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A report from the Minnesota Department of Health

Report on the feasibility and desirability of rate regulating the ambulance industry

February, 1996
Minnesota Department of Health
Emergency Medical Services Section

Pursuant to 1994 Minn. Laws Chap. 625 Art. 5 Sec. 8

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I. Executive Summary

In the 1970s the Minnesota State Legislature decided the public health would be best served by a non-competitive ambulance marketplace, and chose the monopoly model to provide ambulance service in Minnesota. The ambulance provider base at the time was mostly municipal. Since then, industry maturation has caused a shift toward more private and hospital-based systems. The number of municipal providers is shrinking. In 1995 alone, six municipal licenses were not renewed.

Evolution of the industry has paralleled evolution in other health service organizations. Paramedics were introduced to the United States in the late 1970s. The insurance industry began moving patients to "centers of excellence," demanding more technology in the mobile health care field in the 1980s. Health maintenance organizations (HMOs) and managed care organizations (MCOs) began transferring patients from out-of-network to in-network facilities. As we move through the 1990s, managed care organizations are acquiring ambulance companies. A current national trend shows capitated ambulance services, which rewards providers for not transporting patients to hospitals. Future emergency care will be performed at home or at the work site. The patient may be moved to outpatient ambulatory care facilities, or even clinics. This trend is documented in a federal document to be released later this year, "EMS Agenda of the Future."

Throughout this evolution, rising training and equipment costs have caused significant rate increases. Managed care organizations have realized the value of the changing environment, and are pushing the sophistication even further. In the meantime, Medicare and uninsured patients have seen significant price increases. They are questioning the wisdom of the non-competitive environment, and the ability to choose between differing levels of care. Since neighboring ambulance providers may be organized differently (tax supported vs. for profit), the public does not understand why charges vary so widely.

Public policy debates on the monopoly issue have always come to the same conclusion: ambulance service is the safety net for health care. If the industry were deregulated, patients might choose service based on the level of care provided (therefore less cost), and would arrive at the emergency room sicker. This will raise costs in other segments of health care. In sparsely populated areas, service could disappear completely. As a result, deregulation is unlikely. Questions have been raised about why the industry is the only monopoly allowed by state law that is not rate-regulated.

There are currently state-imposed controls on inappropriate rate increases by ambulance services. While these controls are in place, they are not an optimal rate-regulation system. Financial data reporting by the ambulance industry has also been ordered by the legislature, but will not begin until 1996. Whether inappropriate pricing exists is difficult to determine without financial data.

Consumers have complained about ambulance service charges. The state grants a competition-protected license through a designated primary service area. The state does not regulate charges to consumers, nor does it permit citizens a choice of ambulance provider. Charges vary significantly between ambulance services and are affected by level of service, by personnel, and by many other variables.

Ambulance services have expressed concern regarding the incongruity of the primary service area designation (which they support) with other trends in the health care delivery marketplace. Managed competition assumes competitive price bidding which is non-existent under primary service areas. Many in the industry support rate regulation as the most effective way to provide services in an otherwise competitive health care marketplace. The Minnesota Ambulance Association and the Minnesota Board on Aging supported the legislation which mandated this report.

In addition, some ambulance services have experienced, and continue to experience, difficulty with finances volunteer retention, or both. As part of the rate regulation feasibility study, the health commissioner was directed to look at the financial condition of licensed ambulance services. A pilot project is complete and the findings are available in a full-length report, as well as being summarized in this report. The study found that many ambulance services do not have separate financial records for their services, or their financial record keeping is inadequate. There is little uniformity in financial reporting, even among those who have a more sophisticated financial data collection system.

Another complicating factor is that the 1995 Minnesota State Legislature created a new Emergency Medical Services Regulatory Board (EMSRB), which is scheduled to assume ambulance service regulatory authority on July 1, 1996. Because of this, the health commissioner has determined that it would be inappropriate to decide whether the ambulance service industry should be rate-regulated.

The health commissioner recommends the following:

1. The Emergency Medical Services Regulatory Board should continue the public policy discussion on ambulance service rate regulation and report its findings to the legislature as soon as possible.

2. Financial data collection from ambulance services should be a high priority for the Emergency Medical Services Regulatory Board. It is needed before a recommendation on rate regulation can be made.

3. If the Emergency Medical Services Regulatory Board favors rate regulation, it should consider assisting in the development of the rate-setting program. It should not administer rate setting, because of possible conflicts it may have in fulfilling its quality assurance

responsibilities. The Emergency Medical Services Regulatory Board should continue the financial data collection program initiated by the health commissioner. This project will indirectly promote other quality-improvement data activities by establishing some standardization and data collection proficiency.

Minnesota has been careful to separate the rate setter from the quality assurance/consumer protection monitor. Examples include the separation of the Department of Public Service, which serves as the consumer advocate, the Public Utilities Commission which sets utility rates, the Department of Human Services, which sets rates for nursing homes, and the Department of Health, which is responsible for quality assurance in nursing homes. Separation of rate setting from quality assurance should take place with ambulance service rate regulation.

4. If rate regulation moves forward in the future, the Emergency Medical Services Regulatory Board should establish an expert panel to make recommendations on the rate-setting methodology. Three states have models to follow. The board should also recommend a response to the unique needs of all-volunteer ambulance services, which may never have the capacity to adequately report financial data. Representatives from the Minnesota Ambulance Association, the EMS regions, municipalities, third party payers, and the EMS occupations must be included on the panel.

