



Connecticut EMS Chiefs Association

P.O. Box 643
Suffield CT 06078

Date: 20-March-2014

To: Senator Catherine A. Osten, Co-Chair, Planning and Development Committee
Representative Jason Rojas, Co-Chair, Planning and Development Committee

From: Bruce Baxter, President

RE: Raised Bill # 5580- AAC The Pesticide Advisory Council, The recommendations of the
Emergency Medical Services Primary Service Area Task Force and the Elimination of a
Municipal Mandate.

Senator Osten, Representative Rojas, Vice Chairs, Ranking Members, Committee Members, My name is Bruce Baxter. I am the CEO of New Britain Emergency Medical Services, a 501C3 Non Stock, not for profit EMS Corporation based in New Britain, CT. We are the CT Department of Public Health- Office of Emergency Medical Services designated 9-1-1 EMS Primary Service Area Responder (PSAR) for City of New Britain. New Britain EMS is the designated PSAR for EMS First Response, Basic Ambulance Transport as well as providing Paramedic Advanced Life Support for the city.

I also serve as the President of the Connecticut EMS Chiefs Association. The Connecticut EMS Chiefs Association represents the Chief Executive Officers of those ambulance services operating in the State of Connecticut whose sole and primary mission is the response, care and medical transportation of individuals experiencing an acute, out of hospital medical or traumatic emergency. Eligible members of our Association are directly responsible for more than 70% of the 350,000 9-1-1 EMS response managed in the State each year.

My career in EMS spans more than forty years. During the span of my career I have served as a clinical provider (EMT and Paramedic) educator, manager, senior executive and consultant in rural, suburban and urban environments.

Most recently I had the privilege of serving as a member of the EMS PSAR Task Force representing the interests of the non -profit EMS corporations.

I am pleased offer the following testimony regarding the PSAR portion of Raised Bill # 5580.

- 1. The Connecticut EMS Chiefs Associations urges the Planning and Development Committee to join with the Public Health Committee to unanimously endorse PSAR Task Force Recommendations # 1-4 as included in your Raised Bill # 5580**

PSAR Task Force Recommendations #1-4 provide municipalities and other key stakeholder with immediate relief and resolution to the significant challenges and issues associated with the current EMS statutes, rules and regulations associated with PSAR designation.

- Gives municipalities and key stakeholders immediate and on going input into the design, operations and evaluation of their community based EMS system and its designated PSAR provider agencies through the development of a Local EMS Plan Document.
- Provides Municipalities and PSAR providers with a minimum template of performance standards and expectations that must be included and agreed upon in the Local EMS Plan.

The Local EMS Plan Draft Template is not designed to be a “cookie cutter” document with the incumbent PSAR Provider(s) entering the attributes of the current system.

It is designed to be a dynamic process similar to strategic planning where all stakeholders involved in a municipal EMS system discuss the needs of the community, define the structure and performance expectations of the system. Those expectations must be monitored and variances analyzed with corrective action plans and monitoring implemented for negative variance reports. This is an on going process used to identify improvement opportunities and resolve deficits early on in the process.

- The Connecticut Department of Public Health –Office of Emergency Medical Services would intervene in the planning or periodic monitoring process at the request of either the Municipality or PSAR Provider to resolve impasses associated with a provider failing to agree to performance standards and expectations or render opinions regarding
- Sunsets PSAR Provider(s) designation every five (5) years. Renewal is subject to a review of the PSAR Provider(s) performance by the CT Department of Public Health Office of Emergency Medical Services against established performance criteria included in the Local EMS Plan; input from the PSAR Provider’s Sponsor Hospital and Medical Director regarding the quality of care provided to patients in the municipality; and input from the municipality. PSARs will be scored using a “Fails to meet standard- Meets standard- Exceed Standard” approach. Designated PSARs who fail to meet standard may be given a short window of time to resolve the deficits or may be removed as the PSAR at the discretion of the commissioner using the appropriate removal procedures.

