IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, et al.,	)	
	)	
Plaintiffs,	)	
	)	Case No.: 6:22-cv-00450-JDK
v.	)	
	)	Lead Consolidated Case
UNITED STATES DEPARTMENT OF	)	
HEALTH AND HUMAN SERVICES, et al.,	)	
	)	
Defendants.	)	
	)	

AIR AMBULANCE PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND REPLY IN SUPPORT OF SUMMARY JUDGMENT

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INTRODUCTION

The Departments' response ignores the statutory and regulatory text, makes incorrect factual arguments unsupported by the record, and resorts to *post hoc* rationalizations that are absent from the "July Rule," 86 Fed. Reg. 36,872 (July 13, 2021).[1]

As to the 30-calendar-day deadline for an "initial payment" or "notice of denial of payment," the Departments do not even attempt to defend their regulation as written. Instead, they invent an imaginary regulation, which keys the deadline to a "clean claim," and then they defend that imaginary regulation instead. This won't do: The statute unambiguously refers to the "bill," not to a "clean claim." Even if the statute were ambiguous, the Departments' *actual* regulation is arbitrary and capricious because it is not limited to "clean claims." As for the two-IDRs-per-transport rule, the Departments have nothing to say about the statutory text, which defines a transport as one "service" (singular) and states that one "service" should result in one, not two, IDRs. Nor do the Departments even try to explain how their two-IDRs-per-transport rule achieves either of the express legislative goals of increasing "efficiency" and minimizing "cost." The rule is obviously inefficient and expensive, and the Departments do not identify a single practical benefit that it achieves.

As for the exclusion of "contracted rates" from the QPA, the Departments invent four *post hoc* statutory arguments. But *post hoc* rationalizations are impermissible, and in any event none of these statutory arguments survives contact with the actual statutory text. Moreover, the Departments submit no evidence to support the sole basis stated in the July Rule. The Rule

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[1] This rule has been referred to as "IFR Part I" and "July 2021 IFR" in other filings. *See* Air Ambulance Plaintiffs' Complaint; Departments' Motion for Summary Judgment and Opposition to Plaintiff's Motion for Summary Judgment ("Depts. MSJ & Opp."). To be consistent with the TMA Brief, this brief uses "July Rule."

incorrectly claimed that single-case agreements do not "reflect[] market rates." In fact, Plaintiffs' evidence demonstrates that these agreements are negotiated at arms-length and are especially probative in the air ambulance industry, because relatively few commercial air ambulance transports are governed by in-network contracts.

As for the Departments' decision to calculate the QPA using rates drawn from an entire Census Division, the Departments' sole justification is an inexplicable aversion to using the rates contained in third-party commercial databases. That aversion is an arbitrary and capricious reason for choosing such an absurdly large geographic region, since Congress expressly authorized these databases to be used for just this purpose.

The Departments attempt to avoid a decision on the merits of these four challenges by invoking, yet again, the *AAMS* case pending in the District of Columbia. But the doctrine of no-claim-splitting cannot apply here, since neither the "same parties" nor the "same issues" are present in the *AAMS* case.[2]

ARGUMENT

I. The Court Should Strike Down the Departments' Regulation (45 C.F.R. § 149.130(b)(4)(i)) That Extends Indefinitely the 30-Calendar-Day Deadline Congress Imposed on Insurers to Make Payment Determinations.

Congress set an unambiguous deadline for when an insurer must provide an "initial payment" or "notice of denial of payment": 30 calendar days after the provider "transmit[s]" its "bill" to the insurer. 42 U.S.C. §§ 300gg-111(a)(1)(C)(iv)(I), 300gg-111(b)(1)(C), 300gg-112(a)(3)(A) (same, for air ambulances).[3] This action by the insurer (an initial payment or notice

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[2] Air Ambulance Plaintiffs respectfully incorporate by reference all of TMA's Reply Brief arguments except those concerning rates for providers in different specialties (Section I.B).

[3] For ease of reference, this brief, like the previous briefing in this case, cites the relevant Public Health Services Act ("PHSA") provisions in Title 42, United States Code (42 U.S.C. §§

of denial) is a critical initial step in the provider's quest to obtain payment; until that step is taken, the provider cannot even begin the IDR process. *See* Air Ambulance Plaintiffs' ("AA Pls.") MSJ at 11–15. There are no exceptions to this statutory deadline.

The Departments re-wrote this unambiguous statute to "suit [their] own sense of how the statute should operate." *Texas Med. Ass'n v. U.S. Dep't of Health & Hum. Servs.*, 587 F. Supp. 3d 528, 541 (E.D. Tex. 2022) (internal quotation marks omitted). The July Rule all but erases the statute's 30-day deadline, stating that "the 30-calendar-day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for services." 45 C.F.R. § 149.130(b)(4)(i). What constitutes "the information necessary to decide a claim"? What information can an insurer demand—and from *whom*—as a precondition for providing the initial payment or notice of denial? The regulation replaces Congress's clear rule with a hopelessly vague standard, which the Departments acknowledged could lead to "abuse" and "gaming" by insurers. *See* July Rule at 36,901.

Congress did *not* expressly delegate any rulemaking authority to the Departments to make rules regarding this 30-calendar-day deadline. The NSA's delegations of authority are specific, limited, and do not extend to pre-IDR steps such as this deadline. *See* AA Pls. MSJ at 14–15, n.14. The Departments do not contest that point in their response.

Instead, the Departments attempt to argue (1) that the statutory term "bill for such services" is ambiguous, and (2) that their regulation reasonably resolves that ambiguity by interpreting the term as meaning a "clean claim." Depts. MSJ & Opp. at 40–42. This argument fails at both steps.

300gg, *et seq.*) and the relevant PHSA implementing regulations in Title 45, Code of Federal Regulations (45 C.F.R. §§ 149, *et seq.*). *See* AA Pls. MSJ at n. 2.

A. The Statutory Text— "Bill for Such Services"—Is Not Ambiguous and Does Not Mean "Clean Claim"

There is nothing ambiguous about the words "bill for such services." A "bill" is "an itemized account of the separate cost of goods sold, services performed, or work done."[4]

"Clean claim" is a much broader term than "bill." Congress is familiar with the term, elsewhere defining it to include other "substantiating documentation" besides the "bill." 42 U.S.C. § 1395w-112(4)(A)(ii) (defining "clean claim" to mean "a claim that has no defect or impropriety (including any lack of any required substantiating documentation)…").[5] Congress made the deliberate choice not to use the term "clean claim" in the 30-calendar-day deadline section, but to instead start the deadline on the date a provider "transmit[s]" its "bill." *See BedRoc Ltd., LLC v. U.S.*, 541 U.S. 176, 183 (2004) ("The preeminent canon of statutory interpretation requires [the court] to presume that [the] legislature says in a statute what it means and means in a statute what it says there." (internal quotation marks and citation omitted)).

Because there was no ambiguity for the Departments to resolve, the Departments lacked authority to change the trigger for the 30-calendar-day deadline. "When, as here, the statute is clear and unambiguous, that is the end of the matter; for this court, as well as the agency, must give

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[4] *Bill*, MERRIAM-WEBSTER DICTIONARY ONLINE, https://www.merriam-webster.com/dictionary/bill [available at: https://perma.cc/AB8P-PYZM].

[5] *See, e.g.*, 42 U.S.C. § 1395h(c)(2) (setting forth the requirements for contracts between Medicare administrative contractors and the Department of Health and Human Services ("HHS")); 42 U.S.C. § 1395u(c)(2) (same, for contracts related to the administration of Medicare Part B benefits); 42 U.S.C. § 1395w-112(4) (setting forth the requirements for contracts with prescription drug plan sponsors); 10 U.S.C. § 1095c(a) (permitting the Secretary of Defense to require interest be paid on "clean claims" submitted under the TRICARE program that are not processed within 30 days); 38 U.S.C. §§ 1703D(d)(2)(A) (permitting the Secretary of Veterans' Affairs to require interest be paid "clean claims" submitted to the Department of Veterans' Affairs that are not processed within statutory timeframes); *id.* § 1703D(f) (instructing the Secretary of Veterans' affairs to establish a definition of "clean claim").

effect to the unambiguously expressed intent of Congress." *Texas v. U.S.*, 497 F.3d 491, 501 (5th Cir. 2007) (cleaned up).