5. Efforts must continue to coordinate data collection projects with other state agencies that collect ambulance service financial data in order to eliminate duplicate collections, and to solicit their suggestions for establishing a rate setting mechanism. EMS is unique; it uses first responders (many from the police and fire communities), and volunteers and much of its funding comes from transportation dollars. EMS is often called upon to respond to trauma on Minnesota's roads.

6. One of the first duties of the expert panel must be to create a financial modeling plan. Financial modeling should be performed to identify the cost impact of rate regulation to the public and ambulance services. They should offer options to the policy makers and the industry based on those financial models.

This report will present the findings of the commissioner in her effort to explore this issue so far. It may be a useful resource for the Emergency Medical Services Regulatory Board in its continuing pursuit of this project.

II. Purpose of Study

In late 1992, legislators heard from citizens about large differences in charges between ambulance services. Legislation enacted earlier in 1992 granted ambulance services an exemption from mandated Medicare assignment. This meant that, unlike other Medicare providers, an ambulance service was not required to accept the Medicare reimbursement amount as full payment and could, instead, bill the patient for full charges (balance billing). Citizens expressed concern because the state granted a competition-protected license and did not regulate charges or permit citizens a choice of ambulance service. Rate regulation began to be discussed in Minnesota, as it had been in many other states.

Members of the ambulance service industry raised other concerns, based on the discount contracting taking place in the managed care marketplace. In other parts of the country, large, multi-location ambulance service companies were signing such contracts. Members of Minnesota's industry expressed support for the primary service area (PSA) concept which has been developed and continues to be refined in this state. PSA boundaries and managed competition service areas did not appear to be suitably matched.

In addition, some ambulance services have experienced difficulty with finances, volunteers, or both. Some ambulance services have struggled to upgrade or purchase equipment, or to recruit and retain volunteers. Therefore, with 60 percent of the industry either rural or volunteer, policy makers determined that ambulance service financial data be collected as part of the review of the desirability and feasibility of an ambulance service rate regulation system.

Minnesota Session Laws 1994, Chapter 625, Article 5, Section 8, directed the Commissioner of Health, in consultation with the Minnesota Ambulance Association and the regional emergency medical services systems, to study the feasibility and desirability of establishing a system of ambulance rate regulation, and to report findings, conclusions, and recommendations to the legislature. The mandating legislation required the report to be part of the report on the financial condition of licensed ambulance services, as mandated by Session Laws of the State of Minnesota, 1993 First Special Session, Chapter 1, Article 1, Appropriations, Section 3, subdivision 4, Health Delivery Systems. Appendix A contains a copy of the legislation, and Appendix B shows the eight EMS regions.

III. Definition of Rate Regulation

Rate regulation means different things to different people. Depending on the payer source, Minnesota ambulance service operators may already be subject to some types of rate regulation. For example, in most cases, federal and state reimbursement programs, such as Medicare and Medicaid, may not reimburse based on actual costs. Some ambulance services have entered into agreements with payers, such as commercial insurance carriers, health maintenance organizations (HMOs), and preferred provider organizations (PPOs), to grant a discount in exchange for prompt payment.

In some areas, ambulance services receive a subsidy from a government agency. Of 57 ambulance services responding to this question in the 1994 Ambulance Service Financial Data Collection Pilot Study, 15 charged residents lower rates than non-residents, as is done in some other states. Many times, to continue receiving a subsidy, the ambulance service must provide annual financial reports to the funding government agency. Ambulance services seeking an increased subsidy, increased rates, or both, may have to provide financial justification to the government agency and seek its approval for the change. Ambulance services seeking a subsidy would have to provide financial justification to the funding government agency. Ambulance service providers are currently subject to the growth limits established under MinnesotaCare reforms.

For this report, rate regulation means any policies, procedures, or other requirements administered by the State of Minnesota which establish and/or control ground ambulance service charges in Minnesota.

IV. Methodology

This report examines the following questions:

A. What organizational models are used by Minnesota ambulance services?

B. What is the role of financial data collection in rate regulation?

C. What are the barriers to ambulance services in reporting financial data?

D. Why consider the desirability and feasibility of ambulance service rate regulation?

E. How is ambulance service rate regulation done by other states or jurisdictions?

F. How is rate regulation done by other rate-regulated industries in Minnesota?

G. Is ambulance service rate regulation desirable?

H. Is ambulance service rate regulation feasible?

Answers to these questions came from many sources. Public input came through consultation with the Minnesota Ambulance Association, the eight regional emergency medical services projects, ambulance operators, and the Minnesota Board on Aging. Input came from public meetings and discussions, written comments on the financial data collection program pilot study forms and survey, and telephone comments on the financial data collection process. MDH staff researched models from other states and jurisdictions with ambulance service rate regulation. MDH staff also discussed the issue with representatives of state agencies that regulate other industries in Minnesota.

As with most research, this study has limitations which should be acknowledged. Many factors must be identified and examined to determine the desirability and feasibility of ambulance service rate regulation. The subject is complex because of the many components of the EMS industry and the variations in the communities served. This study addresses only the primary factors to be considered.

V. Analysis and Discussion

A. What organizational models are used by Minnesota ambulance services?

Ambulance services may be organized within a fire or police department (dual or multiple role), other public service, hospital-based, or private. They may be all volunteer, part-paid and part-volunteer, or all paid. Their owner may be a county, city, city/county, hospital, U.S. Public Health Service, Federal Government, non-profit corporation, other non-profit, individual (sole proprietorship), partnership, Indian Health Bureau, or a for-profit corporation. There are ambulance services in Minnesota that are entirely tax-supported. Some services receive a subsidy from a city, county, community health system, regional EMS project, or other agency. Volunteer services may receive a training subsidy from the Minnesota Department of Health. Other services depend entirely on patient charges.

