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EMERGENCY MEDICAL SERVICES EMS and Managed Care

Monograph 5



International Association
of Fire Fighters



Emergency Medical Services

EMS and Managed Care

Monograph 5



**Department of Emergency Medical Services
International Association of Fire Fighters, AFL-CIO, CLC**

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International Standard Book Number: 0-942920-26-0

Foreword

Today more than 80 percent of fire departments perform some level of emergency medical services (EMS), making professional fire fighters the largest group of providers of prehospital emergency care in North America. No other organization – public or private – is capable of providing prehospital emergency response as efficiently and effectively as fire departments. Fire department operations are geared to rapid response, whether it is for EMS or fire suppression. Cross-trained/dual-role fire fighters are trained to aggressively attack their work whether it involves a fire, a rescue, or a medical emergency. It is no surprise that study after study has shown that fire department-based prehospital emergency medical care systems are superior to other provider types.

However, as we look into the future of prehospital emergency medical care, we are called upon to evaluate our role and the possible need for change in the context of a rapidly evolving medical care system. We must look at what we have learned during the past century and create a vision for the future of fire-based EMS. This vision must address necessary legislation for the protection of fire-based systems. It must address public education, prevention, and the possible expansion of the scope of practice for paramedics. This vision must consider the effects of managed care organizations on prehospital EMS, as well as revenue recovery for the services fire fighters perform. It must also protect fire-based systems from the threat of privatization, as well as protect the citizens we serve by preserving the nation's universal emergency access number, 9-1-1. The information in this series of monographs is designed to guide local fire department leaders through the process of developing a vision for the future of a fire-based EMS system. This monograph is the **fifth** in the series and contains information concerning the impact of managed care organizations on fire-based EMS systems. This section provides definitions and answers to the most frequently asked questions about MCOs and EMS.

The role of the professional fire fighter is constantly changing. We are called upon to act as multi-faceted first responders answering not only fire calls but rescue, hazardous materials, and emergency medical calls. By answering the challenge of change, we can continue to meet the needs of the communities we serve and do what we do best — protect property and save lives.

Harold A. Schaitberger
General President

Acknowledgments

The IAFF would like to acknowledge the Department of Emergency Medical Services staff, specifically Jonathan Moore and Sandy Miller, for their work in the development of this publication.

The IAFF also wishes to recognize the members of the IAFF EMS Committee for their editorial review and support:

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EMS and Managed Care

Table of Contents

MANAGED CARE: WHAT IS IT AND WHERE DID IT COME FROM?	1
HISTORY OF MANAGED CARE ORGANIZATIONS (MCOs)	2
NATIONAL MANAGED CARE STATISTICS	4
MEDICARE/MEDICAID AND MANAGED CARE ORGANIZATIONS	5
MANAGED CARE: CONTROLLING ACCESS TO EMERGENCY CARE	6
EMS AND MANAGED CARE: A DIFFERENCE OF PHILOSOPHIES	8
Oakland, California Area	9
San Diego, California Area	10
Ft. Lauderdale, Florida Area	10
Minneapolis/St. Paul, Minnesota Area	11
EMS AND MANAGED CARE: THE PRESENT	12
MCO Agreement in Portland, Oregon	12
MCO Agreement in Ohio	13
Preparing for MCO Agreements in Arizona	13
EMS AND MANAGED CARE: THE FUTURE	14
OPPORTUNITIES FOR THE FIRE SERVICE	15
MANAGED CARE CONTRACTING: A NEW SPECIALTY FOR THE FIRE SERVICE	17
EMS AND MANAGED CARE PROSPECTUS	23
CONCLUSION	25
GLOSSARY	28
Appendix 1. Managed Care Organizations by State	
Appendix 2. IAFF's Managed Care and EMS Ethics Statement	

MANAGED CARE: WHAT IS IT AND WHERE DID IT COME FROM?

Increasing health care costs along with increased demand for services and consumer desire for affordable insurance coverage, led to the emergence of managed care organizations (MCOs). Managed care means that there are contractual arrangements between the insurer and health care providers that require mechanisms to control costs. Enrollees receive services from designated providers for a prepaid amount, thereby limiting out-of-pocket expenses.¹ Care providers agree to accept lower fees from insurers or abide by contracts for capitated payments. Capitation is a pre-determined amount paid per enrollee. For example, the provider may be paid monthly for each HMO member instead of being paid for the service used by a patient.

There are many types of MCOs in the health care market today. These range from the point-of-service plans to health maintenance organizations (HMOs).² Managed care plans have been able to show cost savings of more than 25% compared to traditional indemnity plans. This savings is primarily attributed to decreased inpatient care and specialist use.³ Managed care systems decrease inpatient and specialist use by restricting access to care through various “gatekeepers” and utilization reviewed mechanisms. The reality in the market today is that managed care is managed financial care rather than managed medical care.⁴

HISTORY OF MANAGED CARE ORGANIZATIONS (MCOs)

Managed care dates back to 1929 when Dr. Michael Shadid established a rural farmers' cooperative health plan in Elk City, Oklahoma. That same year, Drs. Ross and Loos formed a physician-owned and controlled group practice in Los Angeles, California and entered into a prepaid contract to provide comprehensive health services to the employees of Southern California Water Company. Other early prepaid group practice plans include The Group Health Association in Washington, D.C. (1937) and the Kaiser-Permanente Medical Care Programs (1942).⁵ In 1973, Congress passed the HMO Act, which allowed HMOs to enter the Medicare and Medicaid market. This federal legislation was followed by similar legislation in Minnesota and California.

Managed care integrates the financing and delivery of medical care through contracts with selected providers for a predetermined monthly or annual premium. Managed care plans include preferred provider organizations (PPOs), HMOs; self-insured employer plans, and other forms of contract-based payment limiting systems. Managed care organizations, through medical groups, hospitals, and multi-facility integrated delivery systems are taking on responsibility for transport services or are payers for transport services.⁶

In managed care, economic consequences influence decisions regarding patient care. In theory, managed care attempts to limit expenditures for patient care that do not provide additional benefits for the patient. In reality, it may be difficult to know in advance whether or not certain tests or procedures are worthwhile for an individual patient. MCOs limit the amounts paid to participating physicians and may strongly discourage referrals to specialists or treatments that MCOs judge to be "experimental."

This is done by requiring approval for specialized tests and treatments in advance of treatment. Without advance approval, most MCOs will not pay for specialized service. “Gatekeepers” without the expertise or education of physicians decide whether a patient will go to the hospital, wait for a scheduled office visit, or even see a doctor at all. Many of these decisions are by telephone without personal contact with the patient. Regardless of promises made, managed care may boil down to rationing of care.⁷

Managed care has already achieved most of the savings available from cutting excess hospitalizations. The only way for managed care or the fee-for-service sector to control the long term rise in health costs is to deny access to expensive new technologies and treatments⁸ even if they are useful, including prehospital medical care, ambulance transport, and emergency department admissions.

NATIONAL MANAGED CARE STATISTICS

Managed care is growing in all regions of the country. When offered by most employers as a benefit option, it is selected by a large majority of employees motivated to pay less for health coverage. Seventy-five percent of all employed persons are enrolled in an HMO, a PPO, or a point of service (POS) plan.⁹ Among households across the country with health care insurance, greater than 66% are already enrolled in some type of managed care program.¹⁰ Higher concentrations of managed care enrollment in the southern (71%) and western (85%) sections of the country.¹¹ HMOs are the health plan of choice in the northeast.¹² The Worcester/Boston, Massachusetts area has a managed care penetration of 70.5%, with the entire state passing the 50% mark.¹³ According to the Group Health Association of America, California has the highest level of HMO enrollment at 38.3% of market share.¹⁴

MEDICARE/MEDICAID AND MANAGED CARE ORGANIZATIONS

Because Medicare payments are guaranteed and the majority of those over 65 years are healthy, managed care plans are eager for Medicare members. Enrollment in Medicare managed care grew at a rate of 30% in 1996 alone, exceeding 1995's 27% growth rate.¹⁵ Medicare HMOs now cover 4 million people, accounting for more than 12% of all Medicare-eligible individuals in the United States.¹⁶

Forty-nine states now offer some form of managed care in their Medicaid program which provides payment for medical services to eligible recipients with incomes less than specified levels. Additionally, at least 38 states are mainstreaming Medicaid-eligible citizens into HMOs and PPOs.¹⁷ Capitated programs, in which states contract with private or municipality-run health plans to provide a full range of services to Medicaid beneficiaries in exchange for set fees, are now the fastest growing type of Medicaid managed care programs.¹⁸

MANAGED CARE: CONTROLLING ACCESS TO EMERGENCY CARE

MCOs espouse the worthy goal of controlling cost. In some MCOs, however, there is intense pressure to limit utilization which may, in turn, limit patient access to needed services.¹⁹ For emergency care, MCOs commonly use a telephone preauthorization system to control access or require that subscribers go to only specified facilities. Often subscribers must call in-house gatekeepers for treatment options, and follow instructions or risk having to pay for medical care themselves.

