

Overview of Emergency Medical Services For Minnesota Elected Officials

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Emergency Medical Services (EMS) is truly a “system”. It is composed of a number of clearly identified components, including such things as the availability of 911 telephone access; to the presence of appropriately trained ambulance personnel; and, skilled hospital emergency department staff to receive patients.

The ‘system’ is largely the result of an aggressive federal initiative that began with the passage of the EMS Support Act in the early 1970s. Billions of dollars were directed to the individual states to create EMS Systems. Additional funding was appropriated on two subsequent occasions. However, until the 9 / 11 tragedy there had been little in the way of federal follow-up or for that matter, interest, in EMS. Although millions of dollars have been appropriated by Congress for “Homeland Security”, an equitable means of distributing the funds has been elusive. According to *EMS INSIDER*, a national ambulance trade journal, EMS has received only 4% of the Homeland Security dollars. Further, grants do not necessarily go to the areas with the greatest need. For example, the least populous state Wyoming has received \$31.96 per capita for Homeland Security, while New York received \$4.57 per resident. For these, and a variety of other reasons, EMS Systems vary widely throughout the country in their make-up, quality of care, revenue sources, even access to services. Homeland Security appropriations are simply pork barrel legislation at its worst.

Minnesota is fortunate in that the state legislature has been extraordinarily supportive of virtually all aspects of the delivery system for nearly two decades. Since the federal government has largely ignored EMS, the individual delivery systems are almost exclusively dependent on state legislatures for both policy and funding initiatives. Subsidies from local units of government may also be necessary.

Despite a pro-active, EMS-friendly environment at the Minnesota Capitol, our state’s delivery system is a patch-work quilt facing many challenges. It lacks statewide consistency on training availability, funding, communications dollars and local government support. First Responders, who arrive at the scene before the ambulance, are generally unregulated, provide varying levels of care, and are generally not reimbursed by third-party [insurance] payers. First Responders may register with the state Emergency Medical Services Regulatory Board (EMSRB), but registration is voluntary. Virtually all volunteer ambulance services are located in rural areas of the state. Many must hold annual fundraising events to pay for equipment, uniforms and training. Further, securing reimbursement from third-party payers, such as Medicare is so complex that small, volunteer services simply do not have the expertise to secure the money they are due. Consequently, in rural Minnesota one commonly witnesses volunteer ambulance crews raising money to support their local ambulance services so that they may volunteer their time to respond to their community’s medical emergencies.

Minnesota is heavily dependent on volunteers to staff ambulances.

Approximately 64% of all ambulance personnel in the state are considered “volunteers”. Compare this with Georgia, a state that is demographically similar to Minnesota, which has no volunteer ambulance operations anywhere within its borders.

The volunteer ambulance personnel in Minnesota save the healthcare system well over \$40 million per year, according to the Minnesota Office of Rural Health.

Perhaps the greatest challenge to the statewide EMS System in Minnesota is the lack of sufficient personnel to staff volunteer ambulance services. The pool of potential volunteers is dwindling as the result of simple demographics. The aging rural population means that fewer and fewer people are willing or able to fulfill the demands placed on them as ambulance crews. Working on an ambulance is physically demanding and, at times, dangerous. As a result of all of these factors, we are losing 1 or 2 rural ambulance services a year in Minnesota. Another disturbing trend is projected shortages of full-time paid personnel.

State Regulation

Minnesota is unique in the nature of its regulatory authority. In 1995, the legislature passed a bill that created the Emergency Medical Services Regulatory Board (EMSRB). Like virtually every other piece of EMS legislation over the past 20 years, it was an initiative of the provider community, not the state. The Board is an independent regulatory body, appointed by the Governor. It has jurisdiction over ambulance services through its licensing authority, as provided for in Chapter 144E. The Board proposes its own legislation, including appropriations, and hires an executive director in the unclassified service. Included in the composition of the EMSRB are a state representative and senator; Commissioners of Public Safety and Health (or their designees), who serve in an *ex-officio* capacity.

Prior to 1995, ambulance services fell under the jurisdiction of a small ‘section’ within the Minnesota Department of Health. All medical transportation-related authority was transferred to the Board, effective July 1, 1996. For a number of reasons, the industry and the legislature felt that continued access to quality emergency medical care was an emerging public health issue. Access to EMS was seen as particularly problematic in rural Minnesota. Consequently, the EMS System needed to be overseen by a high profile, independent regulatory entity with broad-based expertise in all aspects of out-of-hospital emergency medical care.

Minnesota is only one of, perhaps, five or six states in the country with a truly independent EMS regulatory authority. Kansas, Indiana and Kentucky have similar independent state agencies.

