House Bill 1728 Workgroup Meeting (Medevac)
Virginia Office of Emergency Medical Services
1041 Technology Park Drive, Glen Allen, VA 23059
April 24, 2017
10:00 a.m.

Representatives Present:	Representatives Absent:	OEMS Staff:	Guests:
Julia Marsden, Facilitator	**Paul Davenport,** Vice President of Emergency Services, Carilion Clinic (representing VHHA)	Tim Perkins, Technical Assistance Planner, VDH OEMS	Amanda Lavin, Office of Attorney General
Lt. Jay Cullen, Virginia State Police		Gary Brown, Director, VDH OEMS	Chris Shaffer, PHI Air Medical
Anita Perry, Medevac Committee Chair		Scott Winston, Assistant Director, VDH OEMS	Susan Smith, Carilion Clinic Lifeguard
Deputy Chief Eddie Ferguson, Goochland County Dept. of Fire, Rescue & Emergency Services		Camela Crittenden, Trauma & Critical Care Manager	Brian Solada, Air Methods
Derrick S. Ruble, Director of 911 & Emergency Communications, Tazewell		Wanda Street, Secretary Senior, VDH OEMS (Transcriptionist)	Terry Austin, Air Methods
James (Jim) Young, Insurance Policy Advisor, Virginia State Corporation Commission			Jay Lovelady, VCU LifeEvac
Bill Zeiser, Transportation Unit Supervisor, Virginia Department of Medical Assistance Services			Kelly Parker, Virginia Hospital & Healthcare Association (VHHA)
Doug Gray (sitting in for Kyle Shreve), Virginia Association of Health Plans			Michael Player, Peninsula EMS Regional Council
George Lindbeck, State Medical Director, Virginia Department of Health			Aimee P. Seibert, VACEP
Rob Hamilton, President, Med-Trans Air Medical Transport (representing medevac operators)			Robert Baratta, America's Health Insurance Plans (AHIP)
Erik Bodin, Director, VDH Office of Licensure and Certification			Lindsey Berry Winter, Anthem
Paul Sharpe, Director of Trauma Services, Henrico Doctor's Hospital (representing VHHA)			Karah Gunther, VCU Health
Ed Rhodes, Rhodes Consulting Group			Jeffrey Ferguson, VCU Health/Virginia State Police Med-Flight I

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
I. Call to order:	The meeting was called to order at 10:05 a.m. by the Facilitator, Julia Marsden.	
II. Introductions/Opening Statements:	Senator Marsden welcomed everyone to the meeting and asked everyone to introduce themselves and the organization that they represent: **Ed Rhodes** – Rhodes Consulting Group which represent all the Fire and EMS agencies except professional fire fighters and volunteer fire fighters. **Doug Gray** – Virginia Association of Health Plans. Kyle Shreve is his colleague and will participate as well. We represent people who provide health insurance in the State. They do Medicaid managed care for about 700,000 women and children and 212,000 enrollees in long term support services. They also provide coverage to the State. Some of the members help administer the State's benefits. They also do the private marketplace as well. **Wanda Street** – Office of EMS **Derrick Ruble** – 911 Director for Tazewell County, VA. He is representing the 911 centers across the Commonwealth. **Anita Perry** – Chair of the Medevac Committee. Also serve on the EMS Advisory Board. **Tim Perkins** – Office of EMS **George Lindbeck** – Office of EMS **Rob Hamilton** – President of Med-Trans. I am representing the air-medical operators and the air medical association. **Jay Cullen** – Virginia State Police **Amanda Lavin –** Office of Attorney General **Paul Sharpe –** HCA Virginia. Representing our health system. **Jim Young –** Bureau of Insurance. We regulate insurance. **Eddie Ferguson –** Deputy Fire Chief in Goochland County. Has been involved with air medical services for about 20 years. I am representing EMS. Gary Brown introduced himself by saying that he is the Director of the Office of EMS and he welcomed everyone here. We have a very important charge before us in terms of the legislation. There are a lot of things we need to address so that we can submit our findings and recommendations to the Commissioner of Health and then to the Virginia General Assembly. All of our meetings are open to the public. He realizes that many people want to be on the workgroup; however, we must keep the workgroup manageable according to the composition that was laid out in the original language of the bill. He encouraged everyone present and anyone else who might be interested to attend these meetings and provide comments to us. Also on the OEMS website there will be an opportunity for the public to provide comments as we go through this process and start posting information. Again, welcome and he appreciates everyone being here. Mrs. Marsden also gave the audience an opportunity to introduce themselves. Please see guest list above. Mrs. Marsden explained HB1728. It asked that the Virginia Department of Health convene a workgroup composed of the stakeholders. As you can see we have a lot of different stakeholders represented. We have representatives from law enforcement, EMS providers, health insurance providers, state medevac committee,	

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	emergency physicians and other interested parties.	
III. Review of House Bill 1728 Language:	The workgroup is charged with the following tasks. We are to review the rules, regulations and protocols governing the use of air transportation services also known as air ambulance in emergency medical situations. We are to review those rules, regulations and protocols governing dispatch of air transportation services, providers and response to emergency medical situations and then develop recommendations for change to such rules, regulations and protocols that will address differences in procedures governing dispatch of air transportation services, providers in emergency medical situations, differences in billing that may affect individuals involved in emergency medical situations during which air transportation service providers are dispatched for the provision of air transportation and other issues related to the use of air transportation services in emergency situations. We are an advisory body and shall serve as subject matter experts to inform and advise the Virginia Department of Health as to potential findings and recommendations that will be reported to the Governor and the General Assembly. The workgroup will have the opportunity to review the draft of the written report under the development of OEMS prior to submission to the office of the Health Commissioner. And the Office of the Commissioner has requested a draft report to be submitted to OEMS no later than October 15, 2017. OEMS will post all workgroup meeting agendas, minutes, reference documents, and other resources on the OEMS website. OEMS will receive public comment on the use of air medical services through their website at the conclusion of every workgroup meeting. The Virginia Department of Health shall report its findings and recommendations to the Governor and the General Assembly by December 1, 2017. Tim stated that he had a few housekeeping items to share. The restrooms are to your right when you exit out of the back of the room. If you need to use your cell phone, please go to the front receptionist area because there are people working in cubicles just outside of the conference room. The language of House Bill 1728 was projected for everyone to view. Mrs. Marsden asked if there were any questions or discussion about the actual bill. Doug Gray stated that it is fair to say that there is a variety of ways that air transport is addressed across the Commonwealth for a variety of reasons. Some are provided by the State and some are provided by others and some are a combination of the two that overlap. People who are transported find themselves in different financial situations depending on who provides the service. There doesn't appear to be a whole lot of understanding of what's going to happen to them before it happens. So that generates complaints. We can tell you that one of the reasons that this language came about was complaints to legislators from people who have been transported about both the coverage of the cost of the transport and the amount of the cost and their responsibility for their portion of the cost. All of those things led to the drafting of this language and interest in trying to understand whether there is a policy at the State level and about how these services are provided or whether this just happens to be what you get in any region. Doug looks forward to understanding a little bit better and hopefully in a report at the end of this helping everyone else to understand why it is that you have what you have, where you have. And what we might be able to do, if anything, to address the concerns of the constituents who really are in a situation where they don't understand what's happened. That's really the	

