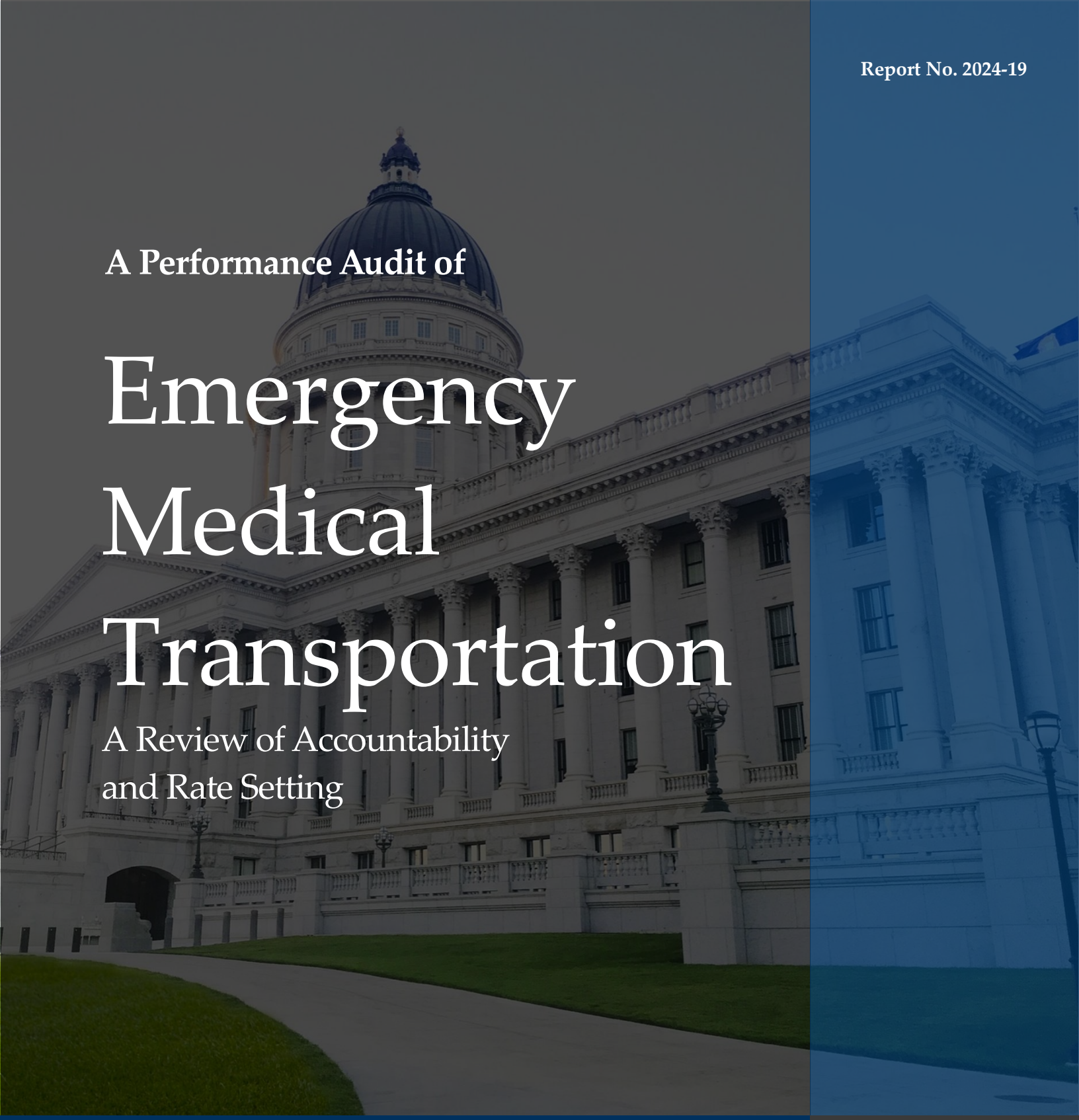
Report No. 2024-19



A Performance Audit of

Emergency Medical Transportation

A Review of Accountability and Rate Setting

Office of the Legislative Auditor General

Report to the **UTAH LEGISLATURE**

LEGISLATIVE AUDITOR GENERAL

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November 19, 2024

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report:

"A Performance Audit of Emergency Medical Transportation" [Report #2024-19].

An audit summary is found at the front of the report. The scope and objectives of the audit are included in the audit summary. In addition, each chapter has a corresponding chapter summary found at its beginning.

Utah Code* 36-12-15.3(2)** requires the Office of the Legislative Auditor General to designate an audited entity's chief officer. Therefore, the designated chief officer for the Bureau of Emergency Medical Services is Jess Anderson. Jess Anderson has been notified that they must comply with the audit response and reporting requirements as outlined in this section of ***Utah Code.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

Kade Minchey

Kade R. Minchey, CIA, CFE

Auditor General

kminchey@le.utah.gov

LEGISLATIVE AUDITOR GENERAL

AUDIT SUMMARY

REPORT 2024-21 | NOVEMBER 2024

Office of the Legislative Auditor General | Kade R. Minchey, Auditor General

PERFORMANCE AUDIT

EMERGENCY MEDICAL TRANSPORTATION

AUDIT REQUEST

In May 2024, the Legislative Audit Subcommittee prioritized an audit request of emergency medical transportation entities.

BACKGROUND

The Bureau of Emergency Medical Services (BEMS) oversees emergency medical services (EMS) agency licenses throughout the state through granting licenses for agencies to operate within exclusive geographic areas. BEMS is also tasked with setting the maximum rates EMS agencies are allowed to bill for their services.

Our office explored how EMS agencies are held accountable and what tools Utah has in place to ensure patients receive the highest quality care possible. We also explored Utah's uncommon process for setting rates and the data BEMS uses to determine how much EMS providers can charge.

KEY FINDINGS

- **1.1** Existing tools to hold EMS agencies accountable can be improved and clarified.
- **1.2** Separating 911 transport from interfacility transfers may limit the impact of recent legislation and limit local accountability.
- **2.1** Utah's rate-setting process could be improved to increase transparency and ensure adequate funding for emergency medical services.

RECOMMENDATIONS

- **1.1** The Bureau of Emergency Medical Services should make the process for submitting complaints against emergency medical service providers and agencies clearer and more accessible.
- **1.2** The Bureau of Emergency Medical Services should provide guidance on the process outlined in ***Utah Code*** for agencies to contest and apply for existing licenses.
- **1.3** The Legislature should consider granting the Bureau of Emergency Medical Services the authority to levy fines against licensed emergency medical services agencies for the purpose of holding agencies accountable and improving patient outcomes.
- **1.5** The Legislature should consider changing statute to allow cities and counties to select who performs interfacility transfers within their jurisdictions.
- **2.1** The Bureau of Emergency Medical Services should clarify the process for setting emergency medical transportation rates in *Administrative Rule* and specify which benchmarks and data are to be used in the rate-setting process.

Summary continues on back >>

REPORT SUMMARY

Utah's Emergency Medical Services System Could Benefit from Greater Accountability

Our office received numerous complaints regarding the quality of patient care when patients are being transferred between hospitals by licensed emergency medical services agencies. We reviewed the state's process for overseeing agencies and found that hospitals have not fully used current processes to hold agencies accountable.

We also found areas where accountability could be improved. For example, the process for filing complaints and contesting current ambulance licenses could be easier and more accessible. In addition, increased local control over hospital-to-hospital transfers could increase agency accountability.

