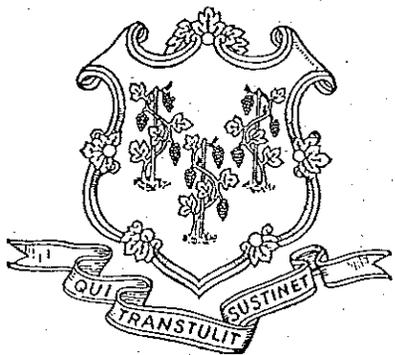


# **REGULATION OF EMERGENCY MEDICAL SERVICES: PHASE 1**

Connecticut

General Assembly



LEGISLATIVE  
PROGRAM REVIEW  
AND  
INVESTIGATIONS  
COMMITTEE

**May 1999**

**CONNECTICUT GENERAL ASSEMBLY  
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE**

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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LEGISLATIVE PROGRAM REVIEW  
& INVESTIGATIONS COMMITTEE

**REGULATION  
OF  
EMERGENCY MEDICAL SERVICES**

**Phase I**

MAY 1999



## KEYPOINTS

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### EMERGENCY MEDICAL SERVICES

#### *Background*

- Key legislation establishing regulation of emergency medical services (EMS) in Connecticut was enacted in 1967, 1974, and 1980.
- Ambulance services must be certified or licensed to operate. Commercial services are licensed and nonprofit providers are certified. There are currently 167 certified and 17 commercial providers. About 107 of these ambulance services charge for their services.
- Connecticut's regulation of EMS is comprehensive and involves territorial assignment of providers (into primary service areas), rate setting, and determination of need.
- Ambulance services that charge must have approval from DPH to offer new or expanded services. The purchase of an existing ambulance provider in its entirety is exempt from the DPH determination of need requirements.
- Primary services areas (PSAs) were first designated in 1974 as a result of legislative action. For each town, DPH designates PSA responders at three levels – first responder, basic life support (BLS), and advanced life support (ALS).
- There are currently 181 designated first responders, and 183 BLS and 107 ALS responders.
- DPH sets maximum allowable statewide rates that each provider *may charge* for different levels of ambulance service.
- Government and private third party payers establish rates for what they *will pay* for ambulance transport service.
- Medicare recipients comprise the largest portion -- 55 percent -- of both emergency and non-emergency ambulance call volume; Medicaid makes up 12 percent.
- The top six commercial providers handle between 75 and 80 percent of all ambulance calls in Connecticut. The filed rates by these commercial providers have all exceeded the provider statewide average rate since 1994.

#### *Findings and Recommendations*

- Committee recommendations maintain the current system, but suggest policy enhancements to improve the ability of both local and state government to perform oversight functions.

- Reasons for the scope of recommendations include:
  - need for enhanced accountability;
  - unclear need for wholesale change;
  - recent significant changes just implemented or proposed; and
  - complexity of the current system.
  
- Recommendation areas include:
  - local EMS plans need to be established;
  - mechanism to resolve EMS provider and municipal differences over performance agreement is required;
  - model guidelines for local EMS plans and agreements need to be developed;
  - municipalities' ability to remove EMS providers for poor performance needs to be improved;
  - annual report on local EMS plans is necessary to track performance;
  - response time measurement is imprecise, and requires common definition;
  - sales of existing ambulance companies holding PSAs should include adoption of existing performance agreements; and
  - outcome measures need to be developed to assess EMS system.
  
- Further refinements to the system will be explored in Phase II of the EMS study.
  
- The committee took no action on alternative approaches that would alter the fundamental regulatory structure.

*The chart that follows summarizes the proposed changes to the EMS system. It provides an overview comparing the current regulatory structure to the proposed changes for each of the main participants in the system.*

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## Proposed Changes Regarding Accountability in the EMS System

<i>Current Regulation</i>	<i>Proposed Change</i>
<b><i>Department of Public Health</i></b>	
Planning for EMS is disconnected with municipalities	Municipalities become a <b>planning partner</b> with the state
May inspect response time records	<b>Required</b> to receive and publish uniform information on response times
Has minimal performance standards in regulation	Will provide guidance documents on performance agreements and oversee system of locally determined performance standards
In most cases, the <b>only entity</b> providing oversight of providers that could lead to corrective action or negative consequences	<b>Municipalities</b> have greater role in providing oversight and in developing corrective action plans
May remove a provider if it determines that it is <b>in the best interest of patient care to do so</b>	This standard is <b>maintained</b>
Extent of subcontracting by PSA holders is unknown	Subcontracting and mutual aid agreements must be disclosed in EMS plan and agreements
<b><i>Municipalities</i></b>	
Participate in initial sign-off for indefinite PSA assignment – <b>no reconsideration of PSA</b>	<b>PSA assignment can be reconsidered every three years</b> if previously agreed to performance standards are not met
Have <b>attenuated role</b> in EMS planning	Have a <b>direct and active role</b> in determining the level and quality of service provided in own community
May contract for services	<b>Must</b> have an enforceable agreement with providers
May develop performance standards. Municipalities that have developed standards, in most cases, only have standards for basic ambulance service	<b>Must</b> develop performance standards based on local conditions and resources for the continuum of EMS providers from dispatch to advanced life support
May monitor performance standards	<b>Must</b> monitor the performance of providers
Residents may receive information on the performance of their municipality's EMS provider	<b>Must</b> report publicly on the performance of providers on at least an annual basis and will be publicized by DPH
May petition DPH for removal if an <b>emergency exists and if the actions of the PSA holder jeopardize the safety, health, and welfare of the citizens</b>	May petition DPH for removal of a PSA responder based on <b>poor performance</b> as defined by the municipality as well as existing standard
No assurances about provider performance, if the current provider changes ownership	New owner <b>must abide</b> by existing performance contracts
<b><i>Providers</i></b>	
May enter into an agreement with municipality	<b>Required</b> to enter into an agreement with municipality
May be subject to performance standards	<b>Required</b> to adhere to locally determined performance standards



# Executive Summary

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## Regulation of Emergency Medical Services

The regulation of emergency medical services at the state level is the responsibility of the Department of Public Health. The regulation includes both economic and quality assurance elements. Services are delivered within a multitude of organizational structures – commercial, nonprofit, and volunteer, and in some cases combinations of those – depending on location and, sometimes, time of day.

Key legislation establishing the regulation of emergency medical services (EMS) in Connecticut was enacted in 1967, 1974, and 1980. The 1967 state legislative initiatives resulted from national attention to emergency medical issues and system deficiencies. The business regulation tools under review in this study -- the designation of primary service areas (PSAs) for emergency medical services, setting rates for those services, and the determination of need requirement for new or expanded services -- originated in 1974 and 1980.

Earlier this year, newspaper accounts reported situations where ambulances took too long to respond to calls, or did not come at all. Also, issues concerning the reimbursement for ambulance transport services were raised. Thus, the program review committee called for a study of the regulation of emergency medical services.

The program review committee authorized a scope of study on March 9, 1999. The focus of examination targeted the three cornerstones of business regulation of emergency medical services:

- assignment of exclusive service areas for emergency ambulance providers – called primary service areas;
- setting of maximum rates that providers are allowed to charge; and
- determination of need for licensing and certification.

At the same time, the scope called for an identification of areas and proposed changes that could be acted upon this legislative session. The recommendations listed below maintain the current regulatory system but propose policy enhancements to improve the ability of both local and state government to perform oversight functions of emergency medical services.

The committee concluded there was no groundswell of discontent with the current system, although there are pockets of problems. Many participants expressed support for the present structure, although acknowledging need for improvements. The committee found there is need for some corrections in the system, but concluded more radical alternative proposals would be more disruptive than remedial to a system in place for more than 20 years.

The committee also found that efforts are currently underway to improve the system. For example, a statewide emergency medical services plan was finally adopted in 1997, which the Department of Public Health began implementing in 1998. Regional EMS councils and

coordinators have begun conducting inventories of services in their areas, and various work groups are several months into updating EMS regulations.

Given the limited time frame and the complexities of the EMS system, the recommendations focus on the designation of PSAs, with an examination of rate-setting and determination of need for services, along with other system refinements, to continue into a second phase of the study over the next few months.

The recommendations would improve the current system by:

- requiring performance standards to be developed in local EMS plans and in written agreements with providers;
- adopting a more realistic approach for a town to remove a PSA holder if the provider is performing poorly;
- building an accountability loop that includes:
  - providers;
  - towns;
  - state Department of Public Health; and
- establishing a common basis to compare performance and begin evaluation of the system.

At its May 6, 1999, meeting, the program review committee approved eight recommendations, including a policy option, and authorized a Phase II of the study to continue an examination of several aspects of the system. The approved recommendations are listed below.

## **Recommendations**

### **1. Local Emergency Medical Service Plans**

The local legislative body of each town shall establish a local Emergency Medical Services (EMS) plan that would include, but not be limited to:

- identification of who will carry out each level of service – dispatch; first response; basic life support (ambulance transport) and advanced life support (paramedic);
- establishment of performance measures for each segment of the system;
- establishment of a monitoring system that will identify who will receive information necessary for monitoring, who will provide the information, how frequently the information will be monitored, and what will require corrective action on the part of any service providers, including provisions for progressive sanctions; and
- any written agreements or contracts developed between the town and its providers (including any subcontracts, written agreements, and/or mutual aid agreements providers may have with other entities to provide service).

All plans shall be filed with the Department of Public Health by January 1, 2000, and be updated and refiled with DPH every three years. Towns are encouraged to consult their Regional EMS Council, their regional coordinator for EMS, the regional EMS medical advisory committees and the sponsor hospital(s) in their area for assistance in development of the plan, and shall submit the plans to their Regional EMS Council for review and comment. DPH may reject a plan if the department deems it in the best interest of patient care to do so.

## **2. Mechanism to Resolve Differences Between Primary Service Area Responder and Municipality About Performance Agreement Terms**

The Department of Public Health shall monitor receipt of written agreements or contracts that must be submitted with a local EMS plan. If no written agreements are submitted by January 1, 2000, DPH shall notify the town and the PSA responder no later than March 1, 2000, that a hearing will be held within 60 days of the notice, if agreements are not submitted by that date. DPH could prioritize the holding of hearings based on its categories of urban, suburban, and rural, with areas of greatest population scheduled first.

The hearing would be held to determine if the standards adopted in a local EMS plan were *reasonable* based on criteria that DPH uses including the state EMS plan, model guidelines developed, and standards, contracts and written agreements in use by towns of similar population and characteristics.

If the standards were determined reasonable by DPH, the PSA responder would have 30 days to sign the agreement or lose the PSA. If DPH found the standards were unreasonable it would establish standards considered reasonable given the criteria used above. If a town refused to agree to the standards established by DPH, the PSA holder would have to meet the minimum state regulatory standards in place.

## **3. Model Guidelines for Local EMS Plans and Agreements**

The Office of Emergency Medical Services shall, with the advice and assistance of the EMS Advisory Board and Regional Councils, develop model local EMS plans and performance agreements, recognizing the differences in the delivery of EMS services in urban, suburban, and rural settings, to guide municipalities in the development of these documents.

### **4A. Municipality-Initiated Process to Remove PSA Responder for Poor Performance**

Grant municipalities the ability to petition DPH every three years for the removal of a basic life support or advanced life support PSA responder based on unsatisfactory performance of that responder as outlined in the local EMS plan and associated agreements.

