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**IN THE OFFICE OF ADMINSTRATIVE HEARINGS**

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| In the Matter of:<br><br>RBR Management, LLC dba Community Ambulance,<br><br>Applicant. | Docket No. 2017-EMS-0104-DHS (EMS No. 0283)<br><br>**COMMUNITY AMBULANCE'S WRITTEN CLOSING ARGUMENT**<br><br>(Assigned to the Honorable Tammy L. Eigenheer) |

RBR Management, LLC dba Community Ambulance ("Applicant" or "Community Ambulance") submits its written closing argument for the consideration of Administrative Law Judge Tammy L. Eigenheer ("Judge Eigenheer"). After nine (9) hearing days on Community Ambulance's Application for a Certificate of Necessity ("CON") to provide 11,315 year-one interfacility and convalescent transports, with a focus on improving service to and meeting the needs of Dignity Health's patient population in Maricopa County, Community Ambulance respectfully requests Judge Eigenheer recommend that the Director

of Arizona Department of Health Services ("ADHS") approve the proposed Application, directing the Bureau of EMS and Trauma Services ("BEMSTS") to issue a CON to Community Ambulance. [ADHS-1]

There are a number of factors in statute and rule that must be proved before issuing a CON. During the hearing, Community Ambulance succinctly proved each of these factors by a preponderance of the evidence, including those factors identified as the focus of the CON hearing: (1) there is a public necessity in the Maricopa County service area for an additional interfacility ambulance service; (2) Community Ambulance, through its operators and owners, has the professional expertise, integrity, fiscal competence, and resources necessary to operate an ambulance service and provide interfacility and convalescent transports in Maricopa County; and (3) the proposed rates and charges in the Phoenix Uniform Rate Group are just, reasonable, and sufficient. These factors having been established by a preponderance of the evidence, along with the other factors in statute and rule, support granting Community Ambulance a CON to operate in Maricopa County.

**1. APPLICABLE STATUTE AND REGULATIONS AT ISSUE IN HEARING**

A.R.S. § 36-2233(B) provides that the Director shall issue a certificate of necessity if all of the following apply:

> 1. The ambulance service has a certificate of registration issued by the department for at least one ambulance pursuant to § 36-2212[1].
>
> 2. The director finds that public necessity requires the service, or any part of the service proposed by the applicant.

[1] Community Ambulance is prepared to register all six (6) of its ambulances pursuant to A.R.S. § 36-2212 at or around the time the Director of ADHS issues a CON.

3. The director finds that the applicant is fit and proper to provide the service.

4. The applicant has paid the appropriate fees pursuant to § 36-2240.

5. The applicant has filed a surety bond pursuant to § 36-2237.

**2. THERE IS A PUBLIC NECESSITY FOR THE PROPOSED SERVICE**

Public necessity, as used in A.R.S. § 36-2233(B)(2), means "an identified population needs or requires all or part of the services of a ground ambulance service." Importantly, previous findings have stated that the public necessity requirement does not require evidence the existing CON holders are not meeting the needs of the community. *In the Matter of American Medical Response of Maricopa, LLC*, 2014A-EMS-0305-DHS, 50:10-18, ¶38 (findings based on testimony of Terry Mullins regarding the Bureau's Guidance Document, GD-099-PHS-EMS). The Guidance Document is clear that the public necessity rule "recognizes that the primary focus should be on the best interests of the public and not upon protecting the territory or service interests of current providers in the area, although the impact on the current provider(s) of service, and on the public in and near to the application area, are factors to be considered."

Uniquely, the interests and needs of the patient population in this case are best represented by the healthcare providers from Dignity Health and Arizona General Hospital ("AGH") who interact with interfacility ambulance service providers on behalf of their patients on a near daily basis. [*See e.g.* Tr. 548:20-549:7 (Brandon Hestand), Tr. 636:2-11; 637:4-14 (Karger)] Healthcare providers, like Dignity Health and AGH, are significant consumers of interfacility ambulance services and have clear insight into how the system is performing. Further, non-profit healthcare providers, like Dignity Health, offer substantial healthcare services and community support and depend on interfacility ambulances to achieve

their mission and goals.

As Jeffrey O'Malley ("O'Malley"), Vice President, Partnership Integration, Arizona Service Area, testified during the hearing, Dignity Health and Community Ambulance did not obtain a needs assessment because Dignity Health – the fifth largest health system in the nation with 74 total facilities and clinical offices in Maricopa County – knows its needs and knows that those needs in the interfacility transport space have not been adequately met through the existing, available ambulance options. [CA-126; Tr. 437:22-12] Dignity Health, as O'Malley testified, is looking for something more – more consistency, more reliability and a higher degree of integration with the ambulance service, which includes greater transparency. Despite his efforts to work with each of the Intervenors, O'Malley does not believe Dignity Health's needs and goals for an integrated, aligned, efficient, and reliable interfacility transport system can be achieved with the existing CON holders in Maricopa County service area today. [Tr. 430:09-431:19] Through an enhanced ambulance offering such as that proposed by Community Ambulance, Dignity Health will be positioned to further enhance the services provided to the residents of Maricopa County and its surrounding areas.

In determining whether to issue a CON to more than one ambulance service for interfacility or convalescent transport services in this matter, the Director considers the following public necessity factors set forth in A.A.C. R9-25-903(A)(B):

> 1. The factors in subsections
>
> (A)(2): The population demographics within the proposed service area;
>
> (A)(3): The geographic distribution of healthcare institutions within and surrounding the service area;

(A)(4): Whether issuing a certificate of necessity to more than one ambulance service within the same service area is in the public's best interest, based on:

(a) The existence of ground ambulance service in all or part of the service area;

(c) The availability of certificate holders in all or part of the service area;

(d) The availability of emergency medical services in all or part of the services area;

(A)(5): The information at 9-25-902(A)(1) & (A)(2); and

(A)(6): Other matters determined by the Director or the applicant to be relevant to the determination of public necessity

2. The financial impact on certificate holders whose service area includes all or part of the service area in the requested certificate of necessity;

3. The need for additional convalescent or interfacility transport; and

4. Whether a certificate holder for the service area has demonstrated substandard performance.

No single factor in the public necessity analysis is determinative. The Director considers and balances information introduced at the hearing on these factors in the context of the Application and the proposed service area. Any failure to provide information or establish any one factor does not, by itself, constitute grounds to deny an application. *See In the Matter of: American Medical Response of Maricopa, LLC,* Decision, 2015-EMS-0190-DHS, Conclusions of Law, at 67:23-26, ¶11 (citing A.A.C. R9-25-903).

**2.1. The population demographics within the proposed service area and geographic distribution of healthcare institutions. (A.A.C. R9-25-903(A)(2) & (3))**

According to the U.S. Census Bureau, as of July 1, 2017, Maricopa County has an estimated population of 4,307,033. *See In the Matter of: Maricopa Ambulance, LLC,* April 18, 2016 Administrative Law Judge Decision, Findings of Fact, at 2:26 ¶2; CA-150.[2] The U.S. Census Bureau reports that Maricopa County is the fastest growing county and the 4th most populous county in the United States, adding just under 500,000 additional residents since 2010. *Id.* Both Linda Hunt, the CEO of Dignity Health Arizona ("Hunt") and O'Malley confirmed that from their work in assessing the need for additional medical facilities, growth in Maricopa County continues apace, with the most growth being seen in the northwest and southeast portions of Maricopa County. [Tr. 77:18-21; 216:3-25] Hunt testified that based upon data Dignity Health collects on population growth, it appears that Maricopa County is seeing "2 to 3 percent cumulative growth over the next 5 to 10 years." [Tr. 77:9-17]

Maricopa County "contains thousands of public and private healthcare facilities throughout the county." *In the Matter of: Maricopa Ambulance, LLC*, Findings of Fact, at 2:25-26, ¶2; *see* [CA-183-185] Among these are many Dignity Health facilities, including seven (7) acute care hospitals, four (4) urgent cares, and multiple freestanding emergency rooms, ambulatory surgicenters, physician clinic locations, and a number of other entities totaling about 74. [Tr. 75:16-23;

[2] The Court can take judicial notice of these U.S. Census Bureau facts and facts found in a previous CON hearing and in the exhibits that were not admitted during the hearing. *See* Ariz. R. Evid. 201 ("judicially noticed fact must be one not subject to reasonable dispute in that it is either (1) generally known within the territorial jurisdiction of the trial court or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned."); *In re Sabino R.*, 198 Ariz. 424, 425, 10 P.3d 1211, 1212 (Ct. App. 2000) (court may take judicial notice of any fact the trial court could take notice, and may take notice of its own records or those of another action tried in the same court.)

*see also* CA-28, CA-183] To accommodate this ever-growing population, Hunt testified that Dignity Health plans to build and open several additional facilities, including a 50 bed AGH hospital in Mesa, an expansion of pediatrics and women's services at Mercy Gilbert Medical Center ("MGMC"), an additional tower at Chandler Regional Medical Center ("CRMC") "because [CRMC] is very full", two (2) new freestanding emergency rooms in Tempe and Surprise, "and [Dignity] continues to look at one other location." [Tr. 76:10-25; Tr. 638:1-639:23; ABC-28; CA-183] Hunt also testified that she is aware of plans for Dignity Facilities west or northwest of state route 303. [Tr. 102:05-09]

When asked if she was aware of other health systems that are also planning to open new facilities in Maricopa County, Hunt testified: "[p]robably the better question is who's not going to open up more facilities." [Tr. 77:22-25] Based on her knowledge of the marketplace, Hunt testified that Banner Health is opening a new hospital in the East Valley two (2) miles away from CRMC and expanding into the City of Maricopa and Casa Grande. [Tr. 77:24 – 78-3] Hunt further testified that Tenet (Abrazo) is looking to build micro-hospitals in the West Valley, and Steward Health, HonorHealth, and Phoenix Children's Hospital are all "expanding to meet the needs of the growing population." [Tr.78:3-9]

The continued population growth across Maricopa County also includes areas of less densely populated sections of the County. Daisy Mountain Fire & Medical Fire Chief Mark Nichols confirms that the community his department serves has seen continued growth over the past five (5) years. [Tr. 1451:9-19] Chief Nichols further testified that Sonoran free-standing emergency room located within CON recently broke ground to expand into a full-service hospital. [Tr. 1451:20-1542:03]

Dignity Health also seeks to extend healthcare services into these areas.

As O'Malley testified, the performance of existing ambulance providers gets worse the farther away from the city center you travel:

> I would point out is -- and this was a trend we saw which kind of helped us form the need early on when we started getting some of these reports, so really, the end of 2015 into 2016 was that typically the response rates, the further you get away -- so the further you go out into those less populated areas, the worse the response times get. And we -- then we heard about Laveen; it's three from the bottom. You know, even on the most generous response time allotment of 75 minutes for those scheduled, you know, they're hitting 83 percent. Tick up a couple, you see AGH -- Dignity Health AGH ER - Goodyear, again, further outside the city, only 50 percent of those. And -- and that was a recurring theme that I saw. I don't know if the data is 100 percent accurate, but as a common theme, it seems like the less populated areas, which are growth areas, which are areas Dignity Health is trying to build healthcare services in, the further out you go, the worse it gets. [Tr. 251:18 - 252:10]

Meeting the needs of those residing in rural and less densely populated areas of Maricopa County is a significant reason awarding a CON to Community Ambulance serves the public benefit. To be sure, the CON rules and regulations are designed to address the needs of these communities, and not to maximize the profitability and efficiencies of the Intervenors' operational plan. Expansion of healthcare to serve those residing in less densely populated communities should not be inhibited by the inability of the existing ambulance providers to timely respond to the needs of those communities. Community Ambulance will help serve this need.

After material errors were revealed in AMR-44 during the hearing, AMR's own data confirms continued growth in ambulance transports in Maricopa

County since 2013. [AMR-84; Tr. 1854:17-164:5 (testimony from AMR representative acknowledging errors in AMR-44 changing AMR's negative transport growth numbers into positive transport growth numbers)] Hunt further testified on cross-examination by AMR's counsel that Maricopa County is a county in which the aging population is on the rise. [Tr 159:03-06] O'Malley confirmed not only that the patient population in Maricopa County is aging but as it ages that patient population requires a more acute level of service. [Tr. 215:13-216:13]

The evidence of an ever-growing and aging population, continued growth in transport demand, and expansion of new healthcare facilities across Maricopa County confirms that the "market for ambulance transport in Maricopa County is large enough to sustain multiple private providers." *See In the Matter of: Maricopa Ambulance, LLC*, 2015-EMS-0190-DHS, Conclusions of Law, at 25:3-4, ¶17.

**2.2. Issuing a certificate of necessity to more than one ambulance service in Maricopa County is in the public's best interest (A.A.C. R9-25-903(A)(4)(a)(c)(d))**

**(a) The existence of ground ambulance service to all or part of the service area;**

**(c) the availability of certificate holders in all or part of the service area; and**

**(d) the availability of emergency medical services in all or part of the services area**

Admittedly, there are multiple CON holders in all or part of the Maricopa County service area. But contrary to positions taken by Intervenors during the hearing, a good many of these CON holders are public CON holders, most of whom only provide 911 ambulance service to all or part of the service area. *See e.g. In the Matter of: Maricopa Ambulance, LLC*, 2015-EMS-0190-DHS,

Conclusions of Law, at 25:9-13, ¶18. Only a handful of these public providers also provide interfacility and convalescent transports: Buckeye Valley Rural Volunteer Fire District, North County Fire and Medical, Daisy Mountain Fire District, Sun Lakes Fire District and City of Mesa.