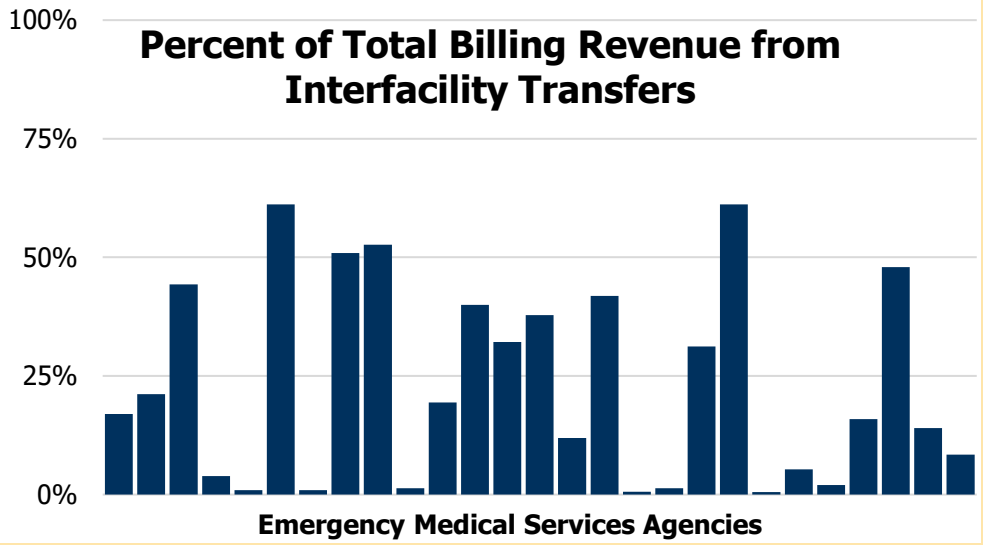
Utah's Uncommon Statewide EMS Rate Structure and Seemingly Higher Rates Necessitate a Clearer Rate-Setting Process

Utah has an uncommon approach to setting statewide rates for EMS providers. Our office also identified instances where Utah's rates appear to be high compared to other states, but they also play a crucial role in providing funding for ambulance agencies throughout the state.

We reviewed the rate-setting process and found that the Bureau of Emergency Medical Services lacks clear policies for rate setting. The data that has historically been used for rate setting is also unreliable, complicating the Bureau's ability to regulate emergency medical services and ensure these services are adequately funded.

Utah's Emergency Medical Services Agencies Rely on Interfacility Transfers

Our office received billing revenue data from a sample of EMS agencies throughout the state. The data revealed that while not all agencies receive revenue from interfacility transfers, several agencies rely heavily on this revenue. In some instances, agencies received more than 60% of their billing revenue from interfacility transfers.



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CHAPTER 1 Summary

Utah's Emergency Medical Services System Could Benefit from Greater Accountability

BACKGROUND

Emergency medical services (EMS) in Utah are provided by agencies that operate in exclusive geographic areas. The Bureau of Emergency Medical Services licenses these agencies and ensures EMS is provided statewide. Ground ambulance transportation can take the form of initial transportation resulting from a 911 call and interfacility transfers between medical facilities. Currently, cities and counties determine who provides 911 transportation while interfacility transfers are determined by historical licenses.

FINDING 1.1
Existing Tools to Hold EMS Agencies Accountable Can Be Improved and Clarified

RECOMMENDATION 1.1

The Bureau of Emergency Medical Services should make the process for submitting complaints against emergency medical service providers and agencies clearer and more accessible, including providing a clear link on the website, specifying which form to use, and ensuring there is a pathway for submitting complaints against licensed EMS agencies as well as EMS personnel.

RECOMMENDATION 1.2

The Bureau of Emergency Medical Services should clarify *Administrative Rule* to ensure that investigations against a licensed emergency medical services agency have a process and potential outcomes that conform to ***Utah Code***.

RECOMMENDATION 1.3

The Legislature should consider granting the Bureau of Emergency Medical Services the authority to levy fines against licensed emergency medical services agencies for the purpose of holding agencies accountable and improving patient outcomes.

RECOMMENDATION 1.4

The Bureau of Emergency Medical Services should provide guidance on the process outlined in ***Utah Code*** for agencies to contest and apply for existing licenses. This guidance should include a description of the process, the possible results, and the estimated costs associated with filing an application.

FINDING 1.2
Separating 911 Transport from Interfacility Transfers May Limit the Impact of Recent Legislation and Limit Local Accountability

RECOMMENDATION 1.5
The Legislature should consider changing statute to allow cities and counties to select who performs interfacility transfers within their jurisdictions.

CONCLUSION

Our office received complaints from medical providers about the quality of patient care provided by EMS agencies that covered areas such as availability of oxygen, insufficient training for ambulance personnel, and long wait times. We found that existing channels to hold EMS agencies accountable are available but are not being used by hospitals. We also found that these channels could be improved, local accountability could be bolstered, and statute could be clarified to improve accountability for EMS agencies to ensure patients receive the highest-quality care possible.

Chapter 1
Utah's Emergency Medical Services System Could Benefit from Greater Accountability

Utah Code establishes exclusive geographic service areas for the state's emergency medical services (EMS) system.[1] The Bureau of Emergency Medical Services (BEMS) in the Department of Public Safety oversees licensing for these areas and ensures that all areas of the state are covered by an EMS agency. BEMS also sets maximum fees that EMS agencies can charge for ambulance transportation.

Our office received numerous complaints from medical providers against EMS agencies regarding interfacility transfers, or transportation between medical facilities.[2] These complaints ranged from malfunctioning equipment that impacted oxygen for the patient to long wait times. We examined the current processes for overseeing and licensing interfacility transfers and EMS agencies in Utah and found that while there are available channels to hold agencies accountable, they are not being used by hospitals.

In addition, the inability for cities and counties to influence which EMS agency provides interfacility transfers may negatively impact funding for EMS agencies. Interfacility transfers provide funding that supports EMS agencies, but they are governed by exclusive geographic licenses managed by the state. We believe that current methods for holding agencies accountable could be reinforced, and statute could be clarified to improve accountability for EMS agencies to ensure patients receive the highest-quality care possible.

1.1 Existing Tools to Hold EMS Agencies Accountable Can Be Improved and Clarified

We received complaints from hospital administrators and staff regarding the quality of care during interfacility transfers. We explored the avenues available to stakeholders to hold agencies accountable and found that these processes have not been used by hospitals. These include filing formal complaints against an agency or challenging an agency's license. While these processes are untested,

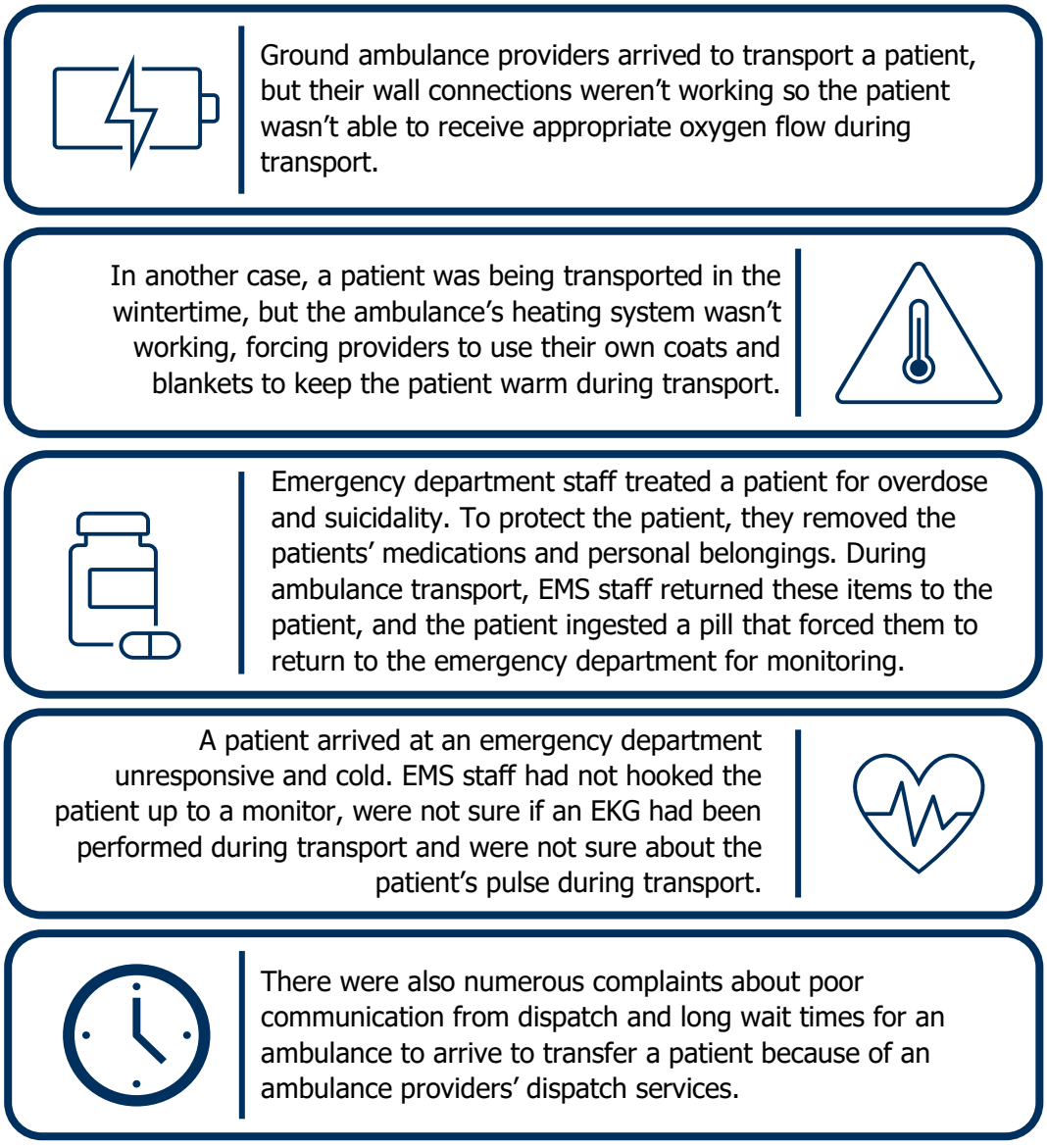
[1] ***Utah Code*** 53-2d-502.