### **4B. Policy Option: Pilot study**

*A pilot study shall be considered to assess the effect of PSA holder selection based on the periodic issuance of a RFP with right of first refusal for the current PSA holder. The pilot would involve three to six towns in urban, rural, and suburban contexts that contract with commercial providers.*

*Phase II of the current program review study would identify the details for implementing the pilot program including: feasibility of such a pilot project, its design and measurement, identification of elements to be assessed, time frame, selection of pilot municipalities, impact on service delivery and market, and who would conduct the evaluation of the pilot.*

#### **5. Annual Performance Report On Local EMS Plans**

Each town will be required to annually report by March 31, on a form furnished by the Department of Public Health, on the implementation of its plan for the previous calendar year, including:

- total number of EMS calls;
- number of calls requiring each level of service;
- number of refused calls and number of calls requiring mutual aid response;
- name of service provider for each level of service;
- using the common definitions of response times established by the Department of Public Health fractile response times for each levels of the EMS system – dispatch; first response; basic life support, and advanced life support; and
- the monitoring and compliance of the providers with locally developed performance standards, and if non-compliance has been identified what steps the town has taken, or will take, to enforce provisions of the contract.

The Department of Public Health shall compile the information – grouping towns according to urban, suburban and rural categories-- and make the information available to the public in a report card format by July 1 of each year. The department shall make the report card available on its web site, and shall submit a copy to the Public Health Committee of the General Assembly.

#### **6. Establish Common Definition for Response Time Measurement**

DPH shall establish and reinforce a common definition for response time to include the time a call is received by a Public Safety Answering Point to the time each dispatched responder (i.e., first responder, supplemental responder, BLS, ALS) arrives on scene and every significant point in between for reporting purposes.

#### **7. Purchases of Ambulance Companies Require Acceptance of Existing Performance Agreements**

An express condition of the purchase of a business holding a PSA, subject to the determination of need exemption, is that the purchaser must abide by the performance standards to which the purchased business was obligated pursuant to its agreement with the municipality.

#### **8. Outcome Measure Development to Assess EMS System**

DPH shall research and develop appropriate outcome measures for the emergency medical services system and shall submit to the Public Health Committee of the General Assembly, by January 1, 2001, and annually thereafter, a report on the progress toward development of such measures. After outcome measures are implemented, DPH shall include in its annual report an analysis of system outcomes.



# Introduction

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The regulation of emergency medical services (EMS) in Connecticut at the state level is the responsibility of the Department of Public Health (DPH). The regulation includes both economic and quality assurance elements. Services are delivered within a multitude of organizational structures -- commercial, nonprofit, and volunteer, and in some cases combinations of those -- depending on location and, sometimes, time of day.

Earlier this year, newspaper accounts reported situations where ambulances took too long to respond to calls, or did not come at all. Also, issues concerning the reimbursement for ambulance transport services were raised. Thus, the program review committee called for a study of the regulation of emergency medical services, and approved a scope of study on March 9, 1999.

The scope's focus targeted the three cornerstones of business regulation of emergency medical services:

- assignment of exclusive service areas for ambulance providers -- called primary service areas (PSAs);
- setting of maximum rates that providers are allowed to charge; and
- determination of need for licensing and certification.

While the scope outlined a broad review, the committee also expressed an interest in determining if any areas for legislative change could be identified and acted upon during this legislative session. This report lays out what the committee believes are findings and recommendations the legislature could consider during the 1999 session. The findings and proposals for change focus essentially on the designated primary service areas. While there is descriptive information on the regulatory components of rate-setting and determination of need in the report, the committee does not believe it has the information nor has it had sufficient time to fully analyze the potential impact of any changes in these areas. The committee intends to continue examining these two areas in Phase II of the study.

Recognizing the provision of ambulance transportation is fundamentally a local service, the recommendations are aimed at requiring performance contracts using standards developed at the local level. The proposals would improve accountability at all levels -- provider, town, and state -- of the system. In addition, the recommendations establish a realistic, useable process for changing a PSA holder when there is poor provider performance of a locally agreed-upon contract.

## Methods

Information for this report was obtained through a variety of sources.

- *Department of Public Health.* Committee staff interviewed Department of Public Health personnel, including both EMS systems development staff as well as staff in the regulatory area who handle complaints, oversee the setting of rates, and designate

the primary service areas for EMS services. Committee staff also met with the DPH adjudication staff who serves as a hearing officer, and issues decisions regarding "need" for new or expanded ambulance services. Staff examined many documents provided by DPH including: the state EMS plan (1997) and recent supplements; PSA assignment lists; rate summary sheets from 1994 through 1999; and 1999 rate application filings for the five largest commercial and five largest nonprofit ambulance providers. Staff also examined decisions in 10 certificate of need cases and two rate cases, along with hearing transcripts from the rate cases. Also reviewed were complaint data, including number filed and the outcomes since 1996.

- *Other state agencies.* Committee staff met with personnel in the state Department of Public Safety's Office of Statewide Emergency Telecommunications, and spoke with and/or reviewed materials from staff in the insurance, social services, and transportation departments, as well as the Office of the Attorney General.
- *Municipalities.* Staff contacted towns in the state with populations of 50,000 or more to determine what type of agreements those towns had with ambulance transport providers. Staff collected and reviewed those contracts or other written agreements used in those towns, and the results are presented in Appendix A. In collecting those contracts, staff discussed the provision of services with local officials, chiefs, and other personnel from local fire and police departments, health directors, and corporation counsel staff. In addition, staff met with representatives of the Connecticut Conference of Municipalities. Staff also observed a regional communications center that handles dispatch for 20 towns in the Southcentral part of the state, and a public safety answering point that dispatches for a large city.
- *Service providers.* Committee staff met with members of the Connecticut Ambulance Association, which represents a number of commercial providers in the state. Staff also interviewed two nonprofit service providers, and met with volunteer ambulance providers through their state EMS Advisory Board and Regional Council representatives. Staff observed a commercial provider's communication and dispatch operation, and accompanied ambulance personnel on three separate "ride-along" observations, two in Hartford, and one in Waterbury.
- *EMS representative groups.* Committee staff met with the state EMS Advisory Board, representatives of the EMS Regional Councils and Regional EMS coordinators, and the EMS Medical Advisory Council, and attended a one-day seminar attended by many EMS providers, towns, and hospital staff.
- *Other.* Staff also reviewed newspaper articles in the Hartford Courant, the 1972 Yale Trauma Study, and other historical reports, as well as legislative hearing transcripts and floor debates. Documents and reports from the American Ambulance Association, National Association of State EMS Directors, and the American Society for Testing and Materials were also reviewed. In addition, staff has contacted many states by phone regarding how EMS is regulated, and anticipates completion of that during Phase II.

## **Report Organization**

This report contains five chapters. Chapter One provides historical background and describes the process for the regulatory components currently in place. Brief descriptions of the current landscape in terms of licensed and certified providers, existing PSA holders, and current rates and trends are also presented within each regulatory component. Chapter Two presents the rationale for the committee's proposals, which essentially offer refinements to the current system. Chapter Three contains the findings and recommendations followed by a rationale for each recommendation. Chapter Four outlines what the committee intends to examine in the second phase of the study. Chapter Five presents alternative models for EMS regulation, which would require additional study to assess the impact of implementing any of the systems in Connecticut. The committee did not approve further inquiry by staff into these alternative models.



## History and Description of Regulatory Components

The regulation of emergency medical services by Connecticut state government is closing in on its first 25 years. As one would expect, the extent and character of the regulation has changed during that time period, although many core regulatory requirements have been in place since the beginning, with varying degrees of implementation. To provide context for the current issues prompting this study, this chapter discusses both the historical origins and the present structure of the economic regulatory tools that are the study's primary focus. First, certain key legislative events pertinent to Connecticut's emergency medical services are highlighted. Then, the regulatory tools as they are currently structured are described.

### HISTORICAL BACKGROUND

National attention to emergency medical issues arose in the late 1960s and early 1970s, prompted in large part by rising deaths from motor vehicle accidents. In 1966, a joint report by the National Academy of Sciences and the American Medical Association entitled "Accidental Death and Disability: The Neglected Disease of Modern Society" highlighted national deficiencies in emergency first aid and prehospital care, among other topics. The federal National Highway Safety Act and the Emergency Medical Services Act both provided federal funds for state EMS expenditures.

Three key dates mark the statutory growth of emergency medical services regulation in Connecticut: 1967, 1974, and 1980. The earlier legislative initiatives reflect the national trend. The business regulation tools under review in this study -- the designation of primary service areas (PSAs) for emergency medical services, rate-setting for those services, and the determination of need requirement for new or expanded ambulance service -- originated at different times. Another key regulatory aspect, not directly under review, are the DPH licensing and certification requirements for ambulance services. The statutory history of these provisions is discussed in this section.

**1967 legislation.** Connecticut first began regulating commercial ambulances in 1967, with the establishment of the Ambulance Commission and its responsibilities for licensing commercial ambulance services and personnel, as well as handling complaints. (Nonprofit ambulance services were specifically exempt from commission regulation.) To be licensed, an ambulance provider had to pay a \$100 fee, and provide proof of financial responsibility through insurance coverage. Upon determination by the commission that an applicant was "financially responsible, properly trained and otherwise qualified to operate an ambulance service", a license was issued effective for one year. This enactment was the first recognition in Connecticut that emergency medical transport was a distinct service, as opposed to what traditionally had been a sideline to funeral home and transport businesses.

By the same act, the legislature also required the public utilities commission to set rate schedules and address rate complaints for ambulance service, in consultation with the Ambulance Commission.

**1974 legislation.** In 1974, the Ambulance Commission was abolished and Connecticut began comprehensively regulating EMS with the passage of Public Act 74-305. The regulatory structure was broadened to cover nonprofit ambulance services in addition to the commercial services. The act split responsibility for EMS oversight between two state agencies – the Department of Health and the Commission on Hospitals and Health Care (CHHC). It authorized CHHC to plan, coordinate, and administer the system, and take over the rate setting function previously at the public utility control agency. The act created an Office of Emergency Medical Services (OEMS) within the health department with the power to license, certify, and inspect specified aspects of the EMS system and to enforce standards.

The act also established a 25-member advisory committee composed of representatives involved in all aspects of EMS to advise and assist the commission in its functions. In addition, a state coordinated regional system for the delivery of EMS throughout the state was established. The act assigned the regions the activities of planning, monitoring and evaluating regional services, and inventorying EMS resources within the region.

Except for a 1975 change transferring CHHC's responsibility to the commissioner of the health department, much of the current statutory structure and authority related to EMS is based on the 1974 legislation.

The 1974 legislation was an outgrowth of a study conducted by the Yale Trauma program with the involvement of participants in the emergency medical services field. The report found, as in the rest of the nation, "no well planned and organized system for emergency care ... existed in Connecticut." The study was to: identify the deficiencies in emergency care in Connecticut; determine the steps necessary to remedy these deficiencies; project the costs of such steps; establish priorities and schedules to achieve the identified goals; and establish a system for program review, evaluation and accountability. The final report was issued in December 1972. For several months afterward, a legislative group worked on drafting legislation to implement the report recommendations, which became P.A. 74-305.

Also in 1974, prompted by a television news story on ambulances entitled "Scandal Rides the Ambulance", a legislative subcommittee launched an investigation into "all aspects of ambulance services." The committee held several days of hearings in the spring of 1974, issuing a report in July 1974. Floor amendments to the comprehensive 1974 legislation discussed above reflected concerns uncovered by the ambulance investigations (e.g., prohibiting gifts to emergency room staff in exchange for ambulance business, and banning the provision of liquor for ambulance patients).

*Primary service areas.* The concept of primary service areas (PSA), or specific geographic areas served exclusively by designated licensed or certified providers to answer emergency calls, originated in the comprehensive 1974 legislation. Under their area-wide planning and coordination responsibilities, the regional councils were, and still are, to plan for

“clearly defined geographic regions to be serviced by each provider including cooperative arrangements with other providers and backup services.” (The Yale study did not specifically call for exclusive designated areas, although it did recommend a regional planning requirement for the coordination and delivery of regional emergency medical care.) Virtually all the specific provisions about PSAs are set out in regulation, originally established in 1975 and amended in 1988.