As the numerous letters of support from various fire districts and municipalities advocate, public providers whole-heartedly support Community Ambulance's CON Application. [ADHS-17 (July 5, 2017 Letter of Support from Thomas Dwiggins, Fire Chief, City of Chandler Fire, Health & Medical Department); ADHS-18 (July 17, 2017 Letter of Support from Greg Ruiz, Fire Medical Rescue Chief, City of Tempe Fire Medical Rescue Department); ADHS-19 (July 18, 2017 Letter of Support from Mary Cameli, Fire Chief, Mesa Fire and Medical Department); ADHS-20 (July 24, 2017 Letter of Support from the Honorable Mayor of the Town of Gilbert, Jenn Daniels); ADHS-21 (July 27, 2017 Letter of Support from Paul Adams, Chief of the Avondale Fire & Medical Department); ADHS-23 (March 5, 2018 Letter of Support from Kara Kalkbrenner, Fire Chief, Phoenix Fire Department); ADHS-24 (Letter of Support from Mark Nichols, Fire Chief, Daisy Mountain Fire District)] All of the aforementioned community leaders knowingly and intentionally signed these letters of support voicing their full-throated support for Community Ambulance's Application. There is no evidence to suggest otherwise. What is also notable is that those public providers with interfacility capabilities who did not submit letters of support conspicuously did not intervene to oppose Community Ambulance's Application or request a carve-out of their service areas. Clearly, there is undisputed and overwhelming support from these community leaders from various political subdivisions, all of whom represent and serve the residents of Maricopa County.

Of course, Intervenors are also available to provide interfacility and convalescent transports. Certain of these CONs, however, do not necessarily reach all of Maricopa County. As was established during the hearing, Maricopa Ambulance is excluded from providing ambulance service to (1) Buckeye Valley Rural Volunteer Fire District; (2) North County Fire and Medical; (3) Daisy Mountain Fire District (CON 105); and (4) Sun Lakes Fire District (CON 137). [CA-43] In addition to limitations on the number of ambulances it can operate, ABC's CON also excludes (1) Buckeye Valley Rural Volunteer Fire District and (2) North County Fire and Medical, except for the campus of Banner Del Webb Hospital. [ABC-1 (CON 139); Tr. 1485:4-1487:5 (Neal Thomas acknowledging that if a Dignity Health patient was not in ABC's service area, ABC could not pick that patient up for a transport.) This leaves AMR Maricopa (CON 136) and AMR's Professional Medical Transport (CON 71) as the only unrestricted county-wide options for interfacility transports – which poses a risk to those communities during periods of system overload or if the existing CON provider is not adequately performing its functions.

If awarded, Community Ambulance's CON would also cover all of Maricopa County and give patients and healthcare providers a choice of ambulance service provider. Community Ambulance will also be better positioned to enhance and improve interfacility service to otherwise underserved and identified rural areas of Maricopa County (as discussed below at § 6). Urban areas will benefit too. As Fire Chief Mary Cameli of Mesa Fire and Medical Department, the second largest Fire Department in Maricopa County, states: "By granting this CON application, inter-facility transportation services will be enhanced for all with the addition of more available ambulances to serve the needs of all levels of inter-facility patient care." [ADHS-19]

### 2.3. The financial impact on existing CON Holders

Granting a CON to Community Ambulance, which anticipates providing 11,315 year-one interfacility and convalescent transports in Maricopa County, with a focus on providing a dedicated and integrated interfacility ambulance service for Dignity Health patients, to and/or from Dignity Health's facilities, may have a minor financial impact on Intervenors, but will not "drive any of the current providers out of business." *See Maricopa Ambulance,* Decision, 2015-EMS-0190-DHS, at 20:21-25, ¶20; *AMR of Maricopa, LLC*, Decision 2014A-EMS-0305-DHS, 70:28-71:2, ¶30 ("[T]he statutes and regulations do not require that existing CON holders remain whole and suffer no adverse financial impact, which would necessarily occur at some level.")

#### 2.3.1. *De Minimis Financial Impact on AMR*

AMR in Maricopa County had a preferred provider agreement with Dignity Health and continues to be the primary provider of ambulance transport services systemwide. [CA-24; CA-29; MA-37; Tr. 666:1-667:10] AMR is the largest ambulance company in the country and certainly the dominant ambulance provider in Maricopa County, handling 211,782 of the over 300,000 transports recorded in Maricopa County for 2017. [AMR-54 at 5] The fractional loss of 11,315 transports will have only a slight financial impact on AMR, but certainly will not drive AMR – the largest ambulance company in the State of Arizona – out of business. Nor should Dignity Health be forced to continue using AMR when, as the evidence showed, Dignity Health has been dissatisfied with AMR's level of service and failure to honor its contractual commitments to, among other things, provide accurate and honest transport data reporting and not interfere with Dignity Health's efforts to develop an ambulance service in Maricopa County.

Community Ambulance developed its 11,315 transports figure for the

application based on AMR's 2016 first quarter transport reporting to Dignity Health. [Tr. 330:8-23] Those 11,315 transports represent approximately 5% of the total transports all of AMR's Maricopa County CON Holders handled in 2017. Despite the number of transports reported in the application, AMR developed its year-one (1) financial impact analysis using 13,023 transports rather than 11,315. [AMR-54] It is important to note here that the 13,023 transports reported by AMR represents nearly 100% of the Dignity Health transports available in Maricopa County.[3] The problem with that analysis, however, is that Applicant has acknowledged it will not be providing 100% of the Dignity Health transports in Maricopa County. [Tr. 924:13-22] That is a practical impossibility given the number of Dignity facilities and the wide dispersion of those facilities around the Valley. *Id.* Despite Intervenors' suggestions, it has never been Applicant's contention that it is or will be staffed or equipped in year one (1) to run 100% of the Dignity Health transports or do more than the 11,315 transports set forth in its application. *Id.*

In fact, when Community Ambulance submitted its revised ARCR on March 27, 2017, it did not update its pro forma transport information to include additional transports. [ADHS-12; Tr. 2132:11-2133:2] AMR's financial impact analysis goes on to say that AMR will lose 18,941 transports in year two (2) if Community Ambulance is awarded its CON. [AMR-54; Tr. 2133:3-9] That figure is equally overstated and unreliable because it includes all of AMR's 2017

[3] Under the preferred provider agreement, Dignity Health employees were directed to call AMR on a one-call system [Tr. 284:11-15] and AMR would arrange for the transport even if it used a different ambulance company. [Tr. 2044:19-2046:8] AMR has turned only four calls to another provider since January 2016 and all four turned calls were to ABC Ambulance [AMR-46; Tr. 1498:06-15], which is owned and run by Neal Thomas [Tr. 1389:8-10] who happens to also be the President of Comtrans [Tr. 1391:1-4], an AMR affiliate. [Tr. 1466:25-1467:9]

transports from a non-Dignity facility to a Dignity facility. [Tr. 2133:3-9] Neither Dignity Health nor Community Ambulance has any influence or input into the ambulance provider chosen by non-Dignity facilities, like Banner Health or HonorHealth, or even Dignity Health minority-owned affiliates like Concentra and Phoenix Children's Hospital, for example. [Tr. 182:22-183:13]

AMR's financial impact analysis also assumes that if Community Ambulance is awarded a CON, AMR will bear 100% of the lost income from those transports. [AMR-54] That assessment ignores the fact that AMR has already lost several thousand Dignity Health transports to Maricopa Ambulance as a result of AMR's demonstrated poor ambulance responses, lack of collaboration, inaccurate and misleading reporting, and willingness to breach its customer agreement with Dignity Health by intervening in this Application process.[4] This fact is underscored by the service agreement that Dignity Health entered into with Maricopa Ambulance on the eve of the hearing [MA-37] yielding approximately 3,600 annualized transports to Maricopa Ambulance. [Tr. 1631:13-20]

While it is impossible to tell the exact proportion of the 11,315 transports that would have otherwise been provided by AMR, the number of actual lost transports AMR will lose if Community Ambulance is awarded a CON is significantly less than 11,315. The bottom line is that the financial impact on AMR in losing less than 5% of its total transports in the Maricopa County service area – largely due to AMR's own failure to adequately perform – will not put AMR out of business.

[4] It appears that Dignity Health is not the only customer dissatisfied with AMR's service. Since the beginning of 2017, AMR has lost its preferred contract with HonorHealth, and 911 contracts with the City of Scottsdale, City of Surprise, and City of Goodyear. [CA-141; Tr. 1651:05-16; Tr. 1661:04-11; Tr.1657:07-1678:09-22; Tr. 1679:04-12]

#### 2.3.2. *De Minimis financial impact on Maricopa Ambulance*

Currently, Maricopa Ambulance provides about 3,600 annualized transports to Dignity Health facilities in Maricopa County pursuant to a recently executed service agreement with Dignity Health. [Tr. 1631:13-20] In view of Community Ambulance's CON Application, the parties did not draft the service agreement as a preferred provider agreement because Maricopa Ambulance recognized the potential short-term nature of the transports. [Tr. 1668:06-1669:12] This is important because Maricopa Ambulance, a subsidiary of national ambulance company Priority Ambulance, (1) did not have a significant number of Dignity Health transports until it entered into the service agreement with Dignity Health [Tr. 1690:10-25] and (2) entered that agreement with full knowledge that it could lose a majority of those transports if Community Ambulance was awarded a CON. *Id*. Notably, Maricopa Ambulance did not prepare a financial impact analysis on the transports identified in Community Ambulance's Application or the 3,600 (annualized) transports that it currently provides to Dignity Health. [Tr. 1687:07-09] Likely because there is no unanticipated financial consequence on Maricopa Ambulance if Community Ambulance is awarded a CON. In fact, Maricopa Ambulance, in an effort to woo Dignity Health's business, offered to jettison lower-use or infrequent-use clients to other providers and shift those ambulances in service of Dignity Health's needs. [CA-193; Tr. 303:18-304:07] Not only does this demonstrate that there is no financial harm to Maricopa Ambulance, but shows an actual need for additional ambulances in the Maricopa County marketplace.

Furthermore, Priority Ambulance CEO, Brian Gibson, competently testified that Maricopa Ambulance is showing significant growth even without these recent Dignity Health transports, by adding additional transports to its

ambulance service through 911 contracts with the City of Scottsdale, the City of Surprise, the City of Glendale, and through a preferred provider agreement with the HonorHealth system. [Tr. 1672:06-11; 1663:21-1664:15] According to testimony from Mr. Gibson, Maricopa Ambulance expects to do an additional 10,000 transports for the City of Scottsdale [Tr. 1656:7-16], 12,000 transports for the City of Glendale [Tr. 1674:01-04], and 10,000 transports under the HonorHealth contract in 2019. [Tr. 1667:03-07] And this analysis does not account for the fact that even if Community Ambulance is awarded a CON, Maricopa Ambulance will still receive transports for Dignity Health facilities through collaborative back-up agreements with Community Ambulance or directly through the service agreement with Dignity Health. With an additional 30,000+ transports under contract, losing some but not all 3,600 Dignity Health transports, which Maricopa Ambulance already contemplated it may lose, will hardly result in the type of financial harm that the statutes and regulations are designed to protect against and will clearly not result in Maricopa Ambulance going out of business.

#### 2.3.3. *No Financial Impact on ABC*

With respect to ABC, the evidence adduced at hearing confirmed that the entry of Community Ambulance will have no material financial impact on ABC's operations. When asked through subpoenas for records of Dignity Health transports, ABC represented it had none. During the hearing, it was revealed through unadmitted exhibit AMR-46 that AMR turned a total of four (4) Dignity Health transports to ABC in 2017 and 2018. [Tr. 1492:17-1494:24] ABC's CEO, Neal Thomas ("Thomas"), readily agreed on the record that losing these four (4) transports would not have any negative financial impact on ABC. [Tr. 1498:06-15]

What's more, on February 12, 2018, ABC represented to ADHS and BEMTS through a request for a rate increase that "it has experienced steady growth, and during 2017, saw its operations grow significantly with increased transport activity, increased headcount, and a move to a new headquarters facility to accommodate its needs." [ABC-55][5] Through this request for a rate increase, ABC represented to the Department "[t]ransports grew from 4,735 in 2016 to 8,067 in 2017." And, without any Dignity Health patient transports, ABC told the Department that "[t]ransports in 2018 are expected to continue to grow from the levels achieved in the fourth quarter of 2017. Total transports of 11,140 are projected for 2018, which is a 38.1% increase from 2017." ABC submitted these growth projections knowing that Community Ambulance had applied for a CON implying that Community Ambulance's CON would have little to no financial impact on ABC or its projected growth. ABC enjoys this growth without the benefit of any meaningful quantity of transports for Dignity Health or AGH.

Nor should ABC be permitted to claim that it would be adversely impacted by the entry of Community Ambulance into the system when, as of the hearing date, it had not actively marketed its transportation capabilities directly to Dignity Health facilities or the AGH system. [*See e.g.* Tr. 597:09-11 (testimony of Brandon Hestand, paramedic liaison for CRMC and MGMC); Tr. 671:12-23]

During the hearing, ABC contended that approximately 47% of its total transports are derived from the Arizona Care Network ("ACN"), a physician-led, physician governed clinically integrated network and Mercy Care Plan. And,

[5] Although not admitted during the hearing, ABC-55 was submitted to ADHS/BEMSTS on February 12, 2018, is part of the ADHS/BEMSTS file, and is relevant for the Court's consideration of a financial impact, if any, on ABC should the Director grant Community Ambulance a CON. Further, as it is a matter of public record, the Court may take judicial notice of ABC-55. *See* Ariz. R. Evid. 201.