B. The Regulatory Text Is Not Limited to "Clean Claims" But Allows Insurers to Delay Based on Their Supposed Desire to Obtain Documents from Third Parties

Even if the statutory text— "bill for such services"—were ambiguous, the Departments' regulation should still be struck down because it is arbitrary and capricious. The Departments do not even try to defend their regulatory text as written. Instead, the Departments pretend that they wrote a *different* regulation—one that used the words "clean claim" and then defined those words carefully to make clear that the insurer may only delay its initial payment or notice of denial if the insurer is waiting for relevant information uniquely within the provider's control. Depts. MSJ & Opp. at 40–42. The Departments then defend that imaginary regulation. *Id.*

The Departments' imaginary regulation is irrelevant here; the challenge before this Court is to the regulation as it is actually written. And the actual regulation does not use the term "clean claim." The term "clean claim" appears only in the non-binding preamble to the July Rule and is not even defined there.[6] *See Peabody Twentymile Mining, LLC v. Sec'y of Lab.*, 931 F.3d 992, 998 (10th Cir. 2019) ("... while the preamble can inform the interpretation of the regulation, it is not binding and cannot be read to conflict with the language of the regulation itself." (collecting cases)). In their brief, the Departments define "clean claim" by quoting the definition in their non-binding informal guidance, but that definition is hopelessly vague and broad—much broader, indeed, than Congress's definition of "clean claim" in other statutes.[7]

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[6] In the preamble to the July Rule, the Departments used the term "clean claim" to describe when the 30-calendar-day deadline "generally" begins. July Rule at 36,900.

[7] In the "guidance" document, the Departments define the term "clean claim" to require the absence of "incomplete documentation that delays timely payment," whatever *that* means. Federal

The actual regulation uses language that is even broader than the Departments' understanding of what "clean claim" means. According to the actual regulation, "the 30-calendar-day period begins on the date the plan or issuer receives *the information necessary to decide a claim for payment*." 45 C.F.R. § 149.130(b)(4)(i) (emphasis added). That text provides no limiting principle: the lack of any information the insurer deems "necessary," from *any* source, empowers the insurer to delay its initial payment or notice of denial, indefinitely.

The Departments contend that insurers do not read the actual regulation to mean what it says; instead, the Departments assert (without any evidence) that insurers understand that they are not permitted to "withhold initial payment or notice of denial of payment based on a lack of information outside the provider's control." Depts. MSJ & Opp. at 41. Isn't it pretty to think so? As Plaintiffs' declarations attest, insurers are routinely delaying their initial payment or notice of denial based on their supposed need to obtain additional information from third parties such as other insurers who may also be liable. As the attached declaration from Air Methods attests, 53% of Air Methods' bills to insurers, during the last year, did not receive an initial payment or notice of denial within the 30 calendar days required by the statute. Ex. B (Copenhaver Decl.) ¶ 9. Insurers gave no reason at all for approximately 90% of those delays. *Id.* For the ten percent of delays in which insurers gave some explanation, nearly half of those explanations (approximately 4% of the total delays) related to the insurer's demand for additional information from third parties (the

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IDR Process Guidance for Disputing Parties (Apr. 2022), at 33 (AR010978). By contrast, Congress's definition of "clean claim" is limited to the "required substantiating documentation" *from the provider*. *See* 42 U.S.C. § 1395w-112(4)(A)(ii), *supra* 4, n.5. The Departments' informal guidance definition can reasonably be read to require that all "documentation" (from whatever source) be "complete" in order for a claim to count as "clean." Under that reading, the insurer would again be empowered to make endless demands for yet more information outside the provider's control, as a pretext for delaying its initial payment or notice of denial.

patient, or another insurer) regarding whether the patient had additional insurance coverage. *Id.* ¶ 10. Air Methods is still awaiting initial payment, or a notice of denial, on bills submitted nearly one year ago, in April and July of 2022. *Id.* ¶ 10. Another Plaintiff, East Texas Air One, is still awaiting initial payment, or a notice of denial, for a bill submitted in April 2022. Ex. A (Mariani Decl.) ¶ 3–6.

The Departments' regulation deviates from the statute's unambiguous mandate and enables precisely the "abuse and gaming" which the Departments—and commentators—anticipated. *See* July Rule at 36,900. The Court should vacate and remand this rule.

II. The Court Should Strike Down the Departments' Guidance Requiring Two Separate IDR Processes for a Single Air Transport

A. The Departments' Two-IDRs-per-Transport Rule Contradicts the Statute and the Departments' Own Regulations, Which Define an Air Ambulance Transport as a Single "Service."

The unambiguous text of the NSA requires that a dispute over the amount of payment for a *single* air ambulance transport be resolved in a *single* IDR process:

- 42 U.S.C. § 300gg-112(c)(1) states that "air ambulance *service*" (singular) "means medical *transport*" (singular) "by helicopter or airplane" (emphases added). This language is clear: one "transport" means one "service."
- 42 U.S.C. § 300gg-112(b)(1)(B) states that a provider may "initiate the independent dispute resolution process ... with respect to [an] *item or service*." (emphasis added). This language is equally clear: one "service," one IDR "process."

The fact that an air ambulance provider bills the insurer using two HCPCS billing codes (a flat "base" or "liftoff" amount and a "per mile" amount) is irrelevant for purposes of this statutory text, which defines "service" as the transport itself. Congress required one IDR per "service," not one IDR per "billing code." The statutory text flatly contradicts the Departments' suggestion that a single air transport is actually *two* services, one for each billing code. *See* Depts. MSJ & Opp. at 44–46.

The Departments' published regulations, like the statutory text, also require that a single transport be resolved in a single IDR process. The regulations define the term "air ambulance service" to mean a single "medical *transport* by ... [an] air ambulance." 45 C.F.R. § 149.30 (emphasis added); *see id.* § 149.520(a) (the definitions in 45 C.F.R. § 149.30 apply to air ambulance IDRs). The regulations also recognize that one air transport counts as one "qualified IDR … [s]ervice" (singular). *Id.* § 149.510(a)(2)(xi)(A).

This textual argument was plainly laid out in the Air Ambulance Plaintiffs' opening brief. AA Pls. MSJ at 18. The Departments have no response. Their opposition does not even attempt to reconcile their new two-IDRS-per-transport rule with the plain text of the statute and regulations. This Court should therefore strike down the rule.

B. The Departments' Focus on "Batching" Rules Is Irrelevant

Rather than engage with the statutory and regulatory text just quoted, the Departments' brief focuses instead on the regulations pertaining to so-called "batched" IDRs, which are irrelevant here. In contrast to a single IDR (which determines the rate for a single service), a "batched" IDR sets the out-of-network rates for *multiple different* services. 42 U.S.C. § 300gg-111(c)(3)(A) ("Batching" occurs when "multiple … services are … considered jointly as part of a single determination"). For example, in a "batched" IDR an arbitrator might be asked to determine the appropriate amount of reimbursement for, say, five different heart surgeries of five different patients. In order to qualify for "batching," the "multiple services" in question must have been furnished by the same provider; billed to the same insurer; be "related to the treatment of a similar condition"; and must have been furnished within 30 days of each other. *See id.* § (c)(3)(A)(i)-(iv).

The Departments argue that (1) this "batching" provision delegated the Departments rulemaking authority to determine the criteria under which "multiple items or services" may be considered in a "batched" IDR, (2) the Departments' rules governing batching were a permissible

exercise of that authority, and (3) the two-IDRs-per-transport rule guidance is a permissible extension of the "batching" rules. Depts. MSJ & Opp. at 43–46.

This argument entirely misses the point: there is no "batching" when an air ambulance provider initiates an IDR over a *single* air transport. "Batching," by definition, means that "multiple … services are … considered jointly" in the same IDR. 42 U.S.C. § 300gg-111(c)(3)(A). A single air transport is not "multiple … services." On the contrary, the NSA clearly defines "air ambulance service" (singular) to mean one "transport" (singular). *Id.* § 300gg-112(c)(1).

The Departments complain that allowing a single transport to be determined in a single IDR will mean "defining 'services' one way for air ambulance transports and a different way in all other instances under the Act." Depts. MSJ & Opp. at 45. This complaint is irrelevant because Congress quite obviously decided to treat air ambulance services differently, in numerous ways, from all other emergency medical services. As a result of that decision, Congress enacted a separate section of Title 42 of the PHSA devoted solely to air ambulance IDRs. *Compare* 42 U.S.C. § 300gg-111 (non-air-ambulance IDRs) *with* § 300gg-112 (air ambulance IDRs).[8] It is hardly surprising that Congress also included a separate definition of "air ambulance service," which states that one "transport" (singular) counts as one "service" (singular). *Id.* § 300gg-112(c)(1).