Areas of Regulation

The EMSRB has regulatory authority over virtually all aspects of the medical transportation industry; ambulance coverage areas (Primary Service Areas); ambulance personnel; and, individual ambulance providers. The Board serves as a conduit for various grants appropriated by the state legislature, historically sought at the request of the EMS community. These include the Comprehensive Advanced Life Support (CALS) program that subsidizes rural hospital emergency department personnel training; and, the 8 Regional EMS Programs. They also administer a modest

amount of federal funding and grants. The volunteer ambulance recruitment & retention plan and volunteer ambulance training reimbursement are also administered by the EMSRB.

Neither the EMSRB (nor any other state entity) has any authority over what ambulance services may charge. Because of historical billing differences among the varying types of services, the reimbursement needs of individual services are very diverse. Despite interest from some organizations, there is not enough data to even consider implementing a rate regulation system at this time. Some ambulance services are subsidized, either directly or indirectly with local tax dollars, others are not. Ambulance providers were successful in securing legislation that allows for voluntary creation of EMS Taxing Districts, whereby one or more local governmental units may form a special taxing district to levy an ad valorem tax to support local EMS functions. These eligible functions include but are not limited to: 1st Responders support, ambulance service operations, continuing medical education, communications and equipment purchases. Funds may also be utilized to pay for programs established under Regional EMS Programs.

The EMSRB manages numerous programs, including a diversion program for providers with substance abuse problems; they collect data on ambulance service's activities; and, makes all final determinations on ambulance license applications., in addition to other duties.

Ambulance Service Licensing & First Responders

Each ambulance service operating in Minnesota must have a license granted by the EMSRB. There are approximately 300 ambulance services, owned/operated by about 295 license holders. Each emergency provider operates within an exclusive geographic territory, called a "Primary Service Area" or "PSA". In return for this exclusive franchise, each service must provide emergency care to anyone within their area, regardless of ability to pay or source of payment. To obtain a new ambulance license, the applicant must demonstrate a clear need through a contested case proceeding. Non-controversial license changes have an expedited process. Non-emergency or so-called "scheduled" ambulance service is somewhat competitive, primarily in the 7 County Metropolitan Area. The EMSRB has been diligent in its efforts to eliminate overlapping PSAs, which are remnants of the pre-PSA laws.

First Responders serve an important role in the EMS System. They tend to be the first to arrive at the scene a medical emergency. They are generally not reimbursed by health insurers, Medicare or any state public assistance programs, such as Medicaid. However, modest payment may be made through automobile or other insurance. This service is provided by State Troopers, firefighters, 1st Responder squads organized by a municipality, private volunteer squads or other local law enforcement personnel. Their primary role is to stabilize patients until the ambulance arrives. Training levels for 1st Responders varies widely throughout the state, although there is a federally established minimum level of education. As mentioned earlier, First Responders are not regulated in Minnesota, unless they submit to the voluntary registration program through the EMSRB.

The constitutionality of PSAs has been challenged, but upheld by the Minnesota

Supreme Court (the “Twin Ports Decision”). “*Twin Ports*” has been subsequently upheld by state courts on several occasions. However, because of a Minnesota Court of Appeals decision, air ambulance providers have no exclusive operating areas (i.e.: PSAs). The competition among air ambulance providers is unregulated because, the court ruled, the federal government has sole jurisdiction (through the FAA) as to where air ambulances may operate. Consequently, air ambulance services are openly competitive with no restrictions on service areas. However, through referral agreements, air ambulance providers tend to provide service to particular regions within the state. Rotor-wing (helicopter) ambulance operating areas are limited by fuel capacity. Fixed wing services can provide medical transportation over much greater distances.

Types of Services

Air Ambulance - This is provided by both fixed wing and helicopter ambulances. These types of operations tend to offer sophisticated, advanced treatments. They may be called upon to provide critical care transfers between health care facilities, but may also respond, and must be reimbursed for, emergency scene response. Personnel and equipment fall under the auspices of the EMSRB, but not the geographic areas where they may provide service, as noted above. Last, specially trained nurses are often utilized to provide direct patient care both in cases of emergency scene response or scheduled transfers. Helicopters generally do not respond to a medical emergency or accident scene unless the patients are in very serious condition and their survival is dependent on rapid transport to a hospital.

Ground Ambulance - May be provided at either the Basic or Advanced Level. Both may be licensed to operate as an “emergency” or “scheduled” service - or both.

Basic level services usually staff Emergency Medical Technicians (EMTs), who receive approximately 120 hours of initial training, and must satisfy continuing education criteria.