Dignity Health's involvement in the ACN and Mercy Care Plan could somehow result in a loss of these transports. This is simply not the case, as the dearth of any evidence to support ABC's theory would suggest.

The ACN is governed by a 21-member Board of Managers, composed of 15 independent physicians representing all regions of the Valley and a blend of primary care physicians and specialists, five (5) healthcare administrators representing Dignity Health Arizona and Abrazo Community Health Network, as well as one (1) Medicare beneficiary. [ABC-21; Tr. 15-79:7; 79:13-20] The ACN is independent from Dignity Health and Dignity Health has no power to direct or control which ambulance service providers the participants in the ACN utilize for transport services. Through a letter dated November 8, 2018 addressed to Adriane Hofmeyr, counsel for ABC, David A. Hanekom, MD, FACP, CMPE, the CEO of ACN, explained ACN's role and unequivocally confirmed ACN does not contract with ambulance companies. That letter, a true and correct copy of which is attached as Exhibit 1 to this Closing Argument for inclusion in the record on Community Ambulance's Application, states in pertinent part:

> Arizona Care Network has entered in to [sic] arrangements with various payers to improve care for patients treated by ACN providers, including an arrangement with Mercy Care that has been in place since 2014. Mercy Care does not delegate provider network contracting or credentialing functions to Arizona Care Network. As a result, Mercy Care retains its right and authority to contract with and credential physicians and other healthcare providers to be considered in-network for all members, including those patients covered under ACN's arrangement with Mercy Care.
>
> Arizona Care Network's Board of Managers determines which medical groups and other provider organizations participate in the network, which includes primary care

> clinicians, specialists, ancillary providers and facilities. ACN strives to coordinate the delivery of healthcare services within this selected network of providers to maximize opportunities to effectively diagnose, treat and rehabilitate as necessary patients served by the network.
>
> **Arizona Care Network does not contract with or otherwise credential/certify ambulance companies.** Ambulance companies provide a vital service to patients; however, ACN does not coordinate or participate in the arrangement or interfacility transport services of any patient covered under our various payer agreements. Rather, we believe it is most appropriate for these arrangements to be made by and between the patient and his/her family, and the physicians, nurses and other capable support staff representing the involved facilities.

[Exhibit 1 to Written Closing Argument, (emphasis added)]

Mercy Care Plan (which now includes Mercy Maricopa Integrated Care) is a Medicaid plan that oversees approximately 360,000 members and is a joint venture between Dignity Health and Ascension Health but administered and managed on a day-to-day basis by Aetna. [Tr. 79:23-80:16] Hunt unequivocally testified Dignity Health has no authority to require the Mercy Care Plan to use any one ambulance service. [Tr. 80:17-25] O'Malley confirmed that the facilities – not the payors (like Mercy Care Plan) – request ambulance transports, and even testified that through a collaborative approach with all CON holders, ABC could assist with Dignity Facility transports ABC does not have today. [Tr. 434:10-25; Tr. 1492:17-1494:24] Aside from pure speculation, ABC has put forward no competent evidence to support a theory that it will lose transports from ACN or the Mercy Care Plan if Community Ambulance is awarded a CON.

As established during the hearing, granting a CON to Community Ambulance, who will provide 11,315 first year transports for Dignity Health patients and facilities, will have only a minor financial impact on AMR and

Maricopa Ambulance, and (as Thomas acknowledges) no material financial impact on ABC.

### 2.4. Community Ambulance has demonstrated a need for additional interfacility transport services in Maricopa County

Community Ambulance has also established the need factor by a preponderance of the evidence. The question of need for additional interfacility transports in the system is focused primarily on the public health and welfare and whether the public's best interest will be served by the addition of an interfacility transport company. These interests are, of course, balanced with the impact, if any, on the existing CON holders, including their ability to continue to provide services to those members of the public residing in rural areas of Maricopa County.

As established during the hearing and discussed at §§ 2.4 and 6 of this written closing argument, the financial impact on Intervenors will be slight and the impact on residents of rural areas will be improved overall by the availability of an additional provider to assist during peak loads or periods of system overload. In addition to acting as a relief valve to assist the incumbent CON holders servicing rural communities during times of high volume, the public's best interest will be served through the introduction of the experienced, qualified, and dedicated ambulance service of the owner-operators of Community Ambulance. As discussed below, Rob Richardson ("Richardson") and Brian Rogers ("Rogers") have a long and decorated history of both public service and experience in the efficient and successful operation of private ambulance companies. This valuable experience includes the well-recognized capacity to react and respond to a mass casualty event in collaboration with public first responders and other private ambulance providers in a system. [Tr. 795:26-797:22; 1300:21-20] And, Rogers is now working

with FEMA to develop a response to mass casualty events that will be taught and implemented nationwide. [Tr. 1304:02-1305:06] The residents in Maricopa County and surrounding areas will be the beneficiaries of adding Community Ambulance, Richardson, and Rogers.

#### 2.4.1. *Competition serves a public necessity*

The best interests of the public will further be promoted through the competition Community Ambulance introduces into the large Maricopa County market – competition that has previously been found to serve a public necessity.

Each Intervenor has previously testified or argued in their earlier successful efforts to obtain a CON that competition serves the public benefit. In recommending that the Director of ADHS award Maricopa Ambulance a CON, Administrative, Law Judge Diane L. Mihalsky stated:

> Past history from the evidence that was submitted at the hearing in Case No. 2014A-EMS-0305-DHS [AMR's CON HEARING] and Maricopa Ambulance's evidence that was submitted in this matter establishes that competition among private providers of ambulance service in a large market serves a public necessity. [*See In the Matter of: Maricopa Ambulance, LLC,* 2015-EMS-0190-DHS, Conclusions of Law, at 25:14-17, ¶19]

The Director of ADHS adopted this Conclusion of Law in her May 17, 2016 Decision awarding Maricopa Ambulance its CON. *See In the Matter of: Maricopa Ambulance, LLC,* 2015-EMS-0190-DHS, Decision (May 17, 2016).[6]

AMR, the largest ambulance company in the country, the State of Arizona, and Maricopa County, previously advocated the benefits of competition when it

[6] https://portal.azoah.com/oedf/documents/2015A-EMS-0190-DHS/2015A-EMS-0190-DHS-0172.pdf

applied for its CON, but now thinks the existing three providers are enough, implying the Director should shut the door. [Tr. 2064:24-25] AMR's shifting and protectionist position on the public benefits of competition is convenient now that it has its own CON and recently lost transports due to its own underperformance. In fact, the inadequate ambulance service provided by AMR and the inability for the other intervening ambulance companies to meet the needs of a large consumer of ambulance services (like Dignity Health) establishes the need for additional, competitive alternatives. AMR's shift in positions to say now there is sufficient competition when the market – as represented in this case by Dignity Health and AGH witnesses – is seeking alternatives to the current options available in the system underscores how the public would benefit from the introduction of Community Ambulance.

ABC, through its opening brief for its CON application hearing argued "[i]t is in the public's best interest to have competition" and that "competition is a positive thing, especially in this limited regulatory environment, and the public needs it and the options it provides." *See* ABC's Prehearing Legal Memorandum, 2012A-EMS-0101-DHS, 15:2-3; 15:24-16:1.[7] Thomas also testified quite strongly in favor of competition between ambulance providers in Maricopa County during ABC's CON hearing:

> Q. Mr. Thomas, would you describe why you believe that the public would benefit from competition between ambulance providers in this county?
>
> A. My belief is that competition fosters innovation, and that is part of the Director's guidance on contemporary protocols, and it is also my experience that competition is also a very good cost control. [*See* ABC Con Hearing

[7] https://portal.azoah.com/oedf/documents/2012A-EMS-0101-DHS/2012A-EMS-0101-DHS-0184.pdf

Transcripts, Volume 1, 10/1/2012, 2012A-EMS-0101-DHS, 289:9-291:11 [CA-98]]

Not surprisingly, ABC has back-peddled significantly from that position to protect its economic interest, which is not at risk as explained above, but concedes the primary focus when determining public necessity should be on the best interests of the public rather than protecting the territory and property rights of the current providers in the area. [Tr. 1514:24-1515:4]

Maricopa Ambulance, who retained and relied on economist Dr. David Argue's expert opinions extolling the benefits competition at its own hearing, held fast to this view during the testimony of CEO Brian Gibson during Community Ambulance CON hearing:

> Q. Okay. Do you agree with me that if an ambulance company like Maricopa Ambulance is providing a higher quality of care for its patients, it puts pressure on the other ambulance companies to try to match that level of service?
>
> A. Yes.
>
> Q. And you agree that that competition can result in better ambulance service for the patient populations in the service area, right?
>
> A. Yes.
>
> Q. And you would agree that that competition is beneficial for a hospital system to ensure the quality of patient care during ambulance transports?
>
> A. I think it would be beneficial to all – all patients.
>
> Q. All patients?
>
> A. Yeah.

[Tr. 1695:07-23]

> Q. Maricopa Ambulance believes in healthy competition amongst the ambulance providers in the system, right?
>
> A. That's correct.

[Tr. 1696:12-15] Maricopa Ambulance should welcome and support the additional competition Community Ambulance would inject into the market and the attendant benefits such competition would deliver to the healthcare providers and public of Maricopa County.

The continued population growth and expansion of new healthcare facilities across Maricopa County serves to reinforce the benefits health systems and patients will reap from choice in the ambulance service market. Dr. Argue, who testified to the benefits of competition in an ambulance market regulated by certificates of necessity believes competition in this market will redound to the benefit of the patient populations:

> Even in healthcare markets. . .competition is generally helpful in healthcare markets. It's been shown to result in better quality and lower prices of services.

Dr. Argue opined that patients would be the beneficiaries of the introduction of a new provider, like Community Ambulance, into the market:

> the patient population isn't going to be any worse off and they could easily be better off. If a new provider comes in, provides higher level of quality, then that's going to make those patients that are served, for example, by Dignity better off by being able to get the service that Dignity promises them. It also has an effect -- kind of a halo effect or -- what is it -- a "rising tide rises all boats" effect, where if Community Ambulance is providing a higher quality of care -- I don't know whether they are or aren't, but this is a question to be considered. If they are, then that's going to put pressure on all of the other ambulance providers in the county to do the same thing, to match that. Because they

> will be concerned about the hospitals who should pressure them to be concerned about not meeting up to the community standard. So even if they're -- Community Ambulance is not ready to serve everyone else in the county, it can add pressure to the competitive pressure to force everyone to have higher quality services. [Tr. 1222:10-1223:4]

As Dr. Argue further testified, if a provider is not living up to standards, healthcare systems have other options available in the marketplace. [Tr. 1208:23-1209:18] This has proved true with Maricopa Ambulance recently supplanting AMR as a 911 provider for several municipalities in Maricopa County, and as the preferred interfacility provider for the HonorHealth system. In fact, Maricopa Ambulance's rapid growth on the back of dissatisfaction with AMR reinforces the need for additional choice in interfacility ambulance providers in Maricopa County.

#### 2.4.2. *Fire chiefs, mayors, and hospital systems in Maricopa County recognize the need for Community Ambulance in the system*

The letters of support submitted in favor of Community Ambulance's Application from fire chiefs, mayors, the former CEO of AGH, as well as the testimony from Dignity Health's witnesses, all further establish a need for another ambulance service option in Maricopa County.

As the numerous letters of support from various fire districts and municipalities advocate, public providers whole-heartedly support Community Ambulance's CON Application. [*See* ADHS 17-24]

- Phoenix Fire Chief Kalkbrenner, through her March 5, 2018 letter of support, told BEMSTS that the Phoenix Fire Department – the largest fire department in the State of Arizona – has observed an unmet need for additional non-emergency ambulance transportation, especially when the current providers are overtaxed or providing extended response times to the numerous facilities within Phoenix city limits. [ADHS-23]

- City of Chandler Fire Chief, Thomas Dwiggins, told BEMSTS, in part, that the Chandler Fire Department is "confident that this application is in the best interest of all citizens of Maricopa County. By granting this CON application, inter-facility transportation services will be enhanced for all with the addition of more available ambulances to serve the needs of all levels of inter-facility patient care." [ADHS-17]

- Mayor Jenn Daniels through her Letter of Support stated that "Market diversity and competition in healthcare delivery services further work to the benefit of our citizens." [ADHS-20]

- Bob Honeycutt, the former President and Chief Executive Officer of AGH, through this September 14, 2017 support letter, provided BEMSTS with his view from a hospital system's perspective:

> Arizona General Hospital has been challenged by an unmet need for additional non-emergency ambulance transportation when the current providers have experienced extended response times when the 911 system's in Maricopa County have become overtaxed or system saturation has occurred and the current providers are utilizing the daily existing inter-facility ambulances to cover the 911 systems.
>
> To the point where Arizona General Hospital has itself had to call 911 to have fire department resources respond to our facility so that an air ambulance can be dispatched to transfer a patient to another facility.
>
> We at Arizona General Hospital pride ourselves on the care that we afford our patients and take every measure to prepare and ensure that when ground transportation is necessary, we immediately take action to start the process for the timely scheduling of that ground transportation.
>
> To the extent that we can schedule an ambulance transport 24 hours in advance, we are diligent in completing that task. However, when an ambulance has been scheduled that far in advance and still does not arrive at the pre-arranged time, and this does happen consistently, then there needs to be something done to correct the failure in

the system.

