Air Medical Funding in the U.S., A Collapsing Stool?

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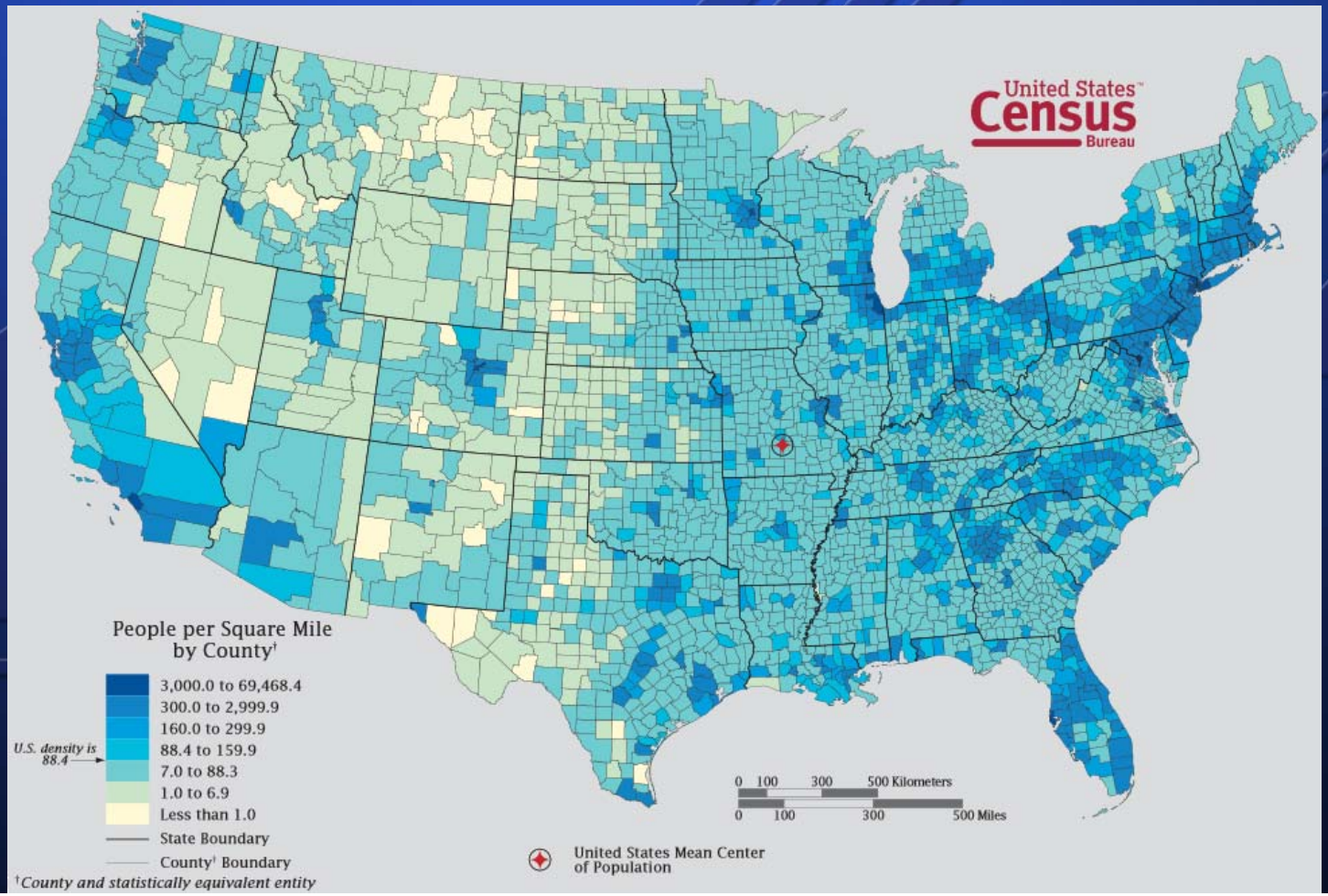
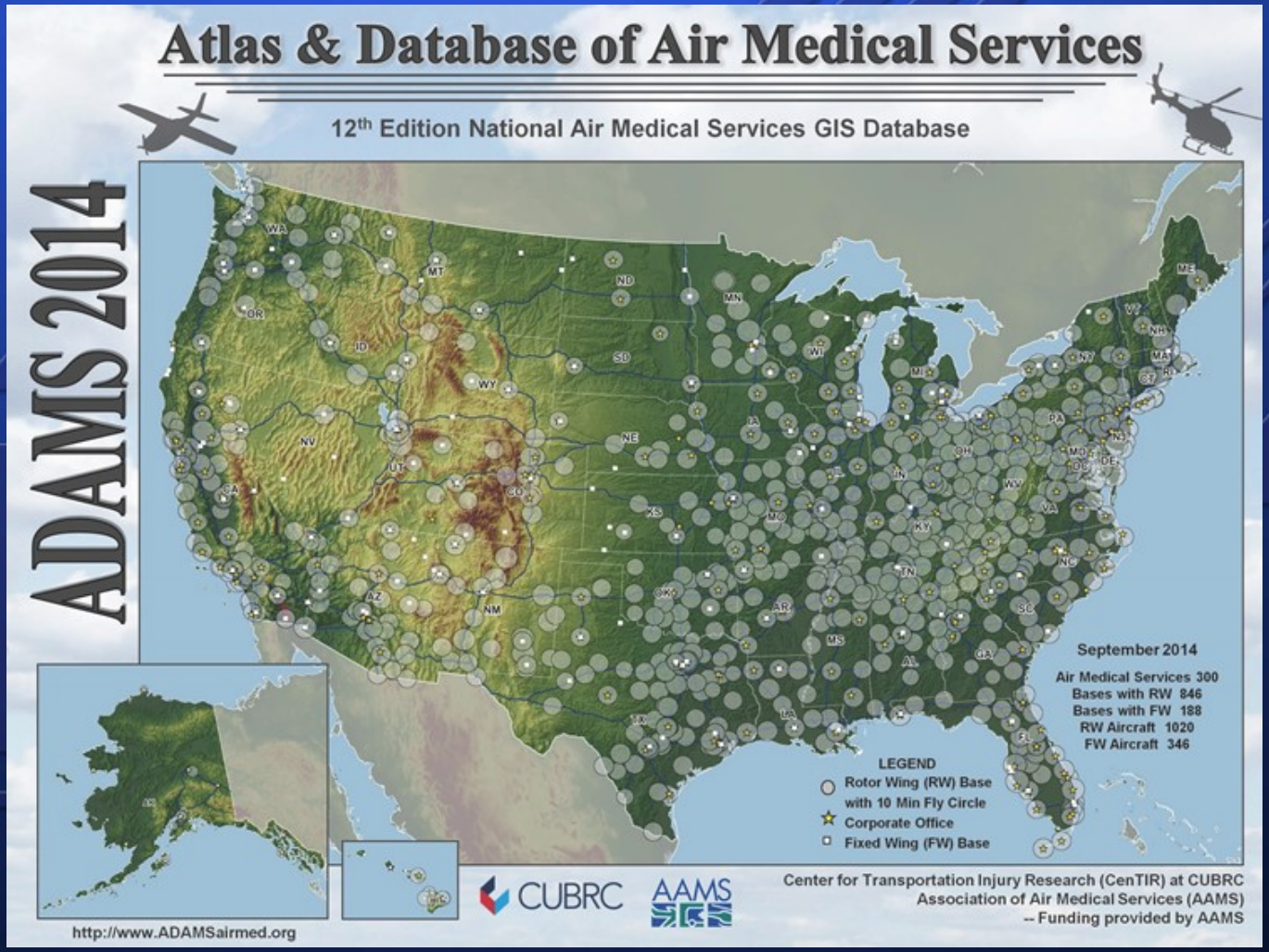
Air Evac EMS, Inc.