Advanced level services are usually staffed by at least one paramedic, who undergoes training which varies from roughly 800 hours to a two-year degree program.

Basic level services are generally limited in their ability to perform invasive procedures. They are able to establish an intravenous line and administer a limited number of pharmaceutical agents. They do utilize Automatic External Defibrillators (AEDs) for cardiac patients. Because of an agreement with an advocacy group in 2002, all basic ambulance services administer Epinephrine to counteract allergic reactions. They utilize “Epi-pens” which are single, pre-measured injectors.

There is also a relatively new category of “part-time advanced life support”. This “specialized license” allows both advanced and basic level service to be provided at differing times, depending on the availability of qualified personnel.

All ambulance services, regardless of level, must have a physician medical director who is licensed in Minnesota. The ambulance service operates on the medical director’s license as an extension of his or her authority. EMTs and Paramedics are certified, not licensed by the EMSRB. Thus, they have no independent practice authority.

Non-emergency, scheduled ambulance trips tend to be a more stable source of income for ambulance services. In many cases, the non-emergency transfers subsidize the lower-paying emergency calls. However, some 3rd party payers have been reducing their reimbursement for all types of ambulance calls in recent years. This has challenged the financial stability of the entire system. EMS, like every other health care provider, must cost shift to remain operational. However, the ambulance industry in Minnesota is facing fewer and fewer options for cost shifting.

Types of Ownership

As related previously, there are approximately 300 licensed ambulance services in Minnesota, with the following types of ownership:

>City	148	(47.7%)
>NFP Corporation	73	(23.5%)
>Hospital	39	(12.6%)
>City/County	19	(06.1%)
>For Profit Corporation	16	(05.2%)
>County	9	(02.9%)
>Federal	3	(01.0%)
>Partnership	1	(00.3%)
>Undefined	2	(00.6%)

Many members of the public are surprised to learn that a significant number of emergency ambulance services are not operated by governmental units.

Role of Regional EMS Programs

The federal EMS Support Act of 1973, as discussed previously in this document, established 303 Regional EMS Programs throughout the United States. Their responsibilities were listed under 15 component areas. The initial funding was reauthorized on several occasions, by Congress, with the clear understanding that it would be phased out. Once the federal grants disappeared, many of the Regional Programs in the country folded.

In 1986, the Minnesota Legislature, at the request of the EMS provider community, created a \$1.5 million dollar dedicated account to allow Regions to continue their work. The areas of responsibility were very general, as placed in statute, resulting in 8 very diverse programs in Minnesota. The biennial appropriation is divided equally among the 8 programs. Several are non-profit corporations; others are established through joint powers boards.

The funding historically came from the Trunk Highway Fund, although the legislature in 2000, moved appropriations to the General Fund. This policy change made funding for these programs less stable as they compete with every other program supported by the General Fund. Regional Programs no longer receive any permanent funding from federal government sources. In addition, the 8 Regions equally share in 90% of all seat belt fines collected throughout the state. This revenue source has decreased over the past couple of years due to fewer seat belt violations being written.

As indicated above, Regional Programs are very different throughout the state. Some issue grants for training and equipment or otherwise support providers in their

areas. Others serve a more active role coordinating the entire emergency medical care delivery system - not just medical transportation - as it applies to EMS within their geographic area, as determined by the EMSRB.

Ambulance Reimbursement - An Uncertain Future

In 1997 as part of the Balanced Budget Act, Congress enacted fundamental changes in the entire reimbursement system for medical transportation in the United States. The BBA mandated the following: First, all ambulance services were placed on a fee schedule; second, ambulance services would no longer be allowed to bill Medicare patients for unpaid balances on their ambulance charges, a procedure known as “balanced billing”. Congress also determined that no additional money would be allocated for the new fee schedule. Consequently, the proposed fee schedule could not cost anymore than the reimbursement system in place at the time. The schedule was artificially created to fit within a specific funding target. Due to the complexity of establishing a fee schedule, a negotiated rulemaking effort was used.

Currently ambulance services are eligible for virtually all third party insurance. The MN CARE insurance program covers ambulance service, however, only for emergency calls. Ambulance services, by law, must respond to all emergency calls. We must treat and/or transport regardless of the person’s ability to pay or source of payment.

Unlike most other states, Minnesota health plans must (by law) reimburse all emergency ambulance calls, regardless of the final diagnosis. Scheduled ambulance transfers have to meet certain criteria for reimbursement. However, health plans must have a physician, nurse or physician assistant “immediately” available to approve or disapprove a transfer, according to state statute.

