STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Acting Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Date: April 15, 2016

To: All Licensed and Certified Emergency and Non-Emergency Transporting Service Providers

From: Renee Holota, Office Supervisor
Office of Emergency Medical Services

Re: Short-Form Rate Application Package for Requesting 2017 Rates

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The Short Form Rate Application Package for 2017 emergency and non-emergency service rates are available on the DPH/OEMS website. You will find the document at www.ct.gov/dph/ems. After you log onto the OEMS website scroll down the homepage and you will find the application. Please download and complete the application, and then mail it to OEMS or send it electronically to renee.holota@ct.gov by the due date specified below. ***You will not receive an application in the mail***.

The **Short-Form Rate Application Package** should be used for requesting emergency and non-emergency service rates for 2017. All providers that received a 2017 Rate Schedule from the Office of Emergency Medical Services must complete the 2017 Rate application, as detailed below. Those providers that have not yet begun to impose approved charges should complete the "Non-Charging Service Certification Statement for 2017".

The 2017 Rate Application package contains the following:

- **Proposed Statewide Rate Schedule of Maximum Allowable Rates for 2017**
- **Waiver Form A,** to be signed by providers that accepted the increase to the 2016 Statewide Rate Schedule. All providers that plan to continue charging in 2017, including those that have not yet begun to impose approved charges must sign and return one of the enclosed Waiver forms.
- **Waiver Form B**, to be signed by providers requesting a rate increase to their 2016 rates that does not exceed 2.3%. The spreadsheet for each of the eligible providers also incorporates the 2.3% CPI increase to their 2016 rates. **Only providers that submitted either a Long Form or a Waiver B last year may submit a Waiver B in 2017.**
- **Certification Form**, which must to be completed, notarized and submitted with all Rate Applications

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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- **Instructions** for Preparing the Short-Form Rate Application for 2017
- Short-Form Rate Application Spreadsheet
- A Rate Application **Checklist**

If you wish to request more than the 2.3% CPI increase in 2017 for any of your approved 2016 rate categories, contact Renee Holota at (860) 509-8103 or renee.holota@ct.gov for a 2017 Full Rate Application package.

Filing Requirements and Due Date:

The Office of Emergency Medical Services (OEMS) must receive in Hartford by no later than **the close of business (4:30 p.m.) on August 31, 2016** the following:

- Notarized Certification form;
- One of the following as appropriate;
  - Waiver form A
  - Waiver form B
  - Non-charging certification form
- Short-Form Rate Application Spreadsheet if charging; and
- Rate Application Checklist form

SCHEDULE OF MAXIMUM ALLOWABLE RATES

EFFECTIVE January 1, 2017 through December 31, 2017

PROPOSED RATE SCHEDULE FOR 2015

Basic Life Support (BLS) Rate	$698.00
Advance Life Support Level 1 Non-ER	$702.00
Advance Life Support Level 1 ER	$1,105.00
Advance Life Support Level 2	$1,141.00
Paramedic Intercept	$785.00
Basic Life Support (BLS) Helicopter Assist	$457.00
Advance Life Support (ALS) Helicopter Assist	$711.00
Advance Life Support (ALS) Assessment	$410.00
Specialty Care Transport (SCT)	$1,518.00

ANCILLARY CHARGES

Waiting Time Charge	$186.00
Per Mile Charge	$16.99
Special Attendant Charge	$137.00

INVALID COACH RATE SCHEDULE

Base Rate	$121.00
Two Patients	$156.00

ANCILLARY CHARGES

Per Mile Charge	$10.56
Second Attendant Charge	$71.00
Waiting Time Charge	$104.00

All charges must be in conformance with the definitions on the subsequent pages entitled "Explanatory Notes On the Implementation of the 2017 Schedule of Maximum Allowable Rates," which are attached to, and become part of, the Rate Schedule.

Certified to be the maximum allowable rates by: _____

Date Certified: _____

EXPLANATORY NOTES FOR THE IMPLEMENTATION OF THE 2016 SCHEDULE OF MAXIMUM ALLOWABLE RATES

Not Applicable or "N/A" – indicates that charges are not applicable in this category for the provider named on page one of this Schedule. Connecticut issues rates consistent with the provider's certification/licensure level.

Basic Life Support – means transportation by ground ambulance vehicle and supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician (EMT).

