and issue their plans on a calendar year basis, which is referred to as a "*plan year*," and the scheduled rate changes become effective as of January 1 of the plan year. As such, the members of the Mississippi Association of Health Plans, Inc., ("*MAHP*") have had plenty of time to make adjustments to their benefits structure and other plan terms to ensure compliance with HB 1489 since the legislation was signed by the governor on May 2, 2024. Although HB 1489 was signed into law on May 2, 2024, MAHP members were placed on notice of the legislation well in advance of it being signed into law. MAHP members, most likely, became aware of HB 1489 when the bill was first introduced in early 2024, which afforded insurers ample time to review ambulance claims information from other states with statutes similar to HB 1489 in connection with the possible new law and adjust its premium and policies prior to filing rates with the Mississippi Department of Insurance.

7. HB 1489 is prospective and as such, does not affect current health insurance plans and policies until they are renewed, which gives MAHP members sufficient time to make the necessary adjustments to their plans and premiums to ensure compliance with HB 1489.

8. The health insurers all have historical billed data with frequency and billed charges that would allow them to estimate the total number and types of covered claims likely to be transported in the coming plan year. Because ambulance service providers were historically not paid for the services covered under HB 1489, which are also called TIP/TAD services, until recently, neither ambulance providers nor MAHP members wree gathering billing information on TIP/TAD services, so they, retrospectively, cannot forecast the total number of TIP/TAD claims that would be billed to health insurers.

9. Many ambulance service providers have rates established or approved by boards, city councils, or various counties. If asked, most ambulance service providers would provide the details of the contracts to commercial health insurers as they are public records and production of the contracts could facilitate the ambulance service provider being paid in accordance with the law. Generally, when ambulance services providers are out of network providers, they receive compensation that is lower than the negotiated local rates or 325% of the Medicare charge for their services. As a general rule,

ambulance service providers have one fee schedule and charge those same fees no matter the county or city where services are provided.

10. Commercial insurers use the same CPT codes for ground ambulance services as those used by the CMS and Medicaid. Those codes are as follows:

A0425	Mileage;
A0426ALS	Non Immediate;
A0427ALS	1 – Immediate;
A0428BLS	Non-Immediate;
A0429BLS	Immediate;
A0433ALS	2 Immediate; and
A0434SCT	Specialty Care Transport.

MAHP asserts that charges for ground ambulance services can get as high as 1,407.59% and 1,921.48% of the Medicare rate for the designated service. In my 27 year career in emergency medical services administration, I have never seen charges or heard of providers charging that amount for their services. A large majority of ambulance services charges are below 325% of Medicare rate for the designated service

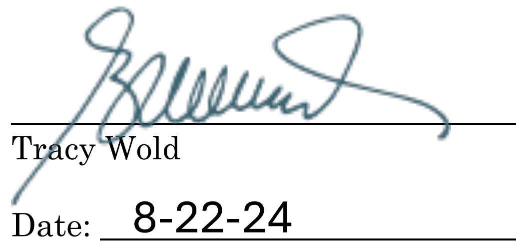
11. CMS implemented a pilot program, ET 3, in which it provided compensation to ambulance service providers for TIP/TAD services. The State of Arkansas has implemented legislation similar to HB 1489 and there have been no constitutional attacks on the legislation.

12. HB1489 does not impact those ambulance providers who are in-network with the commercial plans.

13. TIP/TAD services have the ability to assist with hospital overcrowding. The protection of patients and preservation of our emergency services providers is of utmost importance and criticality. TIP/TAD services promote positive patient outcomes and reduce expenses to CMS, Medicaid, or commercial insurance companies.

14. I have reviewed HB 1489 and as an experience emergency medical services professional, the standards and mandates set forth in the legislation were clear, unambiguous, and consistent with statutes that have been adopted in other states and remain unchallenged.

15. I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.



Tracy Wold

Date: 8-22-24

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

MISSISSIPPI ASSOCIATION OF HEALTH PLANS, INC. **PLAINTIFF**

VERSUS **CAUSE NO. 3:24CV379-HTW-LGI**

MIKE CHANEY, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INSURANCE OF MISSISSIPPI **DEFENDANT**

DECLARATION OF MARIA ZITO

Pursuant to 28 U.S.C. Section 1746, Maria Zito declares as follows:

1. My name is Maria Zito. I am over the age of eighteen (18) and have personal knowledge of the matters set forth in this declaration. I am the Chief Revenue Officer for Priority Ambulance, LLC and its family of companies, including its subsidiary that operates in Mississippi, Shoals Ambulance, LLC d/b/a Baptist Ambulance ("Baptist Ambulance").

2. In my role as Chief Revenue Officer, I oversee the company's Billing Center in Indianapolis, Indiana. That Billing Center provides centralized billing services for all of the company's operations, including the operations of Baptist Ambulance in Mississippi.

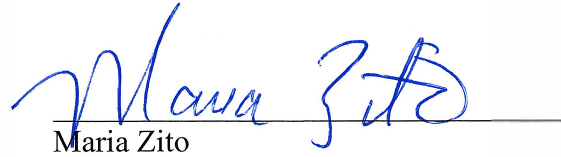
3. Since Mississippi House Bill 1489 went into effect on July 1, 2024, I have been monitoring billing and payments received for ambulance transports performed by Baptist Ambulance in Mississippi. Multiple insurance plans that I understand, upon information and belief, to be members of the Mississippi Association of Health Plans, including, without limitation, Cigna and United Health Care, are **not** paying claims for ambulance transports in accordance with House Bill 1489.

4. Specifically, those insurers have **not** paid Baptist Ambulance's usual and customary rates, nor have they even paid 325% of Medicare rates. Instead, those insurers are continuing to pay as they did before July 1, as if the new law had not even gone into effect. For the removal of doubt, Cigna and United Health Care have continued to pay for transports that were performed on or after July 1, 2024 at rates **less than** 325% of Medicare or Baptist Ambulance's billed rates.

EXHIBIT N

5. The company has written letters to the insurers that are disregarding the new law, pointing out that they are not complying with the law and asking them to reconsider. But, as of the date of this declaration, the insurers have not responded to those communications.

6. I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.



Maria Zito

Date: 8/22/2024