- Gives municipalities a defined and as appropriate expedited process to follow to report and resolve disagreements, unresolved deficits, or non performance related issues with their designated PSAR up to an inclusive of removal for non performance or consistent under performance.
- Provides The Connecticut Department of Public Health with definitions of an "Emergency" and "Unsatisfactory Performance" criteria as well as performance standards to guide the Department's receipt, response and resolution to Municipal complaints with a designated PSAR Provider.
- Assures the involvement of a municipality if or when a designated PSAR elected to transition 50% or more of the ownership or control of its organization to another entity.

We believe this represents a significant first step and enhancement to our current PSAR designation processes that will lead to improved patient care throughout the State. It is a viable and realistic solution to all of the issues brought forth over the past two years by a wide array of stakeholders who are frustrated with the inability to make significant and sustained improvements to their EMS system secondary to designated PSAR provider under performance.

2. The Connecticut EMS Chiefs Associations is adamantly opposed to PSAR Task Force Recommendation # 5 in its current format.

In order to understand our position on Recommendation # 5, it is important to provide a historical perspective of the PSAR designation process and the role it plays with the current EMS regulatory infrastructure in Connecticut.

➤ *Important Historical Perspective*

In the late 1960s and early 1970s EMS throughout the State was disorganized. There were a wide array of providers ranging from funeral homes, police departments, fire departments as well as a large cadre of community based volunteer ambulance services and commercial for-profit ambulance services. Any one could start and ambulance service.

Charges for services rendered based upon the patient relationship with the vendor, the vendors assessment of their ability to pay a bill. Communities serviced by a volunteer ambulance corps with a single ambulance would often engage in the provision of non emergency transfers of their residents to a hospital for a medical test and be unavailable for the medical emergency. This would result in an outside provider oft times 30 minutes away being called for the response. Likewise, residents often called ambulance services they knew about to care for them when they experienced a medical emergency who would then respond often times from a great distance away.

Based upon numerous complaints from patients, municipal officials, and the medical community, the State studied the provision of ambulance service and determined the population was not being well served.

Competition between municipal, local volunteer and commercial for profit ambulance services was so extreme and competitive- that patients' outcomes were suffering.

The current regulatory structure in place to day was initially implemented circa 1979. The new regulatory approach included:

- Primary Service Areas and Primary Service Area Responder Designation:

Designating a specific provider to manage 9-1-1 responses for a specific Primary Service Area or geographic area of the State in order to assure timely dedicated response to emergency calls. Each municipality was to designate a First Responder (R1); Basic Ambulance Transport Responder (R2) and a Paramedic Responder (R3) or each political sub-division within its geographical boundaries.

Primary Service Area responders are required to respond to every 9-1-1 response within their defined geographical coverage area unless until they have no additional resources to deploy.

Supplemental Primary Area Responder Designation is not held to the same response standard and may be dispatched selectively to specific categories of EMS calls and may opt out of the local EMS system response system on other emergency service demand.

- Defining Ambulance Services Scope of Practice by Restricting the Authority to Bill:

Limiting the scope of billing of non-profit and municipal based ambulance services to the provision of and billing for 9-1-1 services with in a designated Primary Service Area or when providing 9-1-1 mutual aid. This was implemented to assure that the then small single ambulance municipal and community-based services would be available for 9-1-1 calls in their jurisdictions.

Allowing for profit ambulance services to engage in both emergency response with in one or more designated primary service areas as well as being allowed to provide and bill for non emergency medical transportation services. This kept the for profit providers from agreeing to respond to calls outside of their designated jurisdictions and rewarded them with increased revenues from a limited and restricted competitive non-emergency transportation market.

The under lying intent was to assure the larger for profit services would have adequate revenues to provide a 9-1-1 response safety net to back up local community services when confronted with multiple calls, as well as assist with large scale incidents.

- Certificate of Need Process:

As with all other aspects of the CT healthcare environment, control of the number of facilities/providers and the control of capitol improvements is directly related to assuring the control of cost to the consumer and assuring the market does not become over saturated competing providers- eroding the fiscal stability of any individual service or the Statewide system and/or escalating costs to the end user.

As such, in order for a new service to conduct business in Connecticut or for an existing service to open additional stations or add vehicles- they are required to factually demonstrate need by seeking authorization through the certificate of need process. There is an application that is filed with the State. The application is reviewed by the State for completeness. Once complete, providers in the region meet with the applicant and to determine their support for the application. If the region supports the application, the State convenes a hearing where the applicant presents their case to a hearing officer and is questioned by interveners. A determination is made based on the presentation and facts included in the application.