Medicare eligible patients are the largest single source of revenue for the medical transportation community. When MN CARE was enacted, the state required that all health care providers accept Medicare assignment. That is, other than the co-pay, health care providers must accept Medicare payment as payment in full. Ambulance providers were exempted from this provision. Thus, had been allowed to bill the Medicare patient for any unpaid balance. This exemption represents in excess of \$25 million per year in income to the ambulance industry in this state. Total Medicare billing represents about 33% of all bills for which ambulance services received only 44% of the amount billed. Last, based on a study done by the accounting firm, *Larson, Allen, Weishar & Co., LLP*, the fee schedule mandated by the Balanced Budget Act of 1997, coupled with mandatory assignment has cost the ambulance industry in Minnesota approximately **\$72,000,000** per year.

70% of ambulance providers in Minnesota did not accept Medicare assignment, when the BBA of 1997 was enacted. Nationally, 4% of all ambulance claims did not accept assignment. The importance of these numbers is that the industry in Minnesota has suffered from the Balanced Budget Act of 1997, perhaps more than ambulance services in any other state.

Ambulance costs are fixed. It costs a set amount of money to assure ambulance availability, 24 hours a day, 365 days a year - regardless of the number of patients treated. One of the fixed costs that is increasing annually, in dramatic fashion, is

liability coverage for non-government-based ambulance providers. Those that are government based fall under the tort caps, prescribed in law. Private services have no liability caps whatsoever. Other increases include wages, worker's comp, equipment, etc. With reductions in revenue, all providers operate within very narrow financial margins.

Originally, the fee schedule was mandated to begin its four-year phase in on January 1, 2000. This deadline was delayed until April 1, 2002. It is now fully implemented.

As a result of the dramatic decrease in ambulance reimbursement, the Minnesota Ambulance Association sought to decrease operating expenses that do not negatively impact on patient care. However, the ambulance system in Minnesota is already very streamlined. There is very little in the way of a financial cushion for volunteer or paid services in the state.

Increasingly, I am hearing from smaller ambulance services in rural Minnesota which are generally staffed by volunteers, that the reduced income will have a significant impact on them as well as urban providers. What are the implications for the public? This remains to be seen. However, it is clear that the medical transportation aspect of the health care delivery system will be seriously challenged in Minnesota.

Ambulances may not be replaced as regularly as has been the practice in the past. Response times may increase, primarily in rural areas. The number of paid staff may be reduced, so that fewer personnel are expected to do more. Some small, rural, volunteers services have ceased operations and more will follow.

Ambulance service tends to be taken for granted. Even the smallest children know that in a medical emergency, they should call 911 and an ambulance shows up. Very few members of the public know who provides the care, how it is paid for or the true cost of that service. As a result of the federally mandated changes, it is important that the public and policy makers understand that the Emergency Medical Services system in Minnesota is entering a period of great uncertainty and will require serious attention in the coming years.

At the legislature and on these pages considerable attention is paid to volunteer or rural ambulance services. However, survival of larger providers is also critical. The larger operations often donate equipment, free or reduced-cost training, and other support to small providers. When the big providers are financially stretched, their ability to provide these support services is affected.

Last, despite the damage inflicted by Congress through the implementation of the BBA, modifications to Medicare continue in the amounts paid to ambulance services depending on location. These rural designations, in particular, may cause even further harm to small ambulance services outside of the urban areas in Minnesota.

Challenging the Current Ambulance Licensing Laws

As noted previously, emergency ambulance service is provided by entities holding a license for a specific geographic territory called a "Primary Service Area" or PSA. Licenses are granted by the EMSRB. Emergency providers do not compete. In return for their exclusive franchise, all requests for emergency ambulance service must

be met regardless of a patient's ability to pay or source of payment.

This system has been in place for over a quarter century in Minnesota. It has served the public and the provider community well. However, recently, there has been increased pressure from some quarters to make fundamental changes in the PSA law. Entities, primarily local governments and fire departments, that do not have an ambulance license and cannot prove a demonstrated need for a new license, want to get into the ambulance business. There appears to be two major reasons that some communities are seeking changes in the law. First, some local governmental units want to have control over who provides ambulance service. Second, some full-time fire departments are facing serious budget challenges. With the reduction of Local Government Aids by the legislature in 2003, some fire departments are facing staff reductions and other cutbacks. Fire calls continue to decrease while ambulance calls increase. There is a widespread belief that ambulance service can be a net revenue generator. Since the changes in Medicare, this is simply no longer true. The current system of Minnesota's PSAs has been the envy of numerous other states. It prevents deleterious competition; assures that an ambulance will respond anywhere in the state, when needed; and, helps assure long-term stability to our EMS System.

Quite simply – the current system in Minnesota works and works well.