#### 2.4.3. *AMR has failed to meet Dignity Health's needs*

Dignity Health's witnesses from Linda Hunt to paramedic liaisons Brandon Hestand and Matthew Karger, who work directly with ambulance companies in Maricopa County on a daily basis, confirm this need.

Hunt tasked O'Malley to solve the bottlenecking and throughput delays caused by ambulance transports. [Tr. 207:04-209:23] In 2015, O'Malley collected information from clinical operational leads across the Dignity system, including the Chief Operating Officer at St. Joseph's, Brett McLain, St. Joseph's Emergency Department liaison, Gabe Gabriel, and Kevin Meek, the Regional Nursing Director for AGH. [Tr. 209:24-215:09] O'Malley learned that the hospital systems were experiencing significant delays. *Id.* In the case of AGH, these delays were upwards of three (3) to four (4) hours long.

In 2015, O'Malley sent out a request for information ("RFI") [ABC-41] and sent it to the then current ambulance and operators and other transportation companies in the service area, including at that time – Rural/Metro, AMR, Phoenix EI Transportation, ComTrans, and Medstar. [224:02-226:21] After sorting through responses, O'Malley initially planned to work with the only two (2) companies who had the ability to provide interfacility ambulance transport services: AMR and Rural Metro. [Tr. 228:08-14; 229:09-24] AMR was new to the market and worked with Dignity Health to develop an interfacility focused solution. Again, one of the largest, most sophisticated, ambulance providers in the world was working to develop a preferred agreement to design an interfacility solution around one of the larger healthcare systems in Maricopa County. As negotiations progressed, however, the leverage shifted from a competitive process between AMR and Rural/Metro to a single provider solution because AMR acquired Rural Metro.

AMR initially promised five (5) dedicated ambulances to Dignity Health, which AMR then reduced in the Customer Agreement at Paragraph 28(e) to just two (2) ambulances that were no longer dedicated but merely positioned *near* two (2) Dignity hospitals. [Tr. 231:15-232:14; Tr. 242:22-244:1; 234:23-235:19]

AMR pitched and eventually agreed in the Customer Agreement at Paragraph 28(b) to a one-call number and dispatch center through which Dignity Health could pick up the phone, dial one number straight to AMR, and AMR agreed to use other ambulance providers in the community in cases where [AMR] were not able to provide timely response or service." [CA-24; Tr. 232.6-14; Tr. 239:12-24; 240:23] When O'Malley asked for reporting about whether AMR was turning calls to other providers under this provision, he could not get any data reporting [Tr. 240:24- 242:6] We know from the hearing that such data reporting can be generated. AMR refused to stipulate to the admission of AMR-46 – AMR CON Holders' turned calls from Dignity facilities, which shows only 4 calls were ever turned to another private ambulance provider. When O'Malley followed up at a quarterly meeting about what AMR does when they cannot handle a call, the first answer he received was "[w]ell we just call 911." [Tr. 241 12-15]

AMR also agreed, through Paragraph 28 of the Customer Agreement, to provide regular data and reporting to Dignity Health. [CA-24; Tr. 244:4-245:23] Reasonably, Dignity Health was looking for "two levels of reporting, one which would be a standardized routine report that we would agree to work on together on what it would capture . . . showing the compliance to our performance standards that are in the agreement. And then the second level of reporting was the ad hoc, you know, which is what – what's the detail behind these standard reports that we need to look at to start investigating the issues that were -- that we're seeing?" [Tr. 245:1-10]

O'Malley also grew frustrated with inaccurate, incomplete, error-ridden, and unhelpful data reporting AMR provided Dignity Health in accordance with Paragraph 28(f) of the Customer Agreement. [CA-24 (Customer Agreement); CA-195 (example of inaccurate reporting); Tr. 246:01-262:12] When asked his overall view of the data reporting he was receiving, O'Malley testified that three-years in he is "still looking for good data." [Tr.262:10-12] The issues being, among other things, AMR's "inability to accurately identify the facilities affiliated with Dignity Health, the inability to classify the transports according to the level of service that was requested and delivered, you know, the data issues with not getting complete reports." [Tr. 262:13-18; *see generally* 246-01-262:9]

These types of data reporting problems do not exist in the partnership between Community Ambulance and Dignity Health. [Tr. 285:12-290:24] As O'Malley testified,

> You know, there is no ownership interest in a vendor contract. There is no fiduciary responsibility. There is nobody sitting at the board overseeing the decisions that we're involved in in a vendor contract. Only in a partnership kind of a situation like this do you see that level of oversight and control and influence and ability to develop and direct policy, procedure. And transparency? You know, I've been on the board, I think, like I said, since March of 2017. If I asked Rob or Brian and I say, "Hey, can I get a report that gives me patient satisfaction scores for the last, you know, six months?" I get it. I mean, it's complete and absolute trans- -- transparency to the board of directors. [Tr. 289:15-290:04]

AMR's promise of performance under the preferred Customer Agreement left Dignity Health and its patients wanting more from the outset of the relationship. Employees on the ground reported back to O'Malley about ongoing issues with AMR's performance under the Customer Agreement, including

inconsistent and unreliable arrival times, lengthy delays, problems in working with dispatch to get accurate estimated times of arrival, unprofessionalism of crews, and the inappropriate use of 911 for interfacility transports. [*See e.g.* CA-232B; 233E, 233H, 233J, 233R; Tr. 277:22-10] O'Malley testified:

> Q: So what sorts of specific problems were being related to you?
>
> A: It was the time limits of -- you know, arrival times. It was the consistency, the reliability of arrival times. It was, you know, being told when they're on the phone, "If you need a faster response, call 911." We felt like that was an abuse of the emergency management system. It was "There's an ambulance parked across the street. I can see it. It has your name on it. Why can't you come over and pick it up?" And then hearing all kinds of logistics challenges about why they can't do that. It was unprofessionalism of crews, the inability to get data, same issue that I had had as well. [Tr. 278:23-279:10]

Dignity Health witnesses working in the facilities corroborated O'Malley's testimony, confirming that AMR has simply not been a good ambulance transport partner. [Tr. 507:01-10 ("Our experience with them is it is inconsistent. It's challenging, just due to the inability for them to resolve our issues and their inconsistent quality of their service.")]

The credible and competent testimony of Brandon Hestand, RN, provides example after example of the ongoing issues Dignity Health had with AMR. Hestand is a paramedic liaison for CRMC and MGMC, who works directly with ambulance companies, fire departments, and first responders to improve patient care in the ambulance transport space. [CA-128 (Hestand Resume); Tr. 548:9-13; 548:20-549:03] Any issues that may arise with respect to private ambulance companies including patient care, transfers issues and delays, Hestand steps in as the liaison between the providers and CRMC and MGMC physicians and staff. In

this role, he has primarily dealt with AMR because "up until recently, they were the only game in town." [Tr. 559:4-11] Thoughtful and measured, Hestand outlined a number of specific issues on which he has addressed with AMR.

For example, Hestand testified a patient had to be transported eight (8) miles by helicopter, rather than by ambulance, because the ambulance AMR dispatched to MGMC did not have the proper equipment on board. [Tr. 552:16-553:13] No one can dispute air ambulance transport costs are significantly more expensive than ground ambulance [Tr. 553:06-13] costing payors, employers, and the public more.

Hestand also testified about delays in patient care when an AMR unit was diverted from an interfacility call to a 911 call, and a second unit did not have the correct equipment to transfer the patient:

> "[T]here have been circumstances where we've had that occur within the ED where we've had to delay, call them back. They've had to -- Actually, we had one where they had to -- actually diverted a unit to the 911 system and then that unit was unavailable and the second unit didn't have an IV pump. There was a lot about that call in specific. I don't have it in front of me, but there was a lot of things about that call that didn't fit right. And that caused a delay in care." [Tr. 554:13-21]

Hestand further testified about a July 31, 2017 email he sent to Allison Skinner of AMR [CA-214] to address the transfer of "quite a few patients out by air that were cardiac patients that were on balloon pumps and Impellas that AMR wasn't – wasn't able to provide the service for. They didn't have staff trained up on – on that type of equipment." [Tr. 583:2-25] Hestand explained that there is an inherent risk "any time you fly a patient, and it's also a cost." [Tr. 583:25-584:6]

Hestand also testified about an August 16, 2017 email to Paul Cloward and

Alison Skinner about a significant delay caused by an interfacility unit being pulled into the 911 system. [CA-233-J; 588:20-590:5; *see also* 2374:1-2374:9]

> Okay. So in this particular instance, we had requested a transport from Mercy Gilbert to Chandler Regional. We were given a 40- to 45-minute ETA. After that ETA had expired, we got a call from AMR dispatch saying their unit was just about here and got pulled into EMS traffic. And then the next ambulance available to us was 45 minutes additional on top of the already 50-minute time frame. This was one that surprised me because I wasn't aware that interfacility units could be pulled into EMS traffic. I understand that EMS is important. I get it, but I just wasn't aware of this being something that they did. [Tr. 589:9-20]

AMR representative Doug Jones confirmed that interfacility transports serve as back-up to "some of our 911 systems." [Tr. 2171:7-14]

Hestand testified about a March 31, 2018 email from a unit secretary and patient care tech for the emergency room at Mercy Gilbert Medical Center, Nicole Berg, concerning a significant delay in transporting an urgent patient on a vent and drip because AMR dispatched an ill-equipped ambulance for that patient. [CA-233H; Tr. 593:18-595:15]

> A: In this case, it was, again, an extended ETA over what we were originally told. Looks like they were -- called it originally at 13:15, asked for a transport. Called back to check status at 13:35 and were told we're -- they were having a hard time finding a unit with a vent. New ETA was advised at 13:40, making another 30 minutes. ETA was then 14:10. The actual pickup time was 14:12. So transport setup was at 12:30, and pickup time was 14:12.
>
> Q. How long was that arrival time?
>
> A. Well, if you go based on the original transport setup

time, we're looking at almost two hours.

Q. But from the original ETA?

A. 13:15, so it's an hour, roughly.

Q. If a patient [is] on a vent and an IV pump, is that patient an urgent patient, a non-urgent patient, or does it depend?

A. It's an urgent patient.

Q. Okay. And why?

A. Because they're on equipment that's helping them breathe. You can't have a vent, you're not breathing, then you die, so it's urgent. [Tr. 594:19-595:15]

Not only will each of Community Ambulance's six (6) ambulances be uniformly equipped with, among other things, IV pumps, ventilators, heart monitors, climate-controlled drug boxes [Tr. 820-20-823:24], but as a dedicated interfacility provider, these types of delays caused by diversions to the 911 system will not occur. As an exclusive provider of interfacility transports, Community Ambulance will not be "pulled into EMS traffic," and will thus be able to meet the needs of these, at times, very critical patients who require urgent ambulance transports. This is a direct benefit to the healthcare system and the public.

Hestand also testified about problems with AMR's dispatch and unilateral decisions to change a physician's order of an urgent transfer to a non-urgent transport. On August 5, 2017, Mark Bott, a charge nurse at Mercy Gilbert Medical Center [CA-233R] emailed Hestand about a transport delay and issues with AMR's dispatch center:

> So in this case, the patient was coming from a rehab center. Sounds like they were going to come to us at Mercy Gilbert. AMR unit was already there with another – had either dropped off – dropped off another patient and the rehab center said, "Hey, while you're here, we have a patient going. Can you just take them for us?" And the crew, like most of them would do, say, "Absolutely. Let's get it done, but we have to" -- they have to process through their call center to make sure that unit is accounted for what they're doing. Sounds like, based on this particular email, that when they called the dispatch center, dispatch center said no, and that this was a non-urgent transport. It was a $900 transport, and it wasn't an emergency. Even though the sending facility pays for those transports -- which is not unusual that a sending facility or a receiving facility will pay -- pay for that type of transport. [Tr. 587:16 - 588:7]

Delays in transports are a common – sometimes daily -- theme Hestand deals with as a liaison, including delays in transports for seriously ill children. Hestand testified about a January 6, 2016 email string concerning a delay in transport for two (2) different patients, "one was a 14-year-old that was found to have a brain mass after displaying stroke-like symptoms. That was an urgent transport. The second was non-urgent where a patient had shifting sinuses that was affecting arterial flow." With respect to the 14-year old brain mass patient, Hestand was unequivocal that a stroke patient is not a 911 patient from CRMC's emergency department. [Tr. 575:07-576:07] A stroke patient transport originating from CRMC is an urgent transport. *Id.*

> Q: And so what was the issue with that urgent transport, that 14-year-old stroke patient -- or, displaying signs of a stroke?
>
> A: There was the delay in transport. Looks like it was 45-minute ETA to pick up the patient. That is outside of what we would deem acceptable for an urgent transport.

> And I think that's kind of generally known that that's too long for that type of a transport. In that case specifically, that -- that child needed to be at a facility that's more appropriate than what we could provide carewise at Chandler Regional.

The second case identified in CA-233M, though non-urgent, also dealt with a lengthy and inappropriate delay.