Congress's delegation of rulemaking authority regarding "batching" was quite limited. Congress authorized the Departments to make rules to "specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single

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[8] Congress also enacted separate sections of the Employee Retirement Income Security Act ("ERISA") and the Internal Revenue Code ("IRC") devoted solely to air ambulance IDRs. *Compare* 29 U.S.C. § 1185e (ERISA, non-air ambulance IDRs) and 26 U.S.C. § 9816 (IRC, non-air ambulance IDRs) *with* 29 U.S.C. § 1185f (ERISA, air ambulance IDRs) and 26 U.S.C. § 9817 (IRC, air ambulance IDRs).

determination." *Id.* § 300gg-111(c)(3)(A). This delegation is thus expressly limited to circumstances in which "multiple … services" are "considered jointly." *Id.* Nothing in this text gives the Departments authority to decide that a single air transport counts as "multiple … services" just because the transport is billed using two HCPCS codes. Neither this nor any other NSA provision delegates power to the Departments to rewrite Congress's definition of "air ambulance service" as a *single* transport.

Congress's meaning was so plain (and the resulting practice of one IDR per transport was so sensible) that everyone involved in the IDR process understood it *for months*. From the very first IDRs in March 2022, through the Departments' abrupt about-face in August 2022, everyone involved (providers, insurers, and IDR entities) agreed with the Air Ambulance Plaintiffs' reading of the statute and regulations. AA Pls. MSJ Ex. A (Brady Decl.) ¶ 5–13, Ex. C (Shepard Decl.) ¶ 2–7, Ex. D (Arters Decl.) ¶ 2–4. Dozens—likely hundreds—of air ambulance IDRs were successfully resolved by the IDR entity making a single decision resolving both billing codes.

C. The Two-IDRs-Per-Transport Rule Is Arbitrary and Capricious

Even if the statutory text were ambiguous as to whether a single air transport could be considered as "multiple … services" requiring "batching" (and there is no such ambiguity), the Departments' belated August 2022 guidance must nevertheless be struck down because it is arbitrary and capricious.

Congress was very specific about the purpose for which the Departments were to use their limited rulemaking authority on "batching." Congress's express instruction was that the Departments should adopt rules that would "encourage[] the efficiency (including minimizing costs) of the IDR process." 42 U.S.C. § 300gg-111(c)(3)(A).

The Departments' new two-IDRs-per-transport rule does the opposite: it *discourages* "efficiency" and *doubles* the "costs," *id.*, of the IDR process for providers and insurers alike, at a

time when the IDR entities are flooded with submissions and are missing deadlines as a result.[9] As explained in the Air Ambulance Plaintiffs' opening brief, the two IDR processes for a transport will each consider the exact same information regarding eight of the nine statutory factors. *See* 42 U.S.C. § 300gg-112(b)(5)(C)(i)-(ii); AA Pls. MSJ at 19–20. Specifically: the patient, the severity of the patient's condition, the pick-up location, the personnel treating the patient, the vehicle, the provider, the insurer, and the parties' prior contracted rates will be the same in both IDRs. Only the QPAs will be different since each billing code will receive its own QPA.

To this day, the Departments have never explained how their new two-IDRs-per-transport rule is rationally related to achieving *any* legitimate legislative or administrative purpose, let alone how the rule is expected to achieve the purposes Congress expressly set for the Departments: "encourag[ing] … efficiency" and "minimizing costs," 42 U.S.C. § 300gg-111(c)(3)(A).

Nor have the Departments submitted any evidence for, or even a coherent explanation of, their suggestion that each of the two billing codes is "associated with a different component of an air ambulance service." Depts. MSJ & Opp. at 44–46. The reason for having two codes is economics, not any real-world "differen[ces]" between "components" of the "service." The flat-rate "lift-off" code compensates the provider for the (very high) fixed cost of maintaining the flight-ready vehicle; it must be paid no matter how short or long the flight is. The per-mile code compensates the provider for the distance travelled with the patient onboard; the total amount

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[9] *See Initial Report on the Independent Dispute Resolution Process April 15–September 30, 2022*, DEP'T OF HEALTH AND HUM. SERVS., DEP'T OF LAB., AND DEP'T OF TREASURY, 6–10 (Dec. 15, 2022), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/q2-and-q3-partial-report-121522.pdf [available at: https://perma.cc/4B2V-QYBK] (describing volume of IDR submissions in the first six months as "significantly more than the number of disputes the Departments initially estimated would be submitted for a full year" and noting the delays associated with timely processing this volume).

billed under this code varies, based on the length of the flight, because the provider incurs additional cost (fuel, time, wear and tear) with each mile flown. The codes do not reflect any *practical* difference between separate "components" of the single service: transporting the patient.

III. The July Rule's QPA Calculation Methodology Unlawfully and Arbitrarily Excludes Case-Specific Contracted Rates from the QPA

The NSA requires that insurers, when calculating the QPA, include all "contracted rates recognized by the plan or issuer ... as the total maximum payment ... under such plans or coverage." 42 U.S.C. §§ 300gg-111(a)(3)(E)(i), 300gg-112(c)(2) (this requirement applies to air ambulance QPAs). A single-case agreement sets a case-specific "contracted rate" that is "recognized" by the insurer agreeing to pay that rate. Such rates must therefore be included in the QPA calculation. The July Rule impermissibly deviates from this statutory requirement by excluding "single-case agreement[s], letter of agreement[s], or other similar arrangement[s]" from the definition of "contracted rates." 45 C.F.R. § 149.140(a)(1).

The only contemporaneous explanation the Departments gave in the July Rule, for excluding case-specific rates from the QPA, was that excluding these rates "most closely aligns with the statutory intent of ensuring that the QPA reflects market rates under typical contract negotiations." July Rule at 36,889.

A. The Departments' New Statutory Arguments Do Not Justify the Exclusion of Case-Specific Rates

1. These New Arguments Should Be Disregarded as *Post Hoc* Rationalizations

Now that Plaintiffs have challenged the July Rule, the Departments' lawyers have concocted additional, *post hoc* rationalizations based on new interpretations of the statutory text. But it has long been "established that an agency's action must be upheld, if at all, on the basis articulated by the agency itself[;] [*p*]*ost hoc* explanations" are "simply … inadequate." *Chem.*

Mfrs. Ass'n v. Env't Prot. Agency, 899 F.2d 344, 356 (5th Cir. 1990) (rejecting an agency's "post hoc" interpretation of the statute because "nothing" in the rule "indicat[es] that the [agency] did in fact apply" that interpretation of the statute when promulgating the rule at issue); *see also Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 50 (1983) ("It is well-established that an agency's action must be upheld … on the basis articulated by the agency itself," and not "counsel's *post hoc* rationalizations."). These newly minted justifications for the Departments' rule were absent from the Departments' published rulemaking and therefore should be disregarded here.

2. The Departments' New Statutory Arguments Are Wrong

The Departments' new interpretation of Section 300gg-111(a)(3)(E)(i) is that the statute requires the QPA to be calculated based *only* on those "payment rates that are contracted for under the *generally applicable terms* of a health plan or health insurance policy." Depts. MSJ & Opp. at 35 (emphasis added). Even if the Court were to consider this *post hoc* rationalization for the Departments' decision to exclude case-specific rates from the QPA, the Court should reject it based on the plain meaning of the statutory text.

The key phrase in the Departments' new interpretation is "generally applicable terms." *Id.* That phrase is absent from the statutory text. And courts "ordinarily resist reading words ... into a statute that do not appear on its face." *Bates v. United States*, 522 U.S. 23, 29 (1997).

Because Congress did not include the "generally applicable" concept in the statute, the Departments resort to four scattershot arguments, based on other snippets of statutory text, in a failed effort to find support for this reading.

i) The Statute's References to "Group Health Plan," "Health Insurance Coverage," and "Under Such Plans or Coverage" Support Including Single-Case Agreements in the QPA.

The Departments' first *post hoc* statutory argument is based on the definitions of "group health plan" in 42 U.S.C. § 300gg-91(a)(1) and "health insurance coverage" in 42 U.S.C. § 300gg-91(b)(1). The Departments attempt to argue that single-case agreements are not made "under such plans or coverage," as the QPA-calculation section requires. *Id.* § 300gg-111(a)(3)(E)(i); Depts. MSJ & Opp. at 35. This argument fails because these "plans" and "insurance" *routinely* covered out-of-network air ambulance transport prior to the NSA.