In a statement of intent prefacing the 1975 regulations, stacking of emergency calls<sup>1</sup>, rotation lists<sup>2</sup>, and lack of accountability were cited as problems to be eliminated by the PSA assignment process. As first conceived, the regional EMS councils were responsible for assigning PSAs, with the approval of the DPH commissioner. In 1988, the regulations were amended to give the PSA assignment authority to OEMS, with the regional councils in the recommendation role.

The designation of exclusive primary service areas was challenged on anti-trust grounds in a 1978 Connecticut superior court case involving the city of East Hartford. Prior to October 1977, three ambulance companies provided emergency ambulance service to East Hartford: Professional, Trinity and Maynard. Most emergency calls came from the police department, which dispatched calls to the three companies on a rotational basis. In July 1977, carrying out the new regulations, the regional council that covered East Hartford designated the Ambulance Service of Manchester (ASM) as the exclusive PSA responder for basic service for the town. The police department began dispatching exclusively to ASM, and Professional Ambulance sued. In upholding the actions against anti-trust claims, the court found that the PSA designation was the “product of specifically directed state action” and was thus exempt from anti-trust restrictions.<sup>3</sup>

In upholding the PSA designation concept generally, the court noted:

... The totality of the mandate set out in the [EMS] statutes furnishes an adequate basis and authority for the promulgation of regulations creating the primary service areas [and] assigning one responder to each such area. . .<sup>4</sup>

**1980 legislation.** In 1980, a determination of need (DON) process in the form of an administrative hearing was established in statute for any ambulance provider that wanted to introduce new or expanded ambulance services. Introduced as a floor amendment to a bill about ambulance rates, the DON process exempted certified providers that did not charge for their services. During House deliberation, one representative noted the amendment “prevents the proliferation of ambulance services in rural areas and in fact will protect some of the smaller

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<sup>1</sup> Emergency call stacking occurred when a company would get more calls for service than it had ambulances available at the time, and instead of passing the overflow to other companies, would keep all the calls for itself, resulting in response time delays.

<sup>2</sup> Rotation lists were used in some areas served by multiple ambulance companies. Typically, municipal police would dispatch emergency calls on a rotational basis, effectively giving turns to the various companies. During the 1974 ambulance investigation, charges were made that some companies would unfairly take calls out of rotation.

<sup>3</sup> Professional Ambulance Service, Inc. v. Richard H. Blackstone, 35 Conn. Sup. 136, 143 (1978)

<sup>4</sup> Ibid.

towns that discharge their [EMS] duties.” Another representative explained that the purpose of the DON review “is to hold down the cost of health care”.

Regulations implementing the determination of need statute became effective in 1983, set out the criteria by which need was to be evaluated, and provided a public participation mechanism. While the determination of need process was not included in the original 1974 legislation, the Yale study raised the issue:

Since there is considerable duplication of ambulance services in Connecticut, it is questionable whether additional ambulance services should be formed without some review of the need and necessity of such services in the area in which the operator intends to serve. The proposed Connecticut Council on Emergency Medical Services should explore the possible applicability of need and necessity requirements to the ambulance field.

## **REGULATORY COMPONENTS**

This section describes the regulatory components of emergency medical services. First, a brief overview of licensing and certification is provided, along with the related determination of need requirement for new or expanded service. All ambulance services must be licensed or certified, whether they provide emergency or non-emergency medical transport services. Likewise, the determination of need requirement applies to both emergency and non-emergency transport providers (for charging providers).

The next regulatory tool described is the primary service area (PSA) designation. As will be explained, PSAs carve out specific geographic territories in which licensed/certified providers are specifically responsible for responding to emergency medical calls. A licensed ambulance company may provide emergency service in a specific town because it holds a PSA, but may also provide non-emergency transport elsewhere. Finally, rate-setting is discussed. Like licensing, rate-setting is applicable to both emergency and non-emergency ambulance service, as long as the provider charges.

### **Licensing and Certification**

All ambulance services must be either licensed (for-profit providers) or certified (nonprofit providers) by the Department of Public Health to operate.<sup>5</sup> The purpose of licensing and certification is to assure consistent standards are met by all who seek to provide the service. Licenses and certificates must be renewed annually.

While the statutory language setting out the requirements for licensure and certification differs somewhat, in reality, the requirements are the same. The main difference is that

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<sup>5</sup> Personnel working for the ambulance service must be individually licensed and certified, and an ambulance service obtains and maintains its provider license in part by ensuring its personnel are appropriately trained and credentialed.

commercial providers pay a \$100 application fee while nonprofit providers do not. Each must show proof of financial stability, including insurance coverage and sufficient cash reserves.

The license or certificate to operate is very specific about the types of services a provider may offer, number and type of vehicles operated by the provider, and where its main and branch offices are located. The license or certificate does not limit the provider to a particular geographic area. Any provider who violates EMS statutes or regulations may have its license suspended or revoked, or be subject to DPH disciplinary action.

Table I-1 shows the number of certified and licensed providers for a six-year period. The certified, or not-for-profit providers, include volunteer, municipal, and hospital-based entities. Almost universally, certified providers provide emergency medical transport services only, primarily within a town or a subsection of a town. They may also provide mutual aid for surrounding towns. The licensed providers are what are commonly known as the commercial ambulance companies. As the table shows, there are many more certified providers than licensed ones, and while the number of certified providers has remained fairly constant, the number of licensed providers has decreased.

<b>Table I-1. Number of Certified and Licensed EMS Providers: 1993-1998</b>		
<i>Year</i>	<i>Certified Providers (not-for-profit)</i>	<i>Licensed Providers (for-profit)</i>
1993	169	26
1994	169	26
1995	169	21
1996	170	20
1997	170	20
1998	167	17*
Source: DPH		
*Of this 17, there are 10 licensed commercial ambulance providers, 3 wheelchair transporters (invalid coaches), and 4 nonprofits that have licenses for historical reasons.		

### **Determination of Need**

The determination of need requirement was added to the statutes in 1980, six years after the comprehensive emergency medical systems legislation was passed in 1974. The DON component is included as part of the licensing and certification process. It essentially provides that, in addition to meeting all the required standards for licensure, a provider seeking either to enter the ambulance market for the first time, or who is already in the market and wants to expand, must prove need, in addition to ability. Because the 1974 licensure requirements predated the 1980 DON legislation, all service providers already licensed did not have to show need for the level of service they offered prior to the DON requirement.

To apply for a license or certificate for new or expanded service, the information an applicant needs to supply includes: business information; the geographic area and population to be served by the proposed service; an analysis of the improvement in cost effectiveness to the provider as a direct result of the proposed service; and an analysis of how the proposed service would integrate with the current emergency medical care system.

What is considered new or expanded service is defined in regulation and includes:

- operating a new emergency medical transport service, non-emergency ambulance transport service, or invalid coach service;
- adding emergency medical vehicles, ambulances, and invalid coaches to operations (not replacements); or
- adding branch office locations.

While not technically defined as new or expanded service, the regulations also require that any certified provider that wants to change from a non-charging service to a charging must go through a determination of need hearing.

*Hearing.* To handle requests for new or expanded emergency medical services in any region, the DPH commissioner consults with OEMS and the regional council and holds a public hearing to determine necessity for the service. A hearing officer typically presides over the hearing process, and prepares a preliminary decision. A final decisionmaker, who can be the commissioner or a designee, reviews the decision and accepts or overturns it.

Written notice of a DON hearing is given to current providers in the geographic region where the new or expanded services would be implemented. According to DPH, the pertinent geographic area is the one in which the applicant indicates it intends to operate. However, there is nothing to prevent the provider, after getting the approval, from going into another area. If an applicant is granted authorization, he or she has a maximum of six months to acquire the necessary resources, equipment and other material.

The factors to be considered by DPH in determining whether there is a need for new or expanded medical service are set out in regulation. They include:

- 1) the population to be served by the proposed service;
- 2) the geographic area to be served by the proposed service;
- 3) the volume of calls for the previous 12 months within such areas;
- 4) the impact of the proposed service on existing services in the area;
- 5) the potential improvement in service in the area including cost effectiveness and response times;
- 6) the location of the proposed principal and branch places of business in relation to health facilities and other providers;
- 7) the need for special services, if applicable; and
- 8) the recommendations of any applicable regional council.

The fourth factor has been the source of some controversy. Providers argued the factor called for a review of the business impact on existing providers from any new potential competition. The Connecticut Supreme Court in 1997 ruled against the providers, on the grounds that the statute upon which the regulation is based requires DPH "to protect the public at large and not the interests of individual competitors." (citing earlier cases).<sup>6</sup>

*Exclusions.* An ambulance service already licensed to provide the basic level of service does not have to go through the determination of need process to get licensed to provide advanced life support service. By regulation, any sale of an existing ambulance service is exempt from the new or expanded requirements under certain conditions, which include that the entire company must be purchased.

*Determination of need activity.* In the last five years, DPH made decisions in 30 determination of need cases. Program review staff reviewed 10 of the most recently completed cases. None of these recent cases reviewed involved totally new prospective providers seeking entry into the business, but rather current providers seeking changes. The nature and outcomes of seven of these cases are described below.

- Four cases involved nonprofit volunteer ambulance providers, all seeking to add an additional ambulance to their current fleets of one. In three, the hearing officer recommended approval; in the fourth, the hearing officer recommended denial, but was overruled by the final decision maker.
- In two cases, certified nonprofits sought to change their status from non-charging to charging, granted in both cases.
- One case involved a commercial company initially requesting four new ambulances and one branch office. It later amended its request to two ambulances and one branch office. The company wanted the addition to meet a veterans' center contract it had recently obtained. The request was denied on the ground that the applicant was able to handle all its calls at its current service level and had only passed on four of 4,392 calls.

The DON provisions will be reviewed further during Phase II of the committee study.

### **Primary Service Area**

The concept of Primary Service Areas (PSA) was included in the original 1974 legislation that formed the current basis of the state's involvement in the regulation of EMS. In order to ensure statewide coverage of emergency medical services and a coordinated response to emergency calls, the state has created PSAs and Primary Service Area Responders (PSARs). Primary Service Areas refers to geographic entities into which the state is divided that may

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<sup>6</sup> Med-Trans of Connecticut, Inc. v. DPHAS, 242 Conn. 152, 165 (1997)

include an entire municipality or a part of a municipality. A PSAR is the EMS provider who has exclusive rights and obligations to provide emergency service in a particular PSA.

**Levels of service.** There are three levels of service recognized by the state that differ in terms of the level of training and skills performed by personnel, as well as equipment required. Each town can have at least one PSA for each level of service. Described below are the three types of services and requirements of the providers.

- *First Responder* – The first responders are typically police or fire personnel trained at the most basic level, called medical response technician (MRT), but do not transport patients. Some, though, are equipped with automatic external defibrillators for cardiac care. First responders are supposed to be the first on scene to provide care as there are usually more first responders available in any given area than any other level of service.
- *Basic Life Support (BLS)* – Basic ambulance service or basic life support is usually dispatched simultaneously with first responders. Basic ambulance service typically provides transport for the patient to the hospital and provides limited medical attention. Personnel must be trained at least at the emergency medical technician (EMT) level.
- *Advanced Life Support (ALS)* – What is commonly referred to as the ALS level of care is really composed of two levels of service that have different regulatory requirements and are called Mobile Intensive Care – Intermediate Level (MIC-I) and Mobile Intensive Care – Paramedic Level (MIC-P). Providers of MIC services must have a sponsor hospital that must appoint a MIC medical director. The medical director is responsible for providing operational oversight and medical supervision of EMS field personnel. Mobile Intensive Care services include the use of: intravenous solutions, pneumatic antishock garment, and airway interventions.