> Hestand: This was a non-urgent, but it was still shifting in the sinuses that was affecting flow in the facial area, which in and of itself would be problematic. If you're decreasing blood flow in any area of the body, it's – it's a medical emergency, and you don't want that to happen. So that was, again, a delay. It looks like -- I'm sorry. It was an hour-and-45-minute ETA. I apologize; I said 45 minutes. I missed the hour portion of that. So it was a long transport, which, again, is not good. Even if it's a non-urgent case, an hour and 45 minutes for a transport out -- you know, going to facility that can specialize in taking care of that patient, it's not acceptable.

[Tr. 576:13 - 577:02]

Hestand and other Dignity Health witnesses testified about AMR inappropriately activating the 911 system, or requiring the facility to activate the 911 system, for urgent and non-urgent interfacility transports. Hestand testified about a stroke patient at CRMC, a Level 1 emergency room, who required a transfer to the Barrows Neurological Institute at St. Joseph's hospital, a higher level of care. [CA-233E; Tr. 561:05-22; 590:21 - 593:01]

> Q. Now, Mr. Hestand, do you recognize this as an email [CA-233E] from you sent on November 27, 2017, to Ms. Skinner, Mr. Cloward, and another representative of AMR Kyle Henson?
>
> A. Yes, sir.
>
> Q. And your medical director is also copied on this email?

A. Yes, sir.

Q. And what's the -- what does this email relate to?

A. This email specifically was in regards to a transportation set up to send the patient to St. Joe's, which was a stroke patient. That's what we typically send there. And AMR called 911 and sent a 911 unit. Chandler Fire specifically showed up in the ER to transfer a patient for us. [Tr.591:2-16]

Q. Okay. The stroke patient that's identified in this email, from your perspective, is an urgent patient or a non-urgent patient?

A. Urgent.

* * *

* * *

Q. And no one from -- Did anyone from the hospital call 911?

A. No, sir.

Q: Who did?

A. AMR. [Tr.592:11-593:01]

The improper utilization and activation of the 911 system for urgent and non-urgent interfacility transports unnecessarily introduces additional costs and risks to the public. Not only does it cost more to send a fire engine, a crew of 4-5 firefighters and paramedics, as well as an ambulance unit to a facility [Tr.472:18-473:8; Tr. 473:18-474:1], but it also takes this 911 crew away from responding to an actual emergency 911 call. Furthermore, when a 911 response is neither expected nor required, this type of response can be "extremely disruptive" to a healthcare facility's operation and the other patients in that facility. [Tr. 473:2-17]

Matthew Karger ("Karger"), a paramedic liaison for the AGH system [CA-175; Tr. 635:1-637:7] also had significant issues with AMR's improper utilization of 911, delays in urgent and non-urgent response times, billing issues, AMR's trivialization of the relatively low number of transports from a freestanding emergency room, and issues related to the professionalism of crews. Karger testified that in his liaison role for the AGH system, he fields "[a]nywhere between 5 to 10 [ambulance transport] complaints per month per facility. So if you do the math on that, on the low end, 50 to a hundred complaints [per month] regarding interfacility transports out of our facilities." [Tr. 640:2-8]

Activation of the 911 system was of particular concern to Karger, who sought clarification from ADHS about the appropriateness of dispatching 911 to AGH's freestanding emergency rooms for urgent calls. These issues arose during meetings with AMR representatives about billing issues and, in part, lengthy ETAs. Karger's concern grew out of AMR representative's position that if "you need a faster response from us, then you need to be calling 911." [Tr. 646:1-7] AMR's own data shows that on at least four (4) different occasions between March 16, 2017 and January 3, 2018, AMR activated the 911 systems for an interfacility transport from a "Dignity Health-ER." *See* AMR-46.[8]

Karger scheduled a meeting with BEMSTS for May 2018, during which his concerns were confirmed by ADHS. Karger testified that representatives of BEMSTS were emphatic that "[y]ou cannot utilize the 911 system" as a licensed emergency room. [Tr. 647:15-648:5] Karger immediately notified all AGH staff of the new policy that the 911 system was no longer to be utilized and that patients

[8] Applicant respectfully requests the Court admit into the record and consider AMR-46, a document prepared by Kirk Schmitt of AMR, provided by AMR in response to a subpoena, and identified as an exhibit "so that everybody has easy access to them and had a good record." [*See* Tr. 1953:10-1955:10]

would be transferred by way of interfacility ambulances. [Tr.648:13-649:08]

After the policy implementation, on May 24, 2018, Karger met with AMR representatives Todd Jaramillo and Alex Lopez to explain that AGH would "no longer be utilizing the 911 systems and that we were expecting faster response times." [CA191; Tr. 649:12-651:21] Karger testified that Mr. Jaramillo was "extremely dismissive" and "didn't seem to really care too much." [Tr. 651:14-19]

Despite Karger's efforts to prevent the use of 911 to AGH's freestanding emergency rooms, the practice continued. In fact, AMR activated the 911 system to a freestanding emergency room in the east valley on October 22, 2018 for a non-urgent patient, all while the first week of hearing for Community Ambulance's CON was under way. [Tr. 661:24 – 665:02; ABC-28]

As Karger testified:

> Q: Okay. Any other non-urgent transport uses that you recall in the past six months?
>
> A. Yes. We actually just had a very large issue. The night of October 22nd, so two nights ago, I was not at work, and my cell phone rang, and it was a -- our facility administrator of our Gilbert Germann location, so our Chandler freestanding, saying that AMR had activated 911 without informing us or asking us if we wanted them to because -- and this is a direct quote from a conversation I had with Alex Lopez in the moment -- they had no interfacility truck to send.
>
> Q. So Chandler is that Chandler location –
>
> * * *
>
> Q. Was this an urgent or non-urgent patient?
>
> A. This was a non-urgent patient.

> Q. Do you know if 911 responded to that freestanding ER?
>
> A. They did. So when my facility administrator contacted me, Chandler Fire was pulling up on scene. Actually, they had made entry into the building already. And she said, "What do I do? We're -- we're not to activate 911. This patient is stable." This patient presented to our emergency room as a potential stroke, had some numbness to extremities and to the left side of his face. We did the head CT, negative stroke, no deficits, no permanent issues that were going on. And the patient was being transported to Mercy Gilbert Medical Center to a telemetry bed with a neuro consult, was not being transferred as a stroke alert, nothing like that. This was a stable patient.
>
> According to my nurse who works at that facility, when he called to arrange transport, AMR dispatch did not notify him that they were going to be activating the 911 system. They simply gave a response of less than 10 minutes, which we were thrilled about, and then that's when he told me that "We saw a fire engine and a 911 ambulance arrive to our facility." [Tr. 661:24-- 665:02; ABC-28]

Karger also has been frustrated with delays in transports from various facilities and issues with crews. For example, Karger testified about a 30-minute ETA AMR provided to the AGH facility for the transport of a non-urgent patient that turned into an hour in July 2018. [Tr. 659:23-660:17] As Karger testified:

> I believe they arrived at the 35- to 40-minute mark. Okay. They continued to sit in our ambulance bay for 10 minutes. Then we were very excited -- we saw them on security camera, got out of the ambulance. We were all busy running around; it was a busy day. Get out of the ambulance, come into our EMS room, take snacks and water out of our facility to their ambulance where they continued to sit in the ambulance for roughly 10 to 15 additional minutes before coming in and making patient contact.

> Q: When was the patient contact made?
>
> A: I believe it was at the hour --- at the hour mark from the initial ETA given. [Tr. 660:4-17]

Karger also testified about surprising and unsatisfactory responses from AMR during a June 20, 2018 meeting at AGH's freestanding emergency room location 51st Avenue and Olive, concerning extended ETAs for urgent patients. [Tr. 651:23-655:25] Karger testified about AMR's inappropriately extended ETAs for an urgent stabbing victim, and the AMR crew coming into the location and saying, "Well, why didn't you call 911?" [Tr. 652:12-19; 654:2-22] He further testified that AMR's representatives at that meeting were dismissive of these concerns he and facility administrator Brenda Lopez raised:

> It was frustrating because they were extremely dismissive of the concerns that were raised by not just myself but Brenda Lopez, who's our facility administrator. Very -- It was hard to get a word in edgewise in that meeting, as often is with AMR's leadership. They kind of try to talk over you; borderline aggressive, certain people; and so not a whole lot was resolved in that meeting, to be completely honest. [Tr. 654:13-22]

As AMR's representatives, including Todd Jaramillo, were going back and forth with Karger and Ms. Lopez, Mr. Jaramillo asked "How many transports do you have out of this facility every month?" Karger answered "46 out this month." Jaramillo's reply was unacceptable: "[w]ell that's not even really that many." [Tr. 655:4-12]

Though Karger would prefer not to use AMR at all, particularly in light of this June 20, 2018 meeting, AGH has no choice. Maricopa Ambulance and ABC are not able to handle all of AGH's transports, especially in the East Valley where ABC does not do many transports and Maricopa Ambulance has a very limited presence.

#### 2.4.4. *ABC and Maricopa Ambulance alone also cannot meet the need*

The other Intervenors are not the solution either. ABC admittedly cannot provide Dignity Health with the systemwide preferred interfacility provider solution it will have with Community Ambulance. Thomas's testimony makes this point clear:

> Q. So if Dignity were to approach ABC to do something similar, would ABC have the personnel and equipment to ramp up its operations to fulfill some or all of these transports?
>
> A. Well, ABC already has 14 ambulances operating, so we could start helping immediately. We could purchase six more ambulances, the same number that the applicant had added. And we could add more personnel to staff those ambulances. That -- I'm not sure that that would cover it or be enough to do the anticipated number of transports with six ambulances, so we'd probably end up using our entire fleet. So yes, we could, but my preference would not be to try to take all of their transports. I would rather work with the existing providers. I think that it's in the patients' best interest that the providers are as efficient as possible so they have as many resources in certain areas so they can have the best and most appropriate response times. So I think it would be beneficial to work with all -- more than one CON provider even though we could do the six ambulances that they are talking about doing.
> [Tr. 1417:9-4]

Of course, the notion that requiring Dignity Health to use multiple, disconnected providers (as it is forced to do now) to meet its interfacility needs, flies in the face of the beneficial reasons hospital systems enter preferred ambulance agreements – like the failed Customer Agreement between AMR and Dignity Health. As Dr. Argue opined:

> The preferred provider contract is an important tool that hospitals use for this kind of service. I've seen this in -- Obviously, we saw it in the Maricopa Ambulance matter. I've seen it in an ambulance matter in Sheboygan, Wisconsin, 20 years ago. I've seen it in the air ambulance matters that I've worked on. It's very common to have preferred provider agreements. And they're common because they work. And the reason they work is because it assures the provider of some level of volume. It's not an exact science. You know, they don't know exactly how many because it depends on availability and so forth. But in essence, the preferred provider agreement tells Maricopa Ambulance or it tells, you know, whoever it is that they've got a certain volume that they can count on. And what that does is it motivates the ambulance company or -- it motivates the ambulance company to dedicate some resources to serving that provider, that hospital system. [Tr. 1213:17-1214:09]

ABC's view is regressive and would not best serve the public benefit.

Furthermore, ABC continues to resist voluntarily agreeing through its CON to arrival time standards. Mr. Thomas testified that he would agree to arrival times only if "DHS required" arrival times and agreed that he is not volunteering to interfacility facility arrival times." [Tr. 1504:05-14] This position is confirmed by ABC's October 17, 2018 strategic application to amend its CON through which it asks to lift the limitations on the number of ambulances it may operate but does not volunteer to include interfacility arrival times in its CON. [ABC-89] This is a non-starter for Dignity Health. Additionally, and notwithstanding its effort to amend its CON, ABC is still restricted through its CON in the number of ambulances it may put in service, still does not have arrival times in its CON, and is admittedly incapable of being the preferred provider Dignity Health needs in Maricopa County and surrounding areas.

Through the hearing, we learned that Maricopa Ambulance is continuing to

grow at a very rapid pace, replacing AMR on a number of municipal 911 contracts and starting to take over interfacility transports that AMR previously handled – including becoming the preferred provider for HonorHealth. But Maricopa Ambulance still has its limitations in its reach. There are geographic restrictions baked into its CON [CA-] and Maricopa Ambulance is admittedly not strong in the East Valley, leaving AMR as the only real option in that part of town. [Tr. 207:16-208:03; MA-39; 668:10-671:9]

#### 2.4.5. *The problems persist, and Community Ambulance can help*

There is a systemic inattention to the particular needs and demands of the interfacility transport system utilized by healthcare systems, like Dignity Health and AGH, that are not being addressed and that require a different solution. Community Ambulance intends to provide that solution. Dignity Health has a relationship with Community Ambulance, a successful ambulance company that has demonstrated levels of integration not found in typical vendor relationships. The needs of the public in Maricopa County are vast and Dignity Health should not be required to cobble together interfacility responses from an unintegrated mix of three (3) different providers before Community Ambulance is granted a CON. AMR has not been a good partner, ABC admittedly cannot meet Dignity Health's needs, and Maricopa Ambulance is both currently unable to cover the entirety of Dignity's Health's transport needs and is very quickly taking on obligations to other 911 and hospital systems that may place Dignity Health in the same position it was in with AMR under the preferred Customer Agreement.

