Improving Emergency Medical Services in Minnesota: A Legal Analysis of Minnesota’s EMS Statutes and Regulations

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The contents of this report represent the views of the authors, and do not necessarily reflect those of RCP, CURA, the Regents of the University of Minnesota, or the Minnesota State Fire Chiefs Association.
Presentation Overview

- **Project Overview**
  - Goal, key issue, and key questions

- **History of EMS in Minnesota**
  - Developments since the 1970s

- **Minnesota’s Primary Service Area System**
  - Exclusive operating areas for EMS providers

- **Federal Antitrust Liability & State Action Exemption**
  - Why Minnesota’s EMS system does not violate federal antitrust laws

- **Comparing Minnesota’s PSA System to Other States**
  - Connecticut, Michigan, California, Texas

- **Suggested Changes to Minnesota’s EMS Laws**
  - Applying elements of different states’ EMS systems
Project Overview

- Collaboration between the University’s Resilient Communities Project (“RCP”) and the Minnesota State Fire Chiefs Association (“MSFCA”)
- **Goal:** Establish local control over the provision of emergency medical services (“EMS”) in Minnesota
- **Key Issue:** Minnesota law requires the state’s Emergency Medical Services Regulatory Board (“EMSRB”) to establish primary service areas (“PSAs”)
- **Key Questions:**
  - Does Minnesota’s PSA system violate federal antitrust law?
  - How does Minnesota’s PSA system compare to other states?
  - What changes could be made to Minnesota law to improve EMS?
History of EMS in Minnesota

- EMS is very much in its infancy
  - Modern EMS did not emerge in the United States until the 1960s
- **Late 1970s:** Scathing exposé of Smith Martin Ambulance
  - Revealed at least one EMS provider prioritized profit over patients
  - Exposed need for government regulation of EMS providers
- **1978–1980:** Primary service areas (“PSAs”) written into Minnesota law
  - Ambulance licensing administered by Department of Health
- **1995:** EMSRB established to administer EMS laws and regulations
  - EMSRB continues to administer PSAs, ambulance licensing, etc.
- **1995–Present:** Immense changes since EMSRB’s inception
  - Population, call volume, technology, and more have greatly evolved
Minnesota’s Primary Service Area System

- PSAs are mandatory
  - “The [EMSRB] shall adopt rules defining primary service areas under which the board shall designate each licensed ambulance service as serving a primary service area or areas.”

- PSAs effectively create exclusive operating areas (like public utilities)
  - Ambulance services may request PSA change to eliminate overlap or expand PSA to provide service to “a contiguous, but undesignated” area
  - Ambulance services may retract service from area within PSA
  - Ambulance service may request to provide service in area within another PSA if other provider withdraws and PSAP endorses the change
  - Ambulance service may apply to provide service in area without PSA

- Minnesota’s PSA system is quite dated and unique
  - No change to law since 1970s and no other state has identical system (CT is closest)
Minnesota’s PSAs Illustrated: Hennepin County
Federal Antitrust Liability & State Action Exemption

- **Antitrust Statutes**
  - Sherman Act: Cannot adopt laws or regulations that improperly circumscribe competition

- **State Action Exemption (Parker Doctrine)**
  - Such antitrust laws do not apply to states acting in their sovereign capacities according to *Parker v. Brown*
    - Based on federalism principles and state sovereignty, the act was intended to affect private restraints on trade rather than state action
    - Immunity also applies to private persons and corporations when it is “official action directed by a state”
    - State action immunity has been applied to other federal antitrust statutes as well as the Sherman Act
  - Immunity has been extended to political subdivisions, cities, or counties when the proper legal test is met. They are not automatically immune
Federal Antitrust Liability & State Action Exemption

- For extension to a state agency or municipality, the actions must be "pursuant to a clearly articulated state policy"
  - The statute does not need to state explicitly that it intends to displace competition, if anticompetitive effects are the foreseeable result
- A state agency or commission created by the legislature is exempt if it is acting pursuant to a clearly articulated state policy
- A municipality must demonstrate that anticompetitive activities were authorized by the state pursuant to clearly articulated state policy to displace competition with regulation or monopoly public service
- Circuit court decisions suggest that the local control model of EMS easily satisfies the Parker Doctrine.
  - AmeriCare MedServices, Inc. v. City of Anaheim, Western Star Hosp. Auth. Inc. v. City of Richmond
Connecticut (Primary Service Area System)