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	background that brought this about, at least from where I am sitting. I think the legislators would benefit, I think everybody would benefit from us articulating what it is that we have, why we have it, and what ideas to make it a little more fair, consistent, equitable, whatever you might want to call it. But from the patients' perspective it doesn't feel real good right now in some situations. In others, it feels great because they got it for free. So it's an interesting challenge. Jim Young stated that what Doug is referring to also is a nationwide concern. All the Bureaus of Insurance nationwide have this problem with their constituents getting a bill that is so extraordinary that often leads to bankruptcy. Tim Perkins gave a point of clarification. Obviously during this process, we have been in touch with Delegate Ransone's office pretty frequently and we actually extended an invitation to the constituent that brought the complaint to Delegate Ransone to participate and either the Delegate or the constituent decided that this was not a good idea. With that said, Delegate Ransone introduced House Bill 1728 because of a constituent that was transported from Warsaw, VA to Richmond, VA due to a stroke. The patient was left with a bill of $35,000 which was not covered by insurance and upon further research and discussions Delegate Ransone's office found that their constituent's situation was not unique. Mrs. Marsden stated that Delegate Ransone would like us to follow the Resolution of the 1997 session that Bobby Orrock and several other patrons of House Joint Resolution 636 which is pretty thorough and it goes into complete review. At this time we need to focus mainly on what the actual bill is referring to rather than an extensive review of this Resolution until we find out further information from Delegate Ransone at this point.	
IV. Review of Pertinent Reference Documents (see Page 2 for list of documents:	Now we will look at the reference documents that are listed on the OEMS website. Tim reviewed the Overview of the Airline Deregulation Act of 1978. Mrs. Marsden asked if there was any discussion on how this relates to the task of the workgroup. Doug Gray said it doesn't necessarily address the entire situation. The bottom line is that in some places people get free service from the State Police and other places there seems to be an agreement between the locality and the air carrier which has nothing to do with federal law. So what the content of those agreements are and what they obligate their citizens to, on their behalf, is of some interest. Don't really understand; don't have any background in it. I think it's something that should be explained. Yes it's true that the federal law limits what a state can do but it doesn't eliminate the state's ability to address certain parts of the issue or to try to figure out what their policy is. At one time I think we had State Police service in three parts of Virginia and I think now we are down to two, at least that's what I've heard. The same thing with federal service. We have federal service in some places and not in others because we have overlapping jurisdiction. Having a good common understanding, I would love it if we could, in the report, provide a map that shows everybody who provides service where and exactly what that means for the constituent. In the cool technology world it would be the kind of thing you could roll the mouse over and say I'm in Halifax County and they have an agreement with X and they can expect X. Tim Perkins stated that he has a map that shows every licensed air medical service in the Commonwealth and	

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	their 50 mile radius. Mrs. Marsden stated that Mecklenburg is the only county that is not truly serviced. Tim said that they can get a helicopter to Mecklenburg in 25 minutes. Each circle represents one air medical service. On the map Tim pointed out the areas that Med-Flight I & II serves. He also pointed out the location of the U.S. Park Police and Fairfax County Police. Maryland State Police does cover parts of Virginia but they are not a licensed Virginia agency. Per Tim there is a regulation that says an agency can come into the state and transport someone out of the state providing point-to-point service if no other resources are available. Ed Rhodes stated that at one time Virginia Beach was considering having their own Med-Flight through the police department. Did that ever come into fruition? Tim replied by saying that Virginia Beach did have an air medical unit, but they have recently surrendered that part of their license. Virginia Beach EMS is now strictly ground transport. Virginia Beach is serviced by Nightingale. It was asked what happens in the overlapping areas. There are a lot of them. Derrick Ruble explained that in his area of Southwest, VA they have eight helicopters that are available just for Tazewell County alone from Virginia and four states. The region probably has 10 to 12 helicopters depending on where you are in Southwest Virginia. Per Anita there are only three that are truly based in the area. Derrick continued by saying it kind of causes a problem for dispatch because it's like who do we call today. It's like spin the wheel. Dispatch centers look at weather and most of us have weather radar and we have some very unique weather conditions. Anita can attest that it's very unique in our region of the state. Her area could be sunny, in the 50's and we could have snow in our area. Med-Flight is called first according to their policy in Tazewell County. They are the closest so they are automatically called first by policy from our sheriff and emergency providers. They are a partially free service. An issue that they have seen in Southwest Virginia now is that the patients or their family ask is State Police coming. If they are not available then they request to take the patient by ground. They cannot afford to fly the patient by air. The word is out. LifeGuard 10 had an issue that Anthem BlueCross wouldn't cover that service for a while. Cost is a concern in the region. They have a very poor population in that region especially being that coal fields are going away. Our concern is also the dispatch. They have seen an overuse of the helicopter at times. He has seen field units fly out a person for an injury from the local hospital, they are actually flown from the scene and within twelve hours they have an appointment at the local hospital to have that arm fixed or something of that nature. Of course, Tazewell doesn't have the equipment in the field. He doesn't want to second guess the first responders, but he is on a volunteer fire department and was with Priority EMS for about 12 years. But sometimes it is over used. The ground crew makes the decision for air medical. Rob Hamilton stated to Doug that you have a great group of people in the room and he congratulates the State. He grew up in Virginia from an EMS provider standpoint. Many of the people sitting around this table and sitting in the audience have participated in the Medevac committee over many years. Mr. Hamilton mentioned that we do have a problem. It is a problem that the air medical industry is proactively trying to work out with the states and the insurance providers to try to solve. He stated that, in Virginia, there hasn't been a great deal of change over the years here. The same providers are still providing. The State has done a wonderful job providing the services they have been providing for years. He has known Jay Cullen for a long time and has sat at his table. He was an EMS provider in Chesterfield County and has watched these guys perform. He gave a	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	live kudos to the delivery of air medical services. Whether it's JLARC reviews that have been done a couple of times or whether it's been Medevac taking proactive approach to rules, regulations or dispatch, you are dealing with a workgroup that has really been leading as far as state, regulatory overview of medevac systems. There is a lot of good cooperation between the services. You have a lot to be proud of here in the State of Virginia as far as its delivery. Are there problems? There are problems certainly. When Delegate Ransone gets a complaint, it certainly draws a lot of attention. But I can tell you that in the big scheme of things, those things grow a lot of legs, but that's not the norm when you look at the thousands of patients transported either from the for-profits or the state police. There have been a lot of disciplined approaches to air medical within the state of Virginia. Doug Gray stated that it would be great if we could help people understand what's happening. This map doesn't do much for somebody who is a constituent. What's the agreement with the locality? How much are they going to charge? These are basic things that everybody should be able to understand. Rob said that a lot of localities do not have agreements. Doug Gray said then there is the discussion of how a helicopter is ordered and who orders it? Why are there two sometimes? Why do they never turn around? From what we've heard, once they are on the way, they are on the way even if someone tries to say they weren't necessary. These are process questions about why it happens and how it happens. Someone is responsible for what the constituent experience is. It would be useful to help people understand what that experience is. Obviously with the state police situation, you can. They are a state agency and you will get an answer directly and straightforward about what happens. He doesn't know if you will have that same situation when you have three competitors that overlap. And so having some understanding of what someone will experience is important. Rob Hamilton stated that Doug is asking good questions and he wants to be clear that we are giving you and ultimately the constituents, the right answers. The comment was made that there are a number of times where providers continue to go. Rob challenged Doug to provide evidence of this. The medevac committee has studied this years' ago and decided that they were not going to allow that. There are legislative regulations that are in place where an agency can be fined for this. The providers in Virginia do a very good job of notifying each other when they are on a mission and when they decline a mission. The communications between the agencies that represent the medevac services and the state are very good. There is not a lot of overlap where multiple competitors are sitting across the street from each other. I see that in other areas of the country and there are concerns about it. If you look at the state of Virginia the distribution of air medical services are very appropriate. That map looks like a lot of circles, but at the end of the day we are providing a valuable resource within 25 minutes to the patient. Don't let the circles of registered air medical providers be a distraction. If you really look at this map, and the studies that were done years ago that said we had about 7 or 8 air medical providers, the number really hasn't drastically changed today. Some of the pioneering air medical services started here some 35-36 years ago. Hopefully that helps provide some clarity to your question. There is not a local government saying I want to contract with a provider. Air ambulances are required to follow the same regulatory process as an ambulance does. So we have to have the locality provide a letter of support and go	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	through same state licensure process that a ground ambulance does. And no more than 30% of the time Virginia based air ambulances are serving the other surrounding states. Just like MedStar out of Washington comes in or Maryland state comes in, we also provide services in Kentucky, West Virginia and North Carolina as well as other places. Doug Gray asked, "how do you set your price when you are the only one in town?' What are your policies for people who can't afford it? Rob Hamilton said he doesn't want to discuss pricing right away but he knows that it is an important point. Doug Gray said that if a constituent can go to the hospital in a state helicopter for free or not, which is an exact situation that has been reported to me by an EMS person and they are in between the two and they are both there. Rob Hamilton said truly are the constituents getting a "free ride"? The tax payers provide it. Doug Gray said of course not. Maybe it costs $35,000 for the state to provide it. He doesn't know. Rob Hamilton said that he can guarantee that the state provides the same high quality level of service delivery that the for-profits are so the cost truly isn't different. Mrs. Marsden interrupted by suggesting to table the discussion on cost because it can be a very lengthy discussion and she has many questions. The workgroup will actually look into and delve into the cost factors. She asked how many actual providers are there in the state. How many actual companies provide service to the state? How many government agencies providing service to the state? There are three: State police, Park police and Fairfax which are Part 91 providers. Virginia Beach used to be a part of the Part 91 providers, but they are ground only now. They had minimal air missions. The Part 135 providers are private vendors listed below: Aeromedical Transport Specialists Centra One LifeEvac Virginia Life Guard/Carilion Patient Transport Specialists Fairfax County Police Nightingale Regional Air Ambulance Service Pegasus Flight Operations PHI Air Medical/AirCare Virginia State Police-Med Flight Wings Air Rescue	