### **Primary Service Area Responder**

The Office of Emergency Medical Services is required to assign a PSAR for each level of service for each municipality in the state. Public health regulations establish the factors to be considered in designating an EMS provider as a PSAR. These include:

- size of population served;
- effect of proposed PSAR assignment on other EMS providers;
- geographic locations of the proposed PSAR;
- proposed PSAR's record of response time;
- proposed PSAR's record of activation time;
- proposed PSAR's level of licensure or certification; and
- other factors OEMS determines to be relevant to the provision of efficient and effective delivery of EMS services.

An application must be filed with OEMS if a provider wishes to be a PSAR. The regional council reviews the application and provides a recommendation to OEMS before the assignment is finalized. The department also requires the chief administrative officer of the affected town to sign off on the application. The department reviews the application and considers it in light of the above factors. There are no additional guidelines followed by the department specifying what those factors mean. For example, while the regulations require the proposed PSAR's record of response time be considered, there is no uniform standard or formula that establishes what would disqualify an applicant. The initial PSA assignments, completed in the mid-1970s, essentially reflected existing service providers.

Some important features of Connecticut's regulatory structure are worth noting.

- A provider only needs to go through the application process once. The PSAR is an indefinite assignment.
- A PSA must be open for a provider to apply or the applicant must demonstrate a need for the service exists. The PSA generally would only become open if a PSA were currently unassigned, the current PSA holder gave up its assignment, or that assignment were revoked by DPH.
- If a company were merged or bought out in its entirety, neither DPH nor the municipality served review or exercise any oversight over that transaction.

**Availability.** Connecticut regulations anticipate a PSA holder's ambulances may not always be available. This could be due to a non-emergency transfer of a patient between a hospital and a nursing home, or to vehicle maintenance. Regulations require that basic and advanced level PSA holders have at least one ambulance available for response to emergency calls 24 hours a day, seven days a week. These providers can arrange to have other providers respond to emergency calls for them, if they are rendering other types of services or are non-operational. Ultimately, the PSA holder is responsible for ensuring someone responds to emergency calls within its area.

**Municipal contracts.** Municipalities may also negotiate with a PSA holder for additional coverage, maximum response times, or for other types of service that may involve additional costs borne by the town. Appendix A presents information on contracts between the state's 16 largest municipalities and EMS providers for service. The review shows both similarities and differences.

- Twelve of the 16 municipalities have or are renegotiating an existing contract with their basic life support provider. One municipality (East Hartford) has an unsigned agreement with its provider. (Waterbury has two BLS providers, but only maintains a contract with one).
- Ten communities have included a provision for some type of payment to providers for services.
- Ten of the 12 communities that have contracts or agreements have included some type of performance measure. Of the two towns that do not have performance measures in contract, one town has performance measures in a letter of understanding

and another has a monitoring committee. (East Hartford has performance measures in an unsigned memo).

- The performance standards typically require the provider to respond to a call within a certain time frame for a certain percentage of the calls. The response time standards in the contracts range from five minutes for 80 percent of paramedic calls to 13 minutes for 80 percent of non-emergency calls.
- Penalty provisions in the contracts include reporting requirements on corrective actions, withholding of payments, monetary penalties, and termination of contracts.

**Revocation of PSA assignment.** Unlike the licensure or certification requirements, there is no requirement the assignment of a PSA be renewed or reviewed by DPH after it is issued. The assignment is considered indefinite but can be revoked under certain circumstances. The DPH commissioner makes the decision to withdraw an assignment after a hearing. A PSA assignment may be withdrawn, according to DPH regulations, if it is determined “that it is in the best interests of patient care to do so.” There are three ways in which a hearing may be triggered that could lead to the revocation of a PSA assignment:

- the regional council may submit a recommendation to OEMS to withdraw an assignment and present evidence to the commissioner for withdrawal;
- the chief elected official may petition the commissioner to immediately suspend and ultimately revoke a PSA assignment if the official can demonstrate an “emergency exists and that the safety, health, and welfare of the citizens of the affected area are jeopardized by the performance of assigned PSAR...”; and
- the commissioner may initiate proceedings on his own without any petition or request.

In addition, a PSA holder must be licensed or certified as an EMS service. The license or certification must be renewed on an annual basis. While there are no specific performance standards in regulation, the department may suspend or revoke an EMS provider’s license or certification for violations of licensing requirements, such as failure to provide properly trained personnel. This action would render a PSA holder unable to fulfill its PSA responsibilities and presumably lose its PSA assignment.

The department has never revoked a PSA assignment, nor has any town initiated, until recently, the withdrawal process. Two towns are currently exploring that possibility with the department.

### **PSA and PSAR Data**

Program review staff received data regarding PSA assignments from the department in March 1999. The data set is incomplete and is in the process of being updated. For example, not all towns have an assigned PSAR for first responder, according to DPH data, even though there is usually, in fact, a first responder. In addition, there are situations where the PSA holder subcontracts with another provider to cover for the PSA holder for certain times of the day or days of the week. The department does not collect information on this. Consequently, some providers may actually cover more territory than PSA data suggest.

<b>Table I-2. Primary Service Areas by Level of Service</b>	
<i>Level of Service</i>	<i>Number</i>
First Responder	181
Basic Life Support	183
Advanced Life Support (MIC-I or MIC-P)	107
Total	471
Does not include 28 supplemental responders as they are not recognized as holding separate PSAs	
Source: DPH data as of March 1999	

Table I-2 shows the number of PSAs by level of service. Because towns may be divided into multiple PSAs and a PSA is assigned for each level of service for each town, there are more PSAs than towns. The table shows there are 181 first responders, 183 BLS, and 107 ALS responders for a total of 471 PSAs divided among the state's 169 towns and municipalities. This does not include the 28 supplemental responders who are not assigned a PSA but assist a first responder. The identification of supplemental responders is a recent addition to the DPH database and is tracked because these responders are usually equipped with automatic defibrillators.

<b>Table I-3. Number of PSA Responders by Classification</b>	
<i>Responder Classification</i>	<i>Number</i>
First Responder	104
Certified Responder	162
Licensed Responder	6
Total	272
Does not include 28 supplemental responders as they do not hold PSAs	
Source: DPH data as of March 1999	

Table I-3 presents the number of different PSA holders by responder classification. Some licensed providers do not hold a PSA and may only be doing non-emergency work, or doing emergency work as a backup to a PSA holder. These licensed providers would not be included in the table. According to the data, there are 104 first responders, 162 certified responders, and six licensed responders for a total of 272 responders within the state's 471 known PSAs.

The six commercial (licensed) providers account for 69 (15%) of the total PSAs. Because first responder calls are not reimbursable through the health care system and can be costly to provide, commercial providers usually do not hold the PSAs for that level of service. In fact, only two first responder PSAs are held by a commercial provider. This means out of the 290 basic and advanced life support PSAs, 67 (23%) are held by commercial providers.

By using the most recent population estimates (1997) published by DPH, the percent of population covered by commercial providers can be approximated. Thirty-eight percent of Connecticut's population is covered by commercial providers at the BLS level, and 26 percent is covered at the ALS level. A total of 45 percent of the population is covered for BLS, ALS or both by commercial providers. The map in Appendix B shows commercial services that hold BLS level PSAs by town. These numbers would tend to underestimate the impact of the

coverage provided by commercial services because not all their activity is known to DPH. For example, as described above, commercial providers cover emergency calls at certain times of the day under subcontracting arrangements with some PSA holders.

### **Rate Setting for Emergency Medical Services**

The provision of emergency ambulance services has been likened to fire protection and police protection. However, there is a fundamental difference -- the way in which the services are paid. Police and fire are generally considered public services paid for by tax dollars, typically at the local level. Public debate over a town's budget largely determines what will be an acceptable level of service and an appropriate amount to pay for it. Ambulance transport services, on the other hand, have been considered a reimbursable health care expense, and therefore the financing of services has been through billing those who use the service -- or their private or government health insurer -- for the costs.

Since the costs are largely borne by individual users, rather than a line item in a public budget, it is important that there is some assurance that the costs are reasonable. In some jurisdictions around the country, a competitive ambulance industry is operational to ensure that costs are reasonable. In Connecticut, a different regulatory structure based on designated PSAs is in place. The adoption of that structure, which establishes a lack of competition for emergency work in any primary service area, appears to require a regulatory component to ensure that charges for ambulance services are reasonable. The committee will continue to examine whether this assumption remains valid, given the health care financing framework in Connecticut today.

For example, while DPH sets rates for what ambulance service providers *may charge*, governmental and third party payers also set rates for what they *will pay* for such services. Thus, it is difficult to determine to what degree rates set by DPH -- or these other payers -- are important in establishing cost reasonableness.

Committee staff also identifies several other areas that appear to have an influence on the provision of ambulance services and who pays for them, including state Department of Social Services contracts with brokerage entities to furnish transportation to medical appointments. The committee will continue to examine how these services may impact on ambulance services and costs.

**Statutory authority.** The statutory authority to set rates is given to the Commissioner of Public Health in C.G.S. Section 19a-177(9). He is given the authority to *establish rates* for the conveyance of patients by licensed ambulance services and invalid coaches and *establish an emergency service rate* for certified ambulance service providers.

The definitions in statute are not exactly clear, but generally licensed ambulance service means a commercial service, while certified means a municipal, nonprofit, or volunteer service. The statutory language implies that certified providers are limited to doing emergency work, while licensed service providers can do both.

**What rates are set.** The *Department of Public Health* sets *maximum allowable rates* for several classifications of services (see definitions used in section describing PSA designations) related to medical transportation. Rates are set for each provider on a statewide basis. By regulation, rates are set for both certified and licensed providers for the following:

- *Basic level ambulance;*
- *Intermediate level response;*
- *Advanced level/paramedic;* and
- For licensed providers (commercials), *invalid coach* rates -- for non-emergency requests to transport a wheelchair patient -- are also set.

It is important to note that the rate set is for the level of service – whether on an emergency or non-emergency basis. (It is again implied that, because the statute says that only an emergency service rate is established for certified providers, they are allowed to do only emergency work if they charge.) Although the rate set is for the level of service, there are ancillary charges which the provider may add to the basic rate; for example, mileage, a night call fee, and an additional charge for waiting.

**How rates are set.** The rate-setting process and its time frame are established in regulation. Rates are set by the DPH commissioner on or before December 15 for a provider to use beginning on January 1 of the following year. By July 15<sup>th</sup> of each year, each provider must submit to DPH financial information for the prior 12 months ending April 30.

**Filings.** Certain financial information is required from all providers, whether they are asking for a rate increase or not. More extensive information is required for those seeking to raise their rates. The regulations require providers file several items with rate requests including: existing rates; income and expenses; salary and benefits; schedules of property and equipment owned; planned capital expenditures; and a summary of trips logged. The Department of Public Health currently has a contract with an outside accountant to review the rate filings based on the regulatory requirements.

**Hearings.** All rate applications filed are considered contested cases which require a hearing. However, each applicant may waive the right to a hearing, and this happens almost universally. In fact, over the past five years, there have been only two hearings held regarding rates.

**Rate-setting method.** Based on the information submitted by the provider, the commissioner establishes the rate considering:

- provider income;
- expenses;
- utilization of services;
- changes in the consumer price index;
- rate differentials set and paid for by other state agencies and third party payers; and
- a reasonable rate of return on gross revenues.