As Dr. Argue opined, Dignity Health "can't afford to have an overall hospital product that's not the same product or better quality than Banner or HonorHealth or anyone else. [Tr. 1229:09 -1229:12] Nor should Dignity Health be forced to take

risks with the delivery of care to its patient population when it has already partnered with an ambulance company it trusts to deliver that care. As Dr. Argue testified:

> [T]here's a risk involved when a hospital contracts with an independent entity that it hasn't worked with before. It doesn't really know how it's going to -- how it's going to work out. They hear good things; the provider is certainly going to promise good things. But in -- in this case, you have a provider that Maricopa -- sorry -- that Dignity is very familiar with and understands the quality and has the same framework and so forth for that. [Tr. 1221:24-1222:06]

Dignity Health has witnessed ambulance companies grow very large in Maricopa County, file for bankruptcy, be acquired, and merge in several cycles over the past few years. These cycles result in periods of significant underperformance the public should not be required to endure. Dignity Health has a partner in Community Ambulance. Dignity Health does not have these systemic problems with Community Ambulance in Nevada and does not expect to have these issues with Community Ambulance in Maricopa County. Considering the CON system is not intended to protect the territory or services of incumbent CON holders, particularly when there has been inadequate service, the needs of Maricopa County's growing patient population would benefit from the addition of an ambulance provider willing to provide a dedicated interfacility ambulance service.

### 2.5. Whether a certificate holder for the service area has demonstrated substandard performance

"Substandard performance" is defined at R9-25-901(46) as follows:

"[A] certificate holder's:

a. Noncompliance with A.R.S. Title 36, Chapter 21.1,

Articles 1 and 2, or 9 A.A.C. 25, or the terms of the certificate holder's certificate of necessity, including all decisions and orders issued by the Director to the certificate holder;

b. Failure to ensure that an ambulance attendant complies with A.R.S. Title 36, Chapter 21.1, Articles 1 and 2, or 9 A.A.C. 25, for the level of ground ambulance service provided by the certificate holder; or

c. Failure to meet the requirements in 9 A.A.C. 25, Article 10.

Because Intervenors refused to provide any meaningful data or information in response to subpoenas issued by Community Ambulance, there is minimal data evidence that any one of the Intervenors has demonstrated substandard performance. Testimony from the hearing and the data reporting AMR produced casts serious doubt about whether AMR – based on its own reporting data and testimony – is compliant with its CON arrival time standards on transports AMR handled for Dignity Health.

Under the terms of the Dignity Health/AMR Customer Agreement, an "**urgent**" transfer is defined as "[p]atients with an **unstable condition**, requiring a higher level of care and intervention." The Customer Agreement defines "**non-urgent**" transfers as "[p]atients with a **stable** condition requiring **immediate transfer**." (Emphasis added) [CA-24, p.9, ¶28]

Under the terms of AMR's CON-136, there is not a definition that matches an "urgent" transfer as defined in the Customer Agreement. There is, however, a striking similarity between the definition of "nonurgent" transfers under the Customer Agreement and the definition of "urgent" transfers under AMR's CON 136 that creates confusion about how to categorize that type of patient. For example, under the Customer Agreement, a stable patient needing immediate

transfer would be categorized as "nonurgent" while that same patient would be categorized as "urgent" under AMR's CON 136.

To be sure, AMR's CON 136 states, in pertinent part, that "Urgent Transfers" are "**immediate** and shall mean a patient that has a high risk of his or her condition deteriorating as determined by the patient's transferring clinician. **Examples of patients requiring an Urgent Transfer include patients in a stable condition**; requiring advanced airway support by secured, intubated, on ventilator, patients on multiple vasoactive medication drips; **patients whose condition has been initially stabilized, but has a likelihood of deterioration based on assessment or knowledge of provider regarding specific illness/injury.**" (Emphasis added) [AMR-4E at p.4]

Simply put, the evidence and testimony beg the question of whether some of the transports that AMR categorized and reported as "non-urgent" under the Customer Agreement should have been categorized and reported as "urgent" under CON 136. At the hearing, Mr. Kasprzyk confirmed the similarities between the two definitions. [Tr. 2031:08-23] This must be so, considering that CON 136 defines a "non-urgent" transfer as a transfer "**scheduled** at least one (1) hour in advance and shall mean a stable patient that has a low risk or medium risk of his or her condition deteriorating as determined by the patient's transferring clinician." [AMR-4E; Tr. 2033:16-24]

How does this translate into potential substandard performance? AMR provided Dignity Health with arrival time contractual compliance reporting based on the contractual definitions of "urgent" and "non-urgent" only – without reference to the CON requirements. [*See e.g.* CA-179] If AMR had reported its performance based on its CON requirements, many of the transports it categorized as "routine" or "non-urgent" would necessarily be recategorized as "urgent"

requiring the faster 30 minute arrival time under the CON.[9] It is unclear whether the information used to prepare the reporting AMR provided to Dignity Health was also used for self-reporting its CON compliance to ADHS.

Based on the overlapping definitions for non-urgent under the Customer Agreement (requiring an arrival within 60 minutes of requested at the bedside time) and urgent transfers under CON 136 (requiring an arrival within 30 minutes of the requested arrival time), any number of the routine/non-urgent transfers performed for Dignity Health under the Customer Agreement may not be in compliance with AMR's CON 136. Put differently, even though arrival times of longer than 30 minutes but shorter than 60:01 minutes from the requested time for stable patients who required immediate transfers may have been compliant with the now terminated Customer Agreement, those same transfers could very well be non-compliant with AMR's CON 136. Notably, even after AMR terminated the Customer Agreement in 2017, it continues to report arrival time compliance to Dignity Health in accordance with the terminated agreement, rather than arrival time compliance with CON 136 as should be the case. [Tr. 2272:04-10]

Furthermore, there are serious questions about when and how the clock starts running for purposes of calculating arrival times for those CON holders who elected to have interfacility arrival times included within their CONs. Mr. Kasprzyk agrees that under CON 136, the arrival time clock starts to run from the "agreed upon arrival." [Tr. 2035:23-2036:04]

When the agreed-upon arrival time for an urgent transfer is "we will be there right now" and the response is 30 minutes or less, there is no question that

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[9] AMR representative Todd Jaramillo testified that where the performance reporting refers to "routine," that term means "non-urgent," and the standards for "urgent" and "non-urgent" transfers are derived from the definitions in the Dignity Health/AMR Customer Agreement. [CA-179; Tr. 2268:25-2269:15; CA-24]

such a transport is compliant with the arrival time requirements. [Tr. 2037:01-2039:03] The confusion sets in, and questions are raised, when there is a call at 9:00 a.m. for an urgent transfer (arrival within 30 minutes under the CON) and an agreed upon arrival time of 9:45 a.m. [Tr.2039-01-2040:04] According to Mr. Kasprzyk, so long as the ambulance arrives at or before 10:15 a.m. (which is 30 minutes ***after*** the agreed upon arrival time), that ambulance transport would still be compliant with the CON. *Id.*

This simply cannot be a correct interpretation of the requirements of the CON arrival times as set forth in CON 136. Nor should it be appropriate to have an urgent patient requiring an immediate transfer wait up to 75 minutes for a transfer that should arrive within 30 minutes (in this hypothetical) of 9:45 a.m. If the clock starts at the agreed upon arrival time, then the unavailability of ambulances to provide an interfacility transport will simply push back the ETA. There is no limit under current CON guidelines to control how far back an ETA can be pushed for the convenience of the ambulance provider, which will inevitably not be "late" if the arrival is within 30 minutes (for urgent transports) of that agreed upon ETA.

Based upon the testimony of Mr. Kasprzyk and others, it seems the term "within" has been misunderstood to mean both before *and* after the agreed upon time for arrival of a transport. Notably, the term "within" is not defined in CON 136 or by the statutes and rules governing ambulance service. Where, as here, "the legislature has not defined a word or phrase in a statute, [courts] will consider the definitions of respected dictionaries." *DeVries v. State*, 221 Ariz. 201, 207, 211 P.3d 1185, 1191 (Ct. App. 2009) (citing *Urias v. PCS Health Sys., Inc.*, 211 Ariz. 81, 85, ¶ 22, 118 P.3d 29, 33 (App. 2005) *see also* A.R.S. § 1–213 (2002) ("Words and phrases shall be construed according to the common and approved use of the

language.") As defined by Merriam-Webster, "within" is defined as "before the end of" as in before the end of a time period. *See* https://www.merriam-webster.com/dictionary/within. The Oxford online dictionary defines "within" as "Occurring inside (a particular time period." *See* https://en.oxforddictionaries.com/definition/within.

Based on these well accepted definitions of the term "within," an arrival 30 minutes (for urgent transfers) or 60 minutes (for nonurgent transfers) ***after*** the agreed upon arrival time is non-compliant with arrival time standards set forth in CON 136. An interpretation of the arrival time requirements under CONs in Arizona based on this well-established definition of "within" would improve patient care and force ambulance services to provide realistic arrival time forecasting that patients and healthcare providers can reasonably rely upon.[10]

Again, because AMR refused to provide any CAD backup data to support its contractual and CON compliance reporting numbers, it is impossible to determine how many of the transfers identified in CA-179 as compliant with the Customer Agreement, were actually non-compliant under CON 136. But it certainly supports the testimony from the many clinical providers that arrival times are simply taking too long. While this may not be a substandard performance issue, it may very well be an issue that requires some additional investigation and clarification.

**3. COMMUNITY AMBULANCE ESTABLISHED DURING THE HEARING IT IS FIT & PROPER TO OPERATE AN AMBULANCE SERVICE IN MARICOPA COUNTY**

The "fit and proper" factor requires a determination by the Director that

[10] Community Ambulance is held to this definition of "within" for compliance with its franchise agreements in Nevada [Tr. 1281:23-1282-22], always assumed that "within" meant on or before the arrival time and intends to continue this practice for its operations in Maricopa County. In that regard, the application and all exhibits were prepared with this definition of "within" in mind. For example, the maps do not provide any "fudge factor" for arrivals 30 minutes after the agreed upon arrival time.

"an applicant for a certificate of necessity … has the expertise, integrity, fiscal competence and resources to provide ambulance service in the service area." A.R.S. § 36-2201(21).

There is no question that Community Ambulance, its operators, and owners have established these criteria. With nearly 70 years of combined experience as emergency medical technicians, paramedics, emergency medical service instructors, and ambulance company operators, Robert Richardson ("Richardson") and Brian Rogers ("Rogers"), who manage and have ownership in Community Ambulance, are knowledgeable, experienced, well-qualified, well-recognized, and dedicated ambulance service operators. [CA-125 (Richardson resume); CA- 173 (Rogers resume)] Community Ambulance, under their leadership, continues to be accredited by the Commission on Accreditation of Ambulance Services ("CAAS") – an external, independent validation Glenn Kasprzyk, Chief Operations Officer of AMR, considers "the gold standard for ambulance services to achieve[11]." [CA-163; Hearing Transcript ("Tr.") 763:1-4; 1996:1-8] "The CAAS standards are designed to increase operational efficiency and clinical quality, while decreasing risk and liability to the organization." [*See* http://www.caas.org/] CAAS accreditation is nationally recognized as one of the highest honors an ambulance provider can receive.

Rod Davis, retired CEO of Dignity Health Nevada, lauded Richardson and Rogers as effective and honorable operators focused on patient care who – through Community Ambulance – had a tremendous impact on solving the overcrowding and bottlenecking issues the Dignity Health-Nevada hospitals were experiencing. [Tr. 37:16-39:18] These are some of the same issues raised by a

[11] Of all the Intervenors – ABC Ambulance ("ABC"); Maricopa Ambulance, LLC, and the AMR CON Holders ("AMR") (collectively referred to as "Intervenors"), only Life Line Ambulance Service, Inc. (CON 62) – an AMR CON Holder – is CAAS accredited.

number of Dignity Health Arizona witnesses – issues Community Ambulance intends to remedy when awarded its CON.