There is a direct relationship between the organization of an ambulance service and it's costs and charges. For example, two neighboring communities may have differently organized ambulance services. One community may have a municipal ambulance service, which the local citizens may have chosen to subsidize through taxes. The other community may have a non-profit, or for-profit ambulance service. It is very difficult to draw a direct comparison between these models. The costs of the two ambulance companies may be identical, but their charges vary widely because one is tax supported and the other is not. Other factors directly influencing cost and price include, but are not limited to, the level of care provided (basic vs. advanced), the cost of capital and how it is accounted for, equipment replacement schedules, and whether the operation is volunteer or paid.

B. What is the role of financial data collection in rate regulation?

The central issue in determining whether ambulance services need to be rate regulated, and with what speed such a process may need to be initiated, is if any inappropriate pricing currently exists. The only way to determine that is through financial data collection. MDH initiated a financial data collection process with a pilot study in 1994. 1996 will be the first year that all ambulance services will be required to submit data.

The collection of financial data will be a very difficult process for ambulance services. In order to draw any comparison between services, a common accounting structure and methodology will have to be used. There are providers today who do not have any accounting procedures. Others use government accounting rules, and some follow the Generally Accepted Accounting Principles (GAAP) and produce financial statements which are audited.

The 1996 financial data collection process has been designed in an attempt to merge these accounting systems into a common accounting base. Many smaller services may have to use the services of an accountant for the first time. The financial data collection forms may have to be adjusted multiple times, before an "apples to apples" comparison can be made between any two given ambulance companies. (See next section for further discussion.)

C. What are the barriers to ambulance services in reporting financial data?

Summary of key findings from the Financial Data Collection Program Pilot Study

1. Many ambulance services could not identify all revenues and expenses. Some services, particularly hospital-based services, received a discounted payment for ambulance and inpatient services and may not have tracked or recorded, or be able to track and record revenues to a department, such as the ambulance service. Services that were part of a parent organization, such as a city, county, fire department or hospital, may have had difficulty identifying and allocating all expenses required to provide ambulance services.

2. Comparisons between services were difficult. The financial data collection program must accommodate the wide range in ability of ambulance service operators to collect and report data. Many representatives of services that were part of a parent organization commented that their financial data did not include all the expenses of providing ambulance service. As a result, comparisons between services will not be meaningful until all services use the same definitions and methodology to recognize revenues and expenses.

3. "Financial statement" had various interpretations. Respondents were asked to submit financial statements and submissions varied widely. Of the 58 respondents whose annual data were entered in full, or in part, 22 had ambulance service-specific audited financial statements, 14 had unaudited statements, 13 had financial statements from a parent organization without the ambulance service separated, and nine had partial, unusable, or no financial statements. Some owners with multiple licenses reported all their activities in a combined financial statement, making it difficult to assign revenues and expenses to an individual license for a level of service.

4. Time to collect data and complete the data collection form varied widely. Regardless of ownership and operation, coordinating data collection

efforts, completing the form, and assembling a financial statement and rate schedule took time. Contact persons for the survey had varying degrees of comfort and experience with financial data and the time to compile and report the requested data varied accordingly.

Participants thought that the first year an ambulance service collected and reported data would take more time than in later years. All volunteer services reported frustrations in finding additional time to complete the pilot study. Surprisingly, some respondents said that they liked compiling monthly data and continued to do so for their service's use.

5. Providing technical assistance for the financial data collection required much more MDH staff time than was anticipated. Technical assistance can help service representatives compile and report data so that comparisons over time and between services will be accurate.

   The pilot financial condition study helped identify areas that need additional work in order to achieve uniform reporting. Future activities should include, but not be limited to:

   a. Defining a minimum data set for revenues, expenses, and other descriptive data, such as number and type of runs.

   b. Determining what modifications should be made for services that are part of a parent organization.

   c. Determining what information will be public. Individuals may want salaries and other data on individuals to be private or non-public.

   d. Determining how revenues from a taxing district, in-kind support and fund raising to keep charges low or meet operating deficits should be treated.

   e. Determining how volunteer time should be calculated.

   f. Developing a methodology to verify financial data.

In general, the effort of financial reporting was recognized as a laudable and needed goal for the ambulance service industry. There appears to be strong support for further efforts in this area.

D. Why consider the desirability and feasibility of ambulance service rate regulation?

Ambulance service industry members, citizens, and policy makers have concerns about ambulance service rates. The state licenses ground ambulance service providers, which includes a competition-protected PSA. Ambulance services include locations with varying population densities and proportions of Medicare beneficiaries; service levels; ownership; operation, such as public, hospital-based, or private; and staffing, such as staffing by all, some, or no paid staff, resulting in a wide variation in ambulance service charges. Under Minnesota law, citizens have no choice of emergency medical services providers. The public, used to comparing products and services by price, does not understand the great variation in the industry and the many factors that affect charges. Some members of the industry and the public have a perception that the current system has the potential to take financial advantage of persons who have no choice of provider. There is great variation in charges by ambulance services.

E. How is ambulance service rate regulation done by other states or jurisdictions?

A Journal of Emergency Medical Services survey identified states with ambulance service rate regulation. Contacting each state that reported having rate regulation revealed that many only did rate regulation or rate setting for services to beneficiaries of various public programs, such as Medicaid. Representatives of states or jurisdictions with rate regulation systems reported that the process requires verifiable financial data. Rate regulation assumes a standard methodology for each service to determine revenues and expenses and a standard format to report financial data to the regulatory agency. Data included revenues, expenses, and net incomes that can be compared over time and to other providers. For a rate increase in excess of limits, the ambulance service must provide financial justification and go through an approval process that may include hearings.