Nothing in these definitions of "group health plan" or "health insurance coverage" supports the Departments' argument. Neither definition uses the term "contracted rates," much less limits that term to "generally applicable" rates. Even worse for the Departments, neither of these definitions limit the defined terms ("group health plan" and "health insurance coverage") to *only* the in-network providers. On the contrary, these broad definitions refer to *all* of the "medical care" that the "group health plan" or "health insurance coverage" pays for, including of course out-of-network medical care. As relevant here, "group health plan" is defined as "an employee welfare benefit plan ... to the extent that the plan provides *medical care* ..." *Id.* § 300gg-91(a)(1) (emphasis added). Similarly, "health insurance coverage" is defined as "benefits consisting of medical care" under a policy or contract offered by a health insurance issuer. *Id.* § 300gg-91(b)(1); Depts. MSJ & Opp. at 35 (same). "Medical care," in turn, is defined to include "amounts paid for transportation primarily for and essential to medical care." 42 U.S.C. § 300gg-91(a)(2)(B). Case-specific rates paid for out-of-network air ambulance transport, pursuant to single-case agreements, are "amounts paid for medical transportation." *Id.* Therefore, out-of-network medical air transport counts as "medical care" that is provided by a "group health plan," *id.* § 300gg-91(a)(1), and also counts as "benefits" of "health insurance coverage," *id.* § 300gg-91(b)(1).

The Departments' narrow reading of these definitions ("group health plan" and "health insurance coverage"), as limited solely to *in-network* coverage, is not only contrary to the definitions; it is also contrary to the widespread practice of these plans and issuers, which was to cover out-of-network air transport. The attached declarations regarding East Texas Air One and Air Methods attest to the frequency with which the insurers stated or implied that the plan or policy did provide out-of-network coverage for air ambulance transport. Ex. A (Mariani Decl.) ¶ 7–9; Ex. B (Copenhaver Decl.) ¶ 3–8. Although most of those insurers disputed the *amount* providers charged for the service, that is beside the point: the point is simply that "group health plans" and "health insurance" did pay for "medical care" from out-of-network air ambulance transports.

The Departments next argue that these definitions ("group health plan" and "health insurance coverage") somehow imply that case-specific rates are not established "*under* such plans or coverage," as Section 300gg-111(a)(3)(E)(i) requires. *See* Depts. MSJ & Opp. at 35 (emphasis added). But "under" simply means "subject [or pursuant] to or by reason of the authority of." *See Ardestani v. INS*, 502 U.S. 129, 135 (1991) (cleaned up). A single-case agreement, which by definition resolves an out-of-network provider's claim for reimbursement from the plan or issuer, is made "pursuant to" the insurer's authority to dispense plan or insurance funds for out-of-network air-transport benefits. *See* 42 U.S.C. § 300gg-91(a)(2)(B). Thus, a single-case agreement with an out-of-network provider is made "under" the plan or coverage for NSA purposes.

The Departments' new reading—that single-case agreements are not entered into "under" a plan or coverage—is also unlawful because it contradicts the ERISA statute. If the Departments were correct that single-case agreements were not made "under" an ERISA plan, then the result would be that ERISA plans, by agreeing to these payments, were violating the statute that requires them to expend funds "for the exclusive purpose of" "providing benefits" due under the plan. 29

U.S.C. § 1104(a)(1)(A). If out-of-network payments were not "benefits" "under" the plan, then ERISA plans could not pay them.

ii) The Statutory Phrase "Coverage Offered by Such Issuer" Does Not Support Excluding Case-Specific Rates From the QPA.

The Departments next argue that the phrase "coverage offered by such issuer that are offered within the same insurance market," 42 U.S.C. § 300gg-111(a)(3)(E)(i), justifies excluding case-specific rates because these rates "are not included in plans or coverage *offered* to individuals in a particular market." Depts. MSJ & Opp. at 35.

This argument grotesquely distorts the term "offered." The statute is referring here to coverage that is "offered" *to beneficiaries*, not to the payment rates that are "offered" to providers. The beneficiaries are offered *coverage* for services; beneficiaries are not even informed of (much less, "offered") the provider reimbursement rates.[10] And the coverage "offered" to beneficiaries *includes* coverage for out-of-network air transports, as previously discussed. *Supra* at 15. Those out-of-network transports often resulted in single-case agreements. *Id.*

Moreover, the Departments are taking this phrase ("coverage offered by such issuer that are offered within the same insurance market") out of context. This phrase is used in Section 300gg-111(3)(E)(i) to specify *which plan's* contracted rates are included in the QPA. After all, many plan sponsors offer many plans, but only some of those plans are offered in the relevant insurance market applicable to the transport at issue.[11] This phrase does *not* govern which *types of*

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[10] *See* Transparency in Coverage Act Final Rules, 45 C.F.R. § 147.211(b)(1)(iii); *see also FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 29*, Dep'ts (Aug. 20, 2021) (https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/ouractivities/ resource-center/faqs/aca-part-49.pdf) [available at https://perma.cc/B7L7-QEKM].

[11] *See* 42 U.S.C. § 300gg-111(a)(3)(E)(i) (requiring contracted rates be "determined with respect to *all such plans of such sponsor or all such coverage offered by such issuer that are*

agreements with providers qualify as "contracted rates." This phrase thus provides no basis for excluding the case-specific rates, contracted for in single-case agreements, from the "contracted rates" of the plans that were offered in the relevant "insurance market."

iii) Case-Specific Rates are "Recognized Rates" Included in the Statutory Definition of the QPA.

The Departments next focus on the word "recognized" in Section 300gg-111(a)(3)(E)(i), and attempt to argue that single-case agreements do not set "recognized rates." Depts. MSJ & Opp. at 35. The Departments provide no citation for this claim. *See id.*

A single-case agreement is "recognized" by the insurer under the plain meaning of the word "recognized." Plans and issuers have fiduciary duties to their beneficiaries to make payments for out-of-network services. When a plan or issuer agrees to such a payment, pursuant to those duties, the plan or issuer is "recognizing" that the case-specific rate set out in the single-case agreement is appropriate. This is the plain meaning of the word. "[R]ecognized" means "to acknowledge ... to admit ... to treat as valid, as having existence or as entitled to consideration; [or] take notice of in some way."[12]

iv) Any Ambiguity Concerning the Dates of the Single-Case Agreements Included in the QPA Does Not Justify Excluding These Agreements Entirely

Finally, the Departments argue that "contracted rates" should only include in-network, "generally applicable" rates because "it makes little sense to think that Congress would have

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offered within the same insurance market." (emphasis added)). The point is to limit the QPA to those "plans" or "coverage" that are "offered within the same insurance market." *See id.* § 300gg-111(a)(3)(E)(iv) (defining "insurance market" as "one of ... the individual ... large group ... [or] small group market[s] ... [or] [i]n the case of a self-insured group health plan, other self-insured group health plans.").

[12] *Recognize*, OXFORD ENGLISH DICTIONARY (Second Ed. 1989), also available at https://www.oed.com/oed2/00199328 [available at: https://perma.cc/QW3B-GSYE].

intended the Departments to include single-case agreements that were in place on a single day, January 31, 2019" in the calculation of the QPA. Depts. MSJ & Opp. at 35.

This argument is also misplaced. Any ambiguity as to *which* case-specific rates should be included does not mean that there is any ambiguity about the threshold question of *whether* case-specific rates are included in the plain meaning of the phrase "contracted rates"—they are. The Departments would have authority to resolve any ambiguity as to time (that is, how far back in time should the insurer go, in gathering the single-case agreements) through notice-and-comment rulemaking. The Departments are *not* permitted to resolve that temporal ambiguity by excluding single-case agreements altogether, since case-specific rates contained in single-case agreements are plainly "contracted rates."

B. Excluding Case-Specific Rates from the QPA is Arbitrary

1. The Departments Admit that Single-Case Agreements Constitute Contracts.

Even if there were any ambiguity about whether case-specific rates qualify as "contracted rates" (and there is no such ambiguity) the July Rule should still be set aside because the Departments' exclusion of them is arbitrary and capricious. *See, e.g., Sw. Elec. Power Co. v. U.S. Env't Prot. Agency*, 920 F.3d 999, 1028 (5th Cir. 2019) ("Because *Chevron* step two and the APA share the arbitrary and capricious standard, the APA reflects the principles of *Chevron*, and analysis under the two standards proceeds similarly." (cleaned up)).

The Departments have no evidence for their assertion that single-case agreements do not "reflect[] market rates" for air ambulance services, which assertion was their sole justification for excluding these rates. July Rule at 36,889; *see Sw. Elec. Power Co.*, 920 F.3d at 1029.

