Murdo, Patricia

Subject: FW: Air Ambulance Membership Observations
Attachments: OIG 03-11 Subscriptions.pdf; ATT00001.htm

From: William Bryant
Sent: Tuesday, January 19, 2016 9:04 AM
To: Murdo, Patricia
Subject: Air Ambulance Membership Observations

Hi Pat,
There is another piece of the air ambulance membership puzzle you may not be aware of, and that is the need for providers to be compliant with Medicare rules of participation, and to stay clear of Federal anti-kickback statutes. Air and ground ambulance providers typically sell memberships to the public in exchange for waiving any out of pocket expenses (copays and deductibles) after their primary insurance company (including Medicare) pays. Federal anti-kickback statutes prohibit simply waiving these deductibles and copayments, so the providers are obligated to charge enough for the membership program to at least break even on the program. If they charged less than this amount, they may be subject to fines and penalties from the federal government. In 2003, The HHS Office of the Inspector General (OIG) issued an advisory opinion on this very issue related to ambulance membership programs (OIG Advisory Opinion No. 03-11). I have attached it for your convenience.

As a result of this guidance, most ambulance providers conduct an internal compliance audit from time to time, to make sure they are in compliance. As a consultant, I have conducted more than a dozen of these compliance audits for hospital and non-hospital air and ground providers around the country, although I have not done any in Montana.

What I find very interesting, is the inordinate amount of attention your Committee is paying to membership programs. From the 5,000 foot level, air ambulance membership programs play a minimal role in air ambulance economic issues, and there seems to be a lot of misunderstanding about that amongst those testifying to the committee. I listened to the tape from the June meeting, and I believe it was one of your members stated that he did not understand the business model, or how a $69 membership fee could offset the high cost of providing the service. The answer is that it cannot, and it was never designed to do so. Virtually all of Membership programs I have reviewed or audited are not intended to replace underlying health insurance, but only to replace the out of pocket expenses for those patients who already have some form of health insurance and protect the patient's finances. For the most part, the membership programs tended to break even, or generate a relatively small amount of excess revenue. It is only a small minority of patients who buy ambulance memberships who have no other form of health insurance. As your committee member appears to have surmised, a provider would have to sell many hundreds of memberships just to cover the full cost of providing a single transport. I think it is safe to say that no emergency helicopter air ambulance service could survive only on membership payments, particularly if sold at the $50-$100 level.
There also seems to be some confusion about what may have "changed" in Montana around the 2007 timeframe, resulting in the change from hospital ownership to private ownership. I sincerely doubt if this had anything to do with membership programs. However, hospitals getting out of the air ambulance business is not unique to Montana, but has occurred all over the country. I represented the air ambulance providers during the negotiated rulemaking process that established the Medicare fee schedule back in 1999/2000. At that time, more than 80% of air ambulances across the country were owned/operated by hospitals. Today, those numbers have almost flipped 180 degrees. Only about 30% of the air ambulance fleet across the country are currently owned/operated by hospitals. The primary driving force for this change was the very same federal legislation

that required the development of the Medicare fee schedule. In the Balanced Budget Act (BBA) of 1997, Congress called for the development of a national ambulance fee schedule, and the elimination of cost based reimbursement for hospital based ambulance services. Prior to the 1997 BBA, hospitals were paid by Medicare on the basis of their costs, not their charges, and not on a fee schedule. The more expensively they operated, and the more inefficient they were, the more money Medicare payed them via their year end cost reports. Once the new Medicare ambulance fee schedule was fully phased in by 2006, and cost based payments were completely eliminated, most hospitals experienced a significant drop in net reimbursement from Medicare, and dozens of them left the ambulance market, as they were often unable to increase their private charges fast enough to compensate for the loss. I consulted with many of these hospitals across the country as they evaluated their positions in a post cost reimbursed market. I can provide you much more insight if you are interested.

Finally, I also reviewed your regulation 50-6-320 that seems to both exempt air ambulances from the insurance code, and place additional requirements on them. I presume this has never been challenged, as based on what I sent you last week, if your Attorney General interprets the law and the DOT guidance the same way that the Texas Attorney General has interpreted it, it would likely be unwound entirely. I am particularly confused about the intent of Section 3 of 50-6-320 that seems to suggest that air ambulances develop some type of reciprocity with other air ambulance providers. What does that mean? If provider B transports a patient who had purchased a membership from provider A, would this obligate provider A to compensate provider B for the amount they wrote off and did not collect from the patient? Alternatively, do they both simply agree to honor the competitor's membership without having collected any fees to cover that cost? Not only could this result in a financial disaster for the less dominant provider, but it could result in a major compliance problem for the reasons outlined in the attached OIG guidance.

I hope you find this information helpful.

Regards,

Bill Bryant
www.sierrahealthgroup.com