In summary, ambulance services must submit financial data with some degree of standardized reporting. Municipalities may not keep records showing ambulance service as a separate line item, so expenses for municipally owned or operated services may be difficult to determine. The frequency of rate increases varies. Below are descriptions of the EMS rate regulation system in three states:

Arizona - Arizona began its current system in 1985. The state has about 80 ambulance services. Most companies provide fire and ambulance service for an exclusive area. Except for Phoenix and Tucson, providers have a monopoly for their area. Providers and the state each present cases for a rate change. The state has had one rate change with hearings in the past five years.

The legislature set up a mechanism for providers to have an annual "inflationary rate increase" based on a formula. The formula allows a maximum percentage increase equal to half the sum of the gross domestic product plus the medical portion of the consumer price index. The 1994 maximum was four percent. An ambulance service may apply for a "general rate increase" by submitting financial statements as part of its justification. The ambulance service can determine its costs and the Arizona EMS Section determines if they are reasonable. Using each rate increase process, an ambulance service could raise rates up to twice a year. Rate increase requests and annual reporting require submission of financial statements. Depending on the service, financial statements may range from a balance sheet, income statement, and other supporting documents to a community's audited financial statement. All data is public, and the state prepares a monthly list of current rates for each ambulance service.

With the exception of the ability to present a rate case, this system is similar to Minnesota's growth limits, which are already in place. Growth limits, however, do not address the issue of whether pricing was appropriate in the first place.

Connecticut - Connecticut began its rate increase process about 10 years ago. The process is NOT a rate review process. The state has about 80 services on the rate process, out of 200 services in the state. The remaining services are volunteer and do not charge. Each company can change rates annually. The state sets the maximum allowable rates. Emergency and scheduled service have the same rates. Processing to determine rate increases takes from July 15 to December 15. Rates may change once a year. The state has the pro forma and actual data for the current year and for two prior years.

Connecticut reviewers consider rates from the following three perspectives, not in priority order:

1. Ensure that the rate process does not put providers out of business. Given the negotiated line items on the pro forma financial statements, should a good business person be able to stay in business?

2. Protect the patient, since 911 gives the ambulance service a monopoly. Is the rate reasonable to provide up-to-date skills and equipment?

3. Satisfy the regulator that proposed rates are appropriate, correct, and within allowable limits?

Hawaii - Hawaii began its current system in 1982. The Department of Health negotiates with Medicare, Medicaid, and primary providers, primarily HMOs and the Blues Health Plans, to maximize reimbursement. The state tries to collect 50

percent of direct ambulance service costs. The state contracts with providers. The state currently has six providers, including an air ambulance. Rates are set through administrative rules. New rules are adopted approximately every three years, after public hearing(s). Hawaii uses HCFA regulations as a guide to fee negotiation, much as hospitals establish fees. Cost and access influence pricing. For example, critical care and non-emergency are two examples of cost centers. The state has a flat base rate of $425.

F. How is rate regulation done by other rate-regulated industries in Minnesota?

Rate regulation in Minnesota began in 1871 with the appointment of a Railroad Commissioner, and the establishment of a Railroad and Warehouse Commission in 1895. Minnesota telephone companies became regulated in 1915. In 1975, Minnesota became the 48th state to regulate rates of natural gas and electric utilities. The Minnesota Public Utilities Commission (PUC) regulates over 350 entities providing electric, natural gas or telephone service. The Transportation Regulation Board regulates the railroad, bus, and truck industries. Local governments regulate water and sewer utilities.

For example, the PUC regulates telecommunications rates. The PUC determines an authorized rate of return for a telephone company. If the company's rate of return is below the authorized rate and the company would like to increase its rates, the company may file a rate case with the PUC. The process takes about ten months and includes public hearings and review of current and proposed rates.

Several other Minnesota state agencies influence utility rates and service. The Minnesota Department of Public Service (DPS) is responsible for representing the public interest before the PUC, conducting investigations, and enforcing PUC orders. The DPS and the PUC were one organization before separating in 1980, to eliminate potential and real conflicts of interest due to organizational structure. The Office of the Attorney General represents the interests of residential and small business utility customers before the PUC.

The federal government also influences utility rates and service through laws passed by Congress and regulatory agencies, such as the Federal Energy Regulatory Commission (FERC), which has authority over wholesale gas and electric rates. The Federal Communications Commission (FCC) governs interstate telecommunication matters.

G. Is ambulance service rate regulation desirable?

1. Advantages for the public

- Rate regulation may improve public confidence in ambulance service charges. There are currently concerns about possible inappropriate pricing.

- Rate regulation may reduce public confusion. Currently, because of the great variety of factors affecting charges, such as service level, run volume, and operation, the public has difficulty comparing charges and understanding why some services have higher charges than others.

- Rate regulation may encourage some services to begin, or refine, cost accounting and to review and establish equitable charges, working towards more efficient systems and delivery of services.

- For the ambulance services which are municipally subsidized, rate regulation may offer more opportunity for projecting and managing costs, ultimately protecting the tax payers.

- Because policy makers have determined emergency services are a public health function with designated service areas, EMS does not fit into the market-based, competitive model which has been chosen for the rest of the state's health care delivery system. Integrating efficiently with the rest of the health care delivery system would be more easily done if rates were not set competitively for delivery of services in a non-competitive service area. Ultimately, it is the health care consumer who will benefit from a well-run health care delivery system.