The specific rate of return is not established in regulation, but is set informally in rate application guidelines. Currently, the rate is set at six percent for commercial for-profit providers, and two percent for non-profits.

### **Other Impacts on Rates**

While ambulance service rates established by the Department of Public Health set a maximum amount that can be charged for a given level of service (along with allowable ancillary costs), that does not mean that is what payers are expending. For example, rates set by other agencies (federal and state) that involve medical transportation services drive what is being paid for ambulance services. For example:

- The federal **Health Care Financing Administration (HCFA)** *as a payer* sets a rate Medicare -- the federal health insurance program for persons 65 and older -- will pay for basic life support medical transportation, and another for advanced life support. Current rates for BLS are set for *four different regions in Connecticut* and range *from \$260 to \$318*, and are the same for emergency and non-emergency calls. Other rates are also set for ancillary services, like mileage and night calls, which add to the total bill.

Preliminary information obtained by committee staff indicates that Medicare patients, or their private supplementary insurers, may be billed for the balance of whatever Medicare doesn't pay. Also, for patients that are eligible for both Medicare and Medicaid, providers have been allowed to bill Medicaid after Medicare paid its portion. The committee will be exploring the issue of balance billing, who is impacted, and to what degree.

- The state **Department of Social Services (DSS)**, *as a payer*, has established a rate for Medicaid patients who are not in managed health care. Similar to both DPH and Medicare rates, DSS rates for ambulance service -- *set at \$99.25 statewide* -- is the same whether for emergency or non-emergency. DSS has also established what it will pay for ancillary services.

The Medicaid program DSS administers now includes the General Assistance (GA) population, who had been the responsibility of individual towns and cities, until the state takeover of GA was completed in July 1998.

- The state **Department of Transportation (DOT)** sets a rate for medical livery -- transportation that can be used for persons who are not in a wheelchair and do not require an ambulance because they are not in a stretcher and do not need other medical attention. Only five providers have rates set by DOT to do this type of work privately (i.e., not participating in a government contract which provides for a capitated or other discounted rate). The current rates range from a \$25 minimum charge to \$50, and a waiting charge that ranges from \$25 to \$50 an hour.

**Transportation to medical appointments.** Medicaid recipients are entitled to transportation services for their medical appointments. Prior to 1997, for those patients not in managed care, DSS paid a fee-for-service based on a medical livery rate set by DOT. In 1996, the state legislature passed Public Act 96-268, which allowed DSS to establish a competitive bidding system to provide these services, where DSS deemed cost savings could be realized. DSS has since entered into contracts with two brokerage entities to provide such medical transportation for Medicaid clients not in managed care plans. Those Medicaid clients covered under managed care plans would be provided these transportation services (as well as emergency or non-emergency ambulance transportation) by the client's HMO for the monthly capitated rate.

**Private insurance.** Private managed care clients typically do not receive transportation to medical appointments as part of their insurance coverage. However, since March 1, 1984, emergency ambulance service has been a *mandated coverage* for health insurers to provide in Connecticut. Connecticut statutes prohibit health insurers and health care centers (HMOs) from requiring their insureds to get prior authorization for 9-1-1 calls.

By statute (C.G.S. Sec. 38a-525), private insurance policies are *not required to provide benefits in excess of \$500* for any one emergency ambulance service. Committee staff discussions with the Insurance Department staff indicate this statute is used as a cap by insurance companies in coverage for ambulance services. For fee-for-service payments, typically, insurance companies would pay 80 percent of the costs, and bill the patient for the balance. This would be allowed since, unlike an HMO with a contract with a provider -- where the provider agrees to accept the payment from the HMO as the total payment for service -- providers may bill the patient for all or part of what the insurer does not pay.

Persons covered under managed care plans (like HMOs) are offered the same coverage for mandated emergency ambulance service as they would receive under any health care insurance. However, HMOs contract with ambulance services and often arrange for rate discounts. Such contracts are proprietary and do not have to be filed with the Insurance Department or DPH. Committee staff has not been yet been able to determine if such contracts apply only for non-emergency transport, and the extent to which rates are discounted.

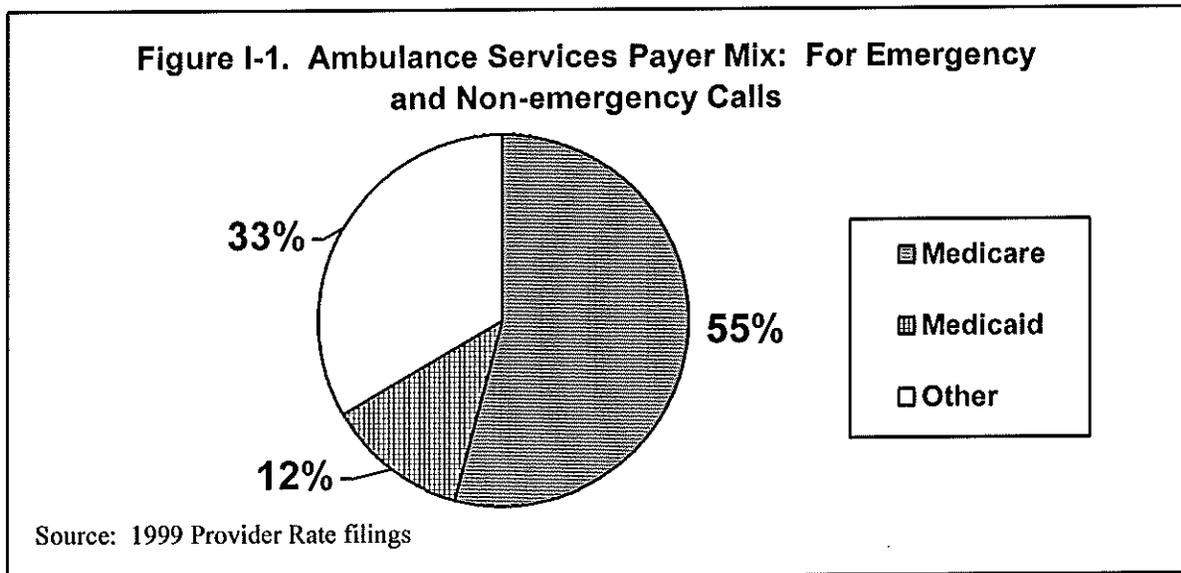
## **Payers**

The payers of ambulance services are generally those who use the service, or their insurers. Ambulance providers must report the total number of persons who use their service, based on call volume, in their annual rate filings. Staff examined the total number of calls in the rate summary reports issued by DPH, and the results are shown in Table I-4. It is important to note total calls include both emergency and non-emergency calls, since both types of calls are filed on the rate forms, and the same rate is set for both types of service. As the table shows, total call volume has increased 24 percent since 1994.

Table I-4. Total Ambulance Calls 1994-1998		
Year	Total calls	Percent Change
1994	312,932	--
1995	354,587	13.3%
1996	366,387	3.3%
1997	375,675	2.5%
1998	388,356	3.3%
Total Increase		24.1%

Source: DPH Rate Summary Reports

**Medicare.** Program review staff examined the payer mix based on information contained in individual 1999 rate filings of seven large providers, three commercials and four nonprofits. The rate filings include the total combined number of emergency and non-emergency ambulance calls for each commercial provider, and just emergency calls for nonprofits. The seven filings examined accounted for more than 247,000 emergency and non-emergency calls, or 63 percent of all call volume for providers who charge for service. Of those calls, 133,797, or 54 percent, are Medicare clients. (see Figure I-1).



**Medicaid.** Using the same call volume information from the 1999 rate filings, committee staff identified that Medicaid patients made up 30,787 calls of the 247,000, or 12.4 percent. Thus, as Figure I-1 shows, together Medicaid and Medicare clients make up two-thirds of all calls.

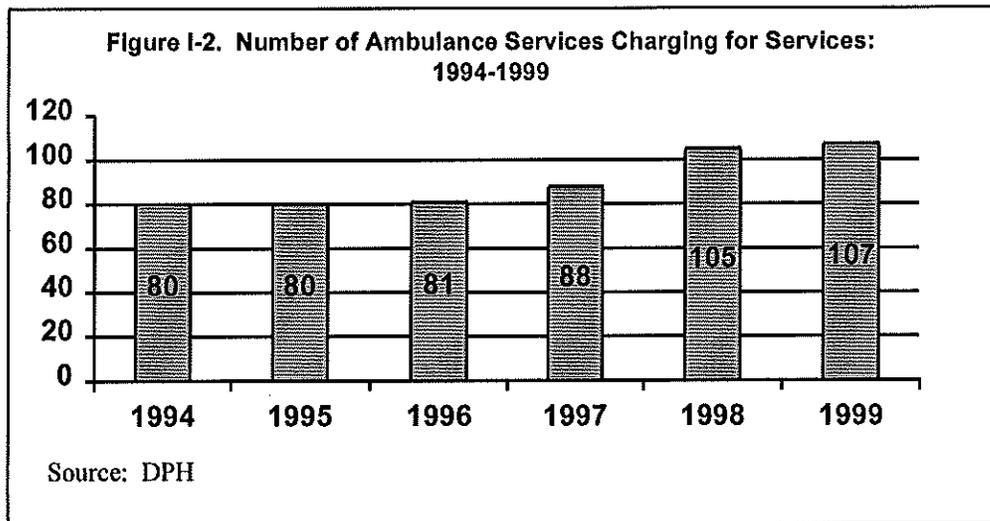
The variation of payer mix among providers appears great, depending on the area of the state, and whether the provider is commercial and therefore eligible to do both emergency and non-emergency work. For example, 89 percent of both emergency and non-emergency calls handled by Professional Ambulance Service of Norwich (PASON) in the Southeast part of the

state are for Medicare or Medicaid clients. In New Britain, which is served by a nonprofit provider, 70 percent of just 9-1-1 calls are for Medicaid or Medicare patients. In Westport, which also has a nonprofit provider, only 45 percent of emergency calls involve Medicare or Medicaid clients.

Committee staff has not yet analyzed the one-third of calls that are not Medicaid or Medicare clients. Questions for further review include how many are uninsured, or, if they have private insurance, whether that insurance company has a contract with one or more providers, and the impact of any discounts on total ambulance service payments.

### Ambulance Rates

As discussed earlier, the Department of Public Health annually sets a maximum statewide rate that each provider may charge for each calendar year. The number of charging providers has been increasing. As Figure I-2 indicates, in 1994, there were 80 providers who billed for ambulance transport services; in 1999, there are 107.



The 1999 average rate for basic life support ambulance service is \$260. The range currently is \$212 to \$386; about 34 BLS providers charge a higher rate than the \$260 average rate. Some of the higher rates are charged by nonprofits. The nonprofit providers claim they must charge the higher rates because doing only emergency work is more costly to the provider, since they cannot spread their expenses among a larger pool including non-emergency calls as can the commercial companies.

The ambulance industry is heavily concentrated -- for both both emergency and non-emergency calls -- among a few commercial providers. Based on call volume information contained in rate filings, between approximately 74 and 80 percent of all ambulance calls have been handled by six commercial providers over the past few years. Table I-5 indicates the overall percentages have not changed much since 1994, although individual companies' part of that market share may have changed, largely because of AMR's purchase of Professional Ambulance.