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	Doug Gray suggested that the Part 91 and Part 135 could be distinguished on the map better by changing the color of the circles and then you can easily distinguish. Each circle represents a 50 mile radius. Dr. Lindbeck stated that there is something that we need to keep in mind for a later discussion is the inter-facility portion of critical care transport and air medical services. Doug Gray stated that where the patients go is sometimes a function of someone's licensure, meaning they have the service there that they need and it's not provided elsewhere. Is that the idea? Like trauma centers? Rob Hamilton stated that typically they are transported to a higher level of care or a service line that is not supported at that facility. It could be a definitive cardiac or stroke center. Doug stated that he was curious because when you look at the circles on the map, he is sure that there are multiple hospitals within the circle and where the patient goes is obviously determined somehow. That would be good to understand. Rob Hamilton said that the programs are usually affiliated with a hospital and that's where the majority of the patients would go. Anita Perry explained that we also have regulations for the state that determine where we deliver our patients. There are guidelines for the trauma patients that break it down according to what's wrong with the patient, where they should go, the closest, most appropriate facility. So if you have a hospital based aircraft that responds to a scene call it does not necessarily come back to that hospital. The patient is taken to the closest, most appropriate facility. This is shown in the documentation that was given called the Virginia Field Trauma Triage Decision Scheme which applies to both ground and air. It is located in the State Trauma Triage Plan. Anita also stated that the first document in our resources is the Virginia EMS Regulations which will explain much of how we are regulated as well as where we deliver our patients. Tim projected the Virginia Field Trauma Triage Decision Scheme for everyone to view. Dr. George Lindbeck stated that there are some minor differences between the Virginia triage scheme and the CDC triage scheme which we all lived through, we survived. The CDC released this triage scheme in about 2013. Does that sound right Paul? Paul replied that it started in 2009, then 2011 and then 2013. Dr. George Lindbeck stated that the most recent update was in 2013. This is for trauma patients and it is to identify patients according to the criteria on the scheme and how the questions are answered. The goal is to get them to the right place, at the right time and as quickly as possible. There was some controversy about this when the trauma plan went through the Governor's Advisory Board; primarily about the roles of non-	

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	designated and lower-designated trauma centers in this strategy. No need to get too far into that discussion today. This provides guidance on where the patient should go for their initial trauma care. Is that fair enough? Doug Gray replied yes. So if there are multiple facilities that provide the necessary care, how do you pick? Dr. Lindbeck stated that the language here would take you to the highest level of care within the system. System being defined locally or regionally. Everyone agrees that the systems differ across the state and across the nation, we all understand that. But for example, if you are in a very rural area would you go to your local hospital first for very brief stabilization while the helicopter was coming to take you to the regional Level I trauma center, yes, that might be your system. The other thing is that you are in a very densely populated area you might drive by or fly over a non-designated hospital or a Level III or II center to go to a Level I center. If you require pediatric care you might go to a Pediatric Trauma Center or burn care a Burn Center, etc. In recent years we have also given more attention to time critical illness such as stroke and STEMI being the two at the top of the list. Doug Gray said there isn't any explanation on when they are equal. Dr. Lindbeck asked equal services, equal distance, equal everything? Doug Gray replied yes. Dr. Lindbeck said that there really is no benefit one way or the other, you just go to the nearest. Paul Sharpe said that the other component of that is sometimes it is out of network for a patient as well and we are talking a helicopter bill. Jay Cullen said from the state police perspective what we do in a situation like that is, if the patient is able to answer questions, we will ask the patient where they would like to go. A lot of times they may have relatives in one region versus the other. They occasionally run into multiple location requests from a family member. They try to remain patient-focused based on the services needed. Doug Gray asked is that the standard with the private services as well. Rob Hamilton said that it is with the exception of the trauma triage guidelines. They dictate taking the patient to the closest, most appropriate trauma center. Derrick Ruble stated that from what he is hearing, public education is going to be a big component and even education to the service providers themselves from the 911 centers all the way down to the field units. It would really be nice for them to see that map full of circles to see what the state does. Also real time information would also be helpful for the availability of service providers.	

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	Anita stated that sometimes the education is also dependent on the EMS provider. Just a few years ago we did a project within Virginia Medevac where we went out and educated on the trauma triage plan to make sure they were calling the helicopter when they should and not calling when they shouldn't. Getting the EMS providers out to provide that education is not always the easiest task. And then retention of the EMS providers is not always there as well. So we can go out and provide the education to a department of 30 and five people show up and then there is turnover within the next two years when we are going out and providing more education. So we saw that as a big challenge. Doug asked if there is a module where you trained about what to do and when. Is that how it works? He is curious about if he sees a horrible accident as he is driving along the highway and he calls it in, can that lead to a helicopter being called? Or does it have to be a first responder? Anita replied that it has to be a first responder. A bystander cannot request an aircraft. They could report the accident and then the 911 agency reports it the EMS. EMS could potentially have an aircraft launched and if the aircraft is not needed it can be cancelled. This was also a part of the education not to over utilize the aircraft. Just because it was on the way, it still can be cancelled. Rob Hamilton stated that most of what Anita is speaking to comes back to proximity. In the state of Virginia you do have helicopters in close proximity so you don't see a lot of air borne, stand by stuff going on. This was a very focused point of reference for the state years ago. Dr. George Lindbeck stated that there were some limited situations in Virginia where helicopters are launched based on dispatch criteria only but it doesn't happen often. Derrick Ruble says that in his rural, farming community they have a rule that two helicopters can be on scene for basically any event before the ground crews get there. This is in collaboration with the ground crews. He feels that most 911 centers, as soon as the ambulance is in route, the fire department is also in route and the law enforcement gets on scene, if they say get an air ambulance they get one. Once in a while we do turn somebody around. It's never perfect. Is the fire department needed every single time? No, but they go. It's better safe to have them to cut those minutes down sometime. Especially like today, it could be weather related so it will take the pilot a few minutes to double check the weather where he has to go. Anita Perry stated that even though you have a lot of circles you have to take into account that it is 25 minutes flight time. You have your lift off time, you have the pilots checking weather so that's still a pretty substantial amount of time from the time a call comes in until that aircraft is on scene to take care of the patient. Jim stated that he was thinking that the 25 minutes was the response time. Jay Cullen mentioned that if an aircraft gets turned around there is no loss to anybody. The providers pick up the cost for burning the gas.	