### 3.1. Expertise

#### 3.1.1. *Robert Richardson, Chief Executive Officer*

Richardson is the Chief Executive Officer of Community Ambulance and a 50%-member of AMG, LLC ("AMG") – the minority owner of Community Ambulance. [Tr.775:5-7] Richardson has worked in emergency medical services since 1985, beginning his career as a paramedic, a certification that is still active today. [CA-125; Tr. 737:16-738-2] In 1989, Richardson began working at Mercy Ambulance in Las Vegas, where he held leadership roles including field supervisor and director of specialty care services. *Id.* [Tr. 733:22-25] During that time, he managed and directed hundreds of major events including concerts, boxing matches, racing events, rodeos, and marathons and contracted specialized medical interfacility transports to meet specific needs of his customers. [Tr.734:1-7-734:9-21] In 1995, Richardson was elevated to Operations Manager of American Med Tech located in Bellevue, Washington. [Tr.735:7-25-736:1-13]

In 2000, Richardson decided to move into the public sector as a firefighter and paramedic for the City of Henderson. [Tr738:20-25:] After working up the ranks, Richardson became a Communications Services Officer and, in 2008, achieved the position of Division Chief of Special Operations, responsible for all supervisory and administrative duties necessary to command, direct, and coordinate the activities of the Special Operations Division of the Henderson Fire Department. [Tr.742:2-19] Richardson retired early from the Henderson Fire Department as Division Chief in 2012 to dedicate all of his time to Community Ambulance. [Tr.743:19-25:744:1-4]

Before retiring from Henderson Fire, Richardson seized an opportunity to

form Community Ambulance to fill a desperate need for interfacility transports in the St. Rose Dominican (Dignity Health) hospital system in Henderson, Nevada to relieve hospital overcrowding, bottlenecking, and throughput issues. [Tr. Richardson and Davis] Starting with three (3) ambulances, Richardson and Rogers have successfully provided thousands of high-quality interfacility ambulance transports in Southern Nevada for more than eight (8) years and added 911 service for Clark County in 2016 and backup 911 for the City of Henderson in 2016. [Tr.753:2-25:754:1-25:763:5-25]

Richardson has an Associate Degree in Paramedicine from Brigham Young University, Idaho (which at the time was called Ricks College), a bachelor's degree in Healthcare Administration from the University of Nevada, Las Vegas, a master's degree in Executive Fire Service Leadership from Grand Canyon University, and has successfully completed the Fitch & Associates EMS Management Training Institute course in Ambulance Service Management. [CA-164] Richardson has also been certified in various aspects of Emergency Medical Services and regularly recognized for his exemplary service. [Tr.744:5-25:745:1-25:746:1-23:747:1-15: 749:1-13:751:1-21:752:2-13] CA-154 (2017 Healthcare Headliner Award); CA-156 (Action Program Award); CA-157 (Certifications); CA-158 (FEMA Certifications); CA-159 NAEMD Certifications; CA-160 CEVO II Certifications; CA-161-162 (Certifications of Appreciation)]

#### 3.1.2. *Brian Rogers, Chief Operating Officer*

Rogers is the Chief Operating Officer and the other 50%-member of AMG. [Tr. 1254:20-1255:04] Rogers has worked in the ambulance industry for over 35 years. [CA-173] Starting out at 18 years old as an emergency vehicle operator [Tr. 1256:01-16], Rogers has worked as an EMT, EMT intermediate, paramedic, and eventually became the Director of Operations for an AMR company in Southern

Nevada before becoming the Chief Operating Officer for Community Ambulance. [Tr.1256:01-1269:13] Rogers has effectively worked and managed every aspect of an ambulance service and has a particular expertise in system-status management and operations. [Tr. 1297:01-1299:11]

In 2001, recruited by John Wilson and Bob Ramsey, Rogers helped launch Southwest Ambulance, now known as MedicWest. [Tr. 1263:5-20] As managing director, Rogers was critical in growing MedicWest from a startup with daily transports of 5 or 6 per day to 150 per day under a new 911 franchise agreement. [Tr. 1264:2-22]

In July 2007, AMR purchased MedicWest, and by February 2008, Rogers left AMR MedicWest to join the Henderson Fire Department. [Tr. 1264:22-1266:09] John Wilson of AMR, however, asked Rogers to continue handling systems status management and deployment planning for AMR MedicWest, which he did for another year and one-half while working for Henderson Fire. *Id.*

With the Henderson Fire Department, Rogers joined as an EMS training officer in the emergency medical services department, a captain-level position within the department. [Tr. 1266:10-15] In that position, Rogers was responsible for EMS training of approximately 200 employees, including clinical education, quality assurance, quality improvement, and research. [Tr. 1266:16-22] In addition, Rogers acted as a liaison to the Southern Nevada Health District and as an advisor to Henderson's Fire Chief. [Tr. 1266:22-1267:02] In addition, the Clark County Fire Chief tasked Rogers with developing a system status management plan for 911 response and transport in the event AMR employees carried out their threats to strike. [Tr. 1267:03-10]

In 2010, Rogers helped form Community Ambulance, and has overseen operations since 2010, including recently acquired 911 service in Clark County

and back-up 911 in the City of Henderson. [Tr. 1269:14-1271:01] In fact, using Rogers' system status management expertise and plans, Community Ambulance consistently achieves the best interfacility arrival times and now 911 response times where it competes directly with private ambulance companies like AMR Las Vegas and AMR MedicWest. [CA-225; Tr. 1286:05-1294:22]

Rogers has been certified and instructed in various aspects of Emergency Medical Services, including Basic Life Support, Advanced Cardiac Life Support, Pediatric Advanced Life Support, and Pre-Hospital Trauma Life Support, served on the American Heart Association's affiliate faculty, and continues to serve as an instructor. [CA-155; CA-237] Additionally, Rogers is still an active certified paramedic. [CA-237; Tr. 1274:15-22]

Rogers has also been recognized at the county, state, and federal level for his exemplary service in EMS. [CA-236 (Congressional awards); CA-152 (letter of recommendation from Clark County Deputy Fire Chief, Jon C. Klassen); CA-153 (Healthcare Headliner Award)] Rogers has a Bachelor of Science in Management from University of Phoenix and Advanced Paramedic training from University Medical Center of the University of Nevada, Las Vegas. [Tr. 1255:14-24]

More recently, Richardson, Rogers, and Community Ambulance's paramedics and EMTs were locally and nationally recognized for their tireless efforts during the harrowing and tragic mass-casualty event on October 1, 2017 at the Route 91 Festival in Las Vegas. [Tr. 1299:2-1303:22; CA-166-169] Not only has Rogers, Richardson, and Community Ambulance been recognized for their efforts during that event, but Rogers has been asked by the United States Department of Health and Human Services ("HHS") to work with HHS and Federal Emergency Management Agency ("FEMA") to develop a mass-casualty response training program to learn from his and others experience in responding

to such an event. [Tr.1304:2-1305:6]

### 3.2. Integrity

Community Ambulance has also established by a preponderance of the evidence that its key personnel have the integrity required to operate an ambulance service in Arizona. As attested to in the Community Ambulance Application and as they testified during the hearing, neither Richardson nor Rogers have ever been convicted of a felony or misdemeanor involving moral turpitude, neither has had a license or CON to operate an ambulance service revoked, and neither has operated an ambulance service without a proper license. *See* AAC 9-25-902(A)(2)(g); [ADHS-1 at 65; Tr. 834:17-08; 1315:16-24]

Community Ambulance and Dignity Health both contribute and invest time, money, and effort into their communities to improve the lives of the underserved. For example, Community Ambulance is active in supporting the public-school system in Nevada and has been recognized for its contributions. [CA-165] Dignity Health is committed to providing high-quality, affordable healthcare to the communities it serves, advocating for those who are poor and disenfranchised, and partnering with others in the community to improve quality of life. In holding true to these values, Hunt testified about Dignity Health's community outreach and investment in underserved communities. For fiscal year 2018, Dignity Health gave "$2.1 billion in free care in the community benefit" and is committed to the service of the underprivileged and underserved across the communities it serves through various programs, including collecting excess food from local farms to provide to senior citizens in need, proving funding to at-risk communities, and providing approximately 5,000 new units of housing for the homeless. [Tr. 82:15-83:13] This level of community involvement and commitment is unparalleled by owners and investors in the current private

ambulance community and represents a unique benefit of Community Ambulance to the public.

### 3.3. Fiscal Competence and Resources

Community Ambulance comes to the Maricopa County service area not only with significant operational expertise and integrity, but with the financial wherewithal and resources to serve the patient populations of Maricopa County and successfully operate an ambulance service in this area. Community Ambulance continues to generate strong margins from its Nevada operations and has between $500,000 and $700,000 in operating cash, which can be readily accessed for Maricopa County start-up operations. Further, Community Ambulance has approximately $1.7 million in available capital lines from which to draw for its Maricopa County operations. [Tr.835:09-835:23]

Additionally, Community Ambulance has the financial backing of its majority owner, Dignity Health, a 40-hospital, $15 billion non-profit company. [Tr. 85:09-16] Dignity Health is the fifth largest health system in the nation and continues to make significant investments in the health and welfare of communities in and around Maricopa County. As Hunt testified, Dignity Health continues its investment in this community as demonstrated through the building of a number of new facilities to care for patients in this growing market. [Tr. 76:10-25 (development of new Dignity Facilities addressed in detail in section 3.1 below); Tr. 157:24-158:02] Dignity Health also currently has approximately $1.6 billion dollars invested in 110 different collaborative partnerships, like Community Ambulance, throughout its system. [Tr.85:17-22] Further, Dignity Health clearly desires to continue its investment in Maricopa County and surrounding communities, in part, by extending its successful collaboration with Community Ambulance into Maricopa County.

There are mechanisms in place for Dignity Health to contribute capital to Community Ambulance to ensure a successful start-up of operations in Maricopa County. Under the terms of the Operating Agreement, majority member Dignity Health and minority member AMG have the ability to make capital contributions or loan money to the enterprise if necessary. [CA-13 (Community Ambulance Operating Agreement, Art. 3); Tr. 787:14-789:01 (Richardson testimony concerning options under Operating Agreement to make contributions to Community Ambulance)] To this end, Hunt has testified that she has independent discretion – without seeking further corporate approval – in her capacity as CEO of Dignity Health Arizona to contribute up to $1,000,000 to Community Ambulance operations. [Tr. 85:17-86-13]

In total, Community Ambulance will have immediate access to over $3,200,0000 to support its start-up operations, with access to more if required. This is more than sufficient capital to support Community Ambulance's Maricopa County operations during the first months before reimbursements from Medicare, Medicaid, and third-party payors are received.

**4. THE PROPOSED RATES AND CHARGES ARE JUST, REASONABLE AND SUFFICIENT**

As Richardson testified during the hearing, and as he indicated in the application process prior to the hearing, Community Ambulance has requested to participate in the Phoenix Uniform Rate Group, and is willing to accept the financial impact, if any, of placing Community Ambulance in that rate structure. [Tr. 826:6-9; 832:7-18; ADHS Ex. 25; CA Ex. 9] Community Ambulance did not initially apply to participate in the Phoenix Uniform Rate Group. [Tr. 827:6-8; ADHS Ex. 1] But, on March 27, 2017, Community Ambulance submitted a revised ARCR using Phoenix Uniform Rate Group rates and included an admittedly

inartful request through a cover letter indicating that Community Ambulance would like to "continue down the path" of the Phoenix Uniform Rate Group. [Tr. 829:3-830:9; ADHS 12] Ultimately, the rates issue was deferred to the hearing for purposes of establishing that allowing Community Ambulance to utilize those rates would be just, reasonable, and sufficient.

Currently, the Phoenix Uniform Rate Group rates are

ALS Base Rate: $952.81
BLS Base Rate: $848.73
Mileage: $19.75
Waiting Charge: $212.18

There can be no dispute that these rates are just and reasonable. Indeed, ADHS has approved this rate group for Intervenors Maricopa Ambulance and AMR, as well as other CON holders operating in Maricopa County, including both interfacility and 911.

Furthermore, these rates are sufficient. Under its revised ARCR [ADHS-12], Community Ambulance calculated that based on 11,315 year-one transports, the implementation of these rates would result in a projected first-year net income of more than $700,000. [ADHS-12]

As required by statute and regulation, ADHS reviewed the revised ARCR with the Phoenix Uniform Rate Group figures and performed its normal analysis of the financial information to produce its Second Findings Letter. [ADHS-13] In its Second Findings Letter, ADHS recommended a decrease in Applicant's mileage reimbursement rate and an increase in its ALS and BLS base rates to offset the lost revenue from the lower mileage reimbursement. *Id.* ADHS did not have any other material changes to the revised ARCR. *Id.* While Applicant could operate profitably at the rates recommended by ADHS through the Second Finding Letter, it has made the voluntary decision to participate in the Phoenix

Uniform Rate Group. [*Id.*; Tr. 1010:15-25] It is Applicant's understanding that participation in the Phoenix Uniform Rate Group is voluntary and participation should be granted by the Director so long as Applicant's financial modeling using the uniform rates continues to show sustained profitability, which is true here. [Tr. 1010:8-25]

During the hearing, Intervenors suggested that there were errors in the revised ARCR submitted by Applicant, but Intervenors never established how, if at all, those issues impacted Community Ambulance's profitability in year one. A review of those issues (as discussed below), demonstrates that Community Ambulance will still be profitable using the Phoenix Uniform Rate Group rates in year one.