In 1997, Representative Ben Cardin presented the “Access to Emergency Medical Services Act,” HR 815 to the 105th Congress. This bill contains the definition of “emergency” using the prudent layperson standard.

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.²⁰

The Cardin Bill will attempt to prevent MCOs from limiting or second guessing patients’ judgments about the care they need in an emergency and directs MCOs to provide education to participants on the appropriate use of emergency services, including use of the 9-1-1 telephone system or its local equivalent.

Figure 1. Sample of MCO Emergency Instruction Card

MCO EMERGENCY CARE INSTRUCTIONS

1. WHEN YOU HAVE AN EMERGENCY YOU MUST CALL AN MCO* HEALTH CENTER OR YOUR MCO PRIMARY CARE PHYSICIAN, EXCEPT UNDER THE CONDITIONS DESCRIBED IN PARAGRAPH 2 BELOW.

IF YOU ARE INJURED OR SUDDENLY BECOME ILL, YOU MUST CALL AN MCO HEALTH CENTER OR YOUR MCO PRIMARY CARE PHYSICIANS FOR INSTRUCTIONS AS TO WHAT YOU SHOULD DO, REGARDLESS OF THE TIME OF DAY OR WHERE YOU ARE. CARE WILL BE PROVIDED, ARRANGED, OR AUTHORIZED AT:

- A. AN MCO HEALTH CENTER
- B. THE EMERGENCY DEPARTMENT OF A HOSPITAL
- C. ANOTHER PHYSICIANS OFFICE

2. EMERGENCY CARE WHEN YOU ARE UNABLE TO CALL AND MCO HEALTH CENTER.

YOU ARE ENTITLED TO EMERGENCY CARE AT THE EMERGENCY DEPARTMENT OF A SHORT-TERM ACUTE CARE GENERAL HOSPITAL, OR INPATIENT CARE IN A SHORT-TERM ACUTE CARE GENERAL HOSPITAL, THAT WAS NOT ARRANGED OR AUTHORIZED BY AN MCO HEALTH CENTER OR YOUR MCO PRIMARY CARE PHYSICIAN IF ALL OF THE FOLLOWING CONDITIONS ARE MET:

- A. IN OUR JUDGEMENT, BECAUSE OF THE NATURE OF THE MEDICAL EMERGENCY, YOU WERE UNABLE TO OBTAIN AUTHORIZATION FOR THE EMERGENCY CARE.
- B. YOU OR A MEMBER OF YOUR FAMILY MUST NOTIFY US IN WRITING OR BY TELEPHONE WITHIN 48 HOURS OF THE EMERGENCY SO THAT YOUR CARE CAN BE COORDINATED BY YOUR MCO PRIMARY CARE PHYSICIAN. HOWEVER, IF IT IS NOT REASONABLY POSSIBLE TO GIVE NOTICE WITHIN 48 HOURS, NOTICE MUST GIVEN AS SOON AS IT IS REASONABLY POSSIBLE.

*"MCO" IS USED INSTEAD OF THE ACTUAL NAME OF THE ISSUER OF THE CONTRACT.

SOURCE: "Managed Care Organizations: A Link in the Chain of Survival," Annals of Emergency Medicine, December 1996, 28:6, p. 720.

EMS AND MANAGED CARE: A DIFFERENCE OF PHILOSOPHIES

Managed care is concerned with the overall health of their group of subscribers; the major emphasis in emergency care is the health of the individual patient.²¹ Emergency systems are designed to be activated by the individual who reasonably believes that an urgent medical condition exists and requires professional intervention. MCOs seek to restrict individual access to health care service, and require consultation with an MCO representative to determine if there is an alternative to costly emergency medical care, adding an extra step to an individual's decision making process. This difference in underlying philosophies has resulted in conflicts between managed care and emergency systems.

Examples of managed care and emergency services conflicts are most clearly seen at the local level. To assess the effects of managed care on the health of the population, The National Research Corporation identified several metropolitan statistical areas (MSAs) with high percentages of insured households enrolled in HMOs or PPOs from 1995 to 1996. Among other variables, researchers looked at the use of 9-1-1 in these areas.

In general, researchers found that the demand for emergency services decline in metropolitan areas where more people are insured through MCOs. This decline, however, was not because MCO subscribers were any healthier, rather, it was because subscribers were instructed to avoid using traditional emergency medical services. For example, in Minneapolis, there was a 25% drop in use of emergency departments between 1990 and 1993 because managed care patients had been instructed to call for advice rather than accessing the 9-1-1 system. In Alameda County, California, the Kaiser-Permanente HMO lowered the

**OAKLAND, CALIFORNIA
AREA**

rate of 9-1-1 calls made by its members by 17% in one year. The findings of the study are discussed below in greater detail.

The National Research Corporation has identified several metropolitan statistical areas (MSAs) that had a high percentage of insured households enrolled in HMOs or PPOs from 1995-1996, in an effort to measure the effects of Managed Care on the total health of the population including the effects on the use of 9-1-1.²² The following paragraphs discuss the findings of this effort.

At 89.6%, the Oakland, California metropolitan area in Alameda County has the second highest penetration of insured households enrolled in managed care in the country.²³ A few years prior to the National Research Corporation study, Kaiser-Permanente, one of the county's largest managed care providers, directed its subscribers in Alameda County **not** to call 9-1-1 for medical assistance. Instead, they were told to call the Kaiser facility for advice from an in-house nurse. The contracted 9-1-1 ambulance provider in the county, American Medical Response (AMR), noted reduction in call volume and, subsequently, in their revenues.

According to an AMR spokesman, losing patients to managed care resulted in a decrease of paying customers and an increase of the uninsured and indigent in the payer mix. AMR's source of revenue was limited to transport services. Since the transport volume dropped when patients were referred away from the prehospital care through 9-1-1, revenue dropped. To recover from this revenue loss AMR increased inter-facility transfers and capitated contracts with managed care providers for on-site services. Their services now include on-site assessment and treatment of minor injuries, as well as health surveillance testing.²⁴

Alameda County restructured its EMS system with the help of a multi-disciplinary task force. The task force consisted of managed care representatives, paramedics, fire fighters, mental health workers, social

service workers, emergency department physicians, dispatchers, consumers, and private ambulance providers. The task force recommended that the communications center still use 9-1-1, but that dispatchers triage calls to separate emergency or non-emergency dispatch centers. Now, non-life threatening calls are turned over to a non-emergency center where protocols will be used to direct patients to the most appropriate treatment. Treatment options include an HMO clinic, an appointment with a private physician, a referral to a social or mental health service, or home care. Life-threatening calls continue to be handled by the fire department (for initial response, BLS, and ALS) and private providers (for transport and contracted EMS services).

**SAN DIEGO, CALIFORNIA
AREA**

Among insured households in the San Diego metropolitan area, 84.5% subscribe to managed care organizations. Kaiser-Permanente (Kaiser), the County's largest HMO, encourages its members to call a seven digit number in its medical center emergency department and to follow the instructions given. Kaiser advises members it will not pay for 9-1-1 ambulance and other non-Kaiser emergency medical services unless the additional time required to reach a Kaiser facility would result in death, serious disability, or significant jeopardy to the subscriber's condition.²⁵ Community Health Group, another HMO in San Diego, has dropped emergency department use in the county to only 108 visits per 1,000 members per year.²⁶ Transport providers have noted that the more calls triaged away from the 9-1-1 system, the harder it is to get funding for transports. Additionally, a managed care organization may refuse to pay for an emergency transport unless the subscriber has an emergency as determined by the MCO. Retrospective review of transports, as well as the potential for payer refusal to reimburse, translates into increased financial risk for the transport provider.

**FT. LAUDERDALE, FLORIDA
AREA**

At 81.5% MCO saturation of insured households, the Ft. Lauderdale metropolitan area is already high in managed care coverage. Managed care saturation will continue to increase since Florida has the largest population in the nation of people 65 and older and Medicare moving

**MINNEAPOLIS/ST.
PAUL, MINNESOTA
AREA**

toward managed care. Competition among public fire department-based services and private companies for contracts to provide EMS is particularly fierce in Florida. Private ambulance companies currently have more experience negotiating capitated contracts with the MCOs. However, 75% of Florida's 9-1-1 responses are still covered by public services.²⁷ To compete with these established provider-payer relationships, fire-based systems must learn to work with managed care organizations.

