INTERFACE

by Jack L Stout

State Regulation and ALS

*Topics covered in "Interface" include questions of law, labor relations, purchasing practices, public safeguards, bidding procedures, regulation, and business relationships. On occasion, Mr. Stout will include material from guest columnists, real-world case histories, news of upcoming procurements, and answers to readers' questions. If you have a question, a problem, or a solution related to the public/private interface in ALS, address your letter to: "Interface," **jems**, P.O. Box 1026, Solana Beach, CA 92075.*

State regulation of the EMS industry varies enormously across the country. But while the U.S. ambulance industry is experiencing organizational evolution of the highest order, state governments, for the most part, find themselves increasingly playing the role of a mere observer or, worse, a nuisance or obstacle. If state government is to play a significant and positive role in the evolution of our industry, an entirely new and far more sophisticated form of state involvement must be developed — an involvement that recognizes and copes with the true complexities of this industry.

When an agency of government involves itself in an industry, it intervenes in that industry. To understand what a state government *could* do to intervene productively in our industry, we must first understand the intervention choices available. At a general level, states may intervene in the following ways.

Removal of state prohibitions against ALS practice. Nearly every state has already made some provision to allow paramedic personnel to render ALS procedures in the field. This was the legislative battle of the 1970s, and, in case you weren't involved, believe me it was a battle. Prior to the 1970s, nearly every state had a medical practices act and a nursing act which made the performance of ALS service by paramedics either downright illegal or at least legally questionable. When a state agreed to allow ALS procedures by paramedics, progress became legally possible. That is, the state wouldn't necessarily help promote progress, but it would, to some extent, get out of the way.

Minimum standards. It seems incredible, but it is a fact that just over a decade ago virtually anybody could clean out the back end of a stationwagon, paint "ambulance" on the side and render ambulance transportation services to ill and injured people as a business, without any form of licensure by the state. (Of course that is still true in many states where so-called nonemergency ambulance service is concerned.)

I remember working for minimum standards legislation in Arkansas. One thing we wanted to do was require that at least one of the two people on board an ambulance be trained at the old 82-hour Dunlap course level. The big fight at the time was not about equipment or about the training of the guy riding in the back with the patient. The fight was about whether there would be *anybody* riding in back with the patient. Rural ambulance providers argued loudly that it would be financially impossible to furnish two personnel, trained or not, on every ambulance, and that if the minimum standards legislation was passed, most of rural Arkansas would be left with no ambulance service at all.

State-level minimum standards legislation doesn't guarantee a community good ambulance service. It just helps to ensure that, if you have ambulance service, chances are it won't be horrible. The key word here is minimum. Rather than promoting excellence in an active way, minimum standards legislation merely establishes the floor, the bottom, the worst it should get. In a sense, minimum standards legislation sort of legitimizes low performance services. A high-quality provider operating far above the state's minimum standards is often forced to compete with much lower quality providers who constantly boast that they meet "all state requirements." *Minimum standards legislation isn't necessarily bad, but it does nothing to promote true excellence, and it is often used by low-quality operators as a justification for their continued existence.*

Certification and inspection of personnel, facilities and equipment. Where certification and inspection programs operate in conjunction with minimum standards legislation, these programs mainly serve to weed out some of the most terrible companies, people and equipment. On the other hand, if we held a convention of all the personnel and company owners who have been removed from the EMS industry as a result of state inspection and testing programs, you could probably hold that convention

Editor's note: The February Interface column, "How Much is Too Much: Pushing Performance to the Limit," was featured as the cover article due to its widespread appeal and importance to all members of the EMS team. Since writing that article, Alan Jameson and Jack Stout have spent some very long, very exciting and very productive days in Kansas City — meeting with management and field personnel to discuss the problems the article identified and to seek out possible solutions to those problems.

The results have been dramatic. What they learned in Kansas City has already been incorporated into the new system being designed for Little Rock, Arkansas. What's happening in Kansas City will eventually affect all providers. A report on the solutions to the problems in Kansas City has been postponed until some final decisions are made there.

In the meantime, the following article addresses another controversial matter of importance. As reported in "Inside EMS" (February 1984), a judge has dismissed the indictment against Eastern Ambulance Service of Syracuse, New York, making this column which discusses the Eastern Ambulance legal concerns particularly timely.

in your living room without overcrowding. Most state minimum standards are so easy to comply with that the worst in the industry have little difficulty getting into line.