**Table I-5. Concentration of Market Share – Percent of Total Ambulance Calls:  
Top Six Providers Annually: 1994 –1998**

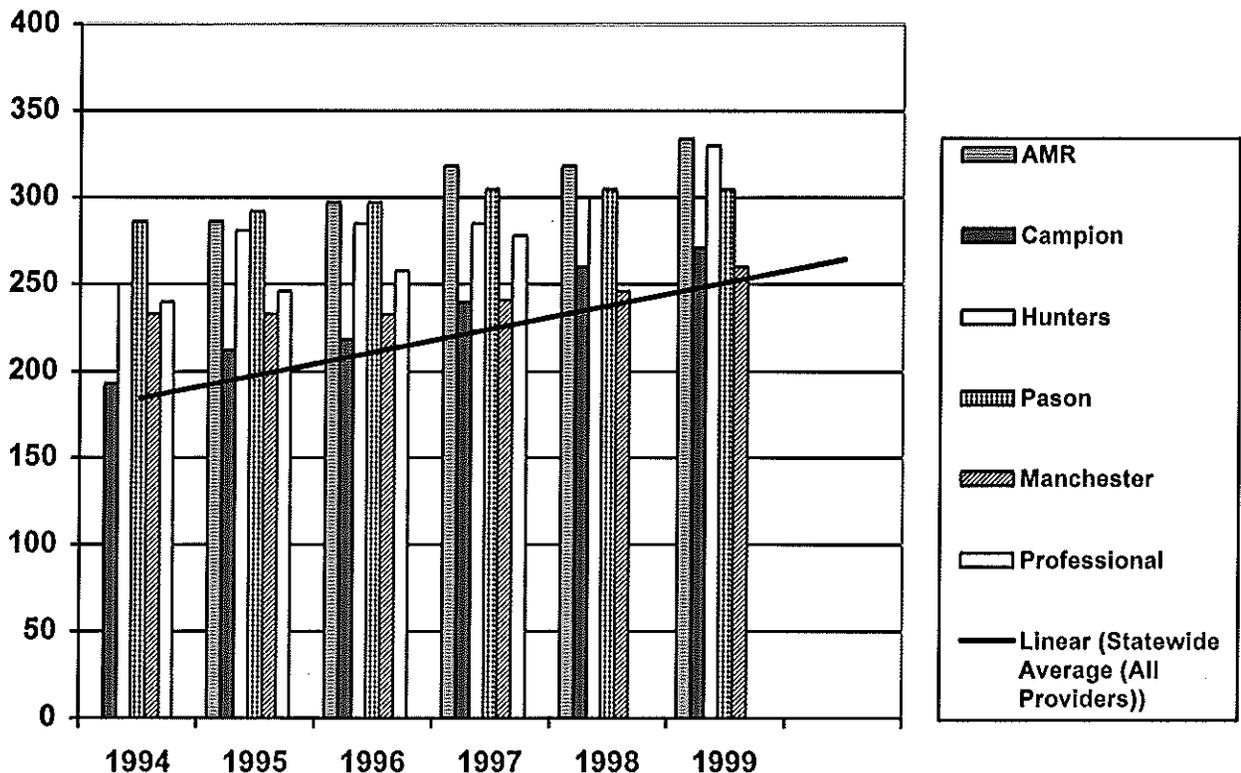
	1994	1995	1996	1997	1998
AMR	27.5	47.9	47.1	46.1	44.3
Campion	9.2	8.2	7.9	8.2	8.3
Danbury**		4.8	4.2	3.3	3.0
Hunters	8.4	8.1	8.6	8.2	8.0
PASON	5.4	5.7	6.3	7.4	7.3
Professional***	18.5				
Manchester	4.5	4.3	4.2	4.2	4.4
Top 6 Total	73.5	79	78.3	77.4	75.3

\*\* Danbury was not among top six providers in 1994. \*\*\* Professional does not have call volume after 1994; purchased by AMR

Source: DPH Rate Summaries

Because these top six providers handle such a large portion of all ambulance calls, both emergency and non-emergency, program review examined trends in rates for these same providers from 1994 through 1999 based on DPH rate summary information. The results are displayed in Figure I-3 below. Also displayed in the figure is a trendline indicating the average statewide rate for all providers for the same period. As the figure shows, in each of the six years examined, the rates filed by the top providers exceeded the average statewide rate.

**Figure I-3. Trends in Rates for Top Six Providers\*\*:  
Comparison with Statewide Average for All Providers**



\*\* AMR does not appear in the graph for 1994 as it had no rate filing for that year; Professional had no rates filed after its 1997 purchase by AMR

Source: DPH Rate Summaries 1994-1999

*Handwritten initials*

### Rationale for Committee Proposals

#### Background

- The program review study focuses on the three cornerstones of economic regulation of *emergency* ambulance services: PSA assignment; rate-setting, and determination of need for new or expanded service.
- Committee recommendations maintain the current regulatory system, but suggest policy enhancements to improve the ability of both local and state government to perform oversight functions of EMS.

#### Reasons for Scope of Recommendations

##### *I. Enhanced Accountability*

- A key concern prompting this study was how the regulatory structure ensures accountability for service delivery, including timeliness of response.
- The focus of the proposals is on establishing performance measures at the local level, and establishing consequences directly related to unsatisfactory performance that could lead to the loss of a PSA assignment by a provider, the ultimate accountability leverage.
- There was interest in determining if need for any legislative change related to accountability could be identified and acted upon in this legislative session.

##### *II. Unclear Need for Wholesale Change*

- The original purpose for regulating emergency ambulance service areas through PSA assignments was to address problems related to multiple providers that diminished accountability and efficient patient service. There is no reason to believe those same problems would not occur again in the absence of geographic assignments.
- These proposals would be less disruptive to a system that has been in place for more than 20 years.
- There does not appear to be a groundswell of discontent about the current system, although there are pockets of problems.
- Various participants in the system with whom staff has talked are supportive of the current structure (although interested in refinement).

- Data are not compiled currently to allow assessment of the actual impact on patient service or business activity under the current regulatory model.
- Significantly different policy approaches involving drastic changes to the current regulatory system (e.g., assigning PSAs to municipalities, with DPH oversight; assigning exclusive rights to both markets in a PSA; and preserving PSAs but pooling the profit of non-emergency work) would need further analysis to assess impact.
- No universally accepted model of emergency medical service system exists, nor is one endorsed by any nationally recognized EMS organizations.

### *III. Recent Significant Changes*

- A statewide emergency medical services plan was finally adopted in 1997, which the department began implementing in 1998.
- The statewide advisory council was totally reconstituted per legislation in 1998, and various work groups are several months into efforts to update EMS regulations.

### *IV. Complexities of Current System*

- The regulation of emergency and non-emergency markets are intertwined, with the rate-setting process complicated by the reality of insurance reimbursement and the determination of need requirement murky in its application. Any significant changes to these factors would require more analysis to credibly assess the actual need for and potential impact of any changes, beyond the time frame of this study.
- *Non-emergency* ambulance services are also subject to the same rate-setting and determination of need requirements.
- Commercial providers who hold PSA assignments for *emergency* ambulance services also compete in the *non-emergency* ambulance services market; noncommercial PSA holders are prohibited from competing in the *non-emergency* market.
- The rate-setting process sets maximum allowable rates for providers, but third party payer reimbursement rates are real drivers in cost recovery, with unclear impact on consumers/patients.
- While staff has been able to look at determination of need cases decided within the last year, the limited types of cases within that time period impedes objective assessment of the requirement as a whole.

## Chapter Three

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### Findings and Recommendations

This chapter contains the committee's findings and recommendations. First, a brief description of the current system, including a summary of the purpose of state regulation, is provided. This is followed by eight detailed sets of findings and accompanying recommendations, with a rationale for each proposal.

Given the current system, as described in Chapter One and summarized below, the complexities inherent in the system, and the overview of proposals presented in Chapter Two, the recommendation areas included are refinements to the current system. The recommendations would improve the current system by:

- requiring performance standards to be developed in local EMS plans and implemented in written agreements with providers;
- adopting a more realistic approach for towns to remove a PSA holder if the provider is performing poorly;
- building an accountability loop that includes:
  - providers
  - towns
  - state DPH; and
- establishing a common basis to compare performance and begin evaluation of the system.

### Description of Current System

The Connecticut regulatory scheme can be described as a *limited franchise* approach. This means the state assigns emergency responders (9-1-1) to exclusive territories (PSAs) for an indefinite period of time. The non-emergency market, however, is left open to competition. In Connecticut, though, only commercial providers (licensed) compete for non-emergency work, while certified services (volunteer, municipal, hospital-based and nonprofit) by statute may not charge for non-emergency work. Other features of the regulatory framework in Connecticut include:

- all emergency and non-emergency providers and their personnel are licensed or certified by the state;
- only three broad performance standards exist in regulation currently: 1) PSA holders are required to respond to all emergency calls 24 hours a day, seven days a week; 2) PSA holders may lose their assignments if OEMS determines "it is in the best

- interests of patient care to do so”; and 3) municipalities can petition the commissioner to suspend a PSA holder if the chief administrative officer can demonstrate that “an emergency exists and that the safety, health, and welfare of the citizens of the affected area are jeopardized by the performance of the PSA responder”;
- municipalities may contract with the emergency services provider assigned to them for better performance or higher level of service but usually at a cost;
  - all providers who charge a fee are subject to a determination of need and rate-setting process established by the state;
  - due to the methods of PSA assignment and rate-setting, there is no notion of competitiveness factored into the emergency market;
  - changes in ownership are not reviewed by the state; and
  - the PSA holder may have an advantage in competing for non-emergency work in that it: is in the community, has name recognition, may have brought a patient in on 9-1-1 call who could become a customer for a return trip, and has infrastructure (dispatch, ambulances, etc.) already established.

**Purpose of state regulation.** The underlying purposes of the limited franchise approach are to:

- assign accountability to one provider in an area to respond to 9-1-1 calls and avoid historical problems with either too many ambulances responding to a call or none at all;
- allow for a systematic response to 9-1-1 calls;
- provide stability to providers to encourage investment and provide for some market efficiency; and
- allow minimum standards to be developed and enforced.

## **1. Local Emergency Medical Services (EMS) Plan Needs to be Established**

### **Findings**

- There is no requirement currently that each town has a plan for how emergency medical services will be provided.
- There is a state-level EMS plan with regional input, but not local level.
- No link exists between the state plan and how it will be implemented at the local level.
- Many towns have ignored their EMS systems – a plan requirement will bring attention to an important service/policy area.
- There is a disconnect between the state level (DPH) regulating in this area and the towns, which are authorized by statute to provide ambulance service in their towns.

- The state has designated the primary service area (PSA) responder with the exclusive right to do the emergency work in that area, but there is no formal town involvement after that first designation -- a plan would provide the opportunity for town and provider(s) to work together.
- In many towns, there are no established standards for what residents expect of any part of their EMS systems – including their ambulance transportation service.
- Without these established standards there is no way to evaluate whether providers are doing a good job or not.
- DPH has not been receiving information that would allow it to evaluate the performance of BLS and ALS providers—and no standards on which to evaluate it even if it did.
- To date, one segment of the emergency medical care system, ambulance transport services, has been the focus of negative attention. Without a look at the entire system from dispatch to first response, through transport and pre-hospital medical care, complete understanding of system problems is impossible.
- In some towns there is ongoing monitoring of ambulance transportation providers but in many towns there is not.
- Neither towns nor the state may be aware of subcontracts or other arrangements that a PSA holder has with another service.