- Clinical Authorization to Practice

EMS services provide different level of clinical practice based upon the minimum level of provider licensure or certification that will staff a PSAR provider's ambulances twenty-four hours a day, seven days per week. Those levels include:

- Medical Response Technician (60 hours of training)
- AED
- Emergency Medical Technician (
- Epi-Pen
- Advanced Life Support- Mobile Intensive Care (Advanced EMT)
- Advanced Life Support- Mobile Intensive Care Paramedic

Similar to the CON process, services wishing to upgrade their level of clinical practice must file an application. Demonstrate they have the need and capability to provide the clinical level of service they desire to upgrade. That plan is filed with the State. Once reviewed a hearing is held by the appropriate regional committee. If the application is approved by the regional entity, the State issues authorization to practice at the requested clinical level.

- Rate Setting:

OEMS establishes the maximum retail rates an ambulance service may charge for each approved level of service provided. Each services rates are established in accordance with a defined annual audit process conducted by DPH that examined each services costs that would take into account the health insurance payer and allow for a 2% operating margin for municipal and non profit sector services and with for-profit (licensed) sector services being allowed a 7% operating margin.

As an alternative services may accept the standard inflation rate DPH provides to increase rates on a year to year basis as opposed to going through the detailed audit process. If a service is looking for a larger rate increase than the COLA increase, they must complete the audit process.

This was designed to protect patients from price gouging and unscrupulous business practices.

- Net Historical Effect of Current Regulatory Process:

The aforementioned foundation pillars of the EMS regulatory process have served the State and its residents well for more than 40 years. The State has reason to be proud.

- Our average retail patient charge for EMS services rendered is 150%- less than the retail charges in Massachusetts; and up to 300% less than the average retail for EMS services rendered elsewhere in the country.
- The vast majority of the State has access to primary response Advanced Life Support –Mobile Intensive Care Paramedic Services through a variety of tiered and full service deployment strategies.
- The approach to restricting non-emergency transportation services to for profit providers has been successful in creating a safety net to assure sudden surges in demand at a local, regional, statewide level assures the availability of a mutual aid response when local 9-1-1 assets are taxed.
- In a number of areas in Connecticut EMS has voluntarily evolved into regional systems with significant cost savings. Large areas of the state are covered by two tier EMS response where the community based ambulance responds to calls. In certain circumstances a regional paramedic provider service is simultaneously dispatched with the community based provider. In some circumstances the regional paramedic unit responds in a transport ambulance providing an immediate back up transport solution is the community-based provider is unable to obtain a full crew to respond with their ambulance.

The for-profit licensed ambulance providers not only provide regional paramedic services but also provide primary back up mutual aid ambulance services to the municipalities usually at no cost- other than the ability to charge patients if transportation is needed. They also have the capacity to manage large -scale incident surge capacity, again at no cost to the community and where no transport may ultimately be provided. Two recent examples

- The response to the Newtown incident saw 20% of the ambulance on scene come from the for profit providers. While only a few patients were transported, they remained on scene at considerable expense without cost.
- High School graduation in New Britain in June 2012 resulted in New Britain EMS managing 120+ patients with heat exhaustion. 15 ambulances in addition to the entire New Britain EMS fleet were on scene. Fortunately only several patients required transport. There was no cost to the municipality for the deployment of the resources.

These are but a few examples of how the structure developed nearly four decades ago continues to work today. The restricted non-emergency market assures ready capacity to support the community based providers at little or no cost

➤ **Rationale for Opposing Recommendation # 5:**

As you know, Recommendation # 5 is the Alternate Provision of PSA Responsibilities which gives municipalities the authority to petition the Commissioner of Public Health requesting a hearing to seek the approval of a new Local EMS Plan with an alternate (new) primary service area responder that will provide the community with the same or enhanced levels of service that provide greater value to the municipality.

There is significant controversy amongst members of the PSAR Task Force as well as stakeholders statewide regarding Recommendation # 5. It is noteworthy Recommendation # 5's inclusion in the report was based on a one (1)-vote margin of success with a majority and minority report included.