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Addendum

Additional Thoughts on Ambulance Primary Service Areas

- Ambulance licenses are issued by the state. This assures that licensing decisions are made by an objective third party, following a contested case hearing. Local politics does not enter into any licensing determinations. Thus insulating local elected officials from having to make difficult choices on which entity will provide service.
- A provider retains their license unless they are out of compliance with the law. This creates a stable and mostly predictable operating environment. The owner knows that they will be in business indefinitely if they comply with their license and the law. This encourages long term investment in the community for purposes of staffing, purchasing equipment, etc. It encourages a commitment to the residents of their service area.

- When the PSAs were initially awarded in the early 1980s, they were designed with an eye to assuring that everyone in Minnesota would have access to emergency ambulance service, keeping in mind the need for financial viability of each service. The population base – within the entire PSA – would adequately support the level of service provided.
- If the law is changed to allow for carve out of specific pieces of current PSAs, it would have a ripple affect on the remainder of the license holder's operating territory. In rural as well as metro areas there are portions that have low run volume because of low population density. Because the service areas were issued to include less populous areas in addition to higher population ones, certain remote areas are afforded high-level ambulance care that would not be available if the higher populated area calls were not present to subsidize service in the low run volume areas.
- Changing the law to allow cities to start or contract for their own ambulance service might leave some rural residents of Minnesota without any ambulance service at all. Low run volume areas simply cannot sustain full-time, paid EMS without substantial subsidies.
- Allowing for local licensing of ambulance services may actually increase the cost of care. Competitive bidding for ambulance would necessitate that vendors retain local lobbyists. Marketing campaigns would have to be designed and consultants would have to be hired to interpret complicated proposals addressing costs, response times, and revenue sharing with the local unit of government.
- Changing the law may allow larger, for-profit, multi-state ambulance services to enter the Minnesota market. Currently, there are none of these large companies here. However, should they enter Minnesota, it will change the entire nature of our industry. Currently, providers are local and aware of the needs of their communities. They understand the other aspects of the health care delivery system and are integrated into it. They do not have to answer to stockholders or investors. These out-of-state corporations have no local roots, thus minimal accountability to their service areas. There are several examples, drawn from other states, where large for-profit providers enter a market, offer low bids and drive out potential competition. Once they have solidified their presence in a community, they seek additional compensation or leave. This was the case, several years ago, in Arizona.
- Operating an emergency ambulance service is not as simple as providing utilities or garbage pickup to residents of a community. It is a complicated endeavor that is extremely difficult if not impossible to operate with a significant profit margin. Private pay, insurers and Medicare continually tighten payment criteria and fail to cover even the cost of emergency care. The bottom line is often met through high-level inter-facility transfers and through ambulance providers expanding their services to include education to EMS, law enforcement, business and the public.
- Changing the law that would allow some services to enter into EMS and remove others will result in lost jobs. Without the cash flow, that would decrease by the

loss of service area (thus, ambulance runs) decreases the need for a static work force. This has the potential of pitting unionized ambulance personnel against each other – even within the same umbrella union.

- The upfront investment in beginning an advanced life support is significant. No revenue will be generated for at least 60 to 90 days at a minimum. Then, it could still take a year or more to merely approach breaking even. This will require increase in local taxes or cuts to other municipal programs that are already being restricted as a result of Local Government Aid (LGA) cuts.
- There are two types of ambulance transportation: Emergency and scheduled transfers. Within many emergency PSAs, the provider handles non-emergency transports. This would include interfacility transfers. If the current provider loses a portion of their emergency PSA, this may reduce or eliminate the availability of interfacility transfers to area hospitals. It would increase demand on the new license holder, particularly if fire based, to be handling scheduled runs throughout the day. It also raises the question if a local community would want its tax dollars supporting scheduled hospital-to-hospital transfers.
- The large, full-time ambulance services donate a significant number of free ambulances, equipment and training to small, rural, volunteer services. When larger services are financially threatened, they are no longer able to continue these critical donated services.
- Perhaps the most significant argument against changing the current licensing laws, with the assumption that a change would allow one service to simply replace another, is fairness. It is difficult to identify any compelling reason to unilaterally take away part or all of a provider's business without cause, due process and just compensation. This is particularly true when a single provider has served a community for many years without problems or, in many cases, a subsidy.
- For hospital-based ambulance services, the loss of PSA would have financial implications not only for the ambulance, but also may threaten the financial viability of the parent hospital. This is particularly true if the parent hospital is a Trauma Center.
- Last, throughout Minnesota there are currently a number of fire-based ambulance services that provide excellent care and have found a way to balance the ambulance, rescue and firefighting needs of their communities. However, these operations are part of the current system.

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