Where state certification and inspection programs are related to higher levels of service, compliance is voluntary. That is, if you want to provide ALS, you must meet these higher standards, but providing ALS is optional. Some states do provide a good system of statewide certification of paramedic training programs, and some also provide a sound system of paramedic testing for individual certification. Where these ALS personnel certification programs are well run by the states, they give ALS providers access to a labor pool of known capability, and provide ALS personnel with an objective means of demonstrating qualifications. These ALS personnel certification programs, when they are well done, represent the most useful form of state intervention to date.

In contrast, some states operate ALS licensure and certification programs so poorly that they provide virtually no consumer protection, and are mainly a nuisance to ALS provider organizations. On more than one occasion I have watched a high-performance ALS provider trying to explain a sophisticated piece of on-board equipment to a clearly unqualified state inspector. The most advanced local systems employ equipment and protocols that are yet to be scheduled for state review. When a state tries to standardize ALS equipment and medical protocols, local initiative may be stifled and held to a standard of mediocrity.

In general, America's finest ALS operations are so far ahead of applicable state standards that the role of the state is irrelevant, superfluous and, without state staff cooperation, may even be a serious nuisance.

Keep in mind that when state prohibitions against paramedic performance of ALS procedures were lifted, some level of state supervision of ALS service delivery was often the political price tag. Unfortunately, the state's response, in most cases, was to extend the minimum standards philosophy, by creating additional layers of minimum standards that would apply to ALS providers. This continued focus upon minimum (i.e., worst allowable service) again makes the state's intervention nearly irrelevant to real progress. A state adopts a new minimum standard only long after the industry's best have already completed the innovation.

Need and necessity. A few states have recognized that the ambulance industry is an economic natural monopoly industry. That is, some states recognize that retail competition is ineffective, that substantial economies of scale exist, and that demand for service, to use the economist's term, is price inelastic. Recognizing these facts, some states have assumed the additional responsibility of protecting the existing industry providers from a financially deadly proliferation of competitors sharing the same fixed market. This form of intervention is distinctly different from the other forms discussed above, since it involves a *positive* action on the part of the state designed specifically to strengthen industry performance.

Unfortunately, the states that currently restrict access to the industry through need-and-necessity legislation have succeeded in restricting entry but have failed to institute alternative forms of competition, rate control and above-minimum, standard-setting procedures appropriate to a restricted access market.

In reviewing applications for new ambulance licenses, some states require the would-be competitor to document need for the additional

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service. This need might include high prices for one or more types of service, poor response time performance, BLS rather than ALS service, and so on. The present provider is allowed to respond, but, if the new applicant makes his point, an additional license may be allowed. The problem is that the entry of the additional provider is likely to destroy economies of scale, making it impossible for either provider to deliver high performance ALS service with reasonable response-time reliability. This is especially true if the new provider desires only to perform selected services such as the lucrative nonemergency transport work in selected neighborhoods. *By licensing the "cream-skimmer" the state destroys the financial integrity of the market it originally intended to protect.*

Need-and-necessity legislation is based upon an absolutely correct assumption about economic reality in EMS. But halfhearted application of such legislation creates more problems than it corrects. What if a community desires a level of service in excess of that currently provided by the state licensee? When Kansas City, Missouri, found itself in that situation, it first tried to negotiate with the state licensee companies and wound up subsidizing the private providers heavily. Still dissatisfied with local service, the city decided to establish its own clinical and response-time performance standards in excess of state requirements, allowing a nationwide bid process to select the most efficient provider of the desired services. However, without a state license, the city couldn't conduct such a bid process, and anyway the financial stability of the Kansas City system couldn't be maintained if multiple state licensees were allowed to operate. Clearly, state cooperation would be necessary.

After two years of negotiation, Kansas City finally had to purchase the company holding the state license in order to conduct its bid. After the bid, the city was subjected to an expensive and time-consuming antitrust suit by yet another company licensed by the state to operate in that jurisdiction. An expensive buyout, an expensive lawsuit, and several years of delay have now provided Kansas City with the power to establish its own higher standards and to conduct periodic nationwide bids for a qualified private operator. Today the state is reasonably cooperative, but it is accurate to say that Kansas City's remarkable progress was achieved *in spite of* state intervention, not because of it.

In Syracuse, New York, Eastern Ambulance Service acquired, mostly by accident of history, the single state license to provide ambulance services in that community. Eastern's current owners inherited the company several years ago and found the condition of its equipment, finances, clinical service and response-time performance to be in bad need of overhaul. The owners embarked upon an aggressive program of upgrading, plowing every dollar of revenue back into performance improvements. While only BLS service is required, the owners upgraded to achieve ALS capability on every ambulance, emergency and nonemergency, and increased production capacity sufficiently to achieve an enormous improvement in response-time performance.