- PSAs are mandatory (like Minnesota)
  - "The [DPH] shall . . . [] Establish primary service areas and assign in writing a primary service area responder for each primary service area . . . ."
  - All municipalities must be covered by a PSA assignment (which is indefinite)
  - Only one primary service area responder assigned for each category of service available

- PSAR assignments require local and regional input
  - The DPH must seek the advice and recommendations of the appropriate regional EMS council and the chief administrative official of the affected town

- Duty to revoke PSAs when public health and safety requires
  - "The [DPH] shall . . . [] Revoke primary service area assignments upon determination by the commissioner that it is in the best interests of patient care to do so."
Connecticut (Primary Service Area System)

- **PSAR assignments can be revoked**
  - Providers can lose a PSAR assignment through two administrative procedures
- **Regional EMS council recommendation**
  - Regional EMS council recommends withdrawal of PSAR assignment
  - DPH initiates administrative proceedings
  - Regional EMS council and PSAR may present evidence and arguments
  - DPH commissioner makes decision
- **Local government petition**
  - Municipality petitions DPH to suspend PSAR assignment
  - Municipality must demonstrate that an emergency exists and that the safety, health, and welfare is jeopardized by the PSAR’s performance
  - Municipality must develop an alternative plan to provide for the PSAR’s responsibilities
Connecticut (Primary Service Area System)

- Additional administrative procedure
  - Extension of EMS providers' duty to provide DPH certain information

- EMS providers must submit data to DPH
  - Calls received; level of care required; response times; number of passed, cancelled, and mutual aid calls; and prehospital data for the nonscheduled transport of patients

- Consequences for failure to submit data (or submitting incomplete or falsified data)
  - DPH conducts administrative hearing
  - EMS provider must show cause why their PSA assignment should not be revoked
  - DPH commissioner may take disciplinary action deemed appropriate
Michigan (Local Control System)

- MDHHS designates medical control authorities ("MCAs") to supervise and coordinate the EMS system in given counties
  - MCAs are administered by participating hospitals
- MCAs have broad authority to set and enforce EMS protocols and standards for providers
  - Effectively act as gatekeepers for EMS providers in their county or counties
- Local governments (or combinations) may operate a transport or non-transport life support operation, or contract with an entity to furnish those services
  - Note: It is permissive, not mandatory
California (Competitive Exclusion Process)

- EMSA administers California’s EMS laws and oversees local EMS agencies
  - EMSA required to assess each EMS area “for the purpose of determining the need for additional [EMS], coordination of [EMS], and the effectiveness of [EMS].”

- Counties may develop an EMS program
  - Counties must then designate a local EMS agency (“LEMSA”) to oversee EMS delivery

- LEMSAs must send annual plan to EMSA
  - LEMSAs plan must outline how EMS will be provided within its area
  - EMSA may reject plan if it fails to meet standards
  - LEMSAs may appeal determination that plan is insufficient

- LEMSAs may establish exclusive service areas
  - Requires a competitive process for selection of provider(s) (“public utility model”)
  - Competitive process not required for continuation of existing services since January 1981
Wisconsin (Statewide Licensing, no PSA)

- **Statewide system overseen by Department of Health Services (“DHS”)**
  - Department prepares biennial state EMS plan
  - Statewide EMS Board which provides recommendations to DHS

- **Licensure and Service Areas granted by DHS**
  - “Any county, city, town, village, hospital, ambulance service provider, or combination thereof may, after submission of a plan approved by the department, conduct an emergency medical services program using emergency medical services practitioners for the delivery of emergency medical care ...”

- **If DHS approves a plan and provide,**
  - Will provide support and technical assistance, assess resources and services and allocate accordingly,

- **No apparent exclusivity or anti-competitive aspect to ambulance provision**
  - Each county has list of providers and their license level available
Oregon (County Plan Model)

- Oregon Health Authority develops a comprehensive statewide EMS system
- Statute explicitly states intent to maintain local control
  - The regulation of ambulance services and the establishment of ambulance service areas are important functions of counties, cities and rural fire protection districts in this state. It is the intent of the Legislative Assembly ... to affirm the authority of counties, cities and rural fire protection districts to regulate ambulance services and areas and to exempt such regulation from liability under federal antitrust laws.
- Each county (or contiguous counties) must develop a county plan
  - Plan must address need for ambulance service coordination, and establish ambulance service areas consistent with the plan
  - Plan must be developed through consultation with persons, cities, and districts with regard to boundaries of any ambulance services areas within the plan
  - Any organization affected may formally notify the county that it wishes to be included in plan development
  - County plans/service areas must be approved by Oregon Health Authority
Oregon (County Plan Model)