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	Jim asked if there are criteria for the response time when a call comes in to the 911 center. What is the goal to launch? Rob answered by saying that every situation is different. We do measure it but he can't put a ten minute launch time criteria on a pilot when there is a weather challenge like today for instance. It is measured for trends of things that may be out of whack. Jim is thinking for emergencies only not when a doctor calls and needs to move a patient or something. Rob stated that especially for emergency only because it doesn't factor one way or the other whether you're an inter facility or a scene somebody has a decision to make if that aircraft is not able to move, so for the patient benefit we need to get that question answered. After a ten minute break the workgroup reviewed the Medevac in Virginia Overview PowerPoint presentation. Tim went through the slides of the Medevac Overview presentation after a brief technical break. Tim showed how the map looked in 1998 with the circles. The current map shows more agency bases. Ed Rhodes pointed out that the amount that goes to the State Police had a figure of $1.6 million. It should be updated to $3 + million. Tim agreed that it should be updated to reflect the current amount. Doug Gray asked about the ambulance authority that is located in some places. In that case, they have control over everything and competitors cannot provide service at least with ground service. In this case because they are federally regulated they can't do that or they can? Rob stated that you could not go and provide emergency services in the City of Richmond without the Authority granting you that permission. We cannot, as an air operator, provide a base in a jurisdiction without the local government providing a letter to the state saying that we could. Doug Gray said, let's say Fairfax County has its' own service, right. So how would that work if a private company wanted to operate there? Rob stated that the County would say they are not going to give you a letter from the County then I wouldn't be able to do it. Doug Gray said, let's say you have a base in Prince William County and you want to do a transport from Fairfax. Can they affect that? Rob stated that they cannot. Doug replied so they really can't control anything other than whether your ground base is located in a	**Tim will update the Medevac in Virginia Overview slides.**