To finance these improvements in

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quality and response-time performance, rates were gradually raised. Increased revenues were plowed back into service improvements, and profits from ancillary businesses were used to cover operating deficits. Owners' salaries were modest, no bonuses were taken, and the service improvements realized were of a type that, while beneficial to the patient, had no noticeable effect upon the balance sheet. The owners' plan was to complete the upgrading of clinical and response-time performance, and then embark upon a program of increasing financial stability for the company.

In the midst of this process, a would-be competitor applied for an additional state license. Concurrently, Eastern's owners were in the process of getting out of a losing wheelchair transport business, and negotiations were under way to sell the wheelchair transport business to the new license applicant. In the course of this sale, a noncompetition clause was added to the contract indicating that Eastern would stay out of the wheelchair transport business if the new applicant would stay out of Eastern's ambulance market.

Just as Kansas City found itself in an extremely awkward situation due to need-and-necessity regulation, Eastern Ambulance found itself in an equally awkward position. Eastern was providing a level of clinical and response-time service far in excess of the state's minimum requirements. Eastern's rates were being compared in the media with rates charged in other systems throughout the state — some subsidized (Eastern is not subsidized) and some operating at a level of clinical and response-time performance far below that provided by Eastern. Eastern was vulnerable to unfair public criticism, and, since no agency of government required the level of clinical and response time performance furnished by Eastern, Eastern couldn't even prove that it's level of service was not excessive.

Because of Eastern's aggressive financing of service upgrading, Eastern's net worth and, therefore, ability to weather a financial storm were minimal at best. What if the state should choose to license an additional ambulance provider? What if the new licensee decided to skim the cream with BLS services? How long could Eastern last? The answer was clear: only a matter of months. What would happen to service in the community? It would collapse.

If the state had required new applicants, in effect, to bid against Eastern for its exclusive license, the situation would have been different. Win or lose, at least the market's financial stability would be preserved by the issuance of a single license. And if the competition for the license was fair, with each competitor bidding to perform an identical level of clinical and response-time service, Eastern would have enjoyed the competitive edge held by any reasonably efficient incumbent provider.

But the state of New York doesn't conduct that kind of all-or-nothing license competition. The state would and does consider the issuance of an additional license, and cream-skimming business practice is not outlawed. Neither the state nor the local governments regulate Eastern's rates, leaving Eastern vulnerable to unfair comparisons and criticism. And even Eastern's clinical and response-time levels are set as a

matter of company policy, not public policy. So when Eastern contracted to protect both itself and its market from a possible cream-skimming intruder through a noncompetition clause in a contract, the New York State attorney general brought criminal and civil charges against Eastern's owners for alleged violation of state antitrust laws. As reported in "Inside EMS" (*jems*, February 1983), a grand jury dismissed the indictments against Eastern on January 10.

The point is that need and necessity legislation is an extremely powerful tool for state intervention. The underlying logic is sound, but effective implementation requires more than a review of each application with an eye toward the effects of a new competitor upon existing providers. Restricting and restructuring competition in an industry is sophisticated business. It should be tackled with great sophistication, or not at all.

Authority of local action. The state of Arkansas recently passed a law that specifically gives Arkansas communities the power to completely restructure the nature of competition at the local level. Cities are allowed to grant exclusive contracts or franchises, to prohibit others from operating and to impose clinical and response-time standards far in excess of those required by the state. However, the cities must allow periodic opportunity for competitive bidding for these exclusive rights, and may not monopolize ambulance services as an in-house service of local government.

Arkansas' law is probably the nation's best example of a state granting specific authority to local government to enable the latter to take positive steps to protect public health and safety through the delivery of better ambulance services. Kansas City had to go to court to find out for certain if it had that power. Fortunately, the courts have agreed. If a state chooses not to accept the responsibility for effectively regulating access to the ambulance industry, at least it should clearly delegate that power to units of local government, as did the Arkansas state legislature.

At the other extreme is the new California EMS law. The California law shifts the entire responsibility for EMS onto the shoulders of county government, but fails to clearly articulate what the powers of county government are relative to this new responsibility. It is reasonably clear that California counties can regulate ALS service delivery. But it is by no means clear that the counties can *require* ALS for all emergency work, and it is even less certain that the counties can control the so-called nonemergency service industry. (A California bill reportedly similar to the Arkansas statute was recently defeated in the California legislature.)

California harbors some of the best publicized yet least efficient ambulance systems of mediocre performance in America. The ultimate cream-skimming opportunities abound in California — the exclusive contracts to provide emergency transport service upon referral from a tax-supported nontransporting government ALS first response provider. With California's new state law, the state has assumed virtually no leadership and no responsibility; the cities have responsibilities but no authority; and the counties now have both responsibility and a poorly defined authority.