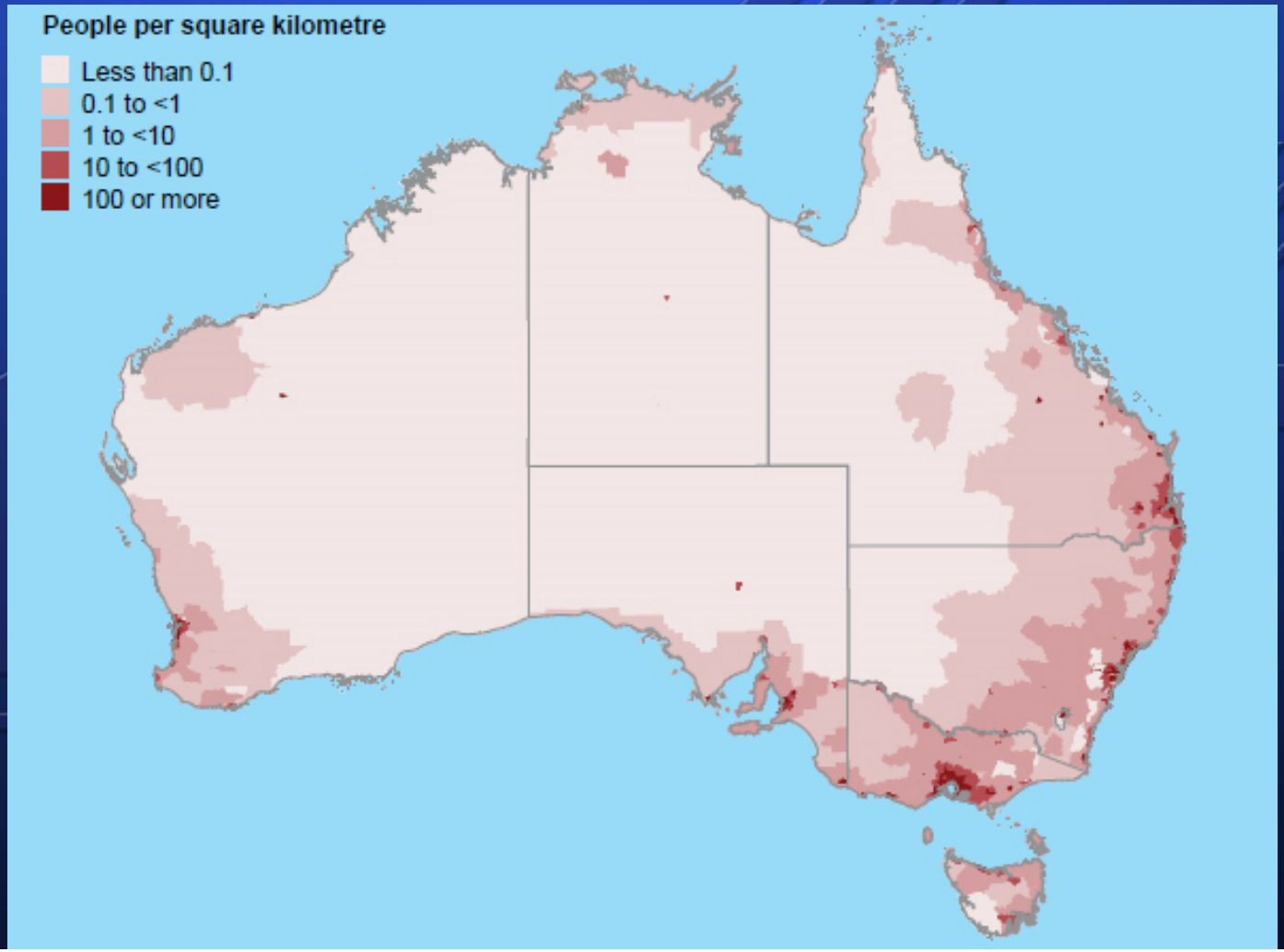
Air Medical Group Holdings

Population Density of the U.S.




Atlas & Database of Air Medical Services
12th Edition National Air Medical Services GIS Database
ADAMS 2014
September 2014
Air Medical Services 300
Bases with RW 846
Bases with FW 188
RW Aircraft 1020
FW Aircraft 346
LEGEND
Rotor Wing (RW) Base with 10 Min Fly Circle
Corporate Office
Fixed Wing (FW) Base
CUBRC
AAMS
http://www.ADAMSairmed.org
Center for Transportation Injury Research (CenTIR) at CUBRC
Association of Air Medical Services (AAMS)
-- Funding provided by AAMS

Population Density of Australia

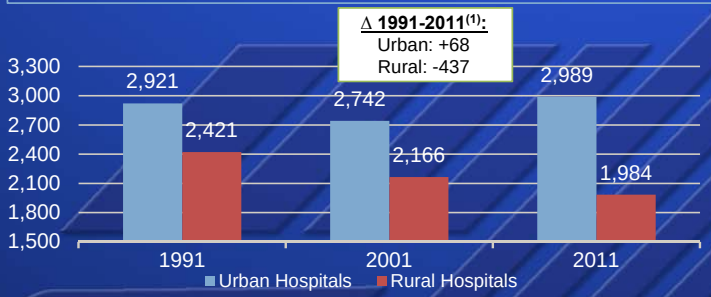


Key Trends Driving Need for Air Medical Services

Trends in hospital and emergency care accessibility and demographics drive an increasing need for air medical services