### **Recommendation**

**The local legislative body of each town shall establish a local Emergency Medical Services (EMS) plan that would include, but not be limited to:**

- **identification of who will carry out each level of service – dispatch; first response; basic life support (ambulance transport) and advanced life support (paramedic);**
- **establishment of performance measures for each segment of the system;**
- **establishment of a monitoring system that will identify who will receive information necessary for monitoring, who will provide the information, how frequently the information will be monitored, and what will require corrective action on the part of any service providers, including provisions for progressive sanctions; and**
- **any written agreements or contracts developed between the town and its providers (including any subcontracts, written agreements, and/or mutual aid agreements providers may have with other entities to provide service).**

**All plans shall be filed with the Department of Public Health by January 1, 2000, and be updated and refiled with DPH every three years. Towns are encouraged to consult their Regional EMS Council, their regional coordinator for EMS, the regional EMS medical advisory committees and the sponsor hospital(s) in their area for assistance in development of the plan, and shall submit the plans to their Regional EMS Council for review and comment. DPH may reject a plan if the department deems it in the best interest of patient care to do so.**

## **Rationale**

The plan requirement would:

- allow what is essentially a local service to be developed at the local level;
- allow towns to decide what are acceptable standards – for example, acceptable response times from first responders and basic life support (ambulance) for a locale given its population and geography—and adopt those in the plan;
- provide accountability measures – without a plan, there is no way to hold towns accountable for implementation of EMS and, in turn, hold providers accountable to their towns, within that system;
- bring a systems approach to what has been a fragmented and often neglected patchwork of services;
- along with the resulting standards, provide a future framework for acceptable benchmarks (for planning and evaluating) for towns of similar size and geography that have been established at a local level, not mandated or set by the state;
- place every Primary Service Area responder on notice there will be service standards in place for the area it serves, and actions will be taken if the standards are not met;
- support and expand on a proposal by the EMS Advisory Board to increase local involvement, without giving municipalities the authority to competitively bid the PSA; and
- encourage towns to work with regional EMS entities, and medical resources in their area to develop a plan.

## **2. Mechanism to Resolve PSAR and Municipal Differences over Performance Agreement is Required**

### **Findings**

- Because PSA responders, at least for BLS, appear to be designated in all areas of the state, there is currently little or no incentive for a service provider to agree to standards.
- Some towns have used a subsidy, beyond insurer or payer reimbursement, as incentive for a PSA holder to enter an agreement.
- A number of towns have contracts, others do not, and some towns and providers are operating under expired contracts. Not all reasons are known about the parties' willingness or unwillingness to sign agreements.
- Without participants who will agree to implement the local plan and be held to its standards, the accountability process cannot be enforced.
- The recommended three-year redesignation of PSAs based on poor performance (see recommendation 4A) is too long for a town to wait if it has a provider who is unwilling to agree to the plan and sign a written agreement.
- There must be outside oversight of whether a town has a written agreement with its providers so that towns and its providers will not jointly ignore the plan requirements.

## **Recommendation**

**The Department of Public Health shall monitor receipt of written agreements or contracts that must be submitted with a local EMS plan. If no written agreements are submitted by January 1, 2000, DPH shall notify the town and the PSA responder no later than March 1, 2000, that a hearing will be held within 60 days of the notice, if agreements are not submitted by that date. DPH could prioritize the holding of hearings based on its categories of urban, suburban, and rural, with areas of greatest population scheduled first.**

**The hearing would be held to determine if the standards adopted in a local EMS plan were *reasonable* based on criteria that DPH uses including the state EMS plan, model guidelines developed, and standards, contracts, and written agreements in use by towns of similar population and characteristics.**

**If the standards were determined reasonable by DPH, the PSA responder would have 30 days to sign the agreement or lose the PSA. If DPH found the standards were unreasonable it would establish standards considered reasonable given the criteria used above. If a town refused to agree to the standards established by DPH, the PSA holder would have to meet the minimum state regulatory standards in place.**

## **Rationale**

- It puts in place a resolution process for towns and service providers when they cannot reach a written agreement on performance standards.
- There would be some incentive for parties to come to agreement on their own.
- The standards used for determining reasonableness would strengthen the role of local standard development.
- The DPH hearing would establish a finite end to disputes.
- It provides incentives to agree to the DPH decision: for providers, the loss of a PSA; for towns, the requirement that the PSA responder will only have to meet minimum standards to respond to calls, with no time requirements.

## **3. Model Guidelines for Local EMS Plans and Agreements to Be Developed**

### **Findings**

- Many municipalities already maintain performance agreements with their emergency medical services providers.
- OEMS, in conjunction with the EMS State Advisory Board and Regional Councils, recognizes in the statewide EMS plan there are severe impediments to developing a single set of EMS performance standards for the entire state, but has a mandate to coordinate, monitor, and evaluate the system.
- The proposed recommendations would require all municipalities to develop plans and execute agreements with their EMS providers.
- Some technical assistance may be necessary to facilitate this process.

## **Recommendation**

**The Office of Emergency Medical Services shall, with the advice and assistance of the EMS Advisory Board and Regional Councils, develop model local EMS plans and performance agreements, recognizing the differences in the delivery of EMS services in urban, suburban, and rural settings, to guide municipalities in the development of these documents.**

## **Rationale**

- Some local governments have not had to develop plans or agreements regarding EMS services and will need some assistance.
- OEMS, along with the Advisory Board and Regional Councils, represent the collective technical expertise over EMS issues in Connecticut and are a logical source for the development of these guidance documents.
- Developing model plans will aid in ensuring local plans are consistent with the statewide EMS plan.
- The proposal would utilize definitions OEMS has already developed for the three categories of geographic service areas in the state.

## **4. Municipalities' Ability To Remove PSA Responders For Poor Performance Needs To Be Improved**

### **Findings**

- Municipalities are empowered to provide ambulance services per C.G.S. Sec. 7-148(c)4(c).
- Municipalities originally approved PSA responders (PSARs) during the initial assignment over 20 years ago in most instances, and the assignment is indefinite.
- There are no requirements for the systematic review of a PSA responder's performance.
- There are no adequate performance measures associated with a PSA assignment, other than responding to all emergency calls.
- The current standard for a municipality to remove a PSA holder is high and difficult to define in operational terms. A municipality may petition the commissioner to suspend a PSA holder if an emergency exists and if the actions of the PSA holder jeopardize the safety, health, and welfare of the citizens. OEMS may remove a responder if it determines "it is in the best interests of patient care to do so."
- Until 1999, a municipality has never petitioned DPH to remove a responder (two towns are currently exploring this option).
- OEMS has never withdrawn a PSAR assignment.

## Recommendations

- 4a) **Grant municipalities the ability to petition DPH every three years for the removal of a basic life support or advanced life support PSA responder based on unsatisfactory performance of that responder as outlined in the local EMS plan and associated agreements.**

## Rationale

- This recommendation is a necessary adjunct to the local EMS plan as it allows municipalities to be a more proactive participant in the EMS system and gives additional leverage to local governments in negotiating with providers.
- It provides some measure of assurance to providers because the burden is to prove the PSA should be taken away, and the standards are agreed to and measurable from the beginning of the process.
- It maintains the state's ability to remove a provider *at any time* for practices detrimental to patient care under current regulations.
- This also maintains a municipality's ability to petition DPH to suspend the assignment of a PSA if an emergency situation exists.

## Policy Option

*Interest has been expressed in a more market-oriented approach for selection and replacement of primary service area holders, involving the periodic issuance of a Request for Proposals (RFP) with right of first refusal for the current PSA holder, as a way to introduce more innovation in the delivery of emergency medical services and reduce costs. However, the full impact of this approach on the EMS regulatory structure and system is not known. If the committee chooses to pursue this issue, policy makers would be aided by additional information on the ramifications of such a change.*

- 4b) ***Recommendation: To that end, a pilot study shall be considered to assess the effect of PSA holder selection based on the periodic issuance of a RFP with right of first refusal for the current PSA holder. The pilot would involve three to six towns in urban, rural, and suburban contexts that contract with commercial providers. Phase II of the current program review study would identify the details for implementing the pilot program including: feasibility of such a pilot project, its design and measurement, identification of elements to be assessed, time frame, selection of pilot municipalities, impact on service delivery and market, and who would conduct the evaluation of the pilot.***

## **5. Annual Report on Local EMS Plan is Necessary to Track Performance**

### **Findings**

- Some commitment is needed from towns that they will be monitoring the plans.
- There can be no improvement in accountability to the system without measuring how plans are being implemented.
- Bad performance will not come as a surprise to towns or providers if ongoing monitoring is happening.

### **Recommendation**

**Each town will be required to annually report by March 31, on a form furnished by the Department of Public Health, on the implementation of its plan for the previous calendar year, including:**

- **total number of EMS calls;**
- **number of calls requiring each level of service;**
- **number of refused calls and number of calls requiring mutual aid response;**
- **name of service provider for each level of service;**
- **using the common definitions of response times established by the Department of Public Health, fractile response times for each level of the EMS system: dispatch, first response, basic life support, and advanced life support; and**
- **the monitoring and compliance of providers with locally developed performance standards and, if non-compliance has been identified, what steps the town has taken, or will take, to enforce provisions of the contract.**

**The Department of Public Health shall compile the information -- grouping towns according to urban, suburban and rural categories -- and make the information available to the public in a report card format by July 1 of each year. The department shall make the report card available on its web site, and shall submit a copy to the Public Health Committee of the General Assembly.**

### **Rationale**

The proposed reporting, data collection, and analyses would:

- complete the accountability loop on how the local plan is being implemented;
- provide incentive for towns to monitor performance;
- provide incentive for service providers to perform well as the results will be publicly examined;
- be an accessible tool for local policy makers to compare service delivery in their town with that in similar towns; and

- provide some information for local policy makers to use in adjusting their plans for the next cycle, (e.g., adding additional funds, or requiring stepped-up corrective action).

## **6. Response Time Measurement Is Imprecise and Requires Common Definition**

### **Findings**

- Current regulations have a narrow definition of response time. Response time is defined as the “total measure of time from notification of the EMS provider that an emergency exists, to arrival of the EMS provider at the patient’s side...”
- Current practices generally do not include regular public reporting or monitoring of the performance of the first responder or the dispatch center, which represent two other important elements of the EMS system that can affect subsequent performance of other providers and patient outcomes.
- Connecticut’s 9-1-1 dispatch system exhibits tremendous variation in terms of the character of service provided and number of dispatchers involved to get an ambulance sent to an incident.
- Because of the dispatch system variation, different systems track response time differently, if at all, resulting in a reduced capacity to evaluate performance between and among systems.

### **Recommendation**

**DPH shall establish and reinforce a common definition for response time to include the time a call is received by a Public Safety Answering Point to the time each dispatched responder (i.e., first responder, supplemental responder, BLS, ALS) arrives on scene and every significant point in between for reporting purposes.**

### **Rationale**

- It recognizes important elements, other than just ambulance response, in the system and provides a common measure for their performance in terms of timeliness.
- The standard will provide for a universal definition of response time, facilitating evaluation of the system.

## **7. Sales of Existing Ambulance Companies Holding PSAs Shall Include Adoption of Existing Performance Agreements**

### **Findings**

- The current exemption from the determination of need process for new or expanded services for purchases of emergency ambulance businesses has provided a loophole for businesses to gain PSA assignments without municipal involvement.

- In the last six years, there has been a spate of such purchases by AMR.

### **Recommendation**

**An express condition of the purchase of a business holding a PSA, subject to the determination of need exemption, is that the purchaser must abide by the performance standards to which the purchased business was obligated pursuant to its agreement with the municipality.**

### **Rationale**

- This provision adds to the theme of the other recommendations to increase municipal control over the PSA holders. (Further review of the sales of ambulance companies that hold PSAs could assess whether the state should institute a review process, similar to a determination of need process, to maintain control of its PSA assignment authority.)

## **8. Outcome Measures Need to be Developed to Assess EMS System**

### **Findings**

- Currently no systematic evaluation of patient outcomes for pre-hospital emergency care exists.
- There are no measures or data to determine what level and type of emergency care service actually produces optimum results for persons with medical emergencies.
- Thus, no way exists to evaluate how patient pre-hospital care could be improved.
- DPH is supposed to have developed a data collection system that includes a uniform patient record keeping system following a patient from initial entry into the system through discharge from the emergency room.
- The Connecticut EMS Plan adopted in January 1997 states that OEMS, in coordination with the EMS Advisory Board and the Regional Councils, shall develop the above required data collection system, and provide the results to providers and the regional councils for quality assurance purposes.