Pay money. In the heyday of the federal programs, some states wedged themselves in as a middle man controlling the flow of federal funds to local agencies. I am convinced that most of the federal money helped to initiate or preserve inefficient government operations, and helped to stagnate the development of high performance private sector ALS organizations. In many cities, these effects continue.

Some states put up their own money for EMS system development, but these funding sources, like the federal sources, are almost completely gone. The real source of EMS money controlled by the states, the Medicaid program, has been mostly ignored by state EMS agencies. Most Medicaid programs fail to distinguish unsubsidized providers from subsidized providers, and fail to distinguish high-quality service from low-quality service. State Medicaid programs could have been deliberately and powerfully employed to promote the growth and prosperity of high-performance, high-efficiency ALS providers, while simultaneously discouraging the growth and prosperity of private sector cream-skimmers and heavily subsidized government operations of low efficiency. But these millions of dollars controlled by the states have not been used for these purposes. It is safe to say that the states that lack the will and sophistication to control effectively competitive access to the industry must certainly lack the will

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and sophistication to manage the state's Medicaid reimbursement system to promote both quality and efficiency.

Summary

It is important to keep in mind that no state has assumed responsibility for seeing to it that each community has made good ambulance service available to its citizens. Most local governments in the U.S. have now accepted some responsibility for the delivery of ambulance services in their communities, and many have accepted full responsibility. But no state has accepted *any* responsibility for seeing to it that a statewide network of high-performance, high-efficiency ambulance services exists.

Think about it this way. If Eastern Ambulance Service, for whatever reason, stops serving Syracuse, New York, and if no comparable provider of ALS services elects to service the community, what will be the responsibility of the state? If the state of New York licenses one or a hundred ambulance companies to serve Syracuse, and none of these companies provides the service currently supplied by Eastern, what will be the responsibility of the state? If the Fresno, California, Fire Department stops providing paramedic rescue service tomorrow, and paramedic service and response times deteriorate accordingly, what will be the responsibility of the state of California? If there is no ambulance service at all in Pine Bluff, Arkansas, what will be the responsibility of the state of Arkansas?

Historically, the states have decided to assume only the responsibility to outlaw and prevent clearly terrible ambulance services. But *outlawing bad ambulance service is not the same thing as assuming responsibility for the availability of good ambulance service. No state has assumed that responsibility.* And even where states have assumed the more aggressive role of implementing need-and-necessity legislation, the states have failed to accept the responsibility for implementing a restructured form of competition and rate regulation. America's most advanced ALS systems operate at a level far in advance of state standards, and in at least one case — Syracuse — the role of the state may be to destroy what may be its most efficient high-performance service system.

What *should* a state do? If it can't help, at least it should get out of the way. It should delegate authorities to units of local government as Arkansas did. If it desires to hand off responsibility and authority, it should do so clearly and completely, not as California has done.

But what if a state really wanted to help? What would be the elements of truly effective state intervention? A state should get serious about need-and-necessity legislation. It needs to structure periodic competition for exclusive rights to each market area, allow local governments a structured opportunity to define above-minimum standards for their communities and give each community the opportunity to decide its own subsidy and rate balance. A state should make service quality and response-time performance a matter of public policy, not company policy, and promote regional development of ALS services by outlawing monojurisdictional service delivery. (A courageous group of doctors in Kalamazoo, Michigan, operating under state authority, is attempting to outlaw monojurisdictional ALS service in Kalamazoo County.)

The states also can outlaw cream-skimming competition. They can eliminate the dangerous and expensive business of allowing so-called nonemergency patients to be transported by nonemergency specialist companies. They can eliminate the inefficient and dangerous patient handoffs associated with non-transporting ALS rescue units who depend upon BLS transport crews. They could require that every ambulance provider assume full responsibility for an entire patient population, with sound clinical and response-time performance standards a condition of licensure. In short, the states could do what several cities have recently done, but on a statewide basis.

Is it likely that any state will tackle a project of such complexity and controversy in the near future? I really doubt it. Perhaps the best we can hope for is the increased adoption of state laws that will recognize the special complexities of our industry, give local governments clear-cut authority to act where the will exists, encourage or require multijurisdictional involvement at the local level and perhaps afford additional protection to companies like Eastern Ambulance so they may proceed with the evolution of this industry.

Will the states ever assume their proper role in the ALS industry? Probably. But just as state-imposed minimum standards generally follow far behind the performance of the industry's leaders, it is reasonable to expect that the nature of state intervention itself will follow far behind the precedents set by the pioneering actions of a handful of local governments. □