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	jurisdiction. Eddie Ferguson said let's take it one step further it doesn't just have to be an authority. Jurisdictions can have local ordinances that can put the local government in complete control of emergency medical services. Many jurisdictions across the state have that pertaining to 911 services and then they will have franchises for private entities for additional transports and that type of thing. Most of the time it keeps the local government in control so that they can guarantee that their public component of government provides ambulances in the county and others don't come in and set up shop. This is more common than the authority model. Ed Rhodes stated that this is the way the Richmond Ambulance Authority operates. They are controlled by a Board made up of stakeholders from the Mayor down. So he can take his county fire department that runs an ambulance, they can take them in but they can't go back and pick them up and bring them home. It's a one-way deal. George Lindbeck stated that theoretically an aircraft operator can put an aircraft in a geographic area, but not be a designated emergency response agency by local government. That's where the state and local regulations and federal regulations start to diverge a little bit. Tim explained that we have a State Medevac Committee which is a subcommittee of the EMS Advisory Board. The committee meets quarterly and talks about appropriate standards and recommends safe, quality systems in Virginia. Last July, the Medevac committee did a complete review of all the state regulations that pertain to air medical service. Tim also explained that there is a Medevac Strategic Plan which needs to go back on the Medevac Committee agenda for review. The strategic plan sets a mission and some action for the future of the medevac system. Paul asked if the draft regulations were available. Ed Rhodes stated that he believes they are on the website under the Rules and Regulations. The NOIRA is open. Scott Winston stated that the draft regulations will be open for public comment beginning next month for a 30 day period. They will be published on the Virginia Register of Regulations. He is not sure if they are posted on the OEMS website yet. Paul suggested that since everyone is here, that we review those. It might be helpful for everybody. Tim stated that the version of the regulations that was provided are the current regulations as they stand right now. The workgroup took a lunch break.	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	Upon reconvening Tim attempted to show a video, but the sound would not work properly.	
V. Determination of tasks the workgroup is to accomplish:	Tim stated that he and Julia decided to ask the workgroup committee members at the table speak about what parts of the bill are most important to you, what parts you want us to look at that should be focused on, the parts that you want to chew on the most. Eddie Ferguson started by saying that he realize he came in late, but asked if the workgroup had already discussed what brought this bill to the General Assembly. Tim replied that we have already discussed that. Eddie said that he will catch up with somebody about what was said. Tim quickly explained to Eddie that there was a gentleman that was transported from Warsaw to Richmond due to a CVA and received a bill for over $35,000 and it wasn't covered by their insurance. Anita wondered if he was privately insured. Tim did not know. Doug Gray stated that covered by insurance means something different depending on the situation. If the air transport provider contracts with us, then there is a direct payment to the provider and that's that. If they don't contract with us, it's a bill that the insurer will have an allowance that they will pay towards it and the rest will be on the constituent. Rob Hamilton asked Doug who he represents again. Doug stated that he represents all of the insurers, including Medicaid. Rob Hamilton stated that one the most significant points for consumers is a broader understanding of that. He definitely thinks that that needs to be a part of the overall discussion. The other thing, not to jump out of order here, is that there should be a workgroup focused on articulating the existing structure is for Medevac coverage in the state. It should be readily accessible for the consumer. Ed Rhodes said that a friend of his got a helicopter ride from Rocky Mount Hospital to Roanoke Memorial and received a bill for $31,200 and Medicare and a secondary insurance took care of the whole bill. Rob stated that today 72-75% of the patients that are flown in Virginia fall into that bracket. He was looking this morning at the DMAS (Department of Medical Assistance Services) web page and $2,000 for an air medical transport is not a bad number for the Medicaid side of our business. There are certain states where we get $200 and $2000 doesn't cover the cost by any stretch of the imagination. Everybody tends to benchmark back to Medicare and you know there is a great deal of an initiative to look at Medicare because it is so much of a benchmark whether you are in emergent transportation, ER as an emergency physician or anesthesiologist or whatever. There is a fundamental piece to Medicare pricing that is a benchmark. The last time we worked on Medicare, as everybody in the room knows, was the late 90's or early 2000's and it was never based on cost. So the initiative that is currently ongoing by a group of air medical providers and some legislative folks at the federal level is to start making this cost centric. From his standpoint, there is not an air operator that wants the	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	patient in the middle. We all got into this business for a lot of different reasons. He stated that he got into this business to learn how to help care for his sister, who is an insulin dependent diabetic. We all come to this as a passionate caregiver who wants to do the right thing for the patient. Our industry, as young as the industry is, is still a relatively unchanged industry so until recently we have never really sat down and said that we need to have a conversation with insurance providers and actually show what it is that we need to do to extend healthcare into the communities where there is no access and without the air medical access the outcomes will be catastrophic. But there has to be a willingness of all sides to come together and look at the problem and fix it. If there is anything that needs to come from this workgroup, it would be 1) this is an amazing State to have air medical coverage in and the Medevac Committee and the Office of EMS has lot to be proud of and 2) there are real problems that we need to have real conversations on and he wants us to address those. You are going to see the ABC News story and a lot of other things, such as consumer reports that are included in your packets, and like other things that have come out in the media, there will be pros and cons and slants to it. I will absolutely share transparently the right and wrong things to look at in those articles as they interact with our discussions. We have to be engaged in this conversation from all sides. He is glad that Doug and his colleagues are here, along with Jim who represents the insurance industry. He feels we have all the right players in the room to hopefully paint some color to this. Ed Rhodes stated that in looking over the legislative bill, it makes reference a couple of times to dispatch of air transportation services. At one time, there weren't any protocols, regulations or instructions for dispatchers at all. Back in the early 80's criminal justice services basically wrote the EMD – Emergency Medical Dispatch protocols along with EMS and a few others. He thinks that we should look at including a chapter in that concerning Medevac dispatch. He feels training of dispatch would benefit the system. Rob asked Ed if he was familiar with the National Association of Air Communications Specialists (NAACS). He feels this is a data point that we can provide to the broader group here. He feels that most of the agencies in Virginia have a NAACS certified dispatcher. Doug stated that the two big categories are the rules for dispatch and how much is charged and why. He thinks the rules on dispatch are pretty broad, when you follow it backwards, why a locality calls a particular provider is an interesting question. When they get called on a practical basis, which he thinks is what Ed is referring to, and whether the people are well-trained, which Anita covered pretty well, if there are better ways train people, that would be helpful. Informing the public is the part that nobody has really taken on. Being able to inform the public in a consistent way would take collaboration from everyone including the providers, the local governments, the state, etc. What are the policies for the state and localities? In terms of the billing, if we could get to some data that would be useful. Transparency would be a good idea, telling people what you are going to charge them up front and having everybody be able to ascertain that in a relatively simple manner whether private or public. It would be helpful to have data about how many transports are hospital to hospital versus an actual emergency, data about where they go and why they go there, data about what they were charged and what was covered. To say someone wasn't covered by their insurance because the insurance didn't pay the whole bill is not accurate. The insurance did make a payment. What it means is that there was no contract and no contracted amount to protect the patient. But we should know how many patients are out of contract and hit	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	with a big bill and go to collections versus ones who have a contracted amount. How many trips are Medicaid, how many are Medicare, how many are commercial, how many are exchange? Having data about all of this would be useful in helping people understand the whole picture about what is going on and how the business works the way it works. We should be able to tell the story relatively simply in a report with data. Rob asked Doug if there are other elements to the insurance side of this. Doug said that they have challenges when there is a monopoly provider in any area because sometimes they refuse to contract because they want to maximize their return on people who can pay. He doesn't know if they are right about their business model, sometimes they are and sometimes they aren't it depends on what percentage of the people who can pay that extra amount. Because if you don't collect it, it's of no value to you. You will end up getting the contracted amount anyway. That happens in some localities. Typically where there is competition, it doesn't happen. So we don't tend to have people who refuse to contract in places where there is competition. Rob asked Doug do you perceive that there is a refusal for air operators to contract. Doug said that he perceives a lack of agreement about rate. They don't want to contract at a rate anywhere close to what the plan is willing to offer. They are in network with some plans it just depends. If they are not under contract with anyone, anywhere; that tells me that there is a big difference in what you would like to make and what the plan would like to pay. The narrower they are, obviously the greater the chances of an agreement. Volume has something to do with it, and the problem is there is not a lot of volume. Rob said that his next question would be, you are respected on the air medical side you have to also have network issues with emergency services. How do you address that on the insurance side to your consumers? Doug stated that it is relatively rare, but when it does happen it's usually lack of competition. So, for example, if a hospital has a monopoly in an area like Fredericksburg used to be or like Williamsburg used to be, the ER doctors who have a monopoly on business that comes in the hospital from the hospital, would refuse to contract and then hit people with balance bills. But if the CON was approved in both those locations, the problems gone. The only place that happens right now is Chesapeake and that is because they are the only kid in town and they know it and they have an exclusive contract with their hospital for ER services and so the practice refuses to contract and goes back and forth with payers. So typically competition leads to a resolution of that dilemma but when people can maximize their return and have no risk of losing the business, it's not going to happen. Rob said that one of the points of interest for us to have is data points of overall percentage of market share that the commercial insurance providers have in the state. Doug asked do you mean the number trips that are commercially paid.	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	Rob said just for the overall on an annual basis. So we can better understand the monopolistic approach. Doug stated that he is not going to pretend it is easy. Because if it was easy, we would not be having this conversation. Rob stated that when we can engage in conversation like we are having today, the needle gets moved and patients come out of the middle of it. It's a falsehood to think that we won't have negotiations. The problem is where you have one bill that rises to the surface and gets a lot of attention. Here in the state of Virginia the majority of us are in network with a large percentage of the insurers. He would love to see some of that information. Doug stated that he can try to get data concerning the networks in which the air medical services are insured with. Jim stated that insurance companies have a provider network and are required to have that list available to every insured person within their membership. The provider network would include helicopter service that has been contracted by name. He would think that it would list the air ambulance service contracts. Doug stated that each and every contract deals with a level of licensure. A lot of people don't understand that a HMO is a different licensure than a PPO; same with your exchange plans, Medicaid and Medicare. So on a continuum of five different contracted programs, some may participate in one or two, but not the other three or four or in three but not the other two. It takes a little work to figure out. Rob stated that this is a challenge. How do we educate consumers when there are so many different derivatives to coverage? Doug said that part of it is whether the patients are actually liable or not. In a lot of the government programs they are not. Eddie Ferguson wants to speak to one particular thing. All of this has to be vetted because there is financial impact to everything we do. He wants to make it clear how rescue operations are handled in the field. They are very much in control of the decisions they make. The decisions are made in a methodical process and they are always trying to do what is best for the patient. They look for the closest, most appropriate resource and that goes from choosing the right hospital to choosing the right air medical provider. He wants to make sure that everybody understands that we have an organized process to handle that and we do it in a way that we think will best benefit the patient. You have to understand too that when an ambulance crew calls an air medical resource they are looking for a higher level of care but they are also looking for transportation to definitive care. So you can't totally ignore the financial aspect of all of this and he is certain that is how we got here today. However, you must understand that fire departments and rescue squads, whether career or volunteer, it really doesn't matter. We have organized ways of handling emergencies on the scene and there is not a lot of confusion on our end as to who we are going to call and what we have in mind. And I will tell you from being	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	on the other end of this, if you are the flight medic that day or the flight crew, when the phone rings you don't know what's on the other end of that situation and as a fire chief, he feels that he is very much in control of the correct application and the success of the mission. The helicopter is not going to dispute a whole lot of what I'm asking. If I say I need you at this intersection, they are going to proceed to that location. Now if there is some big delay because of something on my end, or I didn't time it correctly, then that's on me. He just wants to make certain that no one is getting the idea that fire or EMS is managing this haphazardly or in a way that is lending itself to these troubles. He is very clear on who is going to call, where he has in mind and what he is trying to accomplish. Honestly money does not come into play, because in his locality there is probably two or three systems. They primarily use State Police/Med-Flight because they are the closest, most appropriate resource. They also see UVA Pegasus ~~some~~ come into the western jurisdiction and they charge for service, but that is not his concern at the time he has an emergency. In many other locations, LifeEvac will come in. He just wants to make sure that everyone is clear on the fact that they are not out there just picking services out of the air (pardon the pun). We have a plan and our goal is to do what is right for the patient. Julia Marsden asked Eddie if he had a document that he could give to Tim for display. Eddie stated that these documents are already in existence and a lot of work has been done on this topic. At the regional council level, there are 11 regional councils in the state, and most of those regional councils probably have a medevac committee that is meeting. Tim stated that there is one in the ODEMSA (Old Dominion EMS Alliance) region. Eddie stated that maybe the regions could benefit from a regional medevac committee. He also stated that a tremendous amount of training goes into this, a tremendous amount of EMS education goes into this at the local, grassroots level where the helicopter programs are coming at the request, most often, of the EMS agency to provide education and that education is supported by the Virginia Office of EMS with education credits. Then you have the medical direction committee to ensure that we are doing things right. He just wants to make sure that everyone knows that there is a plan in place to manage emergencies that occur daily in their localities and they try to always focus on what's best for the patient and that being ground ambulance or helicopter or whether they need an ALS provider or whether they need a Level I, II or III trauma center. Julia stated that this is all good discussion as each one of us has a different piece of the puzzle and to be able to share this information with one another, we will gain a lot of knowledge and hopefully come out with a good document by October. Derrick Ruble gave some background information about his 911 center. He stated that they dispatch 17 fire departments and 5 EMS agencies (these are independent agencies). They actually dispatch 42 total agencies including law enforcement. They are one of the biggest in Southwest Virginia until you get to New River Valley/Roanoke area. Some of the things that they have seen are that there is a training disconnect or protocol disconnect when it comes to EMD (Emergency Medical Dispatch). As a group he feels that a standardized white paper should be developed for recommended guidelines for EMD. There are some centers where there is	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	only one dispatcher and when all heck is breaking loose, they may forget something. It happens. He feels that if everyone uses the EMD protocols, there will be better outcomes. He would like to see the workgroup work on that. He would also like to see the workgroup work on radio contact standardization across the Commonwealth with interop channels or establish channels per region. They have had two to three helicopters on scene due to different frequencies. This is a logistical nightmare. Derrick stated that he participated in the Virginia Healthcare Alerting and Status System. This has the framework and the technology. He is not saying we need to track the exact location of helicopters, but it would be nice for safety reasons. He also stated that there is a slight disconnect between the field units and dispatch. He feels that it helps when a sheriff decides how we are going to dispatch helicopters. They had an issue with helicopter shopping and it was not because of pricing. It was because he would get a call about a motor vehicle accident with injury and entrapment and it will be a 45-minute extrication and we need a helicopter. They would say call Med-Flight, call Wings, call whoever. We would call that agency and they would say we are not available; we are on another call. This was before we got the training where we automatically go down the list and sometimes we don't know who is around that month. What would happen is the ground crews would order helicopters and one time we had Med-Flight and Wings come in neither of the two knew the other was coming. This was about a year and a half ago. This could have been real bad. Rob asked what the sequence of follow-up was for this. Derrick stated that following that they found out how it happened. The field unit said they needed a helicopter and they 911 center immediately called Med-Flight. The fire chief from an agency showed up and called Wings directly and they did not know about it. Med-Flight was already in route. Either the pilots saw or heard each other on the radio. That's when the sheriff established protocols to call Med-Flight first, then they will go down the list based on estimated mileage. He stated that it would be nice to look at a screen and know where they are at all times. He stated that he would like to see more public education and feels that regional medevac committees would be very helpful in working out their regional issues. The overall framework is needed to work on the legalities. Ed Rhodes stated that the regional directors are meeting on Thursday, a week from today and this may be a good opportunity to begin the discussion with them. He also asked if any consideration been given about using VDEM as a central dispatch for the helicopters? They would all come under VDEM. Derrick said that with Med-Flight II, Bristol Virginia PD, who handles their dispatch, they still have their own calls to handle. Like this weekend, they were dealing with flooding and the race with 200,000 people. Their dispatch gets tied up and to him it wouldn't bother him a bit to have VDEM (Virginia Department of Emergency Management) handle all Med-Flight operations. But what is the impact to the local flight crew talking to Richmond? Ed also asked if it would work better through the Fusion Center. Jay Cullen said that either way they would be working through the same radio network (STARS). That was	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	something he hoped to gain out of this workgroup; maybe exploring what the possibilities are and what technologies we have in place. How can we dispatch this service better? Maybe VDEM is a viable option. We utilize them here in Richmond, but when we are in Abingdon, we use Bristol PD. The concern you brought up about multiple helicopters on different frequencies is a concern of ours as well and happens frequently to us since we travel to so many different areas of the state and everybody runs on a different frequency. One of the things that we came up with in the Medevac Committee is that the pilots are now on a common VHF frequency and are giving out blind position reports and that is how we are able to recognize where the other aircraft are. But it certainly is a much better situation if everyone is transmitting on the same frequency for all the transmissions because you get an earlier notification that there is another aircraft coming to your location. Certainly this is something that he had hoped to explore through this workgroup. What are the technology opportunities now that weren't in place 10 years ago when we reviewed this? Rob stated that the workgroup can look at this from a COMM and GPS standpoint. We were actually having a conversation about a system that is being trialed. Anita may be able to share more about this, so the technology exists to light up that screen and give more visibility. Derrick said that this technology is not cheap and he didn't realize that. It is also a major undertaking to add it to an aircraft. It would also be great to know what agencies can carry two patients and those that cannot. Then they can call two providers instead of one. Rob said that it is appropriate to be having discussion about a centralized system and no matter what we do we can't prolong access to the patient. So if we run something through VDEM in Richmond for a flight that is in Southwest Virginia, at a certain point and time that flight request will have to get to the certificated entity to say no or no go. We are going to put more time into getting the patient what they need. These are just points that we need to talk through. He is not dismissing the idea and he thinks it is worthy of debate. Ed stated that the reason he said VDEM was because during natural disasters, there is a hub that if anything is going on in the state, even down to transferring equipment from Richmond or Chesterfield down to Bristol, it is not unheard of; or taking equipment from Roanoke to Northern Virginia Rob said he certainly doesn't disagree with Ed on that. Anita stated that she has a very high level elementary approach in the things the workgroup is charged to look at in the following four areas: 1) Rules, regulations and protocols governing the air medical services, 2) Rules, regulations and protocols for dispatch and recommended changes, 3) Billing and 4) Other. Anita's idea is to take those four work areas and put all of these suggestions and thoughts into those four areas. George Lindbeck stated that at the end of this we should come up with an educational package to include explanations about insurance and insurance coverage and the importance of understanding your relationship with your insurance provider. He feels that we can put together a pretty polished public access information packet. We have done this in the past, but refreshed dispatch guidelines may need to be done for air medical	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	programs which focus on PSAPs. There is variability across the state and he feels that we should aim to reassure people that requests for air medical services and dispatch is based on objective criteria, distance, a need for resources and available resources at the destination and the availability of those resources rather than more subjective criteria. He doesn't disagree that at times in the past that there were some pretty subjective guidelines. The old way of doing things was I'm going to call whoever came by and dropped off a load of t-shirts and pens and hats, etc. He doesn't think that is the case anymore. But he feels that we need to reassure people and freshen that up. He would really like to increase visibility of WeatherSafe and weather turndowns and hospital shopping and utilization. They have started this process. He wants to make sure this is visible outside of the EMS community and also encourage programs who are not participating to do so. We need to work with our prehospital providers and also our physician requesters on freshening up. We put together a resource for physicians in 2011on the use of Air Medical Resources. This needs to be updated. Because as we pointed out it is easy for us to focus on the EMS scene end of things and that's what we have gravitated to and what the public sees but there are a flights made in a facility and there are some educational… Tim stated that he struggled with whether or not this should be included in the material. George Lindbeck also stated that this should also dovetail with an effort from the Medical Direction Committee to try to get our arms around critical care inter facility transport in Virginia. He is not sure a real good definition exists. We need a better definition for what constitutes inter facility critical care transport. Do we define it by people, diagnosis equipment or is it a combination of all of those. And then getting with the referrers, the requestors, and coming up with a better strategy and better information. For example, he thinks institutions should have a resource person to help them with transport decisions because what we do in the ED, which is what we all tend to think about, isn't what is going on in labor & delivery, the cath lab or the ICU. He lost track of the number of times when he worked in a fairly busy community hospital and you hear the rotors and you go, who call the helicopter. There is nobody coming in, but someone called from labor & delivery or the cath lab. He feels that this is something that we can work on. Tim stated that George mentioned the WeatherSafe program and for those that aren't familiar with it, it is an internet based program whereby a user can enter their information. They can enter the reasons for turndowns and other data points. Tim said there were 1,990 entries into the WeatherSafe system last year and 2/3 were for inter facility transports. It is a pretty robust system and has come a long way. Rob said that Virginia has a great system in place. He stated that Anita touched on the four most important areas. He also stated that there are other items as it relates to funding like Medicaid. There are some unique approaches that other states have taken in helping with some of that. He is happy to share with the group ways to decrease the cost of care to patients. One of the things he mentioned earlier, is that we have not done a very good job over the years is the value based element of what we do. What we do in the air medical business truly extends healthcare to a lot of these areas. We need to do a better job at showcasing that. He also stated that an October1st deadline is pretty aggressive. Jay Cullen stated that in the interest of moving things along, Anita hit it right on the head with her four items.	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	Jay wants to focus on the dispatch capabilities and protocols and also safety. This industry has obviously moved quite a ways from when state police started with helicopters in 1970 post Hurricane Camille as a public safety rescue unit and they still provide that service. They are still the only agency in the state that provides hoist rescue or search and rescue with a helicopter. The medevac component that they have had since 1984 has really improved that capability because we can provide medical services as well. Overall the system has really changed over the years. They have a lot more helicopters than they had early on and he thinks that getting information out to the public about how the system works is important and also improving safety through the dispatch is important. Amanda Lavin did not have a comment. Paul stated that the most important thing for him is dispatch. He said that George made a great point about educating hospitals. He thinks a lot of times rural or small hospitals are kind of bullied into utilizing the service when it may not be necessary. And that always reflects on what the physician on the other end decided. Well you kind of told them what to decide. So like anybody who has been in Virginia for the last 10 years, I've heard lots of stories about things that are flown and then discharged from the Ed within a couple of hours and things of that nature. It definitely came from a system that lacks transparency, he thinks that if we could, like George talked about, have data out there that showed these kinds of things that identify what flights appear to be and there is always going to be that subjective. We always talk about doing the best thing for the patient but the patient leaves the ED and then in two hours goes home and gets this $39,000 bill and they live in a rural town that doesn't have much funds to it. I'm sorry but it is our duty to think about that too so. Because they won't be able to afford health insurance if you want to take it from a health reason. So it's an important aspect and he thinks there is a lot of over utilization and he thinks the consumer protection part is a huge part. He is glad to see that we have folks to speak to that because back when he had to answer to complaints it wasn't very easy to explain to folks. Then it was $23 or $24,000, now it's in the $30's so it's an important part. As one of the larger health systems in Virginia we want to make sure it is available to us and we also want to make sure we are included. The word monopoly came up earlier and we see that in some parts of Virginia and he thinks transparency is the key to looking at those issues as well. Jim stated that the overall insurance is concerned about the consumer and protections for the consumer that all consumers are treated as equally as possible. However, we take our direction directly from the General Assembly's laws and regulations. Listening to what is being said around the table, he thinks, right now the consumer needs more education, to be more informed. He also thinks that we need to work with the providers and the medical services to try to get everybody, under contracts. He thinks that Doug or someone mentioned there was one area that just has only one air medical service and they are not under contract because they lack competition. He cannot advise the General Assembly to make laws or anything like that but he wonders if there could be some that you are required to contract. Paul stated that this could be something that local government needs education on too because balanced billing is not a consumer friendly thing and they should investigate that before…	