[2] Interfacility transfers can happen for multiple reasons. If a healthcare facility cannot properly take care of a patient, the patient needs to be transferred to a facility with a higher level of care. Stable patients may be transferred to facilities closer to home or to free up beds at higher level of care facilities to make room for sicker patients.

we believe they could also be clarified and improved to address stakeholder concerns regarding interfacility patient care.

Hospitals Have Expressed Concerns About the Quality of Transportation Between Facilities

Our office spoke with healthcare administrators and staff about concerns they have tracked since at least 2020 regarding interfacility transfer agencies. These concerns all relate to appropriate care for patients, including insufficient oxygen availability, malfunctioning equipment, and poor response times. We believe these concerns have merit and could negatively impact patient care.



Source: Auditor generated.

BEMS reports they have not received these complaints and, therefore, have been unable to verify them.

Statute Currently Allows for Multiple Avenues to Hold Interfacility Agencies Accountable, But These Can Be Improved

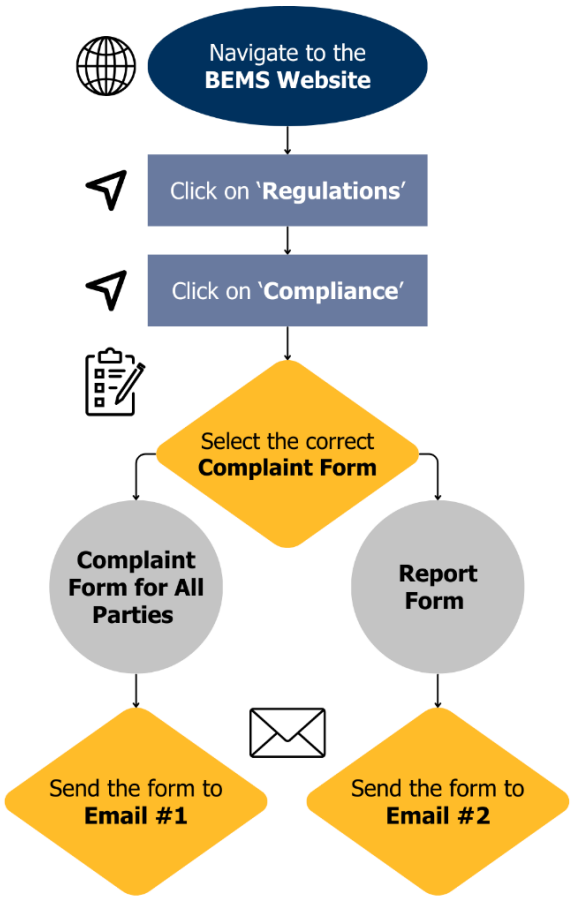
There are currently two ways for an EMS agency to be held accountable by BEMS or stakeholders for the agency's performance during interfacility transfers: filing a complaint or contesting a license. Hospitals told us their concerns but reportedly did not use the formal complaint process against ground interfacility agencies. The process for directly contesting a geographic license has only been undertaken by agencies already licensed in Utah—it's unclear what would happen if an unlicensed entity, such as a hospital, challenged a license. To provide greater accountability for licensed EMS agencies, these tools need to be used, improved, and clarified.

When stakeholders were asked about the complaint process, some reported they were unaware it existed, and others expressed skepticism that the investigation would yield meaningful outcomes.

A Complaint Process Exists, But Hospitals Have Not Used It Against Ground Interfacility Agencies. BEMS has an established process they use to receive and investigate complaints.[3] We asked whether hospitals submitted any official complaints against licensed EMS agencies relating to the issues they brought to our attention and learned that they did not. When asked about the complaint process, some stakeholders reported they were unaware it existed, and others expressed skepticism that the investigation would yield meaningful outcomes. Some of this could be explained by 1) an inaccessible complaint process, 2) apparent inconsistencies between statute and rule on the results of validated complaints, and 3) the inability to issue fines to hold agencies accountable.

Other states have clearer and more accessible processes for submitting complaints. Colorado and Oregon, for example, both have a link directly on their homepages for submitting complaints online. The process for filing a complaint in Utah is not as accessible or easily done, as shown by the following infographic.

[3] *Administrative Rule* R911-5-3300.



Source: Auditor generated.

Currently, the complaint process is buried in a menu on BEMS' website that never uses the word "complaint." Also, there appear to be several possible complaint forms without a description of which one to use. If a complainant can find the relevant website and complete the correct form, it is unclear who to send the completed form to. The BEMS website should make the complaint process easier to find and clarify which complaint form should be used, including which form should be used for filing a complaint against EMS personnel versus an EMS agency. Also hospitals should utilize this tool as a means of ensuring issues of patient care and safety are rectified in a quick and timely manner.

RECOMMENDATION 1.1

The Bureau of Emergency Medical Services should make the process for submitting complaints against emergency medical service providers and agencies clearer and more accessible, including providing a clear link on the website, specifying which form to use, and ensuring there is a pathway for submitting complaints against licensed EMS agencies as well as EMS personnel.

The result of a complaint against a licensed EMS agency investigated by BEMS is difficult to determine given statute and rule. ***Utah Code*** outlines a process for filing a complaint against EMS agencies—if BEMS believes the complaint has merit, they direct the complaint to the appropriate political subdivision to take corrective action[4] *Administrative Rule* indicates that if BEMS receives a complaint against an EMS agency and finds the complaint valid, BEMS has the authority to revoke the license. However, this may not be a viable option. While BEMS can

[4] ***Utah Code*** 53-2d-505.4.

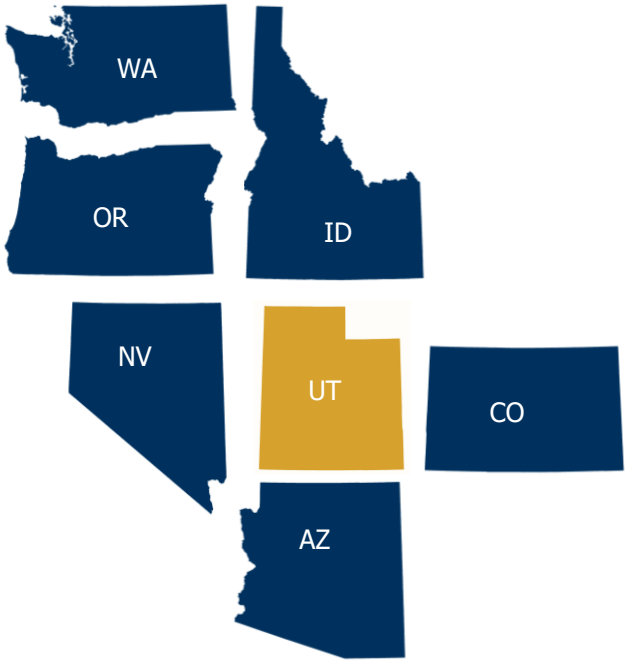
revoke a license, statute makes it clear that BEMS cannot create orphaned areas, making it unclear what the process would be for BEMS to remove a license.[5] Statute and rule create different processes for investigating and reprimanding EMS agencies. BEMS should clarify in *Administrative Rule* their process for investigating complaints against licensed EMS agencies, as well as the potential results of the investigation, and ensure these steps comply with statute.