In the Twin Cities metropolitan area, 85% of insured households are enrolled in managed care plans, with Allina Health Systems being the biggest HMO provider in the state. Approximately 40% of Minnesota's 302 EMS providers are fire-based.²⁸ Like Alameda County, Minneapolis/St. Paul EMS providers noted a decline in transport volume and revenue. Unlike Alameda County, the Minnesota legislature responded to these changes by instituting controls over the managed care organizations. Minnesota passed several laws that have helped to protect EMS providers from the negative financial impact of MCO subscriber access directives. In 1996, state legislators defined the criteria for ambulance service reimbursement with input from the 12 managed care organizations in the state. Retrospective review to decline payment for treatment or services rendered was prohibited. To compensate for EMS revenue losses, 90% of the fines collected for non use of seat belts, about \$1 million per year, is given to the public EMS system to pay for training and equipment.

EMS AND MANAGED CARE: THE PRESENT

MCO AGREEMENT IN PORTLAND, OREGON

Where MCOs are prevalent, revenue for prehospital care is best generated by entering into contracts with local MCOs. Contracts such as these have been established in Oregon, Ohio, and Arizona.

Kaiser Permanente (Kaiser), the largest managed care organization in the Portland, Oregon area covers more than 350,000 members in the region. AMR, the private EMS provider, holds a capitated contract with Kaiser. According to AMR, the “Firstline” program is designed to assess the first line needs of Kaiser members. In the Firstline program, AMR employees provide call intake, assign the proper level of transport vehicle and staff, verify that the transport is an MCO covered service, and ensure that the patient is scheduled into the proper facility.²⁹ The three-phase Firstline program began in February 1995 when AMR established a triage program for “discretionary transports” within the AMR dispatch center. Kaiser advises members to call AMR directly. EMT-dispatchers have a database of Kaiser members and use priority dispatch protocols developed by Kaiser to manage some calls. Kaiser staff members also call the AMR dispatch center 24 hours a day to arrange for medical transportation. Triage officers arrange for ALS, BLS, critical-care, or wheel chair transportation as needed. AMR’s triage officers have a list of community resources that will transport members when the trip is not a covered benefit. The second phase of the AMR/Kaiser Firstline program calls for EMTs and paramedics to conduct additional triage of Kaiser members at the scene and consider alternative access into the health care system. This part of the program initially included Transport Related Groupings (TRGs) that were benefit-driven and designed by AMR management and Kaiser physicians to get the patient “to the right place for the right care at the right time.”³⁰ The third phase of the program calls

**MCO
AGREEMENT IN
OHIO**

for the expanded scope of practice for paramedics to include an aggressive treat-and-release program.

A 1996 contractual agreement between Rural/Metro and Aetna of Ohio is another example of a private ambulance service-MCO agreement. Rural/Metro agreed to a two-year capitated contract to provide all non-emergency transport services for all Aetna plan participants in the state of Ohio. The agreement guarantees payment based on fees established in the contract.

**PREPARING FOR MCO
AGREEMENTS IN ARIZONA**

In January 1997, Rural/Metro of Scottsdale, Arizona announced an agreement with National Health Enhancement Systems, Inc. (NHES). Rural/Metro agreed to market NHES' "call center services" and information, technology, and software products to its managed care customers. The two companies announced plans to combine telephone triage and medical transportation services. Sponsored by managed care companies NHES's Call Center Services are marketed as providing a range of benefits for health plan members. This service includes triage/advice, after-hours coverage for physicians, and health decision counseling for consumers. All these services represent areas in which MCOs are willing to contract.

EMS AND MANAGED CARE: THE FUTURE

The previous examples support the idea that the proliferation of managed care means a move away from the traditional 9-1-1 system. By the year 2000, it is predicted that six of every ten calls to 9-1-1 in California will be the financial responsibility of hospitals, HMOs, and medical groups instead of county EMS authorities.³¹ The rest of the nation is not far behind. Fire-based EMS providers must be aware of, plan for, and begin to implement managed care survival strategies. Private ambulance companies will attempt to contract with MCOs and urge plan members to call telephone triage lines rather than 9-1-1. This will inevitably reduce the number of 9-1-1 calls to fire-based EMS providers especially as MCOs grow to include Medicare beneficiaries.

OPPORTUNITIES FOR THE FIRE SERVICE

Should the shift toward managed care payers continue, what can fire-based EMS systems do to provide their communities with quality service without suffering financial perils?

- Response – Fire-based EMS planners must become educated in the design and administration of payer-provider contracts. The foundation of many of these contracts is capitation, meaning that care providers are paid a flat fee, not each time service is rendered. Fire department-MCO contracts could generate revenue beyond prehospital transportation. The IAFF continues to pursue reimbursement for treatment separate from transport. If the Health Care Finance Administration issues a regulation to require payment for on-scene emergency care, then fire departments could contract with MCOs to provide rapid, cost-effective ALS or BLS response offered by fire departments. The MCOs subscribers would benefit from the rapid initial response. With this source of revenue, the cost of the fire-based provider's care for the insured, as well as the uninsured, would be offset.
- Emergency Transport – In areas where the municipal fire department is responsible for all prehospital EMS, contracts may be negotiated with MCOs for capitated rates rather than the traditional fee for service plans.
- Inter-Facility Transport – Contracts for inter-facility transport can generate revenue. If these contracts can be made without negatively affecting primary emergency obligations, fire departments may chose to pursue them. (See also “Adding Value to a Fire-Based EMS System,” Monograph 7.)

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- Public Education and Prevention Programs – Fire departments already have experience in public fire safety education, distributing smoke alarms, and teaching children appropriate behavior when there is fire. Fire departments can contract with MCOs to provide prevention and education programs to MCO subscribers. MCOs use community education programs to increase visibility, market their services, and garner support from the public and elected officials. Programs could be developed to teach vehicle air bag safety, seat belt and bicycle helmet use, and immunization promotion. For MCOs, injury prevention is more cost-effective than injury treatment. For example, at least one study found safety belt use reduced hospital admissions from crashes by 65% and hospital charges by 67%.³² Injury prevention efforts have succeeded in communities such as Tucson, Arizona, where child drowning related deaths have been decreased by more than 50% following public-education initiatives.³³

MANAGED CARE CONTRACTING: A NEW SPECIALTY FOR THE FIRE SERVICE

Mastering the basics of managed care contracting may become essential for the leaders of fire-based EMS systems. As with any contract for services, EMS providers must determine, in advance, “bottom line” reimbursement requirements. Bottom line figures would approximate the lowest revenue, subsidy, or capitated rates that allow an EMS system to offset the cost of the prehospital safety net required for the uninsured. Once the bottom line is determined, the following areas should be addressed:³⁴

- The payer’s financial viability – If the payer is financially weak, EMS providers should require protections in the contract.
- Pricing alternatives – There are a number of ways to price EMS services under managed care contracts. These include discounts from full charges; flat fees for specific types of services such as BLS and ALS transport within a specified radius; all-inclusive weekly or monthly charges; and capitation which means the provider will accept a set amount per enrollee per month.
- Anticipated volume – In deciding how much to discount prices, it is essential to estimate the anticipated call volume the contract will generate. For example, unless the MCO agrees to grant the provider exclusive ambulance transportation rights within a service area, the large numbers of patients the MCO promises in exchange for discounts may never materialize.
- The relative bargaining strength of the parties – Fire department administrators should know the extent to which concessions from a payer may be extracted. This depends, in large part, on which party

needs the other more. If the fire-based EMS provider has exclusive operating rights for a significant portion of the MCOs service area, the fire department may be in a strong position to require certain provisions in the contract, such as being designated the exclusive provider of all transport including emergency, non-emergency, and inter-facility. The fire department's bargaining strength would be enhanced if federal or state legislation were in place or local ordinances were in effect that prevent "cream skimming" by private EMS or ambulance companies operating in the same jurisdiction.

Other contracting provisions include:³⁵

- Time limits – Contracts typically require the MCO to pay the EMS provider's claim within a specified time period – 30, 45, or 60 days. These time limits are useless unless some related issues are included. First, the contract should specify that the clock starts upon submission of a 'clean claim' (a claim submitted without omissions of pertinent data). Second, there must be a penalty for an MCO's failure to pay within the specified time limits with the strongest penalty being termination of the contract. Other monetary penalties could include:
 - Interest on overdue claims
 - Reversion to the EMS provider's full charges for all untimely paid bills
 - Partial loss of discounts on a graduating basis according to the percentage or dollar amount of claims which are overdue

The EMS provider must be careful of these time limits as well. The MCO may also require the provider to submit claims within a specified time period, such as 10 to 15 days.

