The Connecticut EMS Chiefs Association

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Date: January 10, 2014
To: Representative Peggy Sayers, Chair
MORE Commission Mandates Working Group
From: Bruce Baxter, President
RE: Department of Public Health- Office of Emergency Medical Services Regulations concerning Primary Service Area Responder Designation

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Representative Sayers and Members of the MORE Commission Mandates Working Group:

My name is Bruce Baxter. I am the President of the Connecticut Emergency Medical Services Chiefs' Association (CTEMSCA). The CTEMSCA represents the interests of the Chief Executive Officers of non profit, municipal third services and hospital based 9-1-1 EMS provider services operating in the State of Connecticut whose sole and primary mission is the response, care and medical transportation of individuals experiencing an acute, out of hospital medical or traumatic emergency. Eligible members of our Association are directly responsible for more than 50% of the 350,000 9-1-1 EMS responses managed in the State each year.

I was appointed to serve on the PSAR Task Force by House Minority Leader Lawrence F. Cafero, Jr. to represent the interests of the non profit ambulance services in the State of Connecticut. I appreciate opportunity to share thoughts regarding my perspective on the PSA system with the MORE Commission- Mandates Working Group.

As you are aware, the PSAR Task Force was the result of substitute House Bill 6518 that was introduced in last years legislative session. The Task Force was requested to review the following:

a) The current process for designating and changing primary service areas.
b) Local primary service area contract and applicable subcontract language and emergency medical service plans as such language and plans vary among municipalities and as such contracts and plans pertain to performance and oversight measures.

c) Methods to designate emergency medical service providers that are used by other states that have populations, geography and emergency medical service systems that are similar to those of this state.

d) Process by which municipalities may petition for a change or removal of a primary service area responder.

The Task Force and its members have taken its charge seriously and continue to work diligently on its final document for submission to the Public Health Committee in the legislative defined time frame. As the Task Force has yet to complete its deliberations and approval of a final document, it is premature to offer recommendations for change.

The current DPH-OEMS Primary Service Area Designation System was designed to resolve years of identified system deficits when communities could freely choose and regulate the terms and conditions of services rendered to the individual municipalities. That approach did not work. There was no consistency to the level, quality, consistency or cost of essential 9-1-1, critical care and non emergency medical transportation services statewide. At the time, EMS providers were hesitant to invest in local system or service enhancements out of concern they would not gain a return on their investment, there was no commitment to the 9-1-1 system, municipal buy in to invest in the system was weak, as was the fiscal infrastructure of non municipal providers throughout the state. As a result of those system wide deficits, the State implemented wide sweeping, progressive change to stabilize the Statewide EMS system and assure each community had a dedicated qualified Primary Services Area Responder with the ability to achieve, maintain and enhance fiscal and operational performance for the benefit of patients and operate in an environment that fostered clinical growth and systems advancement.

The foundation of the current system is based on the current EMS statutes and regulations that include:

- The Certificate of Need: Assure there is a demonstrable need for a defined level of clinical service or expansion of a service and the requisite fiscal strength to support the proposed service/expansion prior to its authorization and approval by the Department of Public Health Office of Emergency Medical Services.

- Rate Setting: Establishes maximum retail rates using a well defined healthcare actuarial approach to define maximum retail charges for each service in the State that reflects the services real cost of providing services plus a reasonable profit margin. This approach protects residents from unjustifiable charges.

- Primary Service Area Responder Designation. The well defined review process assures individuals with knowledge of the system review all aspect of a proposed service to be designated to assure the plan is reasonable from a medical operations perspective, clinical service delivery process and fiscal perspective prior to designation.

- Planning: The key to any system success is planning. The current system leverages the use of Community based EMS plans developed by municipalities and their designated PSAR providers to assure community needs are fulfilled. Community plans integrate into regional and statewide planning initiatives. Regional Councils play an integral role in the development of local EMS plans to assure consistency in the provision of core clinical services.

- Lead Agency: DPH-OEMS is active in assuring statutes, regulations in place are adequate for the system; that stakeholders have access to the resources needed to fulfill their obligations; and that identified deficits and complaints are investigated and adjudicated properly providing the designated PSAR provider with the guarantee of an unbiased assessment of the complaint with an opportunity for due process prior to revocation.

The foundation of the CON process, Rate Setting and PSAR designation coupled with the development of a collaboratively developed local EMS Plans by the municipality and designated PSAR providers and regulatory oversight and intervention by DPH-OEMS has provided a strong foundation for the State and its providers to improve the overall consistency, timeliness, and quality of care provided to its residents while controlling competition and costs.

While some argue the current system reduces "home town rule" by limiting providers ability to compete fairly and equally, restricting services practice to specific geographical areas, and limiting the provision of billing for all services other than 9-1-1 emergency services to a handful of for- profit licensed providers at the exclusion of all others, it has provided the fiscal infrastructure that protects patients from price gouging and allows the larger for-profit services the opportunity to offset losses associated with delivering essential 9-1-1 services to their designated PSAR areas while providing an essential 9-1-1 back up response over lay to all other areas of the State. The approach has seen the wide spread development of regional- multi tiered EMS systems via public/private partnerships across the State resulting in CT being one of the few New England States that has 24 hour per day first response paramedic advanced life support coverage statewide.

As with any other complex health care system regulatory approach, Connecticut's approach to regulating EMS systems is not perfect. While we strive for perfection, no system in any business endeavor is perfect 100% of the time. That means, mistakes will be made, and unfortunately expectations will be unmet and at times the consequences will be dire resulting hopefully in sentinel learning moments.

Our association recognizes and actively supports the need to make changes to our regulatory environment that will allow all patients in Connecticut to have access to consistent timely, high quality, customer satisfaction focused, value based 9-1-1 emergency medical services. We believe no matter who provides emergency medical services, there is an associated cost to

providing the service. In the last decade, fee for service health insurance reimbursement for those services has steadily declined eroding the operating margins of most EMS organizations across the country. With the implementation of PPACA this year, fee for service revenues will further erode as 9-1-1 call volumes decrease secondary to patients with minor complaints being directed to a more cost effective location for primary care. The global impact of PPACA on EMS systems will not be fully recognized for 5+ years. As such, we would caution against any dramatic immediate system change as there may be significant and unforeseen consequences that erodes the system infrastructure before its replacement system is in place..

Based on the current Task Force discussions, we will support the following:

- Responsible changes that promote the development of transparent communications between PSAR stakeholders and communities.
- The collaborative development of periodic comprehensive community based EMS plans by municipalities and the PSAR stakeholders that reflect a responsible dynamic approach to meeting the needs of a community.
- Education of all municipalities on the importance of EMS plans and the core components to be included in such a plan.
- The implementation of binding agreements between all designated PSAR holders and their municipalities.
- The periodic review of all PSAR holders performance against established mutually agreed upon (PSAR Stakeholder and Municipal) performance standards included in their EMS plan with input from the municipality and EMS system Medical Director.
- The timely removal of a PSAR holder who has a defined history of failing to meet agreed upon performance standards and has been given reasonable opportunity to correct the deficits.
- The removal of a PSAR holder who refuses to accept the performance standards of a municipality that are deemed reasonable by the State DPH-OEMS.
- Any responsible immediate change that improve the system without destabilizing the current EMS system infrastructure.
- An expedited and well defined hearing process at DPH –OEMS to address municipality concerns with any PSAR stakeholder with a history of performance deficits.