RECOMMENDATION 1.2

The Bureau of Emergency Medical Services should clarify *Administrative Rule* to ensure that investigations against a licensed emergency medical services agency have a process and potential outcomes that conform to ***Utah Code***.

Some States Use Fines to Hold EMS Agencies Accountable, but This is Currently Not Permitted in *Utah Code*. The use of fines provides governments with a tool that can encourage EMS agencies to improve without needing to resort to removing their license, which could require other agencies to cover additional territory and have negative consequences on EMS coverage in the state. Removing a license is also an unclear process.

Nearby States that Allow Fines Against EMS Agencies



Source: Auditor generated.

Six nearby states have the authority to issues penalties against EMS agencies either at the local or state level. For example, state EMS offices in Idaho, Oregon, and Arizona can issue fines against any licensed EMS agencies in the state. Clark County in Nevada has a published fee schedule which lists different fines that can be levied against licensed EMS agencies for issues from poor response time to bad equipment. Multnomah County in Oregon also

[5] *Administrative Rule* R911-5-3300(2).

outlines response time standards in its EMS plan as well as the authority to levy fines if those times are not met.

Currently, BEMS can revoke, suspend, place a license on probation, or refuse to renew a license, something BEMS reports they have only done once in the past 10 years. The ability to levy fines provides an additional option to encourage compliance and improve performance as opposed to taking away a license. The Legislature should consider allowing BEMS to levy fines against EMS agencies to encourage better performance.

RECOMMENDATION 1.3

The Legislature should consider granting the Bureau of Emergency Medical Services the authority to levy fines against licensed emergency medical services agencies for the purpose of holding agencies accountable and improving patient outcomes.

Agencies Can Challenge Current License Holders, But This Process Has Not Been Used in Several Years. Statute outlines a process by which an agency's current license can be challenged by an applicant who wishes to take over either part of or an entire current license in a certain geographic area.[6] Known as "convenience and necessity," this process begins when an entity applies to BEMS for a license and a current license holder contests the application. If the applicant and the current license holder cannot come to a reasonable solution, the process is turned over to a hearing officer who uses criteria outlined in ***Utah Code*** to determine which provider is best suited to provide the service. The BEMS director is authorized to make the final decision regarding how to resolve the dispute. We were able to identify several instances in which current license holders challenged the license of another agency.[7]

This process theoretically provides a path for hospitals and agencies not currently licensed in the state to contest a current license holder, demonstrate their ability to provide a better service, and be awarded a license. However,

[6] ***Utah Code*** 53-2d-506 through ***Utah Code*** 53-2d-509.

[7] In 2013, an administrative proceeding recommended that Ogden City and Gold Cross develop a mutual aid agreement to resolve conflicts over who would provide interfacility transfers within the city. West Jordan applied for an interfacility transfer license in 2018, and Gold Cross objected. Both parties reached an agreement to cooperate in providing interfacility transfer services for the community. In 2020, Gold Cross and Draper City reached a similar agreement to develop a shared agreement for interfacility transfers after Draper City applied for an interfacility transfer license.

BEMS staff have noted that this process is rarely used and when it has been used, it dealt with current license holders seeking to change or alter a license. The process for challenging licenses has not been fully tested because hospitals and other unlicensed entities have not applied for a license. Stakeholders also were skeptical and unsure of how to navigate this process. BEMS could improve this process by providing clearer guidelines on how it works, how agencies could apply, and what the potential costs would be.

RECOMMENDATION 1.4

The Bureau of Emergency Medical Services should provide guidance on the process outlined in ***Utah Code*** for agencies to contest and apply for existing licenses. This guidance should include a description of the process, the possible results, and the estimated costs associated with filing an application.

1.2 Separating 911 Transport from Interfacility Transfers May Limit the Impact of Recent Legislation and Limit Local Accountability

The provider of interfacility transfers in each jurisdiction has generally been determined by which agency has historically held the license, not on agency performance.

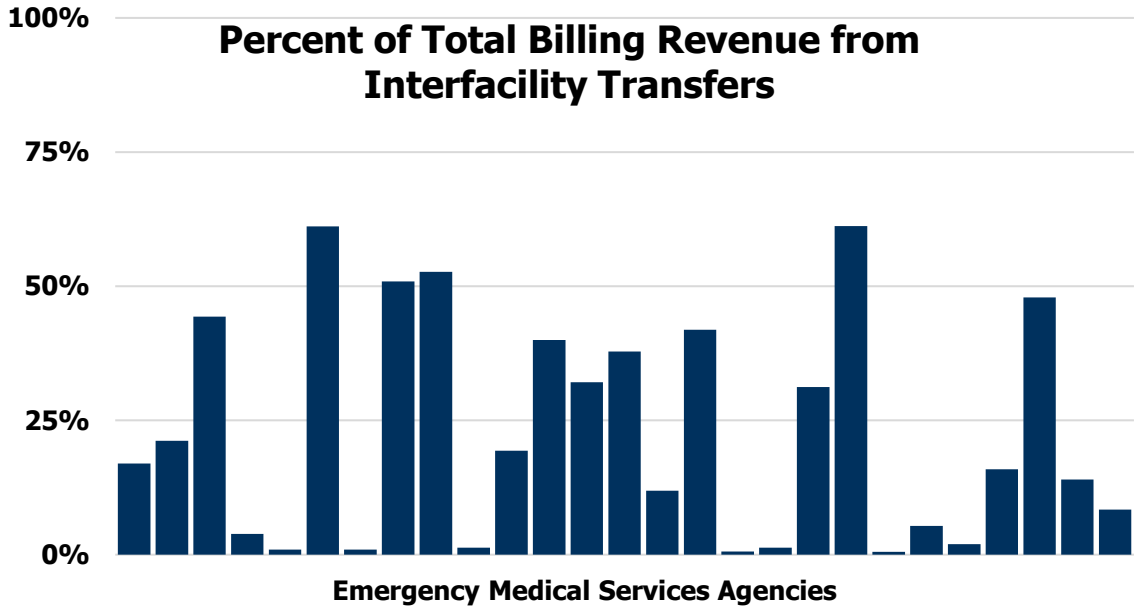
Interfacility transfers provide important revenue to Utah's EMS agencies. Local governments are allowed to oversee and select their 911 transportation agency, but not which agencies perform interfacility transfers within their jurisdictions. The provider of interfacility transfers in each jurisdiction has generally been determined by which agency has historically held the ground ambulance transport license, not on agency performance. This complicates funding for local EMS, limits local control and accountability, and could lead to additional subsidies from local governments. Because interfacility transfers play a critical role in funding EMS agencies, the Legislature should consider changing statute to give local governments more control over who provides interfacility transfers within their communities.

Utah EMS Agencies Rely on Interfacility Transfers to Subsidize 911 Transportation

EMS agencies bill patients according to the license level of the agency, with paramedic licensed agencies authorized to bill the higher paramedic rate. Revenue generated through billing accounts for a large percentage of EMS agencies' total revenue. Our office analyzed billing data from a sample of EMS

agencies to determine the number of interfacility transports as well as the revenue generated from these transports. Figure 1.1 shows the interfacility transfer revenue generated from the sample of EMS agencies in fiscal year 2023.

Figure 1.1 Some EMS Agencies Rely Heavily on Interfacility Transfer Revenue. Billing data shows that some EMS agencies received as much as 61% of their total billing revenue from interfacility transfers.



Source: EMS billing data for fiscal year 2023, provided by a billing agency that accounts for approximately 67 percent of all transported patients.

Interfacility transfers play an important role in providing revenue for EMS agencies. On average, agencies in the sample that performed interfacility transfers received approximately 23 percent of their total billing revenue from these transfers. However, of those agencies that performed interfacility transfers within the sample, several agencies received more than 50 percent of their billing revenue from interfacility transfers. Interfacility transfers appear to be lucrative because some hospitals agree to pay EMS agencies directly instead of agencies having to bill patients, thereby bypassing concerns of patients not being able or willing to pay. BEMS also reports that high mileage can contribute to interfacility transfers being a good source of revenue for EMS agencies since these transfers can cover long distances.