- When a county plan is not adopted, ambulance services may be provided within the boundaries in accordance with policies of the governing body of the city/district.
- Each county is solely responsible for designating and administering ambulance service provider selection.
  - County plan must address the process for assigning, and reassigning, and ambulance service provider to Ambulance Service Area (“ASA”).
  - County must designate one emergency ambulance provider for each ASA, but may designate one or more non-emergency ambulance provider for each ASA.
Texas (Regional Delivery Areas & Municipal Review)

- Department of Health divides the state into EMS delivery areas
  - “That coincide, to the extent possible, with other regional planning areas”

- Both state and delivery area plans are required by statute
  - In formulating “well-coordinated plans,” department shall:
    1. Identify all agencies used for EMS in each delivery area,
    2. Enlist cooperation of all concerned agencies,
    3. Include an interagency communications network,
    4. May include use of helicopters from Dept. of Public Safety or National Guard

- Ambulance providers licensed by the department
  - Applicant required to include a map and description of service area, a list of counties and cities in which the applicant proposes to provide EMS, and a list of all station locations
Texas (Regional Delivery Areas & Municipal Review)

- For an EMS provider to be licensed, must obtain a letter of approval from local authorities:
  - From either (1) governing body of the municipality in which applicant is located and proposes to serve or (2) if not in a municipality, from the commissioners court of the county
- Municipality or county may only issue letter of approval if it determines:
  - (1) Addition of another EMS provider won't adversely affect the EMS already operating
  - (2) Addition will remedy an existing provider shortage that cannot be resolved by providers already licensed in the area
  - (3) Addition of another provider will not cause an oversupply of EMS providers in the municipality or county
- Municipalities are also free to establish standards for an EMS provider that are stricter than minimum statewide standards
Virginia (Comprehensive Plan Model)

- Established a new plan-centered system based on the Model State Emergency Medical Services System Project (2008)
  - To create more cohesion and less fragmented EMS systems across each state
- Statute requires a “comprehensive, coordinated, statewide” strategic EMS plan by the Virginia Office of EMS ("OEMS")
  - Developed 5 year plan
  - Plan incorporates regional EMS plans
- Regional EMS councils must develop and maintain a comprehensive EMS plan for coordinating deliver of EMS services
  - Regional plans must be approved by OEMS
Virginia (Comprehensive Plan Model)

- System also includes local control to a large degree through Local EMS Response Plan
  - Written document that details the primary service areas and responding interval standards that have been approved by the local government and operational medical director
  - EMS provider must provide services within its primary service area, as designated by the local EMS response plan

- Local governments can also impact EMS through ordinances
  - Allowed to enact licensing requirements, limits on agency service areas, limits on amount of providers
  - Any city or town may also establish an EMS agency as a department of government or contract for provision of EMS
Suggested Changes to Minnesota’s EMS Laws

- **Best Case: Eliminate PSAs and give local governments control**
  - Accomplishes the goal of local control over EMS
  - Gives localities choices in important public health and safety decision
  - Faces uphill battle against healthcare lobby
  - Various state models to reference as templates

- **“Connecticut Model”: Modify PSA system to provide safety valve**
  - Give EMSRB power to revoke PSA when in the public’s interest
  - Establish mechanisms for localities to seek alternatives if public safety requires
  - Require EMSRB to consider input from localities when assigning PSAs

- **“Texas Model”: Modify PSA system to give local governments veto power**
  - Gives local governments more control over EMS in their communities
  - Does not give local governments total control
  - More regional supervision
Conclusion

● Establishing local control over EMS in Minnesota will come down to a policy argument, not a legal one
  ○ Compelling evidence that it’s time for Minnesota’s EMS laws to evolve
    ■ Public health and safety should not be a for-profit endeavor
● Other states provide interesting templates and demonstrate there is no perfect system
  ○ Unique challenges (climate, geography, population, etc.) must be considered
    ■ What suits one community may not suit another
● There are multiple ways to change Minnesota’s EMS system for the better
  ○ Every approach has its advantages and disadvantages