Prior to the NSA, an out-of-network air ambulance transport would routinely result in a single-case agreement between the provider and the insurer setting the agreed-upon rate for that

specific service. The Departments do not dispute this point. *Compare* AA Pls. MSJ at 21, 24–25 *with* Depts. MSJ & Opp. at 34–38 (not contesting the point). Commentators made clear to the Departments that single-case agreements *do* "reflect[] market rates" because (a) they are negotiated at arms-length, and (b) are particularly probative in the air ambulance industry, where in-network agreements are comparatively rare, and the majority of commercial transports are out-of-network.[13] Declarations submitted herewith attest to the same point. *See* Ex. A (Mariani Decl.) ¶ 7–12; Ex. B (Copenhaver Decl.) ¶ 3–8.

The Air Ambulance Plaintiffs pointed out, in their opening brief, the total lack of evidence for the Departments' claim that single-case agreements are not a reliable indicator of market rates. AA Pls. MSJ at 24–25. The Departments' response does not point to any evidence that supports their contention. The exclusion of single-rate agreements is therefore arbitrary and capricious. *Sw. Elec. Power Co.*, 920 F.3d at 1029 (finding agency rule arbitrary and capricious where record showed that the technology endorsed by rule would be "ineffective at controlling toxic discharges" and where record showed that rejected alternative technologies would be "more effective").

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[13] *See* AR002094 (April 2021 presentation from Air Methods noting "single-case agreements (i.e., one-off agreements between an air ambulance service provider and a plan for a rate for a single air ambulance transport (or a discrete set of such transports)) are common contract types that provide for a payment amount agreed to between an air ambulance service provider and a payor"); AR002244 (April 2021 report from Air Methods noting that "in light of the unique dynamics of the air ambulance industry ... such agreements are often the best reflection of how the market values air ambulance services."); AR002413 (letter from AAMS stating that, due to the omission of single-case agreements, "the methodology will not produce QPAs that reflect how payers and providers have historically resolved payment disputes at arm's length, nor will the methodology measure of the cost of services"); AR006938–39 (letter from PHI Health, LLC stating that "[t]he QPA also does not include any single-case agreements, which may be a majority of contracts between a provider and an insurer and reflect historical agreements between air ambulances and insurers for reimbursement of air ambulance services").

The exclusion of single-case agreements from the QPA is also arbitrary and capricious because it contradicts the Departments' own position in another portion of the July Rule. That Rule recognizes that single-case agreements constitute a "contractual relationship" for purposes of defining "participating emergency facilit[ies]" and "participating health care facilit[ies]." *See* July Rule at 36,882; 45 C.F.R. § 149.30. It is arbitrary and capricious for the Departments to take these two conflicting positions. *See, e.g., Sw. Elec. Power Co.*, 920 F.3d at 1030 (holding that an agency's interpretation failed *Chevron* step two and was arbitrary and capricious in part because "the agency's rationales contradict themselves" and "unexplained inconsistency in agency policy is a reason for holding an interpretation to be an arbitrary and capricious" (internal citations, alternations, and quotation marks omitted)).

The Departments attempt to reconcile their contradictory interpretations in their brief by pointing out that the statutory definition of "participating healthcare facility" includes the phrase "indirect contractual relationship." Depts. MSJ & Opp. at 37.[14] The attempt fails because there is nothing "indirect" about a single-case agreement. An "indirect contractual relationship" refers to a situation in which a facility's subsidiary (rather than the facility itself) is the contracting party. A single-case agreement, by contrast, is a direct contract between the provider and the insurer.

Because the Departments treat a single-case agreement as a "contractual relationship" for purposes of 45 C.F.R. § 149.30, the same agreement's case-specific rate should also count as a "contracted rate" for purposes of the QPA. The Departments have not provided an adequate

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[14] The statutory definition of "participating emergency facility" makes use of a similar phrase: "contractual relationship directly or indirectly." 42 U.S.C. § 300gg-111(a)(3)(F)(ii). The above arguments apply to this definition as well.

explanation for their contradictory positions on this issue. *See, e.g., Sw. Elec. Power Co.*, 920 F.3d at 1030.

2. The Supposed "Purpose" of the NSA Does Not Justify the Departments' Exclusion of Case-Specific Rates.

The Departments also attempt to reconcile their conflicting interpretations of "contractual relationship[s]" by hand-waving at what they contend to be the legislative purpose of the NSA: reducing providers' reimbursement rates. Depts. MSJ & Opp. at 36. The attempt fails for two reasons: First, here again the Departments' *post hoc* rationalizations are not supported by what they said in the July Rule. That Rule justified the exclusion of case-specific rates solely on the (factually unsupported) basis that such rates did not "reflect[] market rates." July Rule at 36,889.

Second, the Departments' selective account of the NSA's "purpose" is obviously flawed and ignores Congress's intent to provide reasonable and sustainable payments to out-of-network providers, as TMA's briefing explains. *See* TMA Reply at 1–2.[15] Discerning a statutory "purpose" is a tenuous exercise. "[W]hat Congress says in a statute's text is the best guide to what Congress intends." *U.S. v. Koutsostamatis*, 956 F.3d 301, 310 (5th Cir. 2020).

Moreover, the Departments are simply wrong to contend that the NSA's "purpose" was to reduce provider compensation. The Departments' only evidence of this supposed "purpose" is a House Report that described a *different* bill that did not become law. *See* Depts. MSJ & Opp. at 36 (citing H.R. Rep. No. 116-615 (2020) (accompanying the Ban Surprise Billing Act, H.R. 5800, 116th Cong. (2020))).The NSA, by contrast, reflects a compromise designed not only "to protect patients from surprise medical bills" but was also intended to "establish a fair framework to resolve

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[15] Even if the Departments were right concerning the purpose of the NSA, "no legislation pursues its purpose at all costs." *Rodriguez v. U.S.,* 480 U.S. 522, 525–526 (1987). "It frustrates rather than effectuates the legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law." *Id.*

payment disputes between health care providers and health insurance companies."[16] Excluding case-specific rates from the QPA does not serve the purpose of "establishing a fair framework," especially in the air ambulance industry, where there are relatively few in-network transports.

The Court should thus vacate the provision of the July Rule excluding single-case agreements from the "contracted rates" included in the QPA.

IV. The Departments' QPA Methodology Adopts Overbroad Geographic Regions That Are Arbitrary and Capricious

The July Rule's expansive definition of geographic regions permits insurers to calculate the QPA using rates agreed to throughout an entire Census division, whenever the insurer does not have at least three in-network contracts in the part of the state where the transport occurred.[17] Thus, for example, the rates agreed to for transports in Fairbanks, Alaska will be used to generate the QPA for air ambulance transports in Honolulu, Hawaii. AA Pls. MSJ at 27. The Departments justify this absurd outcome on the grounds that (1) it minimizes reliance on third-party databases and (2) these enormous regions still reflect the relevant "market dynamics" for air ambulance services. *See* Depts. MSJ & Opp. at 38–39. Both of these justifications are arbitrary and capricious.

As for the Departments' supposed desire to minimize the use of third-party databases, that desire is directly contradicted by the NSA itself, which expressly endorses and authorizes the use of these databases. *See* 42 U.S.C. § 300gg-111(a)(3)(E)(iii). Nothing in the statute supports the

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[16] *Congressional Committee Leaders Announce Surprise Billing Agreement*, WAYS & MEANS COMM. (Dec. 11, 2020), perma.cc/J2VZ-T6ZL.

[17] States are divided for this purpose into two regions: (a) all the Metropolitan Statistical Areas (MSAs), that is, the urban and suburban areas; and (b) all the non-MSA regions, that is, the rural areas. The Air Ambulance Plaintiffs do not challenge those two geographic regions. But whenever the insurer lacks three in-network rates in the relevant state-specific region, the insurer instead calculates the QPA using enormous regions, which Plaintiffs do challenge, namely: (A) all of the in-network rates in all of the MSAs within the entire Census Division; or (B) all of the in-network rates in all the non-MSA regions within the entire Census Division.