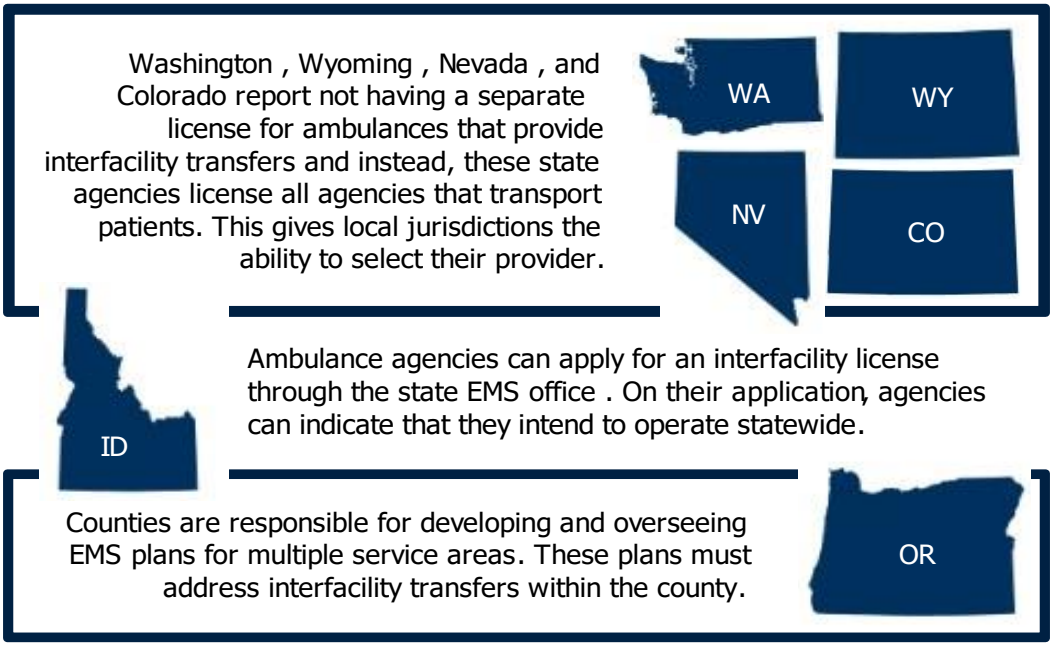
EMS directors report that revenues from interfacility transfers subsidize 911 transportation in jurisdictions that provide both services. Certain cities and counties use general funds to help maintain EMS.

EMS directors report that revenues from interfacility transfers subsidize 911 transportation in jurisdictions that provide both services. Certain cities and counties use general funds to help maintain EMS. If a city or county currently

only provides 911 transportation and is granted the license to provide interfacility transfers, that city or county may be able to reduce subsidies from the local government's general fund. This could negatively impact the incumbent provider of interfacility transfers but would increase local control over an important part of EMS.

Other States Rely on Local Control to Oversee Interfacility Transfers

Other states do not regulate interfacility transfer licenses at the state level and instead allow local and regional control to determine the interfacility provider. These state EMS offices still play a role in licensing agencies to ensure they meet a minimum standard to be able to operate an ambulance within the state. However, conversations with Washington, Oregon, Idaho, Wyoming, Colorado, and Nevada all indicated these states do not play a role in dictating where ambulance agencies are allowed to operate.



Source: Auditor generated.

While some states maintained that improvements were still needed to their EMS systems, particularly for interfacility transfers, it appears local control is being used to meet the needs of stakeholders in other states.

Utah Code Grants Local Governments Control Over 911 Transportation but Not Interfacility Transfers

The Legislature passed House Bill 303 in 2021, which changed the system of exclusive geographic licenses for 911 transportation and gave control to cities

and counties. However, licenses for interfacility transfers are still granted and overseen at the state level by BEMS through the ground ambulance licensing process that appears to award historical standing over local needs. This system requires hospitals to use whichever agency that has the interfacility transfer license for the region the hospital is located within. These interfacility licenses are largely based on historical circumstances, and not necessarily on cost or quality of services or the desires of local stakeholders.

Increased local control of interfacility transfers may help EMS agencies remain financially viable, increase local accountability, and expand opportunities granted to cities and counties under House Bill 303.

Giving control over 911 transportation to cities and counties and not interfacility transfers places restrictions on a city or county's ability to choose their 911 transportation agency, a choice mandated by House Bill 303. For example, Gold Cross is licensed to perform ground transportation and interfacility transfer services within Salt Lake City. Given the billing revenue generated through interfacility transfers from other EMS agencies, if Salt Lake City were to take on 911 transportation only, which House Bill 303 gives them the ability to do, they may need to subsidize EMS using general funds.

Of the 76 EMS agency licenses for interfacility transfers in Utah, only 2 licenses do not include 911 transportation services, indicating a strong link between interfacility transfer and 911 transportation. Increased local control of interfacility transfers may help EMS agencies remain financially viable, increase local accountability, and expand opportunities granted to cities and counties under House Bill 303. The Legislature should consider giving cities and counties the ability to choose which agency provides interfacility transfers within their jurisdiction.

RECOMMENDATION 1.5

The Legislature should consider changing statute to allow cities and counties to select who performs interfacility transfers within their jurisdictions.

If the Legislature gives cities and counties the ability to choose their interfacility transfer agency, Recommendation 1.4 in this chapter may be unnecessary. Placing cities and counties in control of interfacility transfers would change BEMS's role in determining exclusive geographic licenses.

CHAPTER 2 Summary

Utah's Uncommon Statewide EMS System and Seemingly Higher Rates Necessitate a Clearer Rate-Setting Process

BACKGROUND

Utah's emergency medical services (EMS) system relies on statewide rates, which set the maximum dollar amount that ground ambulance providers can bill for services within the state. Utah's approach to setting rates at the statewide level is uncommon. These statewide rates are seemingly high when compared to national averages.

FINDING 2.1
Utah's Rate-Setting Process Could be Improved to Increase Transparency and Ensure Adequate Funding for Emergency Medical Services

RECOMMENDATION 2.1
The Bureau of Emergency Medical Services should clarify the process for setting emergency medical transportation rates in *Administrative Rule* and specify which benchmarks and data are to be used in the rate-setting process. The Bureau of Emergency Medical Services should implement this new approach in the upcoming rate-setting cycle. The Bureau of Emergency Medical Services should present this new rate-setting process to the State Emergency Medical Services Committee.

RECOMMENDATION 2.2
The Bureau of Emergency Medical Services should ensure that all emergency medical services agency directors receive training annually on fiscal reporting guides. This training should address potential problems with allocating costs between fire departments and emergency medical services in jurisdictions that have both.

RECOMMENDATION 2.3
The Bureau of Emergency Medical Services should adopt policies for monitoring and ensuring the accurate submission of financial data prior to the next rate-setting cycle and be able to demonstrate an improvement in the quality of data contained in fiscal reporting guides.

CONCLUSION

We found instances where EMS rates in Utah appear to be high compared to other states. EMS agencies also rely on these statewide rates to generate revenue. Given both Utah's seemingly high rates as well as the importance of the rate to EMS agencies, the Bureau of Emergency Medical Services needs more reliable data on EMS agencies' finances as well as a clearer process for when and how to increase rates.

Chapter 2
Utah's Uncommon Statewide EMS System and Seemingly Higher Rates Necessitate a Clearer Rate-Setting Process

Utah's emergency medical services (EMS) system relies on statewide rates, which is uncommon nationwide. These rates set the maximum dollar amount that ground ambulance providers can bill for services. While there is no clear nationwide database for EMS rates, we identified instances in which Utah's rates appear to be higher than national averages and nearby states. As a result, our office reviewed the rate-setting process to ensure the process is reliable and transparent.

We found that the state rate plays a crucial role in funding EMS agencies, but the rate-setting process lacks clear guidelines or standards. Similarly, the data that could be used to improve the rate-setting process has consistently been unreliable, forcing the Bureau of Emergency Medical Services (BEMS) to adopt new approaches to rate setting that focus on inflation instead of actual EMS agency costs. The process for setting rates could benefit from clearer standards to ensure that the state rate is set according to a reasonable and transparent process. BEMS should also take additional steps to improve the data that the rate-setting process has relied upon.