An emergency response by a certified or licensed ambulance provider, when no transportation is provided due to the fact that the patient is pronounced/presumed dead by an individual authorized by the State to make such pronouncement/presumption after the ambulance is called. **No ancillary fees, including mileage, may be added to this rate for patients that are pronounced dead.**

The ambulance service and personnel must comply with all relevant CT General Statutes and DPH Regulations, including, but not limited to, the minimal vehicle standards and staffing requirements specified, and cited, in DPH Regulations Section 19a-179-10 (b) "Basic Ambulance Service." Basic life support level services are those performed by personnel certified in Connecticut as Emergency Medical Technicians (EMT).

Advanced Life Support Level 1 Non-Emergency (ALS Non-ER) – the maximum charge, in addition to applicable ancillary fees, that may be assessed a patient who is transported in a ground ambulance vehicle by a **licensed** provider for the purposes of receiving, **non-emergency, ambulance services at the Advanced Life Support Level 1.** The ambulance service and personnel must comply with all relevant CT General Statutes and DPH Regulations, including, but not limited to, the minimal vehicle standards and staffing requirements specified, and cited, in DPH Regulations Section 19a-179-10 (c) "Mobile Intensive Care-Intermediate Level (MIC-I) Service, AEMT Level Service is the same." Advanced Life Support Level 1 services are those performed by personnel certified in Connecticut as an Advanced Emergency Medical Technician (AEMT) or Paramedic.

Non-emergency ALS services may include, but are not limited to the following:

1. Inter-facility transport to/from a hospital, skilled nursing facility or the patient's home and/or

2. Round trip transportation to a hospital or non-hospital based out patient facility to obtain necessary diagnostic and/or therapeutic services such as a CT scan, radiation therapy or dialysis for renal disease.

Advanced Life Support Level 1, Emergency (ALS 1, ER) – means transportation by ground ambulance vehicle, supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention, in compliance with the CGS and DPH Regulations, **in the context of an emergency response to a 911 call or equivalent.** An emergency response is defined as responding immediately at the ALS 1 level of service to a 911 call or equivalent. An immediate response is one in which the ambulance provider begins as quickly as possible to take the steps necessary to respond to the call.

Advanced Life Support Level 1 (ALS 1) services include an assessment by ALS personnel or the provision of at least one ALS intervention. An ALS assessment is performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment to determine whether ALS interventions were needed, or may be needed, during transport. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service, or that ALS personnel accompany the patient during transport. It is incumbent on the ALS Service to verify that the call was dispatched as an ALS call according to Emergency Medical Dispatch (EMD) protocols pursuant to Public Act 00-151. **The transporting BLS service is entitled to the BLS Rate in the ALS Assessment billing process.**

An ALS provider is defined as a provider whose staff includes an individual trained and authorized at the Advanced EMT or Paramedic level. An ALS assessment charge is only relevant and reimbursable in an emergency response. The ALS 1 category replaced the Intermediate Surcharge definition used for the 2003 Rate Schedule.

Advanced Life Support Level 2 (ALS 2) – means either transportation by ground ambulance vehicle, supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures:

(1) Manual defibrillation/cardioversion.
(2) Endotracheal intubation.
(3) Central venous line.
(4) Cardiac pacing.
(5) Chest decompression.
(6) Surgical airway.
(7) Intraosseous line.

ALS 2 services are those performed by personnel licensed in Connecticut as Paramedics pursuant to the provisions in CGS Section 20-206jj - 206nn. The ambulance service and personnel must comply with all other relevant CT General Statutes and DPH Regulations, including, but not limited to, the minimal vehicle standards and staffing requirements specified, and cited, in DPH Regulations Section 19a-179-10, (d) "Mobile Intensive Care-Paramedic Level (MIC-P)."

Paramedic Intercept – means Paramedic services furnished by an entity that does not furnish the ground ambulance transport. The provider must be able to document that:

1. Paramedic/ALS services were provided in accordance with medical direction and oversight.

2. The paramedic accompanied the patient to the hospital in the patient transport vehicle

BLS Helicopter Assist – Indicates the maximum charge that may be assessed a patient, including applicable ancillary fees, for a Basic Life Support Ambulance Service providing care at the scene to such patient when such patient is ultimately transported by a state certified or licensed air ambulance.

ALS Helicopter Assist - Indicates the maximum charge that may be assessed a patient, including applicable ancillary fees, for an Advanced Life Support Service providing care at the scene to such patient when such patient is ultimately transported by a state certified or licensed air ambulance.

Specialty Care Transport (SCT) - means inter-facility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including supplies and services, at a level of service beyond the scope of the Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

To assess the SCT charge a provider must be authorized at the paramedic level and must provide such care in accordance with medical direction and/or authorized protocols and applicable Connecticut statutes and DPH Regulations, including, but not limited to, those specified above in ALS 2.