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	Rob stated that balanced billing is occurring for a multitude of reasons. Jim stated that their biggest complaint is balanced billing with one word in front of it "surprise balanced billing". That is what you see across the nation right now in many states including Montana. Doug stated that if someone gets a balanced bill and they want to appeal they can if they are fully insured through the Bureau of Insurance. It goes to an external party and the external party makes a decision. That exists now for fully insured customers. Right? (Jim replied yes, fully insured). So if you all have data that you could share. (Jim said we don't have to share). Doug said that actually you don't because the SCC (State Corporation Commission) is not required actually to follow the Freedom of Information Act (FOIA) like everyone else is because they act in the judicial, administrative and sometimes legislative capacity. But that doesn't mean they can't if they want to share data in a way that is protected. They obviously can't give specific information about a patient. Eddie stated that he will try to be fast, he has read this over and over again and there is a lot of information in there. He is excited about all of the things he hears coming out of this group. He thinks a lot of these things are going to be really good for the Commonwealth. And having said that, he wants to be practical and realistic at the same time. There is a lot of overlap occurring because the State Medevac Committee has/is worked on every one of these issues to try to make the system better. Kudos to them for their good work. When he drilled down through all of this, he thinks about the catalyst that brought all of this here to have the patron submit the bill and the General Assembly to order us together as a group. He wonders and he hopes that was the appropriate use of an aircraft to get that person at their time of need to definitive care. But I understand that we may or may not be able to know all there is to know about that. However, he thinks the reason we are here is because of the price of that bill. And he understands about the Airline Deregulation Act and we have to be realistic as a group. He wonders at the conclusion of our committee will that result satisfy that patron, or that Delegate or Senator or whoever introduced this bill. Are we really going to have a product that's going to be the intention of all of this? Julia stated that she really doesn't know. She hasn't had a chance to speak with Delegate Ransone at this point although she has made a number of calls to her to get exactly from her what she is looking for. She feels that based on the discussion that we have had today, we should be looking into this. You are right the Medevac Committee is taking care of it and doing a good job and everyone here has a piece of the pie and has procedures and protocols currently in place. That is why she feels it is very important to break this group into sub-groups. Julia said that for the next meeting we will have four subgroups and each one of these groups is going to be sharing and bringing information back to the table and then getting back together. It is going to be in the morning whenever our next meeting is going to be, but we haven't decided that yet but we will. It is going to be next month because we don't have much time. But we will be sharing that information together at the sub-groups and then to the main committee so that we can get through this as quickly as possible. But you are right, we need to use what we currently have, share those documents and the data and it keeps going back to the data. The data is going to be the hardest part to pull together because there are a lot of questions about what we should have and what we do need and I hope that we can get it and get it in a timely fashion.	