- Rate regulation may result in better data collection, which can also be used for other purposes, such as comparing and improving services to the consumer.

- Purchasers (including the state) and payers would probably benefit from the predictable and understandable fee schedule.

- Consumer complaints and inquiries could be responded to more effectively.

2. Advantages for ambulance services

- Rate regulation may improve public confidence that inappropriate pricing is not a reality.

- Rate regulation may encourage some services to begin, or refine, cost accounting and to review and establish equitable charges. Without rate regulation, some services may not re-examine their charges as frequently, or work to become more efficient.

- Rate regulation may streamline collections by paperwork with third party payers, thereby increasing collections and reducing days in accounts receivable. Both changes may improve the financial condition of ambulance services.

- Rate regulation may reduce contested rates and questions about service. Rate regulation may reduce questions from the consumers about charges for services received.

- Implementation of uniform billing for services rendered to Medicare beneficiaries, effective in 1995, may make the rate regulation process simpler.

- Rate regulation could result in easier comparisons of charge structures between ambulance services.

- Rate regulation may result in the collection of more comparable data which can be used for continuous quality improvement (CQI), as well as for designing appropriate technical assistance for each ambulance service.

3. Disadvantages for the public

- Depending on how the base rate, or rates, are determined with rate regulation, differences in service variables may result in higher charges for some services than for others.

- Having a rate regulation program may not answer all the public's questions about ambulance service charges. Several factors, such as service level, run volume, and operation, affect charges. Consequently, even with rate regulation, members of the public may have difficulty comparing charges between ambulance services and understanding why some services have higher charges than others.

- Complying with rate regulation may cause ambulance services to incur additional expenses that will be reflected in ambulance service charges.

4. Disadvantages for ambulance services

- Depending on how rate regulation determines the base rate, or rates, differences in service variables may result in higher charges for some services than for others.

- Rate regulation may result in increased expenses for some services. Some ambulance services will have to compile more detailed financial data. Small services may have proportionately higher costs than larger services which can spread costs over more ambulance runs. Many services do not have audited financial statements, or, if part of a parent company, ambulance service-specific audited financial statements. An audit may be a financial hardship for a small volunteer service.

- Volunteer services may not have the time, the expertise, or both, to provide desired the data. According to data supplied by ambulance services through December 1994, the state had 166 all volunteer services, 73 partially paid services, and 68 all paid services.

H. Is ambulance service rate regulation feasible?

Answering this question requires selecting a rate regulation methodology and identifying its associated equipment, staffing, supply and time requirements. Regardless of the methodology selected for implementation, rate regulation assumes that all ambulance service operators can and will:

1. Use the same methodology to determine revenues and expenses and;

2. compile and report ambulance service financial data associated with the provision of licensed ambulance service.

In 1993, the Minnesota legislature asked MDH to begin collecting financial data from licensed ambulance services in the state. At first, MDH planned to collect financial data from all ambulance services. Early in the process, however, through consultation with the Minnesota Ambulance Association, the eight regional EMS programs, and ambulance operators, ambulance service representatives and MDH staff concluded that collecting financial data on all ambulance services was more complicated than had been anticipated.

Ambulance service operator's ability to compile and report data varied widely. Therefore, the focus changed from collecting financial data on **all** services to conducting a pilot study in 1994 with 88 volunteer participants from 297 licensed

ground ambulance services, to identify if, and how, ambulance services collect financial data. Due to their unique operations, the 10 air ambulance services in the state were excluded from the study.

The study clearly indicated that financial data collection is a complex, time-consuming process, especially for smaller, subsidized ambulance services. Consequently, future efforts will require a simpler, user-friendly process and more technical assistance to help ambulance services compile and report data. The report, the "Analysis of the Financial Condition of Licensed Ambulance Services in Minnesota," offers more detail on data reporting capabilities of ambulance services in the pilot study.

VI. Conclusions and Recommendations

A. Why consider the desirability and feasibility of ambulance service rate regulation?

The three main business operating environments are competitive, cooperative, or regulated. Since the PSA approach gives an exclusive service area, competition and cooperation within a geographic area are not options. Regulation of an industry operating in a monopoly environment should be explored.

B. How is ambulance service rate regulation done by other states or jurisdictions?

The process varies between jurisdictions. Rate regulation methodology uses:

1. A standard methodology for each service to determine revenues and expenses and;

2. a standard format to report financial data to the regulatory agency.

C. How is rate regulation done by other rate-regulated industries in Minnesota?

The process varies between industries. Some industries have both federal and state regulation of rates and service. For each industry, rate regulation methodology uses:

1. A standard methodology for each company in the industry to determine revenues and expenses and;

2. a standard format to report financial data to the regulatory agency.

D. What is the impact of the EMS Regulatory Board?

The 1995 Minnesota Legislature created a new EMS Regulatory Board, which is scheduled to assume ambulance service regulatory authority on July 1, 1996.

1. A decision on whether to rate-regulate requires financial data reporting. Financial data reporting will be put into effect in 1996, but is not yet in place.

2. The EMS Regulatory Board will have EMS regulatory authority before good financial data is available.

Based on the above conclusions, the commissioner makes the following recommendations:

1. The Emergency Medical Services Regulatory Board should continue the public policy discussion on ambulance service rate regulation and report its findings to the legislature as soon as possible.

2. Financial data collection from ambulance services should be a high priority for the Emergency Medical Services Regulatory Board. It is needed before a recommendation on rate regulation can be made.