Waiting Time Charge –may be assessed, in addition to the applicable ground ambulance transport charge, on the basis of a minimum wait of one hour. When waiting time exceeds one hour, additional time shall be charged in quarter hour increments.

Per Mile Charge – may be assessed, in addition to the applicable ambulance transport charge, from the point of origin to the point where the patient is transported. Mileage reimbursement shall be based on the number of actual miles the patient is transported.

Special Attendant Charge– may be assessed, in addition to the applicable ambulance transport charge, for the use of attendants with characteristics specifically requested by or on behalf of the patient. Such special characteristics

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 provider.

Bundle Billing – It is permissible for a BLS ambulance service to bill for ALS assessment and interventions provided that the ALS care is rendered by an EMS service, authorized at the paramedic level, which has entered into a bundle billing agreement with the BLS service that submits the bill.

Department of Public Health
Instructions for Preparing the Short-Form Rate Application

1. **SUBMISSION DUE DATE** – Ensure that your **Short-Form Rate application, Waiver Form**, and notarized **Certification**, are physically received by the Office of Emergency Medical Services in Hartford by **no later than the close of business (4:30 p.m.) on August 31, 2016.**

2. **SERVICE INFORMATION** – Provide the name, address and fiscal year of the service provider as well as the name, title, telephone number and e-mail address of the contact person responsible for completing the rate application.

3. **2015 REVENUE INFORMATION** – Line 18 of the spreadsheet **(Total Revenue)** is the only information required for this section. The additional fields are voluntary.

4. **2015 EXPENSE INFORMATION** – Line 41 of the spreadsheet **(Total Expenses)** is the only information required for this section. The additional fields are voluntary.

5. **BASE CALL VOLUME** – Line 66 of the spreadsheet **(Total Ambulance Base Calls)** is the only information required for this section. The additional fields are voluntary.

6. **CANCELLED AMBULANCE BASE CALLS** – Provide the number of cancelled base calls.

7. **2017 REQUESTED RATES** – Indicate "Yes" if you are requesting the Statewide Rate Schedule for 2017. Indicate "Yes" if you are requesting an increase in your currently approved maximum allowable rates that does not exceed 2.3% as calculated and presented on the spreadsheet for those providers that submitted a Waiver B form last year.

2017 Short-Form Rate Application Checklist

Provider: ____

Ensure the following items are included in your rate application submission.

Return the signed, completed Checklist with your rate application submission:

2017 Short-Form Rate Application

1. Completed spreadsheet ☐

Certification Form

2. Certification form signed by the Chief Executive Officer and notarized ☐

Waiver Form

3. Waiver Form signed by the Chief Executive Officer ☐

- Waiver A – accept Statewide Rate Schedule, or ☐

- Waiver B – request higher rate increases (long form) ☐

_____ _____

Name and Title of Preparer **Date**

_____

Signature of Preparer

_____ _____

Phone Number of Preparer **Email Address of Preparer**

Department of Public Health
Short-Form Application for 2017 Rates

	2017 Rate Application
Service Information -	
Service Name	
Mailing Address	
City & Zip	
Contact Name	
Contact Title	
Phone Number	
E-mail address	
Revenue Information -	
Billing Revenue (net of contractual allowances)	
Town Grants/Contracts	
Subscriptions/Membership	
Fund Raising Income, Net	
Non-town grants/Contracts	
Other Revenue	
Total Revenue	$0
Expense Information -	
Total Payroll and Payroll Related Costs	
Volunteer Stipends/Expenses	
Depreciation Expense (Buildings, vehicles, equipment, etc)	
Motor Vehicle Expenses (excluding depreciation expense)	
Communications	
Medical Supplies & Equipment	
Uniforms & Laundry	
Insurance	
Total Building Costs	
Education and Training	
Utilities	
Billing Services	
ALS Agreements	
Travel & Entertainment	
Office Equipment & Supplies	
Legal & Accounting Fees	
Advertising & Promotion	
Bad Debt Expense	
Taxes	
Other Expenses	
Total Expenses	$0
Balance Sheet Information -	
Cash	
Receivables	
Total Assets	0
Total Liabilities	
Fund Balance	
Total Liabilities and Stockholder's Equity	0

Note: Total Assets must equal Total Liabilities and Stockholder's Equity

Statistical Information -	
# of Ambulances	
# of Invalid Coaches	
# of Non-Transport Emergency Vehicles	
# of Locations	
Ambulance Base Call Volume-	
Medicare - Emergency	
Medicare - Non-Emergency	
Medicaid - Emergency	
Medicaid - Non-Emergency	
Non-Third Party - Emergency	
Non-Third Party - Non-Emergency	
Total Ambulance Base Calls	0
Cancelled Ambulance Base Calls	0
Total Invalid Coach Base Calls	