Departments' assumption that these databases should "'be used in only limited circumstances.'" Depts. MSJ & Opp. at 12, 39 (quoting July Rule at 36,888). The Departments do not even attempt to explain why those databases, endorsed by Congress, are not a reliable proxy of the "market rates" in the relevant region. *See* July Rule at 36,889. These databases are frequently used and contain *billions* of records.[18] Moreover, this non-problem (the need to use databases, in cases where the insurer lacks at least three "contracted rates" in the state-specific geographic region) is the Departments' own creation. As described above, the Departments wrongly limited the QPA solely to *in-network* rates, even though the vast majority of emergency air medical transports are *out-of-network*. *See supra* 18–19, n.13. If the Departments had followed the plain meaning of "contracted rate" and had included case-specific rates in the QPA calculation, there would have been many more "contracted rates" for insurers to use in the sensibly sized, state-specific regions.

As for the Departments' assertion that rates agreed to in Fairbanks will reflect the "market dynamics" at work in Honolulu, *see* Depts. MSJ & Opp. at 39, this assertion fails for a total lack of supporting evidence or data. The Departments had access to ample insurers' payment data, as well as the data in third-party databases. If that data really had shown uniform payment rates across climates and time zones, the Departments would have provided some evidence to support that claim. There is no such evidence. The assertion is particularly dubious because so many insurers are limited to just one state, suggesting that their payment rates are also state-specific.

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[18] *See, e.g., FAIR Health Consumer*, FAIR HEALTH, https://www.fairhealthconsumer.org/ [available at: https://perma.cc/FM2X-8RVE] (describing data set of more than "40 billion private health care claim records," and claiming to add "2 billion new records each year").

The Departments also make the related (and equally unsupported) claim that enormous geographic regions minimize the risk that the "'median of contracted rates would be skewed ... [by] particularly high or particularly low payment amounts.'" Depts. MSJ & Opp. at 39 (quoting July Rule at 36,892). This claim makes no sense. The default region (not challenged by Plaintiffs) is the particular state's urban/suburban areas, or the state's rural areas.[19] The regulations require the insurer to use that default region so long as they had just *three* "contracted rates" in that region. *See* 45 C.F.R. §§ 149.140(a)(7)(ii), (a)(15), (b)(1). That invites exactly the kind of "skewing" that the Departments now claim that they want to avoid. If the Departments mean to suggest that the third-party database alternative is somehow more "skewed" than the insurers' own contracts, then this suggestion fails for a complete lack of evidence. As noted, these databases contain *billions* of records. *See supra* n.18. The Departments provide no evidence to support their suggestion that the median rate, calculated based on these massive databases, would be more "skewed" than the median rate calculated based on the insurer's own contracts.

Lacking any factual support in the record and in direct contravention of a congressionally-endorsed alternative (third-party databases), the Departments' expansive definition of "geographic regions" for purposes of determining air ambulance QPAs is arbitrary and capricious and should be struck down. *See State Farm*, 463 U.S. at 43.

V. The No-Claim-Splitting Doctrine Does Not Apply Here.

The Departments invoke the "rule against claim splitting," and point to a lawsuit filed by the Association of Air Medical Services ("AAMS") in federal court in Washington, D.C. *See* Depts. MSJ & Opp. at 17 (citing *Ass'n of Air Med. Servs. v. U.S. Dep't of Health & Hum. Servs.*,

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[19] *See supra* n.17.

No. 1:21-cv-3031 (D.D.C. Nov. 16, 2021) ("*AAMS*")).[20] This is the same lawsuit that the Departments invoked in a failed attempt to transfer the first LifeNet lawsuit to D.C. *See LifeNet, Inc. v. U.S. Dep't of Health & Hum. Servs.*, No. 6:22-CV-162-JDK, 2022 WL 2959715, at *4–6 (E.D. Tex. July 26, 2022) ("*LifeNet I*") (denying the Departments' motion to transfer on "first-to-file" grounds in part due to the Court's prior "substantial" analysis of the NSA and its implementing rules).

The so-called "rule" against claim splitting is actually not a "rule" at all, but instead is a doctrine left to the sound discretion of this Court. *See, e.g., Verde v. Stoneridge, Inc.,* 137 F. Supp. 3d 963, 967–68 (E.D. Tex. 2015). As the Departments concede, this doctrine is *only* applied where "the [second] claim [a] involves the same parties and [b] arises out of the same transaction or series of transactions as the first claim." Depts. MSJ & Opp. at 17 (quoting *Ameritox, Ltd. v. Aegis Scis. Corp.*, No. 3:08-CV-1168-D, 2009 WL 305874, at *4 (N.D. Tex. Feb. 9, 2009)). The Departments come nowhere close to meeting that standard here.

A. The Air Ambulance Plaintiffs Are Not the "Same Parties" as AAMS, the Sole Plaintiff in *Association of Air Medical Services v. HHS et al*.

The D.C. case was filed by one plaintiff: AAMS, a trade association of more than 600 air ambulance providers.[21] The Departments admit that the Air Ambulance Plaintiffs are *not* the same as AAMS. *See* Depts. MSJ & Opp. at 17. The no-claim-splitting doctrine therefore does not apply because this case does not "involve[e] the same parties" as the D.C. case. *Verde,* 137 F. Supp. 3d at 973 (adopting report and recommendation).

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[20] Motions for summary judgment were fully briefed and argued, in the D.C. case, in March 2022. *See AAMS*, ECF 57 (D.D.C. Mar. 24, 2022) (transcript of argument).

[21] *See Join AAMS*, Association of Air Medical Services, https://aams.org/page/join-aams (stating that AAMS has "over 600" members).

1. Neither LifeNet nor Rocky Mountain Holdings Is a Member of AAMS

Two plaintiffs here (LifeNet and Rocky Mountain Holdings) are *not even members* of AAMS. *See* Ex. B (Copenhaver Decl.) ¶ 11; *LifeNet, Inc. v. U.S. Dep't of Health and Hum. Servs.*, No: 6:22-cv-162-JDK, ECF 27-2 at ¶ 13 (Gaines declaration) (E.D. Tex. May 18, 2022). The Departments contend that LifeNet and Rocky Mountain Holdings count as the "same party" as AAMS because they supposedly have a close relationship with Air Methods, which in turn is a "member" of AAMS. Depts. MSJ & Opp. at 17. But the Departments cite no authority for expanding the no-claim-splitting doctrine to include "members" of a trade association, still less to expand it to include "close affiliates" of those members. If the Court were to adopt the Departments' view of the doctrine, the result would be to shut the courthouse doors on an untold number of plaintiffs, with valid claims, who happen to be contractual parties or subsidiaries of a member of a trade association.

And, as to LifeNet, even if the no-claim-splitting doctrine recognized a "close affiliate" exception to the "same parties" requirement, the Departments have not carried their factual burden to prove any relevant "close affiliat[ion]." *Id.* As LifeNet's Rule 7.1 Declaration attests, Air Methods has no ownership stake in LifeNet. *See LifeNet, Inc. et al. v. U.S. Dep't of Health and Hum. Servs.*, 6:22-cv-453-JDK, ECF 3 (Dec. 1, 2022). The Departments' claim of a close relationship presumably refers to Air Methods' contract with LifeNet, whereby Air Methods pays LifeNet a fixed amount for LifeNet's services. This contract was filed under seal in *LifeNet II*. *See TMA v. U.S. Dep't of Health and Hum. Servs.*, No. 22-cv-372-JDK, ECF 44 (Oct. 12, 2022). It appears on its face to be a heavily negotiated, arms-length agreement that is limited to a specific business arrangement. The contract has an expiration date of October 2023. *See id.* §§ 2.3-2.4. There is nothing in the contract that refers to AAMS, and nothing in the contract that gives AAMS or Air Methods any control over LifeNet's decisions to bring litigation in LifeNet's own name.

The fact that neither LifeNet nor Rocky Mountain Holdings is a member of AAMS means that the no-claim-splitting doctrine does not and cannot apply; no further consideration of the other plaintiffs is necessary.

2. Air Methods' and East Texas Air One's Membership in AAMS Does Not Make those Plaintiffs the "Same Party" as AAMS

As for the other two Air Ambulance Plaintiffs (Air Methods and East Texas Air One), the Departments contend that they count as the "same party" as AAMS for claim-splitting purposes because they are two of AAMS' 600-plus members. But here again, the Departments do not cite caselaw holding that the doctrine applies to members of a trade association.