- Coordination of benefits – Some beneficiaries may have coverage from more than one payer. A contract should expressly preserve the

EMS provider's right to bill a secondary payer when one exists. This provision is necessary to specifically address situations in which the contracted MCO is the secondary payer. When the contracted MCO is the secondary payer, the MCO should be required to pay the difference between the amount paid by the primary carrier and the provider's full charges. Additionally, contract language presented by most MCOs may limit the EMS provider's total collections to a capitated amount.

This may result in a windfall to the MCO where demand for services is greater than estimates reflected in capitated fees.

- Coverage issues – Managed care contracts may state that the MCO will pay only for “covered services which are medically necessary.” “Covered services” and “medically necessary” should be defined either in the contract itself or in the payer's agreements with its subscribers. If the terms are defined by subscriber agreements, the EMS provider must insist on reviewing the subscriber agreements or of the MCOs' summaries of such agreements.

If a managed care contract includes a “medical necessity” provision, it must be defined to preserve an EMS provider's right to payment whenever a service has been ordered by a gatekeeper, a physician, hospital discharge personnel or other personnel, authorized by the payer. In addition, medical necessity should be presumed to include the “prudent layperson” definition of an emergency:

The term “emergency medical condition” means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention

to result in:

- a) placing the person's health in serious jeopardy,
- b) serious impairment to bodily functions, or
- c) serious dysfunction of any bodily organ or part.³⁶

A prehospital contract should **not** require preauthorization before services are rendered. Furthermore, provisions permitting retrospective denial of claims should be deleted, since this puts the provider at financial risk.

Under a capitated agreement, an EMS provider should use discretion in assuming responsibility for MCO covered services it does not provide. Such an agreement would obligate the EMS provider to subcontract with other organizations to provide the service.

- Claim denial – Should the provider agree to a claim review denial process, a time limit should be placed on the MCOs ability to deny coverage. The contract should require a specific explanation of the reason for any denial, and the EMS provider should have access to a fair and speedy appeal process for disputed claims. This appeal process should include a hearing before a committee which includes a representative of the MCO, a representative of the EMS provider, and a mutually agreed upon third party. Alternatively, an objective third party should resolve disputes.
- Term and termination issues – In negotiating the length of a contract term, the EMS provider must consider the possibility of the MCO becoming insolvent. If a contract has a lengthy term or has an “evergreen” provision that automatically renews the contract, the EMS provider may not be able to terminate the contract in the event that the payer becomes insolvent. Contract provisions requiring “automatic termination” in the event of insolvency or bankruptcy are

generally unenforceable under bankruptcy law. An EMS provider is likely to need permission from the bankruptcy court to terminate a contract before the end of its term once the payer files for bankruptcy. If an EMS provider contracts with payer who may be financially unstable, the contract term should be limited to one year and/or permit termination on short notice if the EMS provider discovers that the payer is having significant financial difficulties.

In other situations, EMS providers may want a lengthy contract term. For example, if the payer is financially strong and controls a large share of business in the EMS provider's service area, a multi-year term, perhaps an exclusive contract is desirable. Of course, if the EMS provider seeks a multi-year contract, the contract should include annual automatic increases (e.g., based on the consumer price index) or preserve the right to request renegotiation of EMS provider rates on a periodic basis. Both the EMS provider and the payer should have the same termination provisions. Typically, termination is permitted where there is a "default" or noncompliance with a contract specification. Both parties should have a reasonable period (e.g., 30 days) in which to "cure defaults" (fix the problems) before termination becomes effective, except for major defaults, such as loss of insurance, loss of licensure, or material financial defaults by the MCO payer. The contract should specify that if the MCO payer defaults on financial obligations, then the MCO payer has only five or ten days to cure the default, so that the EMS provider is not forced to continue providing services without payment.

- Insurance and indemnification requirements – EMS providers should request reciprocity in insurance and indemnification provisions in contracts with MCOs. MCO payers may be found liable by courts for improper utilization decisions, so MCO payers should be required to maintain professional liability, as well as general liability coverage. For example, if a payer refuses to approve a critical care transport for

an acutely ill patient, and forces the patient onto a BLS ambulance, both the payer and the provider are likely to be sued if there is an adverse outcome. Unless the MCO payer has professional liability coverage for its negligent utilization decisions, the EMS provider is likely to be the financially responsible entity particularly if the MCO payer is financially weak. Indemnification provisions should be carefully limited to damages incurred by the payer as a result of the provider's own negligent acts or omissions. It is also good practice to have indemnification provisions reviewed by the provider's own insurance carrier and legal counsel.

- Dispute resolution provisions – EMS providers should carefully consider both the pros and cons of arbitration provisions. Arbitration decisions are usually non-appealable and occasionally poorly reasoned. One way to minimize this risk is to require a panel of three arbitrators with at least two concurring in the decision. As a general rule, arbitration is quicker, cheaper, and more confidential than court proceedings. Court proceedings are typically open to the public and may expose any negative findings on the part of both the provider and the payer.
- Materials incorporated by reference – MCO contracts may seek to bind providers to policies and procedures that are found in the MCO payer's policy manuals, making these part of the contract (e.g., claims submission requirements or utilization review standards). EMS providers should review all referenced documents in advance of contract closure to avoid any problems with unexpected requirements or standards.

To compete effectively with other potential contractors for service with MCOs, a fire-based EMS provider must be able to negotiate contracts that address these key points.

EMS AND MANAGED CARE PROSPECTUS

Many EMS providers are realizing that there is strength in numbers. Physicians are forming networks of medical groups to effectively meet the needs of HMOs.³⁷ Managed care organizations typically prefer to negotiate with a single entity. Therefore, a fire department may find it difficult to contract with an MCO for exclusive transport rights in a local jurisdiction when the MCO has members that extend throughout the state. Fire departments should be creative in developing basis for an MCO agreement. For example, a fire department could negotiate a capitated fee for members of the MCO transported in their jurisdiction, allowing the MCO to avoid fee-for-service charges.

One alternative is for several fire departments to form a management organization in which all would be participating providers. The management organization would then contract with MCOs for services in a defined area (i.e. county, region or state). Each provider member of the group would be responsible for providing contracted services within their jurisdiction (see Figure 2).

FIGURE 2.

GRAPHIC NOT AVAILABLE IN PDF VERSION.

This method provides an opportunity for fire departments to protect their EMS systems and to gain their share of the revenue for contracted MCO services.

Networks or management groups allow individual EMS providers to maintain or increase market share, negotiate capitated rates, participate in cost containment programs, and share in incentive bonuses. Fire department management groups may develop countywide, statewide, or regional mobile health care alliances and obtain additional services as needed within the network. These services may include legal counsel, marketing, and billing services. Managed care can benefit from fire department management networks through expanded geographic coverage and reduced non-contract provider services. These networks will bring some measure of predictability to a generally uncontrolled environment to allow easier planning and budgeting for mobile health care services. Fire service leaders should consult legal counsel in an effort to avoid violations of anti-trust laws associated with provider networks. Additionally, legal counsel should be sought before entering into negotiations with any private entity. Particular attention should be given to local laws or charter provisions that may restrict such activities.

- Determine the saturation of managed care organizations (MCOs) in your jurisdiction, including number and type of MCOs
- Determine the number of citizens in your jurisdiction that are members of these MCOs
- Obtain a list of services provided by the MCO to its members
- Determine if the fire department could deliver those services on behalf of the MCO in a cost effective manner
- Contact the MCOs and pursue contracting opportunities

Appendix 1 lists MCOs by state and should serve as a starting point for research about MCOs serving people in individual jurisdictions.

CONCLUSION

Managed care organizations (MCOs) may offer opportunities for increased revenue or revenue stabilization to fire departments that provide prehospital EMS. However, fire department officials should take extreme care not to compromise the safety net of prehospital emergency services provided to all citizens in efforts to gain MCO contracts. The economic agenda of managed care must not threaten the primacy of patient welfare.³⁸ Economics, notwithstanding patient welfare, must always be the first consideration.³⁹ (See Appendix 2 for IAFF's Managed Care and EMS Ethics Statement.)

ENDNOTES

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GLOSSARY

Advanced Life Support (ALS) – All basic life support measures, plus invasive medical procedures including intravenous therapy, cardiac defibrillation, administration of medications and solutions, use of adjunctive ventilation devices, and other procedures which may be authorized by state law and performed under medical control.