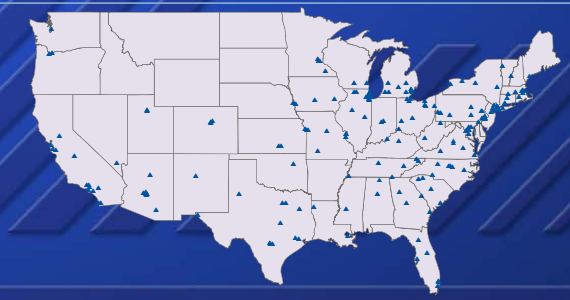
Hospitals by Location Type

- *Decreasing # of rural hospitals increases demand for emergency air transport to urban trauma centers*



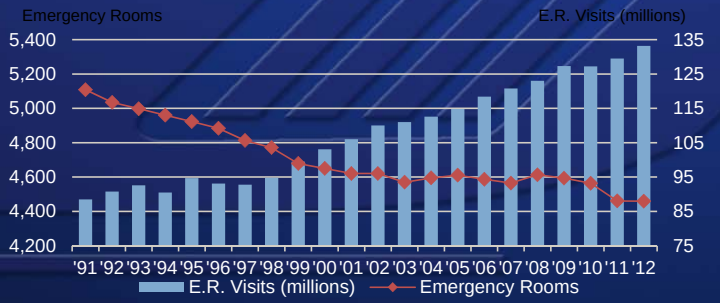
Trauma Centers

- *450 Level I & II trauma centers are located in population centers away from rural areas*



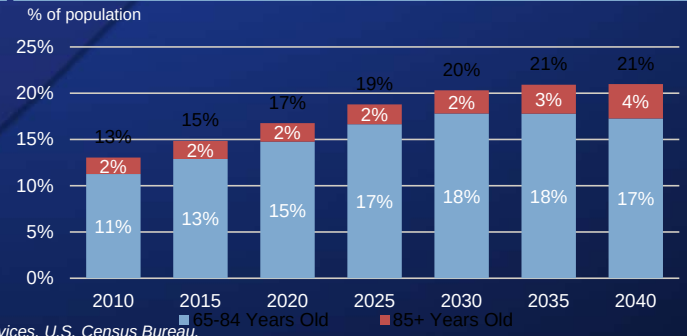
Emergency Rooms vs. Visits

- *# of Emergency Rooms in the U.S. is decreasing, raising demand for air "transfer" of trauma patients*



U.S. Population by Age Cohort

- *Aging of the U.S. population likely to drive increased emergency health events; 33% of Industry transport patients are over 65*



Source: American Hospital Association, Wall Street Research, ADAMS Atlas of Air Medical Services, U.S. Census Bureau.

1. *Data on the number of urban and rural hospitals in 2011 was collected using coding different from previous years to reflect new Centers for Medicare & Medicaid Services wage area designations.*

US Funding Crisis

- Healthcare System design
  - Responsibility and Funding
- Multitude of operations
  - Consolidation
- Variation of Payers
  - Federal System(s)
  - State System(s)
  - Private Systems

Healthcare System Design

- How did this begin?
  - Pay for patient
  - Procedural Cost basis – Fee basis
- Providers
- Multipart system
  - Federal
    - Medicare, Tricare, VA, Pension Benefits
  - State
    - Medicaid, SCHIP, WC
  - Private Payers

HEMS Financial Challenges

- Costs of Aviation
  - Fuel
  - Parts
  - Hulls
  - FAA Mandates
- Costs of Health Care Provision
  - Salaries
  - Supplies
  - Equip
- Training

HEMS Financial Challenges

- Growth in Need for Access to Care
  - Isolated and Rural
  - Lower Patient Volumes
- Costs of Isolated Provision of Care
  - Initial investment
  - Ongoing operating costs
  - 90% Fixed Cost
- State EMS Licensure Prohibiting Discrimination on Ability to Pay

Service Delivery Models

- **Government Funded –** Government Assumes Financial Risk.
- **Hospital-Based Services**
  - Hospital owns the program, while airline certificate holder provides the aviation services to hospital as a vendor. Financial Risk on the Hospital.
- **Community-Based Services**
  - Airline Certificate holder owns program and provides ALL services, including medical. Sole Financial Risk.