3. If the Emergency Medical Services Regulatory Board decides rate regulation is advantageous, it should consider assisting in the development of the rate setting program. It should not administer rate setting because of possible conflicts it may have in fulfilling its quality assurance responsibilities regarding EMS. The Emergency Medical Services Regulatory Board should continue the financial data collection program initiated by the Commissioner. This project will indirectly promote other quality improvement data activities by establishing some standardization and data collection proficiency.

   Minnesota has been careful to separate the rate setter from the quality assurance/consumer protection monitor. Examples are the separation of the Department of Public Service which serves as the consumer advocate, and the Public Utilities Commission which sets utility rates; or the Department of Human Services which sets rates for nursing homes, and the Department of Health which is responsible for quality assurance in nursing homes. Separation of rate setting from quality assurance should take place with ambulance service rate regulation.

4. If rate regulation moves forward in the future, the Emergency Medical Services Regulatory Board should establish an expert panel to make recommendations on the rate setting methodology. Three states have models to follow. The board should also make recommendations on how to respond to the unique needs of all-volunteer ambulance services, which may never have the capacity to adequately report financial data. Representatives from the Minnesota Ambulance Association (MAA), the EMS regions, municipalities, third party payers, and the EMS occupations must be included on the panel.

5. Efforts must continue to coordinate data collection projects with other state agencies that collect ambulance service financial data in order to eliminate duplicate collections, and to solicit their suggestions for establishing a rate setting mechanism. EMS is unique; it uses first responders (many from the police and fire communities), and volunteers and much of its funding comes from transportation dollars. EMS is often called upon to respond to trauma on Minnesota's roads.

6. One of the first duties of the expert panel must be to create a financial modeling plan. Financial modeling should be performed to identify the cost impact of rate regulation to the public and ambulance services. They should offer options to the policy makers and the industry based on those financial models.

Definitions/Components of the EMS Industry

Advanced ambulance service is an ambulance service that provides advanced life support.

Advanced life support (ALS) is an ambulance service that provides all basic life support level treatments and, in addition, provides more advanced patient assessments; more advanced airway management, usually with endotracheal intubation; electrocardiogram (ECG or EKG) heart monitoring, dysrhythmia recognition and treatment of life threatening dysrhythmia with defibrillation or cardioversion; and drug therapy for various cardiac and medical emergencies.

Base rate is the lowest charge, exclusive of mileage, for ambulance services. Base rate may include use of some equipment or supplies. If not, then an itemized bill details equipment and supplies used. Depending on the payer's reimbursement policy, an ambulance service may include charges for equipment and supplies in the base rate or may itemize charges.

Basic ambulance service is an ambulance service that provides basic life support.

Basic life support (BLS) is an ambulance that is staffed by basic emergency medical technicians (EMTs) having 110 hours of training or by EMT-Intermediates with approximately 75 hours of additional training. A BLS ambulance carries equipment and supplies for management of bleeding, fractures, neck and back injuries, burns, childbirth, breathing problems, and other medical emergencies. In addition, some BLS ambulance services have been granted variances to use advanced airway equipment such as the esophageal obturator airway (EOA), intravenous (IV) fluids, and the automatic external defibrillator (AED) after special training under the supervision of their service's physician medical director.

Emergency Medical Technician (EMT) is an individual who has completed a course at the Basic, Intermediate, or Paramedic level and has successfully completed the required examinations for certification. Such individuals typically serve as ambulance attendants but may also serve in law enforcement or fire department settings.

First Responder is an individual who has successfully completed the United States Department of Transportation First Responder Curriculum. Such individuals serve in industry settings, law enforcement, fire departments, and community volunteer groups.

Minnesota Ambulance Association is a not-for-profit ambulance industry trade association that represents the interests of ambulance services, regardless of type of ownership. Membership includes approximately 160 ambulance services and 25 associate (individuals and vendors) members.

Regional emergency medical services (EMS) programs are eight EMS regions, designated biennially by the Commissioner of Health, to assist and support training of personnel; collect and analyze data to assess local and regional needs; assist with planning for emergency and disaster preparedness; integrate EMS communication activities; manage state grant funds for program activities and equipment purchases; assist local community health services agencies; and support and provide community-based fund raising and public information and education activities. Appendix B shows the boundaries of each region. Minnesota Special Session Laws 1993, Chapter 1, Article 1, Section 3, subdivision 4 uses "programs."

Regional emergency medical services (EMS) systems are the same as regional EMS programs. Minnesota Session Laws 1994, Chapter 625, Article 5, Section 8 uses "systems."

Specialized ambulance service is an ambulance service that provides basic or advanced life support service, as designated by the Commissioner of Health, and is restricted by the Commissioner to (1) less than 24 hours of every day, (2) designated segments of the population, or (3) certain types of medical conditions.

Volunteer ambulance attendant is a person who provides emergency medical services for a Minnesota licensed ambulance service without the expectation of remuneration and who does not depend in any way upon the provision of these services for the person's livelihood. An individual may be considered a volunteer ambulance attendant even though that individual receives an hourly stipend for each hour of actual service provided, except for hours on standby alert, even though this hourly stipend is regarded as taxable income for purposes of state or federal law, provided that this hourly stipend does not exceed $3,000 within one year of the final certification examination.

PRIMARY SERVICE AREA (PSA)

"Primary Service Areas, A Discussion Guide," February 1, 1995, provided the following:

What are primary service areas (PSAs) and why were they established?