Basic Life Support (BLS) – Generally limited to airway maintenance, ventilation (breathing) support, CPR, hemorrhage control, splinting of fractures, management of spinal injury, protection and transportation of the patient with accepted procedures.

Capitation: A method of payment for services in which, based on a pre negotiated contract, a health care provider is paid a fixed amount per person per month, regardless of whether the individual actually uses the health care system. This system transfers the risk from the insurance payer to the health care provider.

Coordination of Benefits: A system to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100 percent of the claim.

Covered Expenses: Most insurance plans, whether they are fee-for-service, HMOs, or PPO's, do not pay for all services. Some may not pay for prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the policy.

GLOSSARY (CONT'D)

CPR (cardiopulmonary resuscitation) – The combination of artificial respiration and manual artificial circulation that is recommended for use in cases of cardiac arrest.

Cross-Trained/Dual-Role (CT/DR) – An emergency service that allows personnel trained in emergency situations to perform to the full extent of their training, whether the situation should call for firefighting or medical intervention for a victim. This system type offers a greater level of efficiency than its single-role counterparts.

Emergency Medical Services (EMS) – The provision of services to patients with medical emergencies. EMS has emerged as a field whose purpose is to reduce the incidence of preventable life-threatening and disabling injuries and acute illness whenever possible, and to minimize the physical and emotional impact of injuries and illnesses which do occur. The EMS field derives its origins and body of scientific knowledge from the related fields of medicine, public health, health care systems administration, and public safety.

EMS System – A comprehensive, coordinated arrangement of resources and functions which are organized to respond in a timely, staged manner to targeted medical emergencies, regardless of their cause and the patient's ability to pay, and to minimize their physical and emotional impact.

Fee-for-service: A system in which a health care provider charges a fee for each service performed.

Discounted fee-for-service: A system in which a health care provider is paid on a fee-for-service basis, but agrees to a discount of the usual charges.

Gatekeeper: The primary care physician who manages a patient's

GLOSSARY (CONT'D)

medical treatment. The patient may not seek the care of a specialist or be admitted to a hospital without referral by the gatekeeper. Emergency treatment is generally excluded from gatekeeper control.

Health Maintenance Organization (HMO): An organized system of health care that provides directly or arranges for a comprehensive range of basic and supplemental health care services to a voluntarily enrolled group of persons under a prepayment plan (per person per month).

Managed care: Any form of health care plan that contracts selectively with providers, employers or insurers to channel employees or patients to a specified set of cost-effective providers.

Point-of-service: A plan in which members do not have to choose how to receive services until they need them.

Preferred Provider Organization (PPO): A plan that contracts with independent providers, usually at a discounted rate.

Premium: The amount you or your employer pays in exchange for insurance coverage.

Primary Care Doctor: Usually your first contact for health care. This is often a family physician or internist. A primary care doctor monitors your health and diagnoses and treats minor health problems, and refers you to specialists if another level of care is needed.

Provider: Any person (Doctor, nurse, dentist) or institution (hospital or clinic) that provides medical care.

Prudent-layperson test: Health plans required to cover services provided to a patient who presents with symptoms that a prudent layperson could reasonably assume could result in serious impairment of health in the absence of immediate medical attention.

GLOSSARY

(CONT'D)

Public Education – Public education imparts knowledge or training in specific skills. For example, teaching CPR, how to call for help properly, bicycle safety or briefing public officials about the importance of your service to your community are all public education activities.

Third-Party Payer: Any payer for health care services other than you. This can be an insurance company, an HMO, a PPO, or the Federal Government.

Utilization review or management: An independent determination of whether health care services are a covered benefit, appropriate, and medically necessary on a prospective, concurrent, or retrospective basis to ensure that appropriate and necessary health care services are provided. Utilization review attempts to curtail inappropriate services and ensure that services are cost-effective.

Appendix 1.

Health Maintenance Organizations (HMOs) by State

The following is an alphabetical list of HMOs operating in various states.

ALABAMA:

- Complete Health, Inc.
 - Foundation Health, An Alabama Health Plan
 - Health Advantage Plans
 - Health Maintenance Group of Birmingham
 - Health Options
 - Health Partners of Alabama
 - Healthcare USA--Alabama
 - Healthsecure of Alabama
 - Humana Health Plan of Alabama
 - Mobile Health Plan d/b/a PrimeHealth
 - PCA Health Plans of Alabama
 - Principal Health Care of Florida
-

ALASKA:

Currently there are no HMOs registered to do business in Alaska.

ARIZONA:

- Aetna Health Plans of Arizona
 - Cigna Healthcare of Arizona
 - FHP
 - First Health of Arizona
 - HMO Arizona
 - Humana Health Plan
 - Intergroup
 - Metrahealth Care Plan of Arizona
 - Partners Health Plan of Arizona
 - Premier Healthcare
 - Samaritan Health Plan
 - University Physicians Health Maintenance Organization
-

ARKANSAS:

- American Health Care Providers
 - Complete Health of Arkansas
 - Health Advantage
 - Healthsource Arkansas
 - HMO Arkansas
 - Prudential Health Care of Arkansas
-

CALIFORNIA:

- Added Choice
- Aetna Health Plans of California, Inc.
- Alameda Alliance for Health
- Blue Cross of California
- Blue Shield of California
- CaliforniaCare Health Plans
- Care First Health Plan
- CareAmerica Health Plans
- Chinese Community Health Plan
- CIGNA HealthCare of California
- Community Health Group
- Community Health Plan-LA County Dept. of Health Services
- Contra Costa Health Plan
- FHP
- Foundation Health, A California Health Plan
- Freedom Plan, Inc.
- Great American Health Plan
- Greater Pacific HMO, Inc.
- Health Net
- HMO California
- Inter Valley Health Plan
- Kaiser Foundation Health Plan-Northern California Region
- Kaiser Foundation Health Plan-Southern California Region
- KeyCare
- Lifeguard, Inc.
- Maxicare of California
- MetLife HealthCare Network of California
- Molina Medical Centers
- National HMO
- Omni Health Plan
- PruCare Plus
- Scan Health Plan
- Secure Horizons
- Sharp Health Plan
- Tower Health Services
- United Health Plan
- Universal Care
- Valley Health Plan

- ValuCare
 - VivaHealth Plan
-

COLORADO:

- CIGNA HealthCare of Colorado
 - Colorado Access
 - Community Health Plan of the Rockies
 - FHP of Colorado
 - Foundation Health, A Colorado Health Plan
 - Frontier Community Health Plans
 - Health Network of Colorado Springs
 - HMO Colorado
 - Humana Health Plan
 - Kaiser Foundation Health Plan of Colorado
 - Metrahealth Care Plan of Colorado
 - Mutual of Omaha of Colorado and Primera
 - PruCare of Colorado
 - QualMed Plans for Health of Colorado
 - Rocky Mountain HMO
 - San Luis Valley HMO
 - Sloans Lake Health Plan
 - UniCare
-

CONNECTICUT:

- Aetna Health Plans of Southern New England
 - CIGNA HealthCare of Connecticut
 - Community Health Care Plan
 - Connecticare
 - Constitution HealthCare
 - Enterprise HealthPlan aka BlueCare
 - Health New England
 - Healthsource Connecticut, Inc.
 - HMO Blue
 - Kaiser Foundation Health Plan
 - M.D. Health Plan
 - Oxford Health Plans
 - Physicians Health Services
 - Prudential Health Care of Connecticut
 - Suburban Health Plan
 - U.S. Healthcare
 - Wellcare of Connecticut
-

DELAWARE:

- Aetna Health Plans
 - AmeriHealth HMO, Inc.
 - CIGNA Healthcare of Delaware
 - Delaware Network Health Plan
 - Delmarva Health Plan
 - Healthcare Delaware
 - Optimum Choice
 - Principal Health Care of Delaware
 - U.S. Healthcare
-

DISTRICT OF COLUMBIA:

- Aetna Health Plans of the Mid-Atlantic
 - CapitalCare Inc.
 - CareFirst
 - Chesapeake Health Plan
 - CIGNA HealthCare Mid-Atlantic, Inc.
 - Columbia Medical Plan, Inc.
 - Free State Health Plan Inc.
 - George Washington University Health Plan
 - HealthKeepers, Inc.
 - HealthKeepers (Physician's Health Plan, D.C.)
 - HealthPlus, Inc.
 - Humana Group Health Plan
 - Kaiser Foundation Health Plan of the Mid-Atlantic States
 - M.D. IPA
 - Potomac Health
 - Principal HealthCare of the Mid-Atlantic
 - Prudential Health Care Plan 0- Mid-Atlantic
 - US Healthcare
-

