Sec. 19a-179-21. Rate setting for emergency medical services

Pursuant to the authority of C.G.S. 19a-177, the following regulations are enacted.

(a) **Definitions**

(1) "Commissioner" means the commissioner of the Connecticut department of health services, acting through the office of emergency medical services.

(2) "Department" means the Connecticut state department of health services.

(3) "Certified provider" means a municipal or volunteer ambulance service issued a certificate of operation by the office of emergency medical services.

(4) "Licensed provider" means a commercial ambulance service issued a license by the office of emergency medical services or any volunteer or municipal ambulance service issued a license by the office of emergency medical services prior to July 1, 1981.

(5) "Basic level ambulance response" means the transportation of a patient at the basic life support level.

(6) "Intermediate level ambulance response" means the transportation of a patient requiring definitive medical care by a service certified to the intravenous level.

(7) "ALS/Paramedic level ambulance response" means the transportation of a patient requiring definitive medical care by a service certified to the ALS/Paramedic level.

(8) "Invalid coach response" means a nonemergency request to transport a wheelchair patient.

(9) "Maximum allowable rate" means the highest amount which a licensed or certified provider may charge a patient for a given service in accordance with the appropriate rate schedule.

(10) "Necessary costs" means the costs directly related to the service provided.

(11) "Reasonable return on gross revenue" means that percentage of gross revenue which the commissioner allows to be earned as profits by licensed providers.

(b) The commissioner shall establish maximum allowable rates for each licensed or certified provider annually on or before December 15th of each year. Such rate shall take effect on January 1st of the following year. Certified and licensed providers may render charges which are less than maximum allowable rates.

(c) The commissioner shall set maximum allowable rate schedules for any or all of the following classifications of services:

(1) Basic level ambulance response by a certified provider;

(2) Intermediate level ambulance response by a certified provider;

(3) ALS/Paramedic ambulance response by a certified provider;

(4) Basic level ambulance response by a licensed provider;

(5) Intermediate level ambulance response by a licensed provider;

(6) ALS/Paramedic level ambulance response by a licensed provider;

(7) Invalid coach response by a licensed provider.

(d) The commissioner shall set maximum allowable charges which will allow each provider to impose the following special charges under the following conditions:

(1) Mileage. The mileage charge may be applied from the point of origin within the town of movement of a patient to any final destination other than within the town of origin. Mileage charges are not allowable when the point of origin and the point of final destination of the call are within the boundaries of the same town. Mileage shall be determined from

the public utility control authority's official mileage docket no. 6770;

(2) Waiting time. Charges for waiting time may be assessed on the basis of a minimum of one hour. When waiting time is in excess of one hour, additional time may be charged in quarter hour increments;

(3) Night time. Charges may be assessed for a response between the hours of 7:00 p.m. through 7:00 a.m. the following morning;

(4) Special Attendants. Charges may be assessed for use of attendants with characteristics specifically requested by or on behalf of the patient. Such special characteristics may include, but are not limited to, special training or experience or an attendant of a specific gender. There shall be no additional charge if an attendant with the requested characteristics has already been scheduled by the ambulance provider.

(e) A certified or licensed provider shall not charge for services which are not specified in the appropriate rate schedule.

(f) **Filing:**

(1) On or before July 15th of each year, all licensed or certified providers shall file with the department the following financial information based upon the twelve months immediately preceeding April 30th of the year of the application:

(A) Existing rate schedule;

(B) If the provider requests a rate increase, the requested rate schedule;

(C) A complete financial statement for the twelve months immediately preceeding April 30th of the year of application, including:

(i) a statement of income and expenses on the forms provided by the department based on an accrual method of accounting;

(ii) a balance sheet indicating the condition of the business as of the close of business on April 30th of the year of application;

(iii) a review financial statement prepared in accordance with accepted accounting practices.

(D) Financial projections covering all items in subsection (f) (1) (C) of this section for the fiscal year of application reflecting the existing and requested rate schedules;

(E) A schedule of real property, transportation equipment and all other equipment owned or leased by the provider and currently in use in the provision of ambulance services;

(F) A schedule of planned capital expenditure over the next three years;

(G) A summary by rate classification of trips logged for the immediately preceeding fiscal year;

(H) A schedule of annual compensation and benefits by job classification, including corporate officers and all employees;

(I) Numbers, job titles, annual salary ranges and hourly rate ranges of all corporate officers and employees.

(J) A schedule of any other services provided by the ambulance service provider under the same business structure;

(K) A sworn statement signed by the provider or duly authorized representative thereof that to the best of his/her knowledge the materials submitted in satisfaction of this provision are true, correct and complete and have been prepared from the books and records of the provider.

(2) Ambulance service providers shall provide the commission with any additional financial and operational information which is relevant to the rate setting; is covered under subdivision (1) of this subsection, and requested by it within fifteen (15) calendar days of receipt of the request. The request for additional information shall be made no later than August 31st of each fiscal year.

(3) Any licensed or certified provider who fails to file information required by subdivisions (1) and (2) above by July 15th of each year or within fifteen (15) days of receipt of the department's request, whichever is later, shall be subject to sanctions as provided in section 19-73bb (b), C.G.S., and shall have a maximum allowable rates for all purposes which are the lesser of the following rates:

(A) The rates set in response to the current application;

(B) The rates set following the last filing to which the providers were a party, or if none, the rates in effect at the time these regulations become effective.

(4) The department reserves the right to conduct or order a provider to conduct a full audit as it deems necessary to confirm the accuracy of submitted materials.

(g) For the purpose of the regulations, any application filed in accordance with subsection (f) of this section shall be a contested case; shall require a hearing and shall be governed by sections 19-2a-35 through 19-2a-41, inclusive of the Regulations of Connecticut State Agencies.

(h) **Waiver of right to hearing:**

(1) The applicant may waive his/her right to a hearing by filing along with the application a signed statement which indicates that:

(A) The applicant knows of his/her right to a hearing held under the provisions of sections 19-2a-35 to 19-2a-41, inclusive, of the Regulations of Connecticut State Agencies; and

(B) The applicant willingly waives the right to such hearing.

(2) Notwithstanding subdivision (1) above, the commissioner may order, not later than August 15th, that a hearing be held.

(i) All information filed by the applicant pursuant to subsections (f), (g) and (h) of this section shall be treated by the commissioner as a substantially complete case in support of the application.

(j) **Rate Setting Method.** In setting the maximum allowable rates for each provider, the commissioner shall consider the following:

(1) The necessary costs incurred in providing said service;

(2) Net income after taxes;

(3) Utilization rate of equipment and personnel;

(4) Increases or decreases in the United States Department of Labor consumer price index factors relevant to ambulance maintenance and operation in Connecticut, and any other relevant economic inflationary factors;

(5) The anticipated change in cost to the provider of full compliance with new federal and state laws and regulations;

(6) Rate differential set and paid for by other state agencies and third party payors;

(7) The percentage of cancelled calls of the total number of calls during the preceeding fiscal year;

(8) A reasonable return on gross revenue; and

(9) Any other information the commissioner may deem relevant to the rate setting process.

(Effective June 14, 1988)