2.1 Utah's Uncommon Rate-Setting Process Could Be Improved to Increase Transparency and Ensure Adequate Funding for Emergency Medical Services

Ground ambulance providers are authorized under *Administrative Rule* to bill patients according to the license level of the agency, but they cannot exceed the maximum rates set by BEMS.[8] Our office analyzed the rate-setting process and found that Utah has an uncommon approach to EMS rates and that Utah's rates appear to be higher than other states. EMS agencies rely heavily on these rates for billing revenue. BEMS lacks a clear process for determining these rates and does not have adequate financial data to be able to determine EMS agency finances. This complicates their ability to effectively set rates. BEMS should clarify the process for increasing rates for emergency medical transportation in *Administrative Rule* and focus on improving the financial data they receive from EMS agencies.

[8] *Administrative Rule* R911-8-200(1).

Utah's EMS Rates Appear to Be Higher Than Other States

Utah Code grants BEMS the authority to "establish maximum rates for ground ambulance providers and paramedic providers."[9] These rates can be adjusted annually and include a rate for basic emergency medical technician (EMT), advanced EMT (AEMT), and paramedic level agencies.[10] This process has resulted in rates that appear to be higher than national averages. Utah is also somewhat uncommon in that it sets rates at the statewide level.

Utah's rates are generally updated midway through the year and in 2020, Utah's paramedic rate went from $1,535 to $1,750. In comparison, the national average rate for advanced life support in 2020 was $1,277, a difference of nearly $500.

Our office identified instances in which Utah's rates appear to be higher than national averages and nearby states. Utah's rates are generally updated midway through the year, and in 2020, Utah's paramedic rate went from $1,535 to $1,750. In comparison, the national average rate for advanced life support in 2020 was $1,277, a difference of nearly $500 compared to the paramedic rate in Utah.[11] However, we were unable to confirm whether national averages include bills for specific procedures. National research on healthcare costs found that Utah had the highest mileage reimbursement rate in the nation in 2022. Idaho Falls, Idaho, updated its EMS rates in 2022—advanced life support for a non-resident was $1,168 and a resident was $913, which were both less than Utah's AEMT and paramedic rates at the time. We confirmed with Idaho Falls that their rates appear to be for services comparable to those covered by Utah's AEMT and paramedic rates. In addition, data obtained from a private insurance company operating in Utah also shows that the company has a higher reimbursement rate in Utah for advanced and basic life support when compared to other western states.

[9] ***Utah Code*** 53-2d-503.

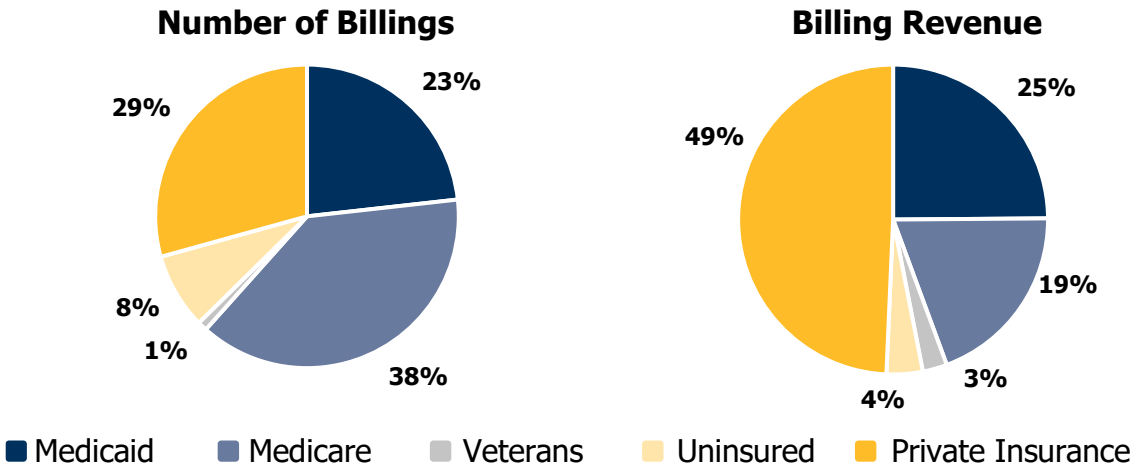
[10] The State Emergency Medical Services Committee, which is made up of stakeholders, may consult with BEMS on rates, but BEMS is ultimately responsible for creating and publishing the rates.

[11] AEMT can also be billed as advanced life support. However, in Utah in 2020, paramedic level agencies performed about 64 percent of advanced life support calls compared to 35 percent performed by AEMT.

Utah's EMS Agencies Depend on the State EMS Rate to Generate Revenue

EMS agencies often receive most of their revenue directly from billing, and a large part of billing revenue is impacted by the rates set by BEMS. Figure 2.1 shows the percentage of ground ambulance billings and billing revenue by insurance category for a sample of EMS agencies in 2023.[12]

Figure 2.1 Medicare and Medicaid Patients Make up the Majority of Ambulance Billings but Not the Majority of Billing Revenue. In 2023, private insurance billings made up a disproportionate share of billing revenue.



Source: Bureau of Emergency Medical Services billing data.

Medicare and Medicaid combined made up over 50 percent of all ambulance billings in the sample for 2023. However, Medicare and Medicaid do not provide the largest share of billing revenue. Although privately insured individuals made up 29 percent of billings, the amount paid from privately insured individual billings made up 49 percent of sampled billing revenue in 2023.

Utah's EMS rates set by BEMS impact what EMS agencies can bill whereas Medicaid and Medicare adhere to different rate policies for how much they reimburse, meaning BEMS does not directly impact Medicaid and Medicare billing.[13] Based on Figure 2.1, EMS agencies rely heavily on revenue from privately insured patients billed the state rates. As BEMS changes the rates, the amount EMS agencies can bill patients also changes and, therefore, the revenue an agency can collect. Given Utah's uncommon system and rates that appear higher than other states, as well as the crucial role the statewide rates play in

[12] This billing data represents approximately 83 percent of billable transports in the state for fiscal year 2023.

[13] Medicaid only pays the state's EMT rate as well as the mileage rate. Medicare pays based on federal fee schedules and includes the base rate as well as mileage.

funding EMS agencies, we believe it is important that EMS rates are set according to a well-understood, reliable process.

The Rate-Setting Process Has Limited Guidance

Statute and rule provide limited guidance for the rate-setting process. An internal BEMS policy lays out a defined process, but BEMS doesn't currently follow it due to data quality concerns. Stakeholders are also unaware of how rates are set. BEMS needs to establish a clear process in *Administrative Rule* for rate setting and make stakeholders aware of this process.

The only statutory language regarding rate-setting specifies that rates set by BEMS must be "just and reasonable." *Administrative Rule* provides clarification that the rates can be adjusted based on "financial data received from licensed ground ambulance providers" but it does not explicitly require this nor define what the financial data must contain.[14] Published BEMS policy outlines the process for analyzing financial data submitted by EMS agencies and setting rates to make a certain percentage of EMS agencies profitable. Conversations with BEMS staff confirmed that this process is no longer used because of data quality concerns. EMS agencies we spoke to, including a member of the State Emergency Medical Services Committee, are under the impression that BEMS still uses financial data collected from EMS agencies to determine EMS rates each year.

BEMS ties rate increases to nationwide inflation rates and billing data provided by billing agencies, not data on EMS agency expenses.

BEMS provided our office with an overview of the current rate-setting process. BEMS ties rate increases to nationwide inflation rates and billing data provided by billing agencies, not data on EMS agency expenses. The billing data contains information from a large sample of EMS agencies and reveals how much agencies billed versus how much agencies were eventually paid. For example, in 2023, a sample of agencies billed on average $2,233.10 per transport, but only received $922.54 per transport, for a collection rate of 41 percent. This billing data is then used to determine how much the state rate needs to increase to both adjust for annual inflation and account for the state's collection rate.[15] According to BEMS, Utah's EMS rates generally increase faster than inflation because amounts collected is a

[14] *Administrative Rule* R911-8-200.

[15] This process also considers the type of billings, whether they be Medicaid or private insurer, and the proportion of these different billing types.

fraction of amounts actually billed using the state rates. BEMS internal policy conflicts with the current practice of targeting inflation based on billing data.