Topic/Subject	**Discussion**	**Recommendations, Action/Follow-up; Responsible Person**
	Eddie said he wants to get back to the financial impact of this and he really believes that is why we are here and if he is wrong just tell him so. He told Julia that he doesn't envy her position and feels that she will do a great job. But the bottom line is that all these things that we discussed today can benefit Virginia' medevac system and he is excited about those. He just wonders if we will be able to satisfy the concern that brought us all together. Julia stated that she hopes so. She doesn't think that based on what she has heard today, it will be a very difficult solution. She is internalizing this and she figures with the brilliant minds that we have here today we might be able to step forward a little. Doug stated that he can help with that. The complaint came to us and a number of others. It went back and Delegate Ransone said that she'd like me to take a look at this and give some suggestions. So she is not unreasonable. She understands that there is no perfect answer to every problem. She is from a rural area and doesn't want a patient to go bankrupt for taking an air medical trip. She went to Delegate Bobby Orrock, the chair of the HWI committee and he knows a lot more about EMS than your average legislator, probably any legislator for that matter. And Delegate Orrock said he thought she should do this. Really the target is to make sure Delegate Orrock is satisfied. Rob asked what a patient should do once he or she receives an EOB (Explanation of Benefits). The insurance will pay x amount. What does the patient do? Every one of these air medical companies have an advocacy process and hardship process just as any other health system would. Doug said it was the typical scenario. They sent it in, the insurer said they would pay a certain amount and they got hit with a balanced bill. He thinks they probably can pay it, but it will have a big impact on them. He is not sure if they are fully insured or self-insured. Rob wants to know if they reached out to the air ambulance agency and what did they offer. Nine times out of 10 if they get a patient into the advocacy process it's not a $35,000 bill that they are looking at and that's the important thing. Whether you are going in to see George at the University of Virginia and find out that George is not a participating hospital, I have to run that same gamut with him or anesthesia or anything along those lines so just to understand the full process. Ed stated that one of the things that you might look at down the road as we approach the deadline is that if we still have a lot of information to vet and need to continue vetting that we ask the Delegate if we can do an interim report and put in an additional bill in January asking to extend this for another 6 to 8 months or whatever it takes. It we submit an interim report that says we still need to vet these issues. He feels that she would be very agreeable to that. Julia stated that she has two other people that are not at the table that she was not aware of. She apologized for not asking them to introduce yourselves: Bill Zeiser and Eric Bodin. She asked them to introduce themselves	