Instead, the Departments invoke a *different* doctrine (claim preclusion) and wrongly assert that this doctrine would apply to bar Air Methods and East Texas Air One from contesting the D.C. court's ultimate decision in the *AAMS* case. But here again, the Departments cite no relevant authority, even though they bear the burden.[22] The Supreme Court has taken a "'constrained approach to nonparty preclusion,'" recognizing only minor exceptions. *Students for Fair Admissions, Inc. v. Univ. of Texas at Austin*, 37 F.4th 1078, 1088 (5th Cir. 2022) (quoting *Taylor v. Sturgell*, 553 U.S. 880, 898 (2008)). The Departments provide no citation or analysis for the argument that AAMS and the member plaintiffs are the "same party" for claim preclusion purposes, and there is substantial precedent to the contrary. *See id.* at 1088–89 (fact that an organization's board members previously filed suit in their individual capacity did not preclude the organization from suing in its representative capacity); *Assurance Co. of Am. v. Kirkland*, 312

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[22] If a decision in *AAMS* is rendered before this Court decides the instant matter, then it will be the Departments' burden to argue and prove claim preclusion as to the two AAMS members before this Court. *See Taylor*, 553 U.S. at 907 (noting that "claim preclusion" is an "affirmative defense" which the party asserting preclusion bears the burden of proving); *see also Webb v. Town of St. Joseph*, 560 F. App'x 362, 366 (5th Cir. 2014) ("any doubt concerning application of the principle of res judicata must be resolved against its application").

F.3d 186, 190 (5th Cir. 2002) (named insured was not the "same party" as company he owned because "[a] party appearing in an action in one capacity, individual or representative, is not thereby bound by ... the rules of res judicata in a subsequent action in which he appears in another capacity" (internal quotation marks and citation omitted)).

The Departments have no evidence whatsoever that East Texas Air One—which operates only three rotor-wing air ambulances, ECF 1 at ¶ 7—exerts any control over AAMS in general, or over the D.C. case in particular, such that East Texas Air One is properly considered to be the "same party" for purposes of claim preclusion or the "claim splitting" doctrine. There is no East Texas Air One employee on the AAMS board of directors. Ex. C (Smith Decl.) ¶ 4.

Nor have the Departments demonstrated that Air Methods "controlled" (or controls) AAMS or the *AAMS* litigation. Although the Departments point out that Air Methods' CFO submitted a factual declaration in the *AAMS* litigation supporting AAMS's associational standing, Depts. MSJ & Opp. at 18, that submission comes nowhere close to demonstrating "control" by Air Methods. *See, e.g., Benson & Ford, Inc. v. Wanda Petroleum Co.*, 833 F.2d 1172, 1174 (5th Cir. 1987) ("[I]t is not enough the nonparty supplied an attorney or is represented by the same law firm; helped to finance the litigation; appeared as an amicus curiae; testified as a witness; participated in consolidated pretrial proceedings; undertook some limited presentations to the court; or otherwise participated in a limited way. Even a nonparty who was heavily involved may remain free from preclusion." (internal quotation marks and citations omitted)). Other members of AAMS submitted very similar declarations, indicating that Air Methods was not the "controlling" member. *See AAMS*, ECF No. 1–5, 1–6, 1–7 (declarations by CFOs of Air Methods, Global Medical Response, Inc., and PHI Health, LLC).

The Departments have not shown that any of the Air Ambulance Plaintiffs is the "same party" as AAMS, as the no-claim-splitting doctrine demands. The Court should therefore reject the Departments' claim splitting argument on that basis alone.

B. The Many Differences Between this Lawsuit and the *AAMS* Case, and the Factual Developments Since *AAMS* Filed Suit, Preclude Application of the No-Claim-Splitting Doctrine

Even if the Departments had shown that the Air Ambulance Plaintiffs count as the "same party" as AAMS, the no-claim-splitting doctrine still wouldn't apply because the two lawsuits do not challenge "the same claim" under the Fifth Circuit's "transactional test." *See Students for Fair Admissions,* 37 F. 4th at 1088–89. The two lawsuits differ in at least three important ways.

First, the instant suit challenges agency actions which are absent from *AAMS*—including challenges to (1) the two-IDRs-per-transport rule, (2) the rules governing a third-party administrator's calculation of the QPA, and (3) the 30-calendar-day deadline for the insurer to provide an initial payment or notice of denial.

Second, the instant suit *omits* challenges that *AAMS* made—including *AAMS'*s challenge to the treatment of all air ambulance providers as a single specialty and the challenge to the now-vacated QPA presumption. *See AAMS*, ECF 1 at 40. Different allegations mean that the no-claim-splitting doctrine does not apply. *See Verde*, 137 F. Supp. 3d at 974 (adopting report and recommendation) (denying motion to dismiss for claim splitting where "[a]t least some of the facts and legal sources related to Defendants' [liability]," differed from the earlier case).

Third, there have been significant factual developments since the *AAMS* case was brought—which the Fifth Circuit has held to be a reason why the "same claim" test is not met. *See Students for Fair Admissions,* 37 F. 4th at 1089. Here, the factual developments include a year's worth of experience with the reality of the IDR process under the Departments' rules, *see* AA Pls. MSJ Exs. A, B, C, D (presenting factual developments regarding payment times and IDR

submission requirements), and also new rules—such as the "two-IDRs-per-transport" rule—governing that process.

C. This Court Should Exercise Its Discretion to Decide this Case

Even if the no-claim-splitting doctrine *could* apply (it can't) this Court should exercise its discretion to keep and decide this case. This is the third challenge that this Court has heard to the NSA regulations; a fourth challenge, brought by TMA, is due to be argued on April 19. This Court's in-depth experience with the statute and the Departments' regulations—and the fact that many of the Air Ambulance Plaintiffs' claims overlap with the TMA Plaintiffs' claims—mean that the reason for the no-claim-splitting doctrine—judicial efficiency—does not apply here. *Cf. LifeNet I,* 2022 WL 2959715, at *4–6 (denying the Departments' motion to transfer on "first-to-file" grounds in part due to the Court's prior "substantial" analysis of the NSA and its implementing rules); *Adidas Am. Inc. v. Shoebacca Ltd.*, No. 3:20-CV-03248-N, 2021 WL 4399745, at *5 (N.D. Tex. Sept. 27, 2021) (noting that "first-to-file rule and related rule against claim-splitting are discretionary doctrines because they primarily rest on principles of comity and sound judicial administration" (internal quotation marks and citation omitted)).

CONCLUSION

The four challenged regulations should be vacated and remanded.

Date: March 24, 2023

Respectfully submitted,

By: *<u>/s/Steven M. Shepard</u>*________________

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CERTIFICATE OF SERVICE

I hereby certify that on March 24, 2023, I electronically filed the foregoing document with the clerk of the court for the U.S. District Court, Eastern District of Texas, using the electronic filing system of the court. The electronic case filing system sent a "Notice of Electronic Filing" to the attorneys of record who have consented in writing to accept this Notice as service of this document by electronic means.

By: */s/ Steven M. Shepard*
Steven M. Shepard

Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, et al.,	)	
	)	
Plaintiffs,	)	
	)	Case No.: 6:22-cv-00450-JDK
v.	)	
	)	Lead Consolidated Case
UNITED STATES DEPARTMENT OF	)	
HEALTH AND HUMAN SERVICES, et al.,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF MARC MARIANI

1. My name is Marc Mariani. I am over the age of eighteen. I am employed by Health Services Integration. My job title is Managing Director and Chief Financial Officer. I have personal knowledge of the matters contained herein.

2. Health Services Integration provides revenue cycle management services to emergency healthcare providers, including providers of ground and air ambulance services. As part of these revenue cycle management services, Health Services Integration handles verification of insurance, compliance reviews, claim follow-up, fair billing and collection practices, and medical necessity reviews.

3. Health Services Integration handles certain components of billing for air ambulance transports performed by East Texas Air One. This includes generating and transmitting bills to insurers for East Texas Air One's emergency air ambulance transports. Since January 1, 2022 Health Services Integration's work for East Texas Air One has included billing for emergency air ambulance transports covered by the No Surprises Act.

4. For transports covered by the No Surprises Act, insurers have frequently delayed payment on East Texas Air One's air ambulance transports for months despite having received all documentation necessary to process the claims.

5. East Texas Air One frequently experiences delays are due to requests for information regarding a coordination of benefits issue or third-party liability from the patient (i.e. the member of the insurance plan).

6. In one instance involving a coordination of benefits issue more than 199 days passed between an insurer's receiving the bill for a transport by East Texas Air One and the insurer's making an initial payment on the claim. And East Texas Air One continues to wait on an initial payment for a claim where the information needed to decide the claim was transmitted on April 6, 2022, i.e. an ongoing wait of more than 348 days.

7. Before the NSA took effect in early 2022, East Texas Air One provided out-of-network transports every year to patients with commercial insurance or a commercial group health plan. In 2018, East Texas Air One provided approximately 179 of such transports.