Given that Utah's EMS rates appear to be higher than other states, the importance of the state rate in funding EMS agencies, and the need for transparency for stakeholders in the rate-setting process, BEMS should clarify its approach for increasing rates, including the data and benchmarks to be used, in *Administrative Rule*.

RECOMMENDATION 2.1

The Bureau of Emergency Medical Services should clarify the process for setting emergency medical transportation rates in *Administrative Rule* and specify which benchmarks and data are to be used in the rate-setting process. The Bureau of Emergency Medical Services should implement this new approach in the upcoming rate-setting cycle. The Bureau of Emergency Medical Services should present this new rate-setting process to the State Emergency Medical Services Committee.

BEMS' Failure to Improve Financial Data Limits Their Ability to Perform Vital Functions

BEMS requires EMS agencies to submit annual fiscal reports, which contain expense data that has been found to be unreliable. These reports, known as fiscal reporting guides (FRGs), include summary-level information regarding an agency's revenues and expenses. Audits over several years have demonstrated problems with FRG data, leading to BEMS not using the data effectively for rate-setting and other processes. BEMS should take steps to improve this data so it can have the option of using full financial data for rate-setting and to more effectively fulfill other regulatory responsibilities.

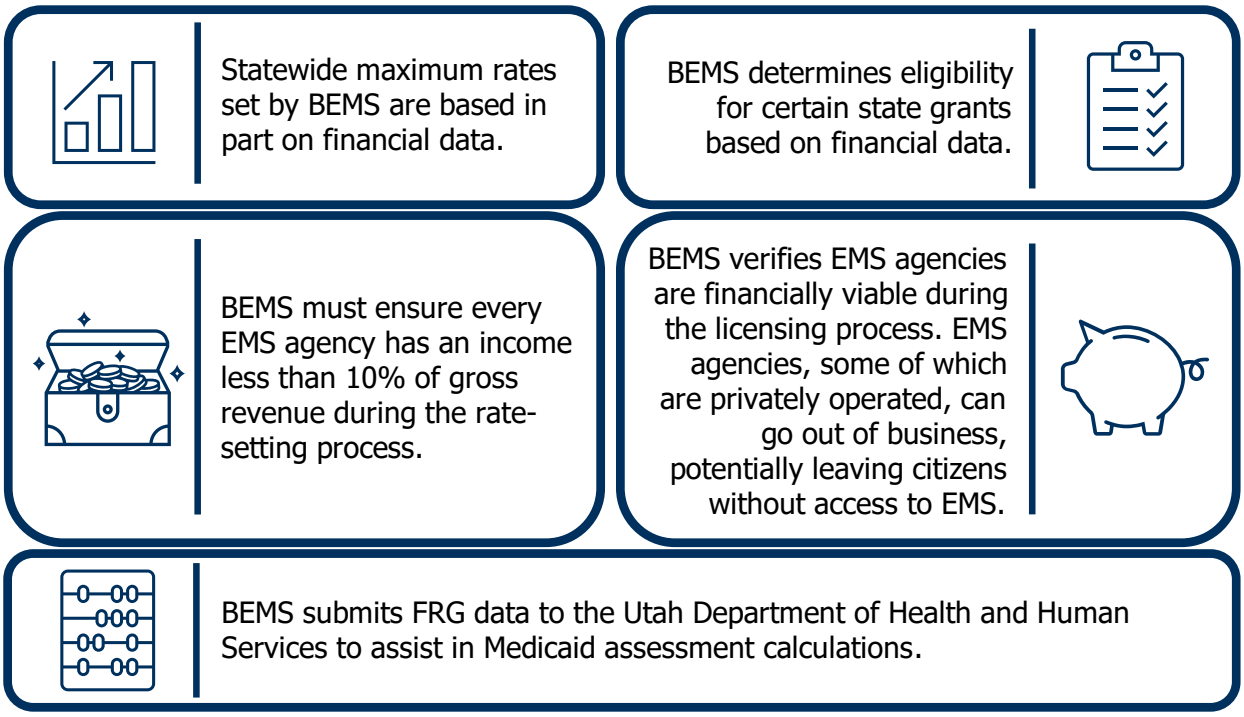
Accurate data is crucial to organizational decision making and should play a role in BEMS's rate-setting process. According to the Best Practice Handbook[16] published by our office:

[16] *The Best Practice Handbook* (2023-05). https://le.utah.gov/interim/2023/pdf/00002695.pdf.

Best Practice Handbook

"Reliable and comparable financial data are critical to decision-making. Processing and using data, despite significant data integrity issues, can aggravate problems by driving incorrect decisions. This creates a scenario where the burden of data collection continues, but the organization is better served, in some circumstances, by not using the data or using it in limited ways."

BEMS collects financial data from EMS agencies and uses it during five key regulatory functions of BEMS, some of which we have already discussed. These responsibilities are outlined in statute and rule. Unreliable data limits BEMS's ability to effectively perform these functions.



Source: Auditor generated.

Our office performed an audit of BEMS in 2014 and noted that better financial data could improve BEMS's ability to provide oversight and could have helped BEMS to proactively identify financial problems with Dixie Ambulance Services.[17] Our review of a sample of 2023 FRGs found inconsistencies when comparing submitted data against audited financial statements. Multiple audits from the Utah Department of Health and Human Services (DHHS) also

[17] *A Performance Audit of the Bureau of Emergency Medical Services and Preparedness* (2014-04). https://le.utah.gov/audit/14_04rpt.pdf.

identified inconsistencies in FRG data.[18] In 2023, auditors found that a sample of FRGs did not "accurately reflect their [ambulance agencies] financial position." Audits from 2022 and 2021 found similar issues. DHHS auditors concluded the following:

DHHS Audit Finding

"Without accurate financial data, [BEMS] is unable to ensure that the rate setting process is adequate or that the agency is operating within the parameters of state rules."

The data appears to be inaccurate because 1) EMS can be paired with fire departments in cities and counties, leading to cost allocation issues, 2) there is not always a person from finance involved in the FRG process, and 3) EMS agencies do not have consistent procedures to accurately complete an FRG.

Despite multiple audits pointing to issues with FRGs, it does not appear that BEMS has dedicated sufficient resources to improving the financial data. BEMS has historically relied on DHHS auditors to audit and monitor FRG data; BEMS does not currently have staff dedicated to analyzing and improving FRG data. It is also unclear whether BEMS provided adequate training for EMS agency directors, especially those who are new. For example, BEMS has a training video on their website designed to improve FRG data. BEMS reported that they make agencies aware during annual conferences that this training is available, but they also reported that this is an informal process.

If FRG data were better, BEMS could reliably use income or losses to help determine state rates and more accurately fulfill other regulatory responsibilities like licensing. Since BEMS already has training resources for FRGs, they should ensure all EMS agency directors receive the training annually. Given that the issue of poor data has occurred over several years, we are uncertain whether training will be sufficient. BEMS should also adopt policies to monitor and ensure the accurate submission of FRG data.

[18] BEMS moved from the Department of Health and Human Services to the Department of Public Safety on July 1, 2024.

RECOMMENDATION 2.2

The Bureau of Emergency Medical Services should ensure that all emergency medical services agency directors receive training annually on fiscal reporting guides. This training should address potential problems with allocating costs between fire departments and emergency medical services in jurisdictions that have both.

RECOMMENDATION 2.3

The Bureau of Emergency Medical Services should adopt policies for monitoring and ensuring the accurate submission of financial data prior to the next rate-setting cycle and be able to demonstrate an improvement in the quality of data contained in fiscal reporting guides.

Complete List of Audit Recommendations

Complete List of Audit Recommendations

This report made the following eight recommendations. The numbering convention assigned to each recommendation consists of its chapter followed by a period and recommendation number within that chapter.

Recommendation 1.1

We recommend that the Bureau of Emergency Medical Services make the process for submitting complaints against emergency medical service providers and agencies clearer and more accessible, including providing a clear link on the website, specifying which form to use, and ensuring there is a pathway for submitting complaints against licensed EMS agencies as well as EMS personnel.

Recommendation 1.2

We recommend that the Bureau of Emergency Medical Services clarify *Administrative Rule* to ensure that investigations against a licensed emergency medical services agency have a process and potential outcomes that conform to ***Utah Code***.