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	and what their concerns are for the meeting today. Bill stated that he works for the Department of Medical Assistance Services (Medicaid) and is a supervisor for the transportation services which includes air ambulance and ground ambulance for emergency and non-emergency for all Medicaid members. What he would like to bring to the table is information needed about the Medicaid program and how Medicaid mirrors the Medicare program. He also has been there long enough to where he was involved in the rate adjustments and he is the subject matter expert in building on all of that. He can also bring data for the Medicaid program and some of the main care plans. A lot of people don't understand that there are different programs within Medicaid and not all Medicaid programs get transportation as part of the benefits. That is part of the big problem we have; members not understanding what services they have. You also get into the protocols, policies and procedures; he writes all of those as well. He can also bring information on the number of appeals for managed care plans from the members. Under Medicaid you have "Fee for Service Plans" and "Managed Care Plans" which are totally different. More than 220,000 more people will be moved into the Managed Care Plan starting in August. This has a lot of implications on the different managed care plans and how the benefits of the plan. Eric apologized for being late. He stated that he is the Director of Department of Health's Office of Licensure and Certification. We have licensed hospitals and we also have a small shop that works with DOI in doing network advocacy work for the insurance. He sees himself here as a resource to help with any hospital level licensure and certification issues.	
VI. Identification of subgroups to address tasks:	Julia stated that we should move on the Identification of subgroups to address tasks. The most expedient way to do this; she has listened to everyone's comments and she thinks there are some obviously logical places on the different subgroups that you should be on. I can send an email to everyone in the group and suggest the different areas. They will be reviewing all of the current procedures for air medical transportation and then they will review what we currently do and make recommendations for changes in the future. And then there is one for the dispatch. There will also be a subgroup for billing. Tim stated that he was going to share some information before we actually form the workgroups. He stated that he asked Delegate Margaret Ransone and asked her to whittle down what the "Other" issues are because that could be anything. What she has asked is that we encourage discussion between air ambulance companies and insurance providers who provide coverage for consumers, which he thinks the billing group will handle. She also has requested that this group explore the idea of a consenting signature from either the patient, this is conscious or aware, or the next of kin/parent/guardian/responsible party before air transportation is called to ensure that the individual understands the costs involved. Rob asked if this is already a requirement for consenting signature. It was stated that CMS requires a consenting signature. Doug stated that he thinks she means signing off on the actual costs, not on the understanding that they might be charged something. Doug also had an observation that data is something that we are interested in across the workgroup and he wonders if one of the subgroups will be charged with data to collect information.	

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	Julia said that's a really good point and it brings her to another question. Who is comfortable with the data and enjoys working with data and pulling that together? Paul stated that the state database information would have to go through Tim. Julia stated that we are assuming that we are going to get the data from the different sources that we spoke about today. Eddie stated that he appreciates Tim sharing these comments because they were the basis of his comments a few minutes ago. He wants all of the information and if there is any other information and if there is any other information that we need to know to be successful; he wants to know it now. That was his point in making those comments earlier because we can do all of this stuff and it will help us in our everyday work, but if we don't get to the bottom of it, then we are not going to satisfy the question. George said that he and Tim can work with Cam and the trauma staff on the state database information and then liaise folks about insurance information and information from air medical programs. When you work with large databases, there is information you can get and then there is information you wish you could get, but can't get. A lot of these decisions about utilization comes down to real life, real time decision making on a requestor's point of view, whether prehospital or inter facility. In analyzing that level of decision making is not something that we are going to be able to do at this level. Agencies can do it and evaluate those calls. He thinks that emergency departments and hospitals should be doing that kind of work when they fly people out. He doesn't think we will be able to get that level of review done. We can do a better job of describing things, he thinks. To make that information available. Rob stated that one of the things on the billing side is to have a discussion on cost. He would start there. Paul stated that we can't really set the cost, but we can set the education and transparency around it. Julia agreed that we can talk about it. There are a lot of pieces to each cost. Some patients are not charged for the actual, physical transport but are charged for the medical services and people don't realize that it is separated out and you can look at it as a whole rather than all the small parts. Doug said it could still get rather specific. Cost is really not an appropriate word. There is what's paid by certain entities under certain contracts, then there's what's charged and then there is what's collected. All of those are different things. The average collected is going to be different than the top line charge; which is part of the challenge. So we are going to have to get specific about what we are talking about so people understand. None of those numbers are the same as the costs. Speaking for a regulated industry, we have a certain amount that we can make on a percentage basis and it we go other that, we have to pay it back. It is pretty specific for us. It is straightforward, it is not so straightforward when you are setting your price so cost is hard to determine.	

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	Julia stated that she feels that the Delegate would be very interested in finding out that this is a very complex issue and that we are looking into it to address Eddie's question. I think that this is the kind of information that probably started the bill but she would be interested in all the different pieces that started this so that she can then go back to the person that brought it to her attention. And it is education as everybody said. There are so many parts to this. But anyway I looked at the subcommittees as being: air transportation, dispatch, billing, and data.	
VII. Determination of timeline for completion of workgroup tasks:	The timelines will be discussed next month per Julia.	
VIII. Public Comment:	Julia asked if anyone in the audience had any public comment. Mike Player, Executive Director of the Peninsulas EMS Regional Council, obviously we are very involved in the regional plan. Our assets and resources are used to provide the regional standard of care which is packaged and determined by the physicians that operate the different agencies that provide care in the region. Although they do not have an helicopter EMS committee in the PEMS Regional Council, we have a EMS Operations Council with a helicopter EMS staff on it that takes care of the 911 and they have an inter facility critical care transport committee that also has designated helicopter EMS agencies represented on that. We also have them represented on our trauma, STEMI, stroke and behavioral health task forces and we also have them involved on our trauma performance improvement committee. So it is a very integral part of our operations. The operational medical directors of the helicopter EMS programs sit on our medical advisory committee and are a part of that. We do have specific protocols for when providers should consider helicopter EMS and how that is dispatched and who gives the proper direction for the actual destination determination whether it be protocol itself, medical control or whether it is the patient. They have all of those and he thinks all of the regional councils are probably similar to the Peninsulas EMS Council.	
IX. Determination of next meeting:	After proposing some dates, it was decided that June 8, 2017 was the best date for the next meeting. It will begin at 10 a.m. The workgroups will meet in the morning and everyone will come together and meet in the afternoon. The place may change and everyone will be notified. The Perimeter Center was suggested and Ed suggested VAVRS.	**Next Meeting: June 8, 2017**
X. Adjournment:	The meeting adjourned at approximately 1:35 p.m.	