8. After providing the transports referred to in the last paragraph, Health Services Integration's regular practice was to send a bill to the patient's commercial insurer for East Texas Air One's charges for these services, calculated using East Texas Air One's standard rates.

9. In most of these cases, provided the insurer agreed that the transport was medically necessary, the insurer responded to the bill as follows: (a) the insurer's response indicated or implied that some amount of coverage was available to the patient, under the terms of the policy or plan, for the out-of-network transport that East Texas Air One's had provided, but (b) the insurer disputed the amount that East Texas Air One had charged for the service.

10. In cases in which an out-of-network insurer refused to pay East Texas Air One's charged rates prior to the NSA, East Texas Air One had the legal right to send a bill to the patient for the remainder (the "balance") of East Texas Air One's billed charges. However, in addition to pursuing internal appeals with the insurer, Health Services Integration (on behalf of East Texas Air One) frequently sought to negotiate with the insurer for a mutually acceptable amount of reimbursement to be paid by the insurer to East Texas Air One as an alternative to pursuing reimbursement solely from the patient.

11. In the course of these negotiations, Health Services Integration typically sought to enter into an agreement with the insurer, pursuant to which the insurer and Health Services Integration (on behalf of East Texas Air One) agreed on a specific rate for the specific transport that East Texas Air One had provided to the insurer's beneficiary. Such agreements are commonly referred to as "single case" or "case specific" agreements. When Health Services Integration (on behalf of East Texas Air One) succeeded in reaching such an agreement with a commercial insurer, the typical result was an agreed rate of payment that was somewhere in between: higher than the amount of payment that the insurer had initially made to East Texas Air One, but lower than East Texas Air One's billed charges.

12. In calendar year 2018, approximately 7% of East Texas Air One's out-of-network transports for patients with commercial insurance or a commercial group health plan resulted in a single case agreement between Health Services Integration (on behalf of East Texas Air One) and the commercial insurer.

I declare under penalty of perjury that the foregoing is true and correct. Executed on March 21, 2023.

Signature: Marc Mariani

Marc Mariani

Exhibit B

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, et al., *Plaintiffs*, v. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., *Defendants*.	Civil Action No. 6:22-cv-00450-JDK Lead Consolidated Case

DECLARATION OF SANDRA COPENHAVER

1. My name is Sandra Copenhaver. I am over the age of eighteen. I am employed by Air Methods Corporation ("Air Methods"). My job title is Associate General Counsel and Chief Compliance Officer. I have personal knowledge of the matters contained herein.

2. Air Methods, including its subsidiaries and affiliates, is one of the largest air ambulance providers in the United States. Although Air Methods generally prefers to be an in-network provider with commercial (i.e., non-Medicare/Medicaid) group health plans and health insurance issuers, under contracts providing reasonable reimbursement, many plans and issuers are unwilling to partner with Air Methods in this way. As a result, Air Methods is an out-of-network provider for a significant number of such plans and issuers.

3. Before the No Surprises Act ("NSA") took effect in 2022, Air Methods provided thousands of out-of-network transports every year to patients with commercial health insurance or commercial group health plans. Of the transports Air Methods provided in 2018 to patients with

commercial health insurance or group health plans, approximately 81% of such transports were out-of-network.

4. After providing the transports referenced in the previous paragraph, Air Methods' regular practice was to send a bill to the patient's commercial insurer or group health plan for Air Methods' charges for these services, calculated using Air Methods' standard rates.

5. In most of these cases, provided the insurer agreed that the transport was medically necessary, the insurer responded to Air Methods' bill as follows: (a) the insurer's response indicated or implied that ***some*** amount of coverage was available to the patient, under the terms of the policy or plan, for the out-of-network transport that Air Methods provided, but (b) the insurer disputed the ***amount*** that Air Methods charged for the service.

6. In cases in which an out-of-network insurer refused to pay Air Methods' charged rates prior to the NSA, Air Methods generally had the right to send a bill to the patient for the remainder (a "balance bill") of Air Methods' billed charges. However, as an alternative to pursuing reimbursement solely from the patient, Air Methods frequently sought to negotiate with the insurer for a higher, and mutually acceptable, amount of reimbursement to be paid by the insurer to Air Methods.

7. In the course of those negotiations, Air Methods typically sought to enter into an agreement with the insurer, pursuant to which the insurer and Air Methods agreed on a specific rate for the specific transport that Air Methods had provided to the patient. Such agreements are commonly referred to as "single case" or "case specific" agreements. When Air Methods entered such agreements with a commercial insurer, the typical result was an agreed rate of payment that was somewhere between: (a) higher than the amount of payment that the insurer had initially made to Air Methods, but (b) lower than Air Methods' billed charges.

8. In calendar year 2018, approximately 25% of Air Methods' out-of-network transports for patients with commercial insurance or a commercial group health plan resulted in a single case agreement (or similar arrangement) between Air Methods and the commercial insurer.

9. Since the NSA took effect, approximately 53% of the bills that Air Methods transmits to payors for services subject to the NSA do not receive an initial payment or notice of denial of payment within 30 calendar days of the bill being transmitted by Air Methods to the payor. Commercial insurers have given Air Methods no reason at all for their delay on approximately 90% of those delayed initial payments.

10. On approximately 4% of those delayed initial payments referenced in the previous paragraph, insurers have blamed their delay on issues related to coordination of benefits. For example:

a. Air Methods submitted its bill for an out-of-network transport to an insurer on or about April 25, 2022. On June 10, 2022, the insurer denied the claim for lack of medical records. On June 24, 2022, Air Methods sent the patient's medical records. The insurer did not begin to reprocess the claim until July 7, 2022. On September 13, 2022, after receiving no response, Air Methods contacted the insurer and was advised that the claim was pending in processing and was being "escalated." On November 10, 2022, the claim was "escalated" a second time. On December 28, 2022, the insurer finally denied the claim based on coordination of benefits and the lack of an auto coverage subrogation document from the patient. The claim remains unpaid as of the date of this Declaration.

b. Air Methods submitted its bill for an out-of-network transport to an insurer on or about July 7, 2022, and the insurer responded on September 30, 2022 saying the claim could not be processed due to a coordination of benefits issue with the patient's auto

insurance. The patient, through Air Methods, provided proof to the insurer that the patient's auto insurance had been exhausted on January 11, 2023. On February 15, 2023, after receiving no response, Air Methods contacted the insurer to confirm the letter of exhaustion had been received. The insurer confirmed it had but stated that the insurer required the accident detail document that was sent to the patient before Air Methods' claim could be processed. The claim remains unpaid as of the date of this Declaration.

11. Plaintiff Rocky Mountain Holdings, LLC, which is a subsidiary of Air Methods, is not a member of the Association of Air Medical Services ("AAMS").

I declare under penalty of perjury that the foregoing is true and correct. Executed on March 24, 2023.

Sandra Copenhaver

Exhibit C

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

TEXAS MEDICAL ASSOCIATION, et al.,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

Civil Action No. 6:22-cv-00450-JDK

Lead Consolidated Case

DECLARATION OF JOHN A. SMITH

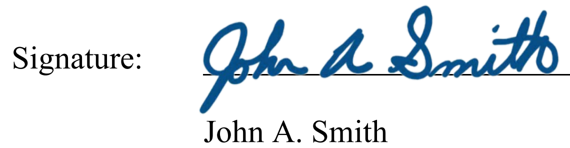
1. My name is John A. Smith. I am currently the President and Chief Executive Officer of East Texas Air One, LLC. I am over the age of eighteen and I have personal knowledge of the facts set forth herein.

2. East Texas Air One is a Limited Liability Company organized under Delaware law, with its principal place of business in Tyler, Texas. From its Tyler location, East Texas Air One carries out air transports using three rotor-wing air ambulances, which routinely transport patients who are located in the Eastern District of Texas.

3. Many of East Texas Air One's air transports are emergency transports of patients who are covered by commercial group health plans or commercial health insurance ("insurers") for whom East Texas Air One is an out-of-network provider. East Texas Air One's rights to reimbursement, for these services, are subject to the balance-billing provisions of the No Surprises Act. East Texas Air One is currently participating in the independent dispute resolution ("IDR") process to resolve disputes with insurers over appropriate reimbursement rates for these services, and East Texas Air One expects to continue to do so in the future.

4. East Texas Air One has never had an employee serve on the Board of Directors of the Association of Air Medical Services ("AAMS").

I declare under penalty of perjury that the foregoing is true and correct. Executed on March 23, 2023.

Signature: 

John A. Smith