Funding

- Very Different Group of Payers
- Readiness Costs – Wazz dat?
- CMS – Centers for Medicare and Medicaid Services
  - Medicare – Aid for the Aged
  - Medicaid – Aid for the Indigent
- Third Party Payors
  - Private funded – employer or self
- Under and Uninsured

HEMS Funding

- Medicare – Aid for the Aged – 35% Of Patients
  - 100% Federal Government program
  - 1980 to 2002 Procedural Fees for Service or Cost Based Reimbursement
  - 1996 COBRA required Negotiated Rule Making for Fee Schedule
  - 1999/2000 Negotiated Rule Making with Ambulance Stakeholders
  - 2002 Fee Schedule set in 1996 dollars and NOT on any Value
  - Set fee for flight and mileage
    - Adjusted by pickup location Urban or Rural
    - Adjusted by GPCI
    - Annual adjustment by CPI

HEMS Funding

- Medicaid – Aid for the Indigent 15% of Patients
  - State Administered, Federal fund matched
  - FMAP based on poverty levels, 52 – 85% paid by Fed
  - State chooses options
    - Enrolled provider is required to provide services – usually at a loss
    - Ambulance an optional service
    - Air is NOT paid for in all locales
    - Reimbursement rates set by individual states
    - Many methodologies of reimbursement
    - In our 13 states range from 0 to 80% of billed

HEMS Funding

- Third Party Payers 35% of Patients
  - Usually a privately funded insurance plan
  - Funded by employer, self or both
  - NO requirements for cover by Fed or State
  - Individually negotiated with employers or by self
  - Various compensation rates
  - Minority of Patients
  - Majority of Reimbursment Dollars

HEMS Funding

- All the Others 15% of Patients
- Underinsured
  - New Health Exchanges
    - Not Required,
    - No Payment at Costs
- Uninsured
  - Despite PPACA there is a considerable Quantum
  - .01/.02 on the Dollar

HEMS Funding

- Third Party Payer Bears the Freight and the Cost Shift of all other sub cost Payers
- Third Party Payer
  - Must have a Margin to Spread Risk
- Third Party Payer Squeeze
  - PPACA caps on Shareholder Equity
  - Subsequent “Squeeze” on small Provider Groups
  - Ignoring the Evidence of Access

HEMS Funding

- Alternative
- Membership or Subscription
- Many entities provide services this way
  - Hospitals, Rural Electric Coops, Fire, EMS
- Method of common interests banding together to provide service
- Not common in Air Medicine, more Prevalent in Ground
- AirMedCares based on the REGA model

HEMS Regulation Conflicts

- Regulated as an Airline Carrier
- FAA retains all authority over aviation ops
- DOT retains authority of economic aspects “Rates, Routes and Services”
- States regulate health care (not all states)
  - Issues – States’ purview to regulate
  - Accreditation
  - Certificate of Need

The Solution?

- Can We Establish Payment for Readiness Costs?
  - Airline Carriers Cannot be Regulated in Rates, Routes and Services
  - Possible Ability to Establish Contracts for Coverage of Geo
  - Who Would Pay?
- Can We Revise Some Rates?
  - Medicare – Federal
    - Effort Under Way, Changes possible for 35%
  - Medicaid – States, some efforts successful
    - Penalties summed to increase FMAP, 54 efforts required too scattered for 15%

The Solution?

- Mandate Coverages for Third Party Payors?
  - Under PPACA “Emergency Services” are part of 10 Essential Benefits, BUT;
    - “Emergency Services” by Definition are only Healthcare Facilities
  - Leg Effort to Require payment for “Prehospital Care?”
    - Far Reaching U.S. Societal Change.
- Redesign the Response System?
  - Every State’s Sovereign Right to Determine Healthcare.
  - Multiple Kingdoms.

The Solution?

- Must be Part of the Larger U.S. Societal Discussion About Healthcare Delivery, NOT The BUSINESS of the Delivery of Healthcare
- Until Then, U.S. Air Medical Delivery will be a Polyglot, Patchwork System in Operations and Payment that Does the Best it Can in the U.S. to Provide Access for Critically Ill and Injured Patients to dwindling locaitons providing Healthcare