We fully appreciate the concepts of open market competition and understand the perceived benefit from a local municipality's perspective. From an EMS the State and Legislature needs to be concerned with the impact regulatory change will have on the entire Statewide EMS system. Just because a change is perceived as being beneficial to a community does not mean it is beneficial for the State as a whole.

We do not believe that Recommendation # 5 has been thoroughly vetted to identify the associated impact of its implementation on the entire statewide EMS system as well as its individual providers. As such we believe including this recommendation in the bill is premature. We do believe there is enough value to warrant the Department of Public

Health to study its impact on the overall EMS system, convene a meeting with stakeholders to discuss the study and its findings and then with consensus from those stakeholders provide a report to those committees with cognizance or interest for future legislative action and implementation.

Our concerns with Recommendation # 5 include:

➤ *Is the immediate need for Recommendation # 5 real or perceived:*

Based upon all the testimony, we are concerned that Recommendation # 5 is being implemented to resolve issues of significant magnitude brought forward by the Municipalities that the Department of Public Health failed to manage appropriately secondary to the lack of best practice internal policies and procedures.

If implemented, we believe that Recommendations 1-4 provide the municipalities with the necessary relief and support necessary to hold Designated PSAR Providers as well as the Department of Public Health accountable for meeting the defined performance standards and expectations.

Recommendations 1-4 will not be met with enthusiasm by a number of current designated EMS PSAR Providers.

Recommendation # 5 is a dramatic shift from a controlled market/restricted competitive market to an open market. The definitions included in Recommendation 5 are vague and subjective. Additionally regardless of the provider, that great a change in the regulatory environment has an economic impact on all organizations capitalization and depreciation schedules. There needs to be time to better assess the entire impact of this recommendation on the overall Statewide EMS system.

➤ *Current Regulations prohibit Non Profit and Municipal Providers from successfully competing on basis of cost*

Current regulations prevent certified (non profit or municipal) providers from billing for the provision of non-emergency medical transportation services as allowed by Licensed (largely for profit providers).

The inclusion of recommendation # 5 disenfranchises every one of the ninety + non profit ambulance services in the State of Connecticut putting them at a competitive financial disadvantage with their for profit colleagues as that class of EMS provider is prohibited by the State from billing or competition in the non emergency medical transportation market.

The provision of 9-1-1 Emergency Medical Services operates at best, at a break even and more often at a loss. This is particularly true in urban areas as well as pocketed suburban and rural areas where the 9-1-1 providers manage a disproportionate share of Medicare, Medicaid, under insured or uninsured patients; cover large geographic areas requiring the deployment of ambulances at various locations in order to maintain clinically meaningful response times; lack the requisite transport volume or patient acuity to fully fund the system by fee for service revenues; or a combination of all. As cited above, current State statutes, rules and regulations prohibit non profit ambulance services from offsetting a portion if not all of these losses through the provision of non emergency medical transportation services currently afforded to the for profit ambulance industry.

Current regulation allows a non-profit provider to go through the Certificate of Need Process to become a licensed provider. That rigor is time consuming and costly. In the past eighteen years provider who have attempted the process have not prevailed at the hearing officer indicated the need to offset 9-1-1 losses and reduce municipal support was not adequate justification. In other states, there is a single classification of ambulance services allowing them to bill for both emergency and non-emergency medical transportation.

This negative consequence could be remedied by legislative action amending current EMS regulations to recognize one universal type of ambulance provider that is capable of providing and billing for 9-1-1 services in their designated PSAs as well as engaging in and billing for non emergency medical transportation. Should a community elect to choose a new provider other than the currently designated non-profit provider, the non-profit would have an opportunity to continue its business and provide services.

However the introduction of additional services to the non-emergency market may dilute revenues to the point there is a decrease in the surge capacity safety net that negatively impacts patients.

➤ *Impact of putting local needs ahead of Regional and Statewide system needs:*

Permitting a municipality to petition for the removal of an incumbent provider without cause risks the creation of single EMS community based silos of excellence with the duplication of overhead, increased EMS systems costs as opposed to decreasing costs. It has the potential to negatively influence the financial stability of the State's regional and statewide EMS surge capacity threshold by reducing dual service assets available to cover multiple communities with essential primary mutual aid ambulance coverage, manage critical care transports and the routine transportation of patients between various healthcare facilities.