### **Recommendation**

**DPH shall research and develop appropriate outcome measures for the emergency medical services system and shall submit to the Public Health Committee of the General Assembly, by January 1, 2001, and annually thereafter, a report on the progress toward development of such measures. After outcome measures are implemented, DPH shall include in its annual report an analysis of system outcomes.**

## **Rationale**

- Outcome evaluation will ensure that dollars spent on emergency service care are well spent.
- The determination of need process is an economic regulation aimed at cost-effectiveness, based on rough measures of service such as numbers of vehicles and branch office location. Assessing outcomes could have the same economic impact by steering EMS dollars where most beneficial, based on patient care measures that should be at the core of the system.
- DPH could use this information to modify its model plan and provider agreement guidelines, and assist towns in refining their plans.



## Chapter Four

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### Proposed Areas for Phase II – Further Refinements to the Current System

The committee adopted the recommendations discussed in Chapter Three, and authorized a continuation of the study to examine the following issues in Phase II of the EMS review.

- a. Review need for rate setting. If rate setting continued, explore need to change financial reporting requirements by segregating non-emergency and emergency calls, rates, and costs.
- b. Review need for determination of need process.
- c. Examine need to implement emergency medical dispatch.
- d. Examine expanding role of certified providers to do non-emergency work.
- e. Review mechanisms and financing for data collection for the system.



## Chapter Five

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### Alternative Approaches Altering the Fundamental Regulatory Structure

The options summarized below would have needed much further exploration than the limited time frame for completion of Phase I allowed. The committee accepted the refinements to the current system presented in Chapter Three and authorized a Phase II of the study to continue examining, instead, issues outlined in Chapter Four. As a result, the options presented in this chapter will not be explored further by the committee.

#### I. Assign exclusive rights to both markets in a PSA (*Exclusive Franchise*)

- *Description* - all general public ambulance calls (emergency and non-emergency) would be consolidated into a single market franchise assigned by the state.
- *Advantages* - maximizes potential for economies of scale, provides market stability when used with performance measures, makes the 9-1-1 work more attractive.
- *Disadvantages* – will meet with opposition by commercial (licensed) providers, may disturb the delicate balance in funding between emergency and non-emergency services as some commercial providers will be receiving less revenue, will require more oversight by some level of government, disrupts current arrangements, will have to determine method to award new franchise, and limits HMOs ability to contract with providers.

#### II. Preserve PSA but pool the profit of non-emergency work

- *Description* – A pool would be established based on the amount of money generated by non-emergency work to assist those providers who take on the responsibility of doing emergency work. This pooling could be linked with the uncompensated care pool for hospitals as the EMS providers must now have a sponsor hospital and receive medical direction.
- *Advantages* - This option would attempt to provide more equity in the system by pooling the inherent financial risk and cost in performing emergency work.
- *Disadvantages* – significant opposition by current commercial providers especially those who do not hold a PSA, may reduce amount of competition, may place additional burdens on current providers to provide backup/mutual aid service because it would eliminate some providers, pooling mechanism would have to be developed and oversight of system by outside entity would have to be ensured.

### III. Assign PSA to municipality, with DPH oversight (*Open Market*)

- *Description* – This option would assign the PSAs directly to municipalities and allow for DPH to perform a check over municipal actions.
- *Advantages* – allows for more local control, enables municipalities to determine level of service and provider, additional accountability would be realized.
- *Disadvantages* – some municipalities may not want the responsibility, regional councils will object to it because they believe changes will be based on purely political considerations rather than system needs, providers may not want it as it also may subject them to replacement based on local political concerns and changes, DPH would have to establish standards.

## **Appendix A**

### **EMS Contracts in Connecticut's 16 Largest Municipalities with BLS Providers**



## Contracts in Connecticut's 16 Largest Municipalities with BLS Providers

Town	Provider for BLS	Type*	Contract	Payment	Minimum Units	Performance Standards	Penalty Provisions
Bridgeport	American Medical Response	C	Yes, 3-yr contract May 1998—May 2001.	Not for standard service. \$37.50 an hour when AMR does stand-by at special events. Not to exceed \$25,000 in a year	4 ambulances (to be returned to city upon termination of contract)	Yes. Maximum response time for all calls- 10 minutes. Average response time of 8 minutes	Yes. \$17.50 a call for each 5-minutes over the response time requirements. For each minute after that, \$17.50 a minute
Bristol	Bristol Hospital	N	Yes, Indefinite term begins 1980	None	At least one unit in the city at all times	No performance standards, but a monitoring committee is established in contract	None
Danbury	Business Systems, Inc	C	Yes, 7/1/98-6/30/03	First year: \$761,105; following years negotiated based on actual costs	1 ambulance at all times, with additional ambulance from 7 am to 11:30 pm M-F, and 11 a.m. to 11:30 p.m. on Sat. Each with a EMT-P. On line EMS	90% of calls within 8 min. for ALS calls Maintain daily incident records of each call, and report monthly to city, along with annual report.	None, although there is arbitration process set up.

Town	Provider for BLS	Type*	Contract	Payment	Minimum Units	Performance Standards	Penalty Provisions
Danbury (cont)					supervision One ambulance at scene of certain fires.		
East Hartford	Ambulance Service of Manchester	C	No, an unsigned memo of agreement	No	2 ambulances – 24 hours a day, 7 days a week	Yes, for emergency- 6 minutes; for expediting situations – 8 minutes; routine – 12 minutes	No
Fairfield	Ace Ambulance (also provides ALS) <sup>1</sup>	C	Yes, 7/1/94 – 6/30/98	1 <sup>st</sup> year, \$60,000 for nonreimbursed and uncollectible claims; COLA adjustments for later years		90% of life threatening calls in 8 minutes (when no more than 2 such calls come in per hour)	Termination of contract
Greenwich	Greenwich EMS (also provides ALS)	N	Yes, 5-year 1996-2001	\$1.2 M annually	3 ALS 3 backup BLS	1. Avg. of 8 min. response time for each (3) station for up to 3 simultaneous ALS calls 2. 5 min. response time for 75% of total ALS calls	Termination of contract
Hamden	American Medical Response (AMR)	C	None	-	-	-	-

Town	Provider for BLS	Type*	Contract	Payment	Minimum Units	Performance Standards	Penalty Provisions
Hartford	American Medical Response	C	1/1/87-12/31/92 (with 2 year extension period) Hartford in process of renegotiation	\$86 for each call for persons the City DSS is liable for; <sup>2</sup> uncollectable calls to police detention facility.	3 fully staffed ambulances from 10:00 a.m. to 2:00 a.m. 7 days. From 2:00 a.m. to 10: a.m., 2 fully staffed ambulances. Upon request at any time, any additional resources. 2 bases of operation within 6 mins. Fire standby services at City request. 500 hrs of community service	Htfd PD call designation Emergency: 6 min; Expedite: 8 mins; Routine: 12 min. (If provider not at operations base or out of PSA, emergency: 12 min.)  Provider to maintain detailed call records, and furnish in form acceptable to the City.	For breach of contract, \$100 to \$1500 for each violation, to be deducted from any payments owed to provider. Withholding of all payments until breach is remedied. Cost of any substitute service paid for by provider (Serious and/or repeated failure by provider to response times triggers above, unless mitigated by specific circumstances.
Meriden	Hunters Ambulance (does ALS)	C	Yes, 7/1/91-6/30/03	For each year of contract, payment increases from \$15,000 in 1 <sup>st</sup> year to \$125,000 in final year.	2 fully staffed ambulances available 24/7 on east and west sides of city.	For life threatening calls, median response no greater than 6.5 minutes; for non-life threatening calls, median response no greater than 8.5 minutes	Cancel contract for non-performance

Town	Provider for BLS	Type*	Contract	Payment	Minimum Units	Performance Standards	Penalty Provisions
New Britain	New Britain EMS Foundation Inc.	N	Yes	Eliminated as of 7/1/97.	2	By letter of understanding. Not specified in the contract	<ol style="list-style-type: none"> <li>Letter of reprimand</li> <li>Modification of methods or procedures</li> <li>Termination of contract</li> </ol>
New Haven	American Medical Response (AMR) (Also provide backup first responder)	C	Yes, 5-year 1997-2002	\$200,000 in 1 <sup>st</sup> year to \$0 in 5 <sup>th</sup> year	3 Mobile Intensive Care Paramedic	Response time of 11 min. or less for 90% of all priority or emergency calls	<ol style="list-style-type: none"> <li>Temporary withholding of payments</li> <li>Select alternate provider for all or part of services rendered</li> </ol>
Norwalk	Norwalk Hospital	N	None	-	-	-	-
Stamford	Stamford Emergency Medical Services, Inc. (BLS and ALS)	N	7/1/96-6/30/98, with automatic annual renewal; either party may elect to not renew	\$650,000 FY 97; \$600,000 FY 98; review afterward for future years.	3 ambulances (EMT-P) 24/7 at each of 2 hospitals and 1 firehouse; 1 ambulance 12/7 at another firehouse; 1 ambulance or flycar 12/7 at street location; minimum of 1 standby response vehicle from 9-5	<p>Eight minutes for 90% of all ALS calls</p> <p>Quarterly reporting of response times</p>	<p>If standard missed during any quarter, must report why and corrective actions taken; if standard missed 3 consecutive qtrs, is breach of major obligation</p>

Town	Provider for BLS	Type*	Contract	Payment	Minimum Units	Performance Standards	Penalty Provisions
Stamford (cont)					weekdays at street location, and on weekends (with EMT-P)		
Waterbury	2 PSAs in Waterbury 1 is held by Campion; other is American Medical Response <sup>3</sup>	C (both)	None with Campion; Yes with AMR. Signed in 1988 for 5 years; in 1993 parties agreed to a contract for five consecutive 1-year periods; that contract was up in April 1998, still working under the old one and negotiating a new one	None for Campion; \$108,730 annually for AMR	Campion – no contract AMR – enough to meet performance provisions	All calls Dire emergencies – 8 minutes; Less urgent – 12 minutes; Report with 10 days calls that exceeded time	

Town	Provider for BLS	Type*	Contract	Payment	Minimum Units	Performance Standards	Penalty Provisions
West Hartford	American Medical Response (AMR) <sup>4</sup>	C	Yes 5-year 1996-2001	\$222,770 annually, with incentive bonus	2 non-transport vehicles with paramedic services, 9-5 each day except holidays	Yes. 1. Paramedic Response time of 5 minutes for 80% of calls when 2 services available; 7 minutes when 1 service 2. Ambulance Transport – not to exceed 7 minutes for 80% of 1 <sup>st</sup> 2 calls; 8 minutes for 80% of 3 <sup>rd</sup> and 4 <sup>th</sup> calls; 13 minutes for 80% of non-emergency	Yes; \$50. Per call that exceeds response time
West Haven	American Medical Response	C	No		-	-	-

\* C= Commercial, N = Nonprofit, M = Municipal

- 1 AMR purchased Ace Ambulance, the original party to the contract.
- 2 Payment for general assistance clients would now come from DSS
- 3 AMR purchased MEDSTAR, which had the PSA before AMR and was the original party to the contract with Waterbury
- 4 AMR purchased two companies – L&M and Professional – that were original parties to this contract

Source: PRI data based on telephone interviews and analysis of municipal contracts

## **Appendix B**

### **BLS Provided by Commercial Services**



# Appendix B. Basic Life Support Services Provided by Commercial Services