A primary service area (PSA) is "the geographic area that can reasonably be served by an ambulance service" (Minnesota Statutes §144.801, subd. 9). Minnesota Rules, Chapter 4690, further defines PSAs and sets forth minimum standards for ambulance service operations within the state. A PSA is a legal, descriptive, designated part of a state license to operate a ground ambulance service within Minnesota. Air ambulance operations are excluded by statute from PSA regulations.

PSAs fulfill several important functions. First and foremost, PSAs provide for the need and goal to have emergency ambulance coverage across the entire state. M.S. 144.804 Standards Subd. 2, (d) states that "an ambulance service shall not deny emergency ambulance service because of inability to pay or due to source of payment for services if this need develops within the licensee's PSA." This requirement of ambulance services within a designated service area protects the public through the provision of quality ambulance service to all Minnesota citizens. The public health, safety and welfare are further protected by the assurance of average response times. This provision is established in Rule 4690.3400 Designation of PSA which identifies the maximum distance from a base of operations allowed for ambulance services. The survival of ambulance services, themselves, is supported by the need to have a sufficiently large population base to justify and support the primary ambulance provider licensed for that PSA. Because pre-hospital emergency medical services provided in a non-elastic market within a designated service area, providers subsidize their emergency services with "scheduled" services, including inter-facility and pre-arranged ambulance transports.

PSA designation defined in Minnesota statutes and rules reflects distinctions between urban, rural and other population characteristics. The distinctions, which may indicate the need for "specialized" ambulance licenses, include:

- variations in population densities within a designated PSA that result in varied average response times and distances to travel; and
- concentrations of high-risk populations or certain types of medical conditions that result in heavy use of ambulance services.

The issuance of any "specialized" licenses due to these distinctions may result in a PSA which is located within another PSA or which overlaps with several other PSAs.

PSA designation for all types of licensed ambulance services occurred primarily during the period 1981 through 1982, following major revision of the ambulance licensing statutes in 1979. The revised statutes and new administrative rules include the definition of and criteria for designating PSAs. (Minnesota Statutes §§144.801-144.8091 went through major revision in 1979; subsequent amendments and rule promulgation occurred during the 1980s and 1990s.)

Ambulance providers were assigned PSAs based upon information they provided to MDH in licensure renewal applications from the year 1980. These assignments or "designations" were not made arbitrarily. The 1980 ambulance license application, as in past years, asked for detailed information about geographic areas served. This information was reviewed by the EMS Section and, if consistent with the new (1980) EMS rules, was eventually designated as the official PSA for the ambulance provider. As a result many overlaps occurred, most involving jurisdictional boundaries. For example, it was not uncommon for a fire district and a hospital district to overlap with two separate ambulance services, claiming "historical" coverage in the same geographic area. As a result, overlapping PSAs occurred naturally, most of which exist today as the "official" PSA designations by the Commissioner.

How were PSAs initially assigned?

Shortly after the 1979 Legislature enacted the law establishing PSAs, the Minnesota Department of Health (MDH) contacted all licensed ambulance services in the state. MDH set standards for reasonable response times and asked each service to describe the boundaries of its existing primary service area, using recognizable demarcation lines (highways, roads, county or township lines, municipalities, etc.). These were then turned into the legal description of each service's PSA.

At that time, the emergency 911 system was not in operation. Many calls went from patients or institutions directly to an ambulance service. Consequently, many ambulances included "occasional" runs generated from these calls as part of their service areas even when that geographic area was most frequently served by another ambulance service. Additionally, some areas of the state (primarily within the Twin Cities metro area) were served by several ambulance services. Each service included all the areas it served in its initial PSA description -- often the same areas that other service providers also included in their PSAs. These actions resulted in a number of overlapping PSAs in the state. Most of the overlaps were worked out over the years through informal agreements among the affected ambulance services for coverage in their designated PSAs. However, numerous overlaps still exist among legal PSA descriptions.

What trends in health care and the ambulance industry are affecting PSAs in Minnesota?

Health reform initiatives will affect the near-future operation of ambulance services within their PSAs, particularly as integrated service networks (ISNs) and community ISNs encompass the state. ISNs will be mandated to negotiate ambulance rates with providers serving PSAs in their locales, both for emergency response and specialized services. This wide-area coverage, as well as geographic expansion of health maintenance organizations and federal Medicare requirements for reimbursement, will continue to exert pressure on ambulance licensees as they "bid" for all types of medical and special transportation ("wheelchair") services. The reality of health reform is to increase access to health care through a system of managed competition, a system that may be somewhat contrary to the current PSA system.

Mandating Legislation

Legislative Directive to Study the Financial Condition of Licensed Ambulance Services in Minnesota

Session Laws of the State of Minnesota, 1993 First Special Session, Chapter 1, Article 1, Appropriations, Section 3, subdivision 4, Health Delivery Systems

Of this appropriation, $50,000 is to establish and administer a financial data collection program on ambulance services licensed in the state. The commissioner shall coordinate this program with the data collection initiatives of Minnesota Statutes, chapter 62J. In designing the data collection program, the commissioner shall consult with the Minnesota Ambulance Association and regional emergency medical services programs.

The financial data collection program must include, but is not limited to, ambulance charges, third-party reimbursements, sources of direct and indirect subsidies, and other costs involved in providing ambulance care in Minnesota.

All licensed ambulance services shall be required to cooperate and report information requested by the commissioner. Information collected on individuals is non-public data. The commissioner may provide summary data under Minnesota Statutes, section 13.05, subdivision 7, and may release summary data in reports.