The sudden decision by one or two communities to petition for a change in provider with a plan to integrate EMS into an existing town department as opposed to the current provider risks regional response systems. The sudden withdrawal of a community from an established program could financially jeopardize the programs viability for the remaining communities negatively impacting patients.

➤ *The Impact on Regionalization:*

Advocates of Recommendation # 5 suggest that it will lead to greater regionalization, as municipalities will be able to consolidate EMS services and reduce costs to the taxpayer.

The prevalence of geographic boundaries, home town rule and perceptual politics of one party in a regional system gaining greater benefit from the regionalized approach than another is pervasive throughout New England culture inclusive of Connecticut.

Municipalities throughout the Northeast inclusive of Connecticut have struggled with breaking down geographical borders and regionalizing school districts, police, fire public works and 9-1-1 PSAPs where there is the real potential to obtain significant cost savings.

Absent of the State of Maine which has had success in fiscally incentivizing regional school districts and 9-1-1 PSAPs to consolidate, New England States inclusive of Connecticut have had greater success in voluntary consolidation and regionalization efforts that over the years has reduced the cost of service delivery to patients, enhanced the clinical level of service delivery to patients and provided an essential mutual aid- surge capacity 9-1-1 response network to support community based providers and their individual community periods of peak demand.

➤ *Impact Study of Recommendation # 5 on Statewide EMS System:*

The understandable perception of municipalities included in Recommendation # 5 has a purely local basis. It does not take in to account that the State EMS system is designed to address the overall needs of the state. The removal or change of a provider or the introduction of additional providers in certain markets needs to be studied well in advance of this recommendation being implemented as a Statute

Finally before closing, it is important to put into perspective some of the inaccurate and negative remarks (written and verbal) made by various passionate constituents and stakeholders regarding the EMS System in Connecticut.

Some advocates of Recommendation # 5 have had a bad experience with their provider. They would like you to believe our current system and regulatory environment is broken and in need of immediate remedy.

EMS in the State of Connecticut is not broken. In fact you should have pride in what we currently have as compared to other states. **It is not perfect and never will be. As with any other healthcare discipline, the system require and benefits from the process of continuous factual data driven efforts to review and improve all aspects of the system.**

Additionally, those indicating the system is broken, have no understanding of its regulatory genesis as the vision and wisdom that went into its creation. I have included an attachment for your review that may be help in your understanding the benefit of that environment to the State as a whole. I urge you to review it before making a decision.

The majority of EMS centric, non-profit EMS servicers in the State of Connecticut are community based organizations whose sole focus is the provision of consistent, high quality, cost efficient, timely care and services to the residents of the communities which our members are privileged to serve. The members of those services take that privilege and the associated responsibility seriously. They are community based. They do not walk away leaving the tasks of "cleaning up residual problems" to municipal based employees, services or leadership as some stakeholders have alluded. The community our members serve is **their community too.** Ownership of a community and its population and associated health care challenges is not exclusive to municipal government and its employees; it is shared by and with your designated PSAR provider, many of whom have made significant investment to improve and enhance services over time.

A number of our member agencies are considered and recognized as industry pacesetters. They have lead the way, in collaboration with their Sponsor Hospitals and Medical Directors in developing new protocols, new techniques, best practices, bringing innovative life-saving technologies and procedures to the forefront of EMS in the State which has benefited countless numbers of patients. Their primary focus has been, is and will always be doing what is in the best interests of the health and well being of the residents and patients they are privileged to serve.

It is important to remind ourselves that ALL Sectors of business and industry, government based, publically traded, private for profit, privates non profit are challenged when a small minority of organizations fail to consistently achieve the requisite levels of excellence desired by its consumer base. It is essential that we do not lump the majority in with the minority.

On behalf of the Connecticut EMS Chiefs Association, I would urge you to revise Raised Bill 5580 redacting Recommendation # 5 pending further study of its impact on the overall State EMS System and move forward with legislation implementing PSAR Task Force Recommendations 1-4. This is a reasonable, measured and responsible first step to enhancing the state wide EMS system.