FLORIDA:

- Aetna Health Plan of Florida
- Anthem Health Plan of Florida
- AvMed Health Plan
- C.A.C. Ramsay Health Plans
- Capital Group Health Service of Florida/Capital Healthplan
- CareFlorida Health Plan
- CareFlorida of South Florida
- CIGNA Health Care of Florida
- Continental Health Plan
- Florida 1st Health Plan
- Florida Health Care Plan

- Foundation Health, A Florida Health Plan
 - Health Options, Inc.
 - Health Plan Southeast
 - HealthCare USA
 - HIPHealth Plan of Florida
 - Humana Health Plan of Florida
 - Humana Medical Plan
 - Metlife Healthcare Network of Florida
 - Neighborhood Health Partnership
 - PacifiCare of Florida
 - PCA Family Health Plan
 - PCA Health Plans of Florida
 - Physicians Healthcare Plans
 - Preferred Medical Plan
 - Principal Health Care of Florida
 - Prudential Health Care Plan
 - Riscare Health Plan
 - * The Public Health Trust of Dade County
 - United HealthCare Plans of Florida
 - Universal Health Plan of Florida
 - Well Care HMO
-

GEORGIA:

- Aetna Health Plans of Georgia
 - CIGNA HealthCare of Georgia
 - Healthsource Savannah, Inc.
 - HMO Georgia, Inc.
 - Kaiser Foundation Health Plan of Georgia, Inc.
 - Master Health Plan
 - MetLife HealthCare Network of Georgia
 - PCA Health Plans of Georgia
 - Prudential Health Care Plan of Georgia
 - United Healthcare of Georgia
 - U.S. Healthcare, Inc.
-

HAWAII:

- Aloha Care (Community Health Centers)
 - Community Health Plan (HMSA)
 - Health Plan Hawaii
 - HMO Hawaii (HMSA)
 - Island Care & Best Care
 - Kaiser Foundation Health Plan
 - Pacific Health Care
 - Queen's Island Care
 - Straub HMO
-

IDAHO:

- Group Health Northwest
 - HealthPlus
 - HealthSense Medical Services Bureau of Idaho
 - Idaho Preferred Healthcare
 - IHC Health Plans
 - Peak Health Plan of Idaho
 - Primary Health Network
 - Qual-Med Washington Health Plan
-

ILLINOIS:

- Aetna Health Plans of Illinois
- American Health Care Providers
- American HMO
- BCI HMO
- Benchmark Health Insurance Company
- BlueCHOICE
- Chicago HMO
- CIGNA HealthCare of Illinois
- CIGNA HealthCare of St. Louis
- Community Health Plan of Sarah Bush Lincoln
- Compass Health Care Plan
- Dreyer Health Plans
- Exclusive Care
- FHP of Illinois, Inc.
- GenCare Health Systems
- Group Health Plan
- Health Alliance Medical Plans
- Health Care Service Corporation
- Health Direct Insurance
- HealthLink HMO
- Heritage National Healthplan

- HMO Missouri
- Humana Health Plan
- Humana--HealthChicago
- Illinois Masonic Community Health Plan Corporation
- John Deer Family Healthplan
- Maxicare Health Plans of the Midwest
- Medical Associates Health Plan
- The Medical Center Health Plan
- Mercy Care Corporation
- Metrahealth Care Plan of Illinois
- Metrahealth Care Plan of St. Louis
- OSF HealthPlans
- Personal Care Health Management
- Principal Health Care of Illinois
- Prudential Health Care Plan
- Rockford Health Plans
- Rush Prudential HMO
- Sanus Health Plan of Illinois
- Share Health Plan of Illinois
- Travelers Health Network of Illinois
- Union Health Service
- United HealthCare of Illinois, Inc./Chicago HMO Ltd.
- United HealthCare of Illinois Inc./Share Health Plan of Illinois, Inc.
- Unity HMO of Illinois
- University of Illinois HMO Plan Trust

INDIANA:

- Aetna Health Plans of Ohio
- Aetna Health Plans of the Midwest
- Alternative Health Delivery Systems
- American Health Network of Indiana
- American HMO
- Anthem Health Plan of Indiana
- Arnett HMO
- BCI HMO
- ChoiceCare Health Plans
- CIGNA Healthcare of Illinois
- Family Health Plan of Indiana
- FHP of Illinois, Inc.
- First Commonwealth Limited Services Corporation
- Health Resources
- Healthsource Indiana
- Health Direct Insurance
- HMO Kentucky
- HPlan
- Humana Health Care Plans of Indiana
- Humana HealthChicago

- Key Health Plan
- M Plan
- Maxicare Illinois
- Maxicare Indiana
- Metrahealth Care Plan of Illinois
- Metrahealth Care Plan of Kentucky
- Partners National Health Plans of Indiana
- PHP Healthcare
- Physicians Health Network
- Physicians Health Plan of Northern Indiana, Inc.
- Principal Health Care of Indiana
- PruCare
- Rush Prudential HMO
- Sagamore Health network
- Southeastern Indiana Health Organization
- United HealthCare of Illinois, Inc./Chicago HMO Ltd.
- Universal Health Services
- Welborn Health Plans

IOWA:

- Care Choices-Mercy Alternative HMO
- Medical Associates Health Plan
- Principal Health Care of Iowa, Inc.

KANSAS:

- Blue-Advantage
- Blue-Care
- BMA Selectcare
- CIGNA Healthcare of Ohio
- CIGNA Healthcare of Kansas/Missouri
- Exclusive Healthcare
- GenCare Health Systems
- Healthcare America Plans
- HealthNet
- HMO Kansas
- Horizon Health Plan
- Humana Health Plan
- Humana Kansas City
- Kaiser Foundation Health Plan of Kansas City
- Lawrence Community Health Plan
- Metrohealth Care Plan of Kansas City, Inc.
- Preferred Plus of Kansas
- Premier Blue
- Principal Health Care of Kansas City
- Prudential Health Care

- Total Health Care
-

KENTUCKY:

- Advantage Care
 - Aetna Health Plan
 - Alternative Health Delivery Systems
 - American Health Network of Kentucky
 - Anthem Health Plans
 - Bluegrass Family Health
 - CHA Health
 - Choicecare
 - FHP
 - Healthsource Kentucky
 - Healthwise of Kentucky
 - Heritage National Healthplan
 - HMPK
 - HPLAN
 - Humana Health Plan
 - Metrahealth Care Plan of Kentucky
 - PruCare
-

LOUISIANA:

- Advantage Health Plan
 - Aetna Health Plans of Louisiana
 - Apex Healthcare of Louisiana
 - Bayou State Health Plan
 - CIGNA Healthcare of Louisiana
 - CIGNA Healthcare of North Louisiana
 - Community Health Network of Louisiana
 - Foundation Health, A Louisiana Health Plan
 - Gulf South Health Plans
 - Health Plus of Louisiana
 - HMO Of Louisiana
 - Humana Health Plan of Louisiana
 - Maxicare Louisiana
 - Medfirst Health Plans of Louisiana
 - MetraHealth Care Plan of Louisiana, Inc.
 - Principal Health Care of Louisiana
 - Sisters of Charity Health Plan
 - Southwest Medical Alliance HMO
-

MAINE:

- Harvard Community Health Plan, Inc.
 - Health Plans
 - Healthsource Maine
 - Healthsource of New Hampshire
 - HMO Blue
 - HMO-Maine
 - Tufts Associated Health Plan
-

MARYLAND:

- Aetna Health Plans of the Mid-Atlantic
 - CapitalCare
 - Chesapeake Health Plan
 - CIGNA HealthCare Mid-Atlantic
 - Columbia Medical Plan
 - Free State Health Plan
 - George Washington University Health Plan
 - HealthCare Corporation of the Mid-Atlantic
 - HealthCare Corporation of the Potomac
 - HealthKeepers (Physician's Health Plan, D.C.)
 - Humana Group Health Plan
 - Maryland Individual Practice Association
 - NYLCare Health Plans of the Mid-Atlantic
 - * Optimum Choice
 - PHN-HMO
 - Physicians Health Plan
 - Principal Health Care of Delaware
 - Principal Health Care Plan of Mid-Atlantic
 - Prudential Health Care Plan
 - Total Health Care
 - U.S. Healthcare, Inc.
-

MASSACHUSETTS:

- Central Massachusetts Health Care
- CIGNA HealthCare of Massachusetts
- Community Health Plan
- Connecticare of Massachusetts
- Fallon Community Health Plan
- Harvard Community Health Plan, Inc.
- Health New England
- Healthsource New Hampshire
- HMO Blue
- HMO Rhode Island

- Kaiser Foundation Health Plan of Massachusetts
 - Matthew Thornton Health Plan
 - MetraHealth Care Plan of Massachusetts
 - Neighborhood Health Plan
 - Prudential Health Care Plan
 - Tufts Associated Health Plan
 - United Health Plans of New England, Inc.
 - U.S. Healthcare, Inc.
-

MICHIGAN:

- Blue Care Network of East Michigan
 - Blue Care Network of Southeast Michigan
 - Blue Care Network-Great Lakes
 - Blue Care Network--Health Central
 - Care Choices HMO/Mercy Health Plans
 - Family Health Plan
 - Grand Valley Health Plan
 - Health Alliance Plan of Michigan
 - HealthPlus of Michigan
 - M-Care
 - NorthMed HMO
 - OmniCare Health Plan
 - Physician Health Plan
 - Priority Health
 - SelectCare HMO
 - Total Health Care
 - Ultimed HMO of Michigan
 - The Wellness Plan
-

MINNESOTA:

- Blue Plus
 - Central Minnesota Group Health Plan
 - First Plan HMO
 - Group Health
 - HealthPartners
 - Mayo Health Plan
 - Medica
 - Metropolitan Health Plan
 - Northern Plains Health Plan
 - NWNL Health Network
 - UCare Minnesota
-

MISSISSIPPI:

- CIGNA Healthcare of Tennessee

- Complete Health of Mississippi, Inc.
 - Progressive Health Management
-

MISSOURI:

- Blue-Advantage
 - Blue-Care
 - BlueChoice
 - BlueCHOICE
 - BMA Selectcare
 - CIGNA HealthCare of Kansas City/Missouri
 - CIGNA HealthCare of St. Louis
 - Citizens Advantage
 - Community Care, A Healthcare Partnership
 - Community Health Plan
 - Exclusive Health Plan
 - FirstGuard Health Plan
 - GenCare Health Systems
 - Group Health Plan
 - Healthcare USA of Missouri
 - HealthLink HMO
 - HealthNet
 - Humana Health Plan
 - Humana Kansas City
 - Kaiser Foundation Health Plan of Kansas City
 - Mercy Health Plan of Missouri
 - Metrohealth Care Plan of Kansas City, Inc.
 - MetraHealth Care Plan of St. Louis
 - Partners HMO
 - Physicians Health Plan of Greater St. Louis
 - Physicians Health Plan of the Midwest
 - Principal Health Care of Kansas City
 - Prudential Health Care Plan
 - Truman Medical Center
-

MONTANA:

- Glacier Community Health Plan
 - HMO Montana
 - Yellowstone Community Health Plan
-

NEBRASKA:

- Care Choices--HMO
 - Exclusive Healthcare
 - HMO Nebraska
 - Mutual of Omaha Health Plans of Lincoln
 - Principal Health Care of Nebraska
 - United HealthCare of the Midlands
-

NEVADA:

- FHP, Inc.
 - Health Plan of Nevada
 - HMO Colorado Inc. d/b/a HMO Nevada
 - Hospital Health Plan
 - Humana Health Plan
 - Nevada Health Visions
 - St. Mary's HealthFirst
-

NEW HAMPSHIRE:

- Harvard Community Health Plan, Inc.
 - HealthSource New Hampshire
 - HMO Blue
 - Matthew Thornton Health Plan
 - Tufts Associated Health Plan
 - U.S. Healthcare, Inc.
-

NEW JERSEY:

- Aetna
- American Preferred
- Americaid
- Amerihealth
- Atlanticare
- ChubbHealth, Inc.
- CIGNA
- CIGNA North
- Community Health Care
- First Option
- Garden State
- Greater Atlantic Health Care
- Harmony
- HIP Health Plan of New Jersey
- HMO Blue
- Liberty
- Managed Health Care Services

- MetraHealth NJ
 - Oxford Health Plans
-

NEW MEXICO:

- Cimarron HMO
 - FHP of New Mexico
 - HMO New Mexico
 - Lovelace Health Systems
 - Presbyterian Health Plan
 - Qual-Med/New Mexico Health Plan
-

NEW YORK:

- ABC Health Plan
- Aetna Health Plans of New York
- Better Health Plan
- Blue Choice
- The Bronx Health Plan
- Capital Area Community Health Plan
- Capital District Physician's Health Plan
- CarePlus
- CenterCare
- Choicecare of Long Island
- ChubbHealth, Inc.
- CIGNA Healthcare of New York
- Community Blue, the HMO of BC and BS of Western Community Health
- Community Choice Health Plan of Westchester
- Community Health Plan
- Elderplan
- Fidelis Care
- Foundation Health Plan
- Genesis Health Plan
- Health Care Plan
- Health Insurance Plan Health Maintenance Organization
- Health Now
- HealthFirst PHSP
- Healthnet
- HealthPlus
- HealthSource
- Healthsource HMO of New York, Inc.
- HMO Blue
- HMO-CNY
- Independent Health
- Kaiser Foundation Health Plan of New York
- Managed Health
- Managed HealthCare Systems of New York
- MD:LI

- MetraHealth Care Plan of NY
 - MetraHealth Care Plan of Upstate NY
 - MetroPlus Health Plan
 - Mohawk Valley Physicians Health Plan
 - MVP Health Plan
 - Neighborhood Health Providers
 - New York Hospital Community Health Plan
 - North American HealthCare
 - North Medical Community Health Plan
 - Northcare
 - NYLCare Health Plans of NY
 - Oxford Health Plans
 - Partners in Health
 - Physicians Health Services, Inc.
 - Preferred Care
 - Prepaid Health Plan
 - Prepaid Health Plan/Slocum-Dickson
 - Prepaid Health Plan/Southern Tier
 - PruCare of New York
 - Sanus Health Plans of Greater New York/NYLCare Health Plan of New York, Inc.
 - Suffolk Health Plan
 - Total Care/Total Care Choice
 - U.S. HealthCare
 - Universal Health Plan
 - WellCare of New York
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NORTH CAROLINA:

- Aetna Health Plans of the Carolinas
 - Blue Cross Blue Shield of North Carolina
 - Cigna Health Care of North Carolina
 - Community Choice of North Carolina
 - Doctors Health Plan
 - Health Maintenance Organization of North Carolina
 - Healthsource North Carolina
 - Kaiser Foundation Health Plan of North Carolina
 - * Maxicare North Carolina
 - Optimum Choice of the Carolinas
 - Partners National Health Plans of North Carolina
 - Personal Care Plan of North Carolina
 - PHP, Inc.
 - Principal Health Care of the Carolinas
 - Provident Health Care Plans of North Carolina
 - Prudential Health Care Plan
 - Qualchoice of North Carolina
 - U.S. Healthcare, Inc.
 - Wellpath Community Health Plans
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NORTH DAKOTA:

- HealthPartners
 - Heart of America HMO
 - Medica Choice
 - Northern Plains Health Plan
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OHIO:

- Advantage Health Plan
 - Aetna Health Plans of Ohio
 - AdultCare HMO
 - Bethesda Managed Care
 - Butler Health Plan
 - Choice Care
 - CIGNA Healthcare of Ohio
 - Community Health Plan of Ohio
 - CSA Health Maintenance Organization
 - DayMed Health Maintenance Plan
 - Dayton Area Health Plan
 - Emerald HMO, Inc.
 - Family Health Plan
 - FHP
 - Health Maintenance Plan
 - The Health Plan
 - Health Power HMO
 - HealthAmerica Pennsylvania/HealthAssurance HMO
 - HealthFirst
 - Healthsource Ohio
 - Health Plan of the Upper Ohio Valley
 - HMO Health Ohio
 - Hometown Hospital Health Plan
 - Humana Health Plan of Ohio
 - John Alden Health Systems
 - Kaiser Permanente
 - Medical Value Plan
 - MetraHealth Care Plan of Ohio
 - Nationwide HMO, Inc./Nationwide Health Plans
 - Paramount Health Care Plan
 - Personal Physician Care
 - Prudential Health Care Plan
 - QualChoice HMO
 - SummaCare
 - Super Blue HMO
 - Total Health Care Plan
 - U.S. Health HMO
 - United HealthCare of Ohio
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OKLAHOMA:

- Bluelines HMO
 - Cigna Healthcare of Oklahoma
 - CommunityCare HMO
 - Foundation Health - An Oklahoma Health Plan
 - Healthcare Oklahoma
 - Pacificare of Oklahoma
 - Proklahoma Care
 - Prucare of Oklahoma City
 - Prucare of Tulsa
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OREGON:

- Health Maintenance of Oregon
 - Health Masters of Oregon
 - HMO Oregon
 - Kaiser Foundation Health Plan of the Northwest
 - Liberty Health Plan
 - PACC Health Plans
 - Pacificare of Oregon
 - Physicians Association of Clackamas County
 - Providence Good Health Plan
 - Qual-Med Oregon Health Plan
 - SelectCare Health Plans
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PENNSYLVANIA:

- Advantage Health Plan
- Aetna Health Plans of Central & Eastern Pennsylvania
- Aetna Health Plans of Western Pennsylvania
- Alliance Health Network
- AmeriHealth HMO
- CIGNA Healthcare of Pennsylvania
- Geisinger Health Plan
- Greater Atlantic Health Service
- Grouphealth Partnership
- The Health Maintenance Organization of Pennsylvania
- Health Partners of Philadelphia
- HealthAmerica Pennsylvania/Health Assurance HMO
- Healthcare Management Alternatives
- Healthguard of Lancaster
- HIP of Pennsylvania
- HMO of Northeastern Pennsylvania
- Keystone Health Plan Central
- Keystone Health Plan East
- Keystone Health Plan West

- MediGroup HMO of Pennsylvania
 - Oxford Health Plans
 - Prudential Health Care Plan
 - QualMed Plans for Health of Pennsylvania
 - Riverside Health Plan
 - U.S. Healthcare, Inc.
 - Vista Health Plan
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RHODE ISLAND:

- Harvard Community Health Plan, Inc.
 - HMO Blue
 - HMO Rhode Island
 - Neighborhood Health Plan
 - United Health Plans of New England, Inc.
 - U.S. Healthcare
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SOUTH CAROLINA:

- Aetna Health Plans of the Carolinas
 - Companion HealthCare Corp.
 - Healthsource South Carolina, Inc.
 - Maxicare South Carolina
 - Partners National Health Plans of North Carolina
 - Physicians Health Plan of South Carolina
 - Preferred Health Systems
 - Principal Health Care of the Carolinas
 - Provident Health Care Plan of South Carolina
 - U.S. Healthcare, Inc.
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SOUTH DAKOTA:

- Dakota Care
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TENNESSEE:

- Aetna Health Plan of Tennessee
- CareChoice - Chattanooga
- CIGNA HealthCare of Tennessee
- Community Health Plan of Chattanooga
- Complete Health of Tennessee
- Health 123
- Health Net HMO
- Healthsource Tennessee
- Healthwise of Tennessee
- Heritage National Health Plan of Tennessee

- Humana Health Plan
 - Memphis Managed Care
 - Mid-South Health Plan
 - Phoenix Health Care Plan of Tennessee
 - Prudential Health Care Plan
 - Southern Health Plan
 - Tennessee Health Care Network
 - Tennessee Managed Care Network
 - Tri-Point Health Plan
 - University of Tennessee Health Plan
 - Vanderbilt Health Plan
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TEXAS:

- Aetna Health Plans of North Texas
 - Aetna Health Plans of Texas
 - Affiliated Health Plans
 - Americaid Community Care
 - Anthem Health Plans of Texas
 - CIGNA HealthCare of Texas (North Texas Division)
 - Community First Health Plans
 - Exclusive Healthcare
 - FHP of Texas, Inc.
 - FirstCare
 - Foundation Health, A Texas Health Plan
 - Harris Methodist Health Plan
 - Healthsource North Texas
 - HMO Blue, Southwest Texas
 - HMO Blue, West Texas
 - HMO Texas
 - Humana Health Plan
 - Kaiser Foundation Health Plan of Texas
 - Memorial Sisters of Charity HMO
 - MetraHealth Care Plan
 - MetraHealth Care Plan of Texas-Austin/San Antonio Site
 - NYLCare Health Plans fo the Gulf Coast
 - NYLCare Health Plans of the Southwest
 - Pacificare of Texas
 - PCA Health Plans of Texas
 - Principal Health Care of Texas
 - Prudential Health Care Plan
 - Rio Grande HMO
 - Scott and White Health Plan
 - Seton Health Plan
 - The Wellness Plan of Texas
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UTAH:

- CIGNA Health Plan of Utah
 - Educators Health Care
 - Employees Choice Health Option
 - FHP of Utah
 - Health Choice
 - Healthwise
 - Humana Health Plan of Utah
 - IHC Care
 - IHC Health Plans
 - Intergroup of Utah
 - SelectMed
 - United Healthcare of Utah
 - Utah Community Health Plan
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VERMONT:

- Community Health Plan
 - HMO Blue
 - Matthew Thornton Health Plan
 - MVP Health Plan
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VIRGINIA:

- Aetna Health Plans of Mid-Atlantic
- Capital Care
- Chesapeake Health Plan
- CIGNA HealthCare of Mid-Atlantic
- CIGNA HealthCare of Virginia-Richmond
- George Washington University Health Plan
- Health First
- Health Plus
- HealthKeepers, Inc.
- HealthKeepers Peninsula Health Care, Inc.
- HealthKeepers (Physician's Health Plan, D.C.)
- HMO Virginia, Inc.
- Humana Group Health Plan
- Kaiser Foundation Health Plan of Mid-Atlantic States
- Maryland--Individual Practice Association
- Optima Health Plan
- Optimum Choice
- Partners National Health Plans of North Carolina
- Penninsula Health Care
- Physicians Health Plan
- Principal Health Care of Mid-Atlantic
- Priority Health Care, Inc.
- Sentana Health Plans

- Southern Health Services
 - U.S. Healthcare
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WASHINGTON:

- Good Health Plan of Washington
 - Group Health Cooperative of Puget Sound
 - Group Health Northwest
 - HealthFirst Partners
 - Health Maintenance of Oregon
 - HealthPlus
 - HMO Washington
 - Humana Health Plan of Washington
 - Kaiser Foundation Health Plan of the Northwest
 - PACC Health Plans
 - Pacific Health Plans
 - PacifiCare of Oregon
 - Providence Good Health Plan
 - Qual-Med Health Plan
 - SelectCare Health Plans
 - Virginia Mason Group Health
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WEST VIRGINIA:

- Advantage Health Plan
 - Carelink
 - HealthAmerica Pennsylvania/HealthAssurance HMO
 - Healthassurance HMO
 - Health Plan of the Upper Ohio Valley
 - Optimum Choice
 - PrimeOne
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WISCONSIN:

- Atrium Health Plan
- CompCare Health Services Insurance Corp.
- DeanCare HMO
- EMPHESYS Wisconsin Insurance Company
- Family Health Network
- Family Health Plan Cooperative
- Genesis Health Plan Insurance Corp.
- Greater La Crosse Health Plans
- Group Health Cooperative of Eau Claire
- Group Health Cooperative of South Central Wisconsin
- Gundersen Health Maintenance Organization
- HealthPartners
- Humana Wisconsin Health Organization

- Managed Health Services Insurance Corp.
 - Maxicare Health Insurance
 - Medical Associates Health Plan
 - MercyCare Health Plan
 - MetLife Healthcare Network of Wisconsin
 - Network Health Plan of Wisconsin
 - North Central Health Protection Plan
 - Physicians Plus Insurance Corporation
 - PrimeCare Health Plan
 - O Care
 - Rockford Health Plans
 - Security Health Plan of Wisconsin
 - United Health Plan of Wisconsin Insurance Company
 - United HealthCare of Illinois, Inc./Chicago HMO Ltd.
 - Unity Health Plans
 - Valley Health Plan
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WYOMING:

- IHC Health Plans

Appendix 2.

IAFF Emergency Medical Services Ethic Statement

Managed Care and Emergency Medical Ethics

Quality emergency medical services (EMS) depends on the integrity of and trust in the provider-patient relationship. If third-party cost concerns supersede patient interests, trust will be eroded. To uphold patient trust and to provide ethical guidelines for emergency medical technicians (EMTs) and paramedics practicing in an increasingly corporate health care environment, the IAFF endorses the following:

- The ethical obligations of EMTs and paramedics do not change when practicing in a managed care environment or any other care environment. The EMS professional's primary responsibility remains with the patient.
- When economic interests of physicians, hospitals, purchasers of health services, or managed care organizations are in conflict with patient welfare, the highest priority is patient welfare.
- EMS professionals must encourage patient autonomy and choice. Patients are best served when managed care organizations' policies and procedures are provided in writing, in easily understood terms, to all enrollees and participating providers at the time of enrollment.