The commissioner shall report to the legislature by February 1, 1995. The report must include an analysis of the financial condition of licensed ambulance services in Minnesota, including a description of:

1. The various organization models used to finance and deliver ambulance services;
2. the factors influencing the total revenues, rates charged, operational and other expenses;
3. limitations and barriers in collecting data on revenues and expenses;
4. the range of revenues collected and rates charged by type of organizational model and by region of the state;
5. any other significant findings relevant to the financial condition of ambulance services in the state.

The commissioner may contract for the collection of data and the creation of the financial data collection system. The commissioner shall report to the legislature on January 15 in each odd-numbered year all of the above information. The commissioner shall assist ambulance services which are unable to comply with data requests. Money appropriated is available in either year of the biennium. For purposes of establishing the base for the next biennium, the commissioner of finance shall assume $70,000 to be available for each biennium.

Legislative Directive to Study the Feasibility and Desirability of Establishing a System of Ambulance Rate Regulation

Laws of Minnesota for 1994, Chapter 625, Article 5, Section 8, Ambulance Rate Study

1. The commissioner of health in consultation with the Minnesota ambulance association and the regional emergency medical services systems shall study the feasibility and desirability of establishing a system of ambulance rate regulation. The commissioner shall report findings, conclusions, and recommendations to the legislature by February 1, 1995, as part of the report on the financial condition of licensed ambulance services in Minnesota required in Laws 1993, First Special Session chapter 1, article 1, section 3, subdivision 4.

2. If the commissioner, under paragraph (a), recommends establishing a system of ambulance rate regulation, the commissioner, in consultation with the Minnesota ambulance association and the regional emergency medical services systems, shall develop a system of ambulance rate regulations for the integrated service network and all-payer option systems. The commissioner shall present recommendations and an implementation plan for this rate regulation system to the legislature by January 1, 1996.

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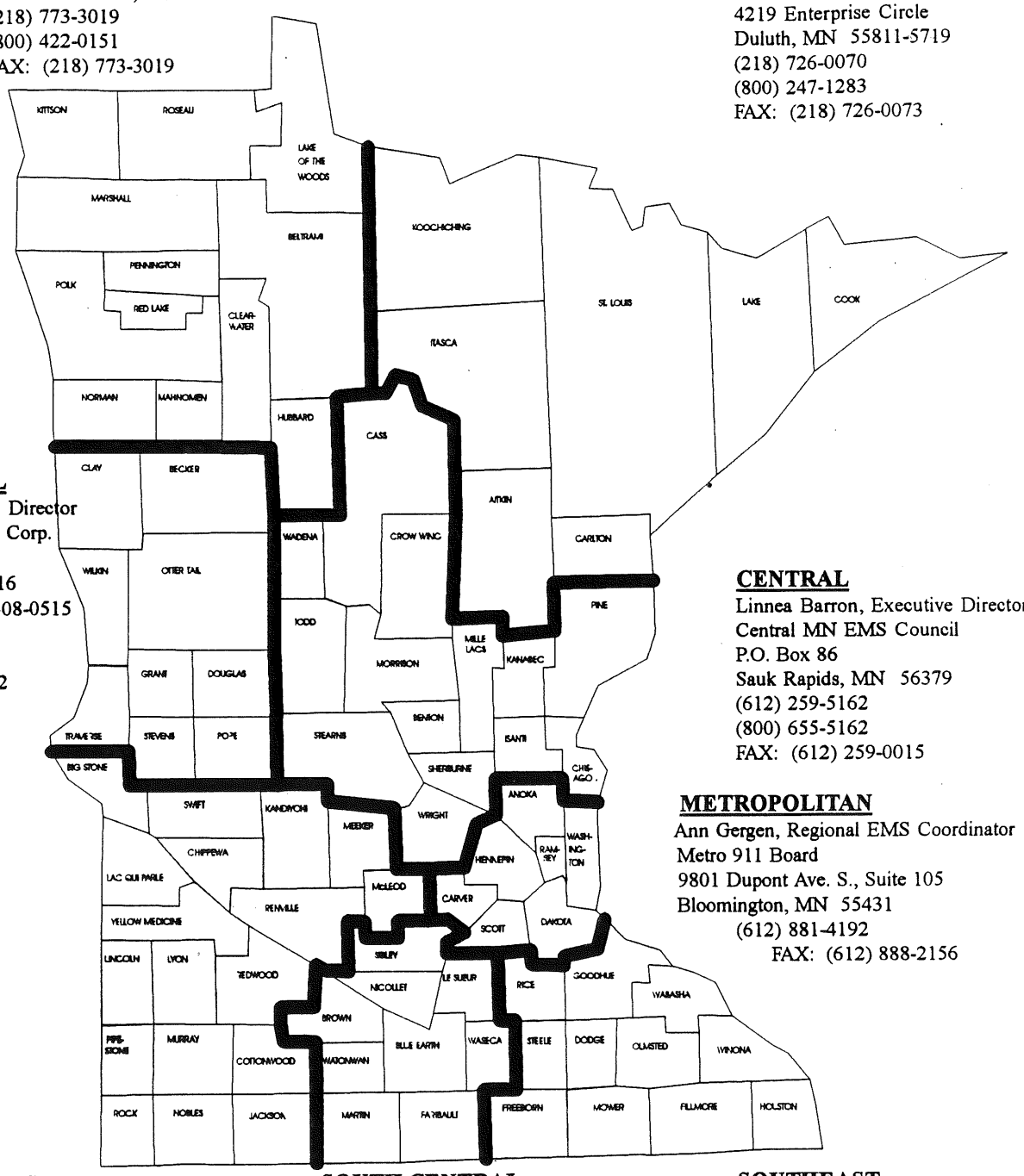

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