Recommendation 1.3

We recommend that the Legislature consider granting the Bureau of Emergency Medical Services the authority to levy fines against licensed emergency medical services agencies for the purpose of holding agencies accountable and improving patient outcomes.

Recommendation 1.4

We recommend that the Bureau of Emergency Medical Services provide guidance on the process outlined in ***Utah Code*** for agencies to contest and apply for existing licenses. This guidance should include a description of the process, the possible results, and the estimated costs associated with filing an application.

Recommendation 1.5

We recommend that the Legislature consider changing statute to allow cities and counties to select who performs interfacility transfers within their jurisdictions.

Recommendation 2.1

We recommend that the Bureau of Emergency Medical Services clarify the process for setting emergency medical transportation rates in *Administrative Rule* and specify which benchmarks and data are to be used in the rate-setting process. The Bureau of Emergency Medical Services should implement this new approach in the upcoming rate-setting cycle. The Bureau of Emergency Medical Services should present this new rate-setting process to the State Emergency Medical Services Committee.

Recommendation 2.2

We recommend that the Bureau of Emergency Medical Services ensure that all emergency medical services agency directors receive training annually on fiscal reporting guides. This training should address potential problems with allocating costs between fire departments and emergency medical services in jurisdictions that have both.

Recommendation 2.3

The Bureau of Emergency Medical Services should adopt policies for monitoring and ensuring the accurate submission of financial data prior to the next rate-setting cycle and be able to demonstrate an improvement in the quality of data contained in fiscal reporting guides.

Agency Response Plan

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Public Safety

JESS L. ANDERSON
Commissioner

November 7, 2024

Office of the Legislative Auditor General
W315 State Capitol Complex
Salt Lake City, UT 84114

Office of the Legislative Auditor General,

I have reviewed the audit conducted by The Office of the Legislative Auditor General (OLAG) on the Bureau of Emergency Medical Services (BEMS) and the recommendations of OLAG. I agree with the outlined implementations on the recommendations outlined below.

Sincerely,

Jess L. Anderson
Commissioner
Utah Department of Public Safety

4501 South 2700 West • Box 141775 • Salt Lake City, Utah 84114-1775 • Telephone (801) 965-4461

Recommendation 1.1

We recommend that the Bureau of Emergency Medical Services make the process for submitting complaints against emergency medical service providers and agencies clearer and more accessible, including providing a clear link on the website, specifying which form to use, and ensuring there is a pathway for submitting complaints against licensed EMS agencies as well as EMS personnel.

1. The bureau agrees with this recommendation and will implement an easily accessible web-based complaint system. The bureau has a program that can be adapted to aid in this process. The bureau will provide a visible and easy-to-find link on the bureau website.
2. Who: Kate Carlson, System Administrator (katecarlson@utah.gov)
3. How: Implement ImageTrend Complaint Process
4. Documentation: Website screenshot and Form Screenshot.
5. Timetable: 60 Days
6. When: January 15, 2025

Recommendation 1.2

We recommend that the Bureau of Emergency Medical Services clarify Administrative Rule to ensure that investigations against a licensed emergency medical services agency have a process and potential outcomes that conform to Utah Code.

1. The bureau agrees with this recommendation and will review the rule and make all necessary revisions to ensure agency and provider complaints conform with Utah Code.
2. Who: Kate Carlson, System Administrator (katecarlson@utah.gov)
3. How: Rule Revision
4. Documentation: Final Rule
5. Timetable: ≅240 days
6. When: July 1, 2025

Recommendation 1.3

We recommend that the Legislature consider granting the Bureau of Emergency Medical Services the authority to levy fines against licensed emergency medical services agencies for the purpose of holding agencies accountable and improving patient outcomes.

1. The bureau agrees that this recommendation could provide a viable alternative to license revocation. The bureau will support and implement any legislative changes that lead to better services and accountability. If legislation is passed, the Bureau will develop any rules necessary to implement the authority granted.
2. Who: Darin Bushman, Division Director (dbushman@utah.gov)
3. How: Rule Revision
4. Documentation: Final Rule
5. Timetable: Pending Legislative Action
6. When: If passed, Administrative Rule by October 31, 2025

Recommendation 1.4

We recommend that the Bureau of Emergency Medical Services provide guidance on the process outlined in Utah Code for agencies to contest and apply for existing licenses. This guidance should include a description of the process, the possible results, and the estimated costs associated with filing an application.

1. The Bureau agrees and will review rules and statutes to develop a workflow for filing and contesting a license. This work should not occur until the 2025 legislative session is complete, as there may be possible legislation related to *Recommendation 1.5* of this audit, that could impact this recommendation.
2. Who: Kate Carlson, System Administrator (katecarlson@utah.gov)
3. How: Rule Revision, Guideline Development, Website Publication
4. Documentation: Final Rule, Finished Guidelines, Availability on the Bureau website.
5. Timetable: Pending Legislative Action
6. When: Pending legislative outcome, Administrative Rule by October 31, 2025

Recommendation 1.5

We recommend that the Legislature consider changing statute to allow cities and counties to select who performs interfacility transfers within their jurisdictions.

1. If legislation is passed, the bureau will develop any rules necessary and work with local jurisdictions to implement the authority granted.
2. Who: Darin Bushman, Division Director (dbushman@utah.gov)
3. How: Rule Revision, Communication to agencies.
4. Documentation: Final Rule, Newsletter Inclusion, Availability on the Bureau website.
5. Timetable: Pending Legislative Action
6. When: Pending legislative action

Chapter 2

Recommendation 2.1

We recommend that the Bureau of Emergency Medical Services clarify the process for setting emergency medical transportation rates in Administrative Rule and specify which benchmarks and data are to be used in the rate-setting process. The Bureau of Emergency Medical Services should implement this new approach in the upcoming rate-setting cycle. The Bureau of Emergency Medical Services should present this new rate-setting process to the State Emergency Medical Services Committee.

1. The bureau agrees that the rate-setting process has been challenging in consistently using FRG reports due to data inaccuracies. The bureau will develop and implement the suggested changes before the next rate-setting cycle.
2. Darin Bushman, Division Director (dbushman@utah.gov)
3. How: Collaborate with key stakeholders to develop a new process for rate-setting, review the new process with the State EMS Committee, and implement necessary rule changes before the next rate-setting cycle.
4. Documentation: Final Rule
5. Timetable: 150 Days
6. When: March 1, 2025

Recommendation 2.2

We recommend that the Bureau of Emergency Medical Services ensure that all emergency medical services agency directors receive training annually on fiscal reporting guides. This training should address potential problems with allocating costs between fire departments and emergency medical services in jurisdictions that have both.

1. The bureau agrees with this recommendation and has a plan in place to develop and deliver training to EMS Directors and their staff annually.
2. Who: Darin Bushman, Division Director (dbushman@utah.gov) Kent Godfrey, Performance Audit Director (kgodfrey@utah.gov)
3. How: Training will be developed to cover common errors and omissions and to teach how to allocate overhead appropriately for mixed fire/EMS agencies and stand-alone EMS agencies.
4. Documentation: Training
5. Timetable: 30 Days for the initial training.

6. When: December 1, 2024

Recommendation 2.3

We recommend that The Bureau of Emergency Medical Services adopt policies for monitoring and ensuring the accurate submission of financial data prior to the next rate-setting cycle and be able to demonstrate an improvement in the quality of data contained in fiscal reporting guides.

1. The bureau agrees with the need for accurate data to be delivered from the agencies annually and will establish guidelines for evaluating FRGs. Getting accurate and timely data is a priority of the bureau to ensure the best rate-setting practices. The bureau is concerned with the ability to analyze and audit this data coming from 84 agencies. Every effort will be taken to reject erroneous data back to the agency for reconciliation, but will likely only identify the most egregious offenses. Any effort to provide substantive audits of this data will require additional personnel within the bureau and should be a consideration moving forward.
2. Who: Kate Carlson, System Administrator (katecarlson@utah.gov)
3. How: Evaluation parameters will be developed in cooperation with the internal performance audit team to allow for FRG evaluation upon receipt.
4. Documentation: FRG Evaluation guidelines.
5. Timetable: 60 days for implementing guidelines and strategies. **More in-depth audits will be dependent on the ability to increase staffing.
6. When: January 1, 2025 - **See #5

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