Requested Rates -

Accept 2.3% increase to your 2016 Statewide Rate Schedule **Yes / No**

CERTIFICATION
TO BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC

2016 Application for 2017 Schedule of Rates

STATEMENT: I solemnly swear that the statements and information contained in this Rate Application for 2017 rates, including the Rate Model, financial statements and all supporting schedules and documentation, are to the best of my knowledge and belief, true and accurate, and that only business expenses related to regulated ambulances and/or invalid coaches are included in the financial and statistical data submitted.

_____

Printed Name of Service Provider

_____

License or Certification Number

_____

_____

Address of Service Provider

_____

Printed Name and Title of Chief Executive Officer

_____

Signature of Chief Executive Officer

_____

Business Telephone Number

_____

Business E-mail address

Subscribed and sworn to me on _____

_____

Printed Name of Notary Public / Commissioner of Superior Court

_____

Signature of Notary Public / Commissioner of Superior Court

All service providers that charge for services rendered must sign and submit this Certification with their completed Rate Application to the Office of Emergency Medical Services no later than close of business (4:30 p.m.) on August 31, 2016. The Rate Application shall be deemed incomplete unless ALL required information including this Certification form and any applicable Waiver form are completed and submitted to OEMS.

WAIVER A FOR 2017 RATES

As the Chief Executive Officer of the licensed or certified service provider identified below, I am aware of the right to a hearing regarding the annual establishment of maximum allowable rates for emergency or non-emergency services pursuant to Section 19a-179-21 (h) (1) (A) of the Regulations of Connecticut State Agencies.

I willingly waive the right to such hearing regarding the establishment of maximum allowable rates for these services for the calendar year beginning January 1, 2017 through December 31, 2017 pursuant to Section 19a-179-21 (h) (1) (B) of the Regulations of Connecticut State Agencies.

I hereby accept the applicable maximum allowable rates for emergency or non-emergency services contained in the Statewide Rate Schedule for 2017, which have been approved by the Commissioner of the Department of Public Health to be effective for the calendar year January 1, 2017 through December 31, 2017.

_____

Name of Licensed or Certified Service Provider

_____

Name and Title of Chief Executive Officer

_____

Signature of Chief Executive Officer

_____

Business Phone Number

_____

Date

WAIVER B FOR 2017 RATES

As the Chief Executive Officer of the licensed or certified service provider identified below, I am aware of the right to a hearing regarding the annual establishment of maximum allowable rates for emergency or non-emergency services pursuant to Section 19a-179-21 (h) (1) (A) of the Regulations of Connecticut State Agencies.

I willingly waive the right to such hearing regarding the establishment of maximum allowable rates for these services for the calendar year beginning January 1, 2017 through December 31, 2017 pursuant to Section 19a-179-21 (h) (1) (B) of the Regulations of Connecticut State Agencies.

I hereby declare that the licensed or certified service provider identified below, for the calendar year January 1, 2017 through December 31, 2017, will not increase its maximum allowable rates for emergency and non-emergency services more than 2.3% from its currently approved schedule of maximum allowable rates, as noted in the attached rate application form.

_____

Name of Licensed or Certified Service Provider

_____

Name and Title of Chief Executive Officer

_____

Signature of Chief Executive Officer

_____

Date

_____

Business Phone Number

State of Connecticut
Department of Public Health
Office of Emergency Medical Services

NON-CHARGING SERVICE CERTIFICATION STATEMENT For 2017

I certify that _____

Name of Provider

does not impose a fee for the provision of any emergency medical services rendered and does not have an approved Rate Schedule issued by the Department of Public Health (DPH). I also certify that in adherence to the provisions of Section 19a-179-21(e) of Connecticut DPH Regulations, the above referenced provider will not charge for services provided in the future unless it applies for, and is granted, an approved Rate Schedule from the DPH.

_____
License or Certification Number

_____
Name and Title of Authorized Person

_____
Signature of Person Named Above

_____
Business Telephone Number

_____
Business E-mail Address

_____
Date

All providers that do not charge for emergency medical services rendered and did not submit a 2016 Rate application must sign and return the completed Certification, by mail, to: Renee Holota at the Office of Emergency Medical Services, **by August 31, 2016.**

CT Department of Public Health
Office of Emergency Medical Services
410 Capitol Avenue, MS # 12 EMS
P.O. Box 340308
Hartford, CT 06134-0308