The first concern raised by Intervenors involved Applicant's staffing and wage model. During the hearing, representatives for Applicant testified that the staffing model would need to be flexible as they develop a complete demand analysis of the market. [Tr. 1297:1-1297:6] Through its application, Community Ambulance calculated that it would run five (5) ambulances twenty-four hours a day, seven (7) days a week. [ADHS-1] The maximum staff that could be on those five (5) ambulances would be 40 full time equivalents [Tr. 1329:15-1330:15], but to account for overtime and to maintain flexibility, Applicant reported 42 full time equivalents on its initial and revised ARCRs. [ADHS-1 at 74; ADHS-12 at 9] The total staffing cost set forth in the revised ARCR is $1,861,816. *Id.* After Intervenors suggested that Community Ambulance must be employing only part-time firefighters due to the lack of overtime included in the ARCR, it became clear to Applicant that it should have reported 40 full time equivalents and separately calculated training, overtime and benefits. To be sure, Richardson testified that Community Ambulance will look:

> For part-time firemen looking for picking up odd jobs. We also have a great local market with talented folks that may want to have an opportunity to go work for a company coming in. And we've also got employees that are working with us up in -- Community Ambulance up in southern Nevada that voiced a desire, passion to be able to come down to Maricopa County and be able to work down here as well, transfer down. [Tr. 823:1-824:14]

And, Richardson further testified that part-time firefighters are just "one of the options we would like to look at." [Tr. 1001:13]

Based on the staffing model Rogers testified to during the hearing and assuming a "worst case" scenario where 100% of the employees are full-time [Tr. 1329:16-1331:16], Applicant would pay each employee 1,976 straight time hours and 208 overtime hours each year. The table of recalculated staffing costs and information related to training and benefits is set forth below:

**Total Wage calculation using 40 FTEs and including overtime**

| | Number of Straight Time Hours | Standard Wage per Hour | Total Standard Wage Cost (1) | Number of Overtime Hours | Overtime Wage per Hour | Total Overtime Wage Cost (2) | Total Cost (1) +(2) |
|---|---|---|---|---|---|---|---|
| 18 Para-medics | 35,568 | $17.16 | $610,347 | 3,744 | $25.74 | $96,370 | $706,717 |
| 20 EMTs | 39,520 | $15.36 | $607,027 | 4,160 | $23.04 | $95,846 | $702,873 |
| 2 Nurses | 3,952 | $30.00 | $118,560 | 416 | $45.00 | $18,720 | $137,280 |
| | | | | | | | $1,546,870 |

Community Ambulance will also provide 40 hours of training to each of its employees. [Tr. 1331:6-16] Training cost is calculated by multiplying the 40 training hours for each employee by the standard wage cost for each of the eighteen paramedics, twenty EMTs and two nurses. For eighteen paramedics paid $17.16 per hour, training costs equate to $12,355. For twenty EMTs being paid $15.36 per

hour, training costs equate to $12,288. And for two nurses being paid $30.00 per hour, training costs equate to $2,400 for a combined training cost of $27,043. Total benefits and payroll taxes on standard wages, overtime wages, and training at a 26% rate requires an additional $409,217 for a total staffing cost of $1,983,131 or an increase of $121,315 over what was reported in Applicant's revised ARCR. [ADHS-12]

Another issue concerning Community Ambulance's ARCR involved the individual allocation of settlement allowances for Medicaid, Medicare and Bad Debt. [ADHS-8; ADHS-13; Tr. 1005:9-1006:16] Based strictly on the Medicaid reimbursement rates in Arizona, it is clear that ADHS recommended, and Community Ambulance adopted, an incorrect re-allocation of settlement allowances in its revised ARCR, which resulted in a Medicaid settlement allowance that was too high and a Medicare settlement allowance that was too low. [ADHS-12 at 6] As Aaron Sams testified on this issue "what matters most is the cumulative total, so the deduction from revenue percentage as a whole impacts how rates are changed and calculated. The individual percentages for Medicare, Medicaid, bad debt, things like that don't individually impact it. It's how they collectively impact how we set rates and charges." [Tr. 1008:8-13] ADHS, through Sams' testimony, agreed that the Bureau's analysis, and therefore Applicant's revised ARCR, presents a fair expectation of Applicant's overall collection rate and financial results even though the individual settlement allowances may have been inadvertently inverted. [Tr. 1008:14-21]

The next ARCR issue involved the contractual discount being offered to Dignity Health in the proposed service agreement and the fact that the discount was not reflected in the revised ARCR. No discounting was included in the original ARCR, or the revised ARCR, because the proposed service agreement between

Applicant and Dignity Health was not finalized until late 2017. [ADHS-1; ADHS-12; CA-17] When the service agreement was finalized, Applicant inadvertently forgot to update that section of its revised ARCR to include some level of discounting under the proposed contract. Despite this inadvertence, the evidence clearly shows that the inclusion of discounting does not have a material impact on Applicant's pro forma financial picture for year one.

The discount under the service agreement only applies when Dignity Health is ultimately responsible to pay for the ambulance transport, which O'Malley testified happens only once or twice per month on average. [Tr. 274:20-275:6; Tr. 366:21-367:5] Assuming 24 transports per year that qualify for the 30% contractual discount and the average cost per transport is $1,161.61 as reflected in the revised ARCR, the total lost revenue as a result of the discount is $8,300 or approximately 1% of Applicant's pro forma calculation of its net income.

The remaining ARCR issue Intervenors raised is nothing but a red herring. They claim Applicant failed to include expenses related to stocking its ambulances with medical supplies because the original and revised ARCRs do not include any "cost of goods sold." [Tr. 1348:22-1349:16] Of course, cost of goods sold should be zero dollars ($0.00) because Community Ambulance is not charging its patients for use of medical supplies. [Tr. 826:14-16; 827:6-24] Contrary to Intervenors contentions, Applicant accurately and appropriately reported the cost of its medical supplies on its revised ARCR at page 6[12] under line 25 "Ambulance Supplies – Nonchargeable." [ADHS-12 at 15] Applicant's ARCR has clearly accounted for the costs of medical supplies – costs it will not recoup – despite Intervenors' assertions to the contrary.

[12] Page 6 refers to the page number on the revised ARCR. The document referred to here can be located at ADHS exhibit 12 at bates number 15.

It is clear from previous CON hearings that mistakes in an ARCR do not preclude the Applicant from receiving a CON. In fact, Maricopa Ambulance had several errors in its ARCR to the point that it resubmitted a revised ARCR during the hearing that resulted in its profitability dropping from over $1.1 million to just $1,542, and yet it was still awarded its CON. *See In the Matter of: Maricopa Ambulance, LLC*, April 18, 2016 Administrative Law Judge Decision, Findings of Fact, at ¶¶ 28, 30, 33. Taking each of the ARCR issues raised during the hearing into account, the impact is marginal. To be sure, Applicant's first-year net revenue on 11,315 transports at the Phoenix Uniform Rates would still be $596,924, after taking into the account the foregoing adjustments.

**5. COMMUNITY AMBULANCE HAS PROVIDED THE INFORMATION REQUIRED OF APPLICANTS AT A.R.S. § 36-2233(A) AND AAC R9-25-902**

With its Application and through its testimony at the hearing, Community Ambulance has provided this Court and ADHS with all of the information and documents required by A.R.S. § 36-2233(A) and AAC R9-25-902:

- Certificates of liability insurance for Community Ambulance. [ADHS Ex. 1 at 21; *see also* CA-238, supplemental certificate of liability insurance submitted with approval of Judge Eigenheer. [Tr. 825:10-826:7]]
- Initial Ambulance Locations. [ADHS-1 at 22; *see also* Tr. 812:11-15; 1312:24-1315-14]
- Ambulance specifications. [ADHS Ex. 1 at 23-50]
- Specifications of communications systems and medical equipment. [ADHS Ex. 1 at 9, 51-60; Tr. 812:16-813:5; 815:11-820:6; CA-223; 820:20-823:24 (uniform medical equipment across all ambulances, including electric gurneys, heart monitors, IV pumps, ventilators, climate-controlled drug boxes)]
- Proposed rates and charges. [ADHS Ex. 1 at 61; ADHS Ex. 12 at 7 (Revised ARCR with Phoenix Uniform Rate Group rates)]

- Plan for temporary services. [ADHS Ex. 1 at 63; Tr. 296:03-11; 834:08-16]

- Proposed service area. [ADHS Ex. 1 at 64; 66-67]

- Confirmation that applicant and its designated managers have (1) never been convicted of a felony or misdemeanor involving moral turpitude; (2) never had a license or CON suspended or revoked by any state or political subdivision; and (3) never operating a ground ambulance service without the required certification or licensure in Arizona or any other state. [ADHS-1 at 65; Tr. 834:17-08; 1315:16-24]

- Initial proposed ARCR. [ADHS-1 at 68-22]; Revised ARCR [ADHS-12 at 3-27]

- Identification of all affiliated organizations with at least 5% ownership in Community Ambulance. [ADHS-1 at 93]

- Information about financing and lease agreements. [ADHS-1 at 149]

- Information about source of funding. [ADHS-1 at 150; CA-13 (Community Ambulance Operating Agreement, Art. 3); Tr. 85:17-86-13 (Linda Hunt testimony regarding her independent discretion to contribute up to $1,000,000 to Community Ambulance operations without corporate approval); Tr. 787:14-789:01 (Rob Richardson testimony concerning options under Operating Agreement to make contributions to Community Ambulance)]

- Information about ground ambulance service contracts and subscription service contracts. [ADHS-1 at 151; 155]

- Statement that a surety bond is not required. [ADHS-1 at 158]

- Resumes of key management personnel. [ADHS-1 at 159-165]

- Copies of the Community Ambulance check payment of CON Application filing fee. [ADHS Ex. 1 at 12-13]

**6. COMMUNITY AMBULANCE'S RURAL PLAN**

As a provider of interfacility and 911 transports in urbanized and rural services areas in Southern Nevada, Community Ambulance is sensitive to and

understands the challenges of operating and maintaining a full ambulance service in sparsely populated rural and wilderness areas. [Tr. 837:20-20; 842:1-17] Both Richardson and Rogers understand that an ambulance company like Life Line, which operates primarily in rural Arizona communities, has to be able to transport non-emergency calls to offset the 911 expense. [Tr. 837-1-20] Rogers testified that Community Ambulance is

> sensitive [to the rural issues] … we do not want to disrupt or cause any problems in those [rural] areas, and so our plan to protect that is that if there's an entity, a CON, that is providing 911 services in that area that depend[s] on those non-911 calls … they would continue to take all those calls. Dignity Health patient or not, they would take those calls … We acknowledge and recognize that they [rural CON holders] need those transports in order to fortify the 911 system in that rural area

[Tr. 1180:21-1181:2; 1181:5-7] From Community Ambulance's perspective, any transports that are in a declared rural area, "the current CON holder would get all those calls, that they would keep doing what [they are] doing." [Tr. 1181:13-24]

Under this contemplated rural plan, Community Ambulance would like to have a collaborative relationship with the existing rural area CON holders to act as back-up, responding to any calls when the CON holder in that area (1) cannot respond at all to a call or (2) needs help to clear extremely long ETA's that are having an impact on patient care and welfare. [Tr. 1181:2-5] Indeed, Community Ambulance is applying for a Maricopa County-wide CON so that it may be available to transport patients requiring interfacility transports to and/or from anywhere in the County, including those patients residing in more remote or rural areas. But Community Ambulance intends to do so in collaboration with the existing CON holders in those designated rural areas. Mr. Kasprzyk of AMR agrees

that it would be beneficial to the public to have another provider available to relieve peak loads:

> Q: But in that circumstance, a car accident involves five people and there's this interfacility patient that's still sitting in Wickenburg. All I'm asking is, it would be beneficial to that patient if AMR would turn that call to another provider who can come into the area; right?
>
> A: Yes.

[Tr. 2070:06 - 2070:12]

Through its rural plan, Community Ambulance will be available to provide an additional layer of protection and service for the existing CON holder, with the focus on sustaining quality and timely ambulance service for patients in rural and wilderness areas.

**7. COMMUNITY AMBULANCE IS COMMITTED TO USING EPCR TECHNOLOGY AND ADVANCING THE CURRENT STATE OF THE ART THROUGH INTEGRATION OF THE EPCR SYSTEMS WITH DIGNITY HEALTH'S CERNER SYSTEM**

As with its Nevada operations, Community Ambulance will continue its use of electronic patient care (ePCR) technology in the Maricopa County service area. [Tr. 813:01-05; ADHS 1] Furthermore, Community Ambulance is presently working with its majority owner, Dignity Health, to transform the traditional paper patient care records "packet," which includes such things as a face sheet, physician certificate and authorization, that travels with the patient (and maintained by the medic) between facilities to an electronic record that is sent to the ePCR. [Tr. 8:15:11-820:6; CA Ex. 223] As Richardson testified, Community Ambulance and Dignity Health hope to have all patient records run through an integrated system so that when a patient is ready for transport, a physician can sign an authorization form electronically and when the ambulance crew arrives

for the interfacility transport, it will have the entire packet available electronically either through the CAD and/or ePCR system. *Id.* When put in practice as conceived, an electronic "packet" will reduce off-load and on-load times, eliminate unnecessary redundancies, reduce the potential for informational errors in transport, improve the continuity of patient care, as well as the comfort and care provided to patients who require interfacility transports. *Id.* This represents innovation in the ambulance system that Intervenors have not brought to this market. Similar to Mr. Thomas's testimony during ABC's CON hearing:

> My belief is that competition fosters innovation, and that is part of the Director's guidance on contemporary protocols, and it is also my experience that competition is also a very good cost control.

[ABC Con Hearing Transcripts, Volume 1, 10/1/2012, 2012A-EMS-0101-DHS, 289:9-291:11 [CA-98]

**8. DATA SUBMISSION TO THE AZ-PIERS SYSTEM**

Community Ambulance has further committed to participating in the Arizona Prehospital Information & EMS Registry System (AZ-PIERS). [Tr.1315:25-03]

**9. COMMUNITY AMBULANCE WILL PARTICIPATE IN THE BUREAU'S QUALITY IMPROVEMENT INITIATIVES**

Community Ambulance is continually committed to improving ambulance service both in Nevada and in Arizona and will participate in the Bureau's quality improvement initiatives. To this end, Community Ambulance is ready and willing to commit to arrival time standards for interfacility and convalescent transports if awarded a CON and will work with BEMETS on those arrival time standards

to incorporate in the CON. [Tr. 833:01-834:03; 1285:23-1286:04] Community Ambulance would also advocate for advances in compliance with capturing and reporting arrival times, including the elimination of the status quo of arrival time self-reporting in favor of the accuracy and transparency of reporting through a program such as Online Compliance Utility ("OCU") system, which removes discretion from the capture of arrival times. The OCU operates within Community Ambulance's CAD system to access data for accurate arrival time reports that cannot be manipulated by CON holders. [Tr. 1282:23-1285:22]

**10. COMMUNITY AMBULANCE WILL ATTEND AND PARTICIPATE IN REGIONAL AND STATE AMBULANCE ORGANIZATIONS**

Richardson and Rogers are both very active in the EMS community in Southern Nevada and have already attended EMS council meetings and made a presentation to AEMS. [Tr. 845:7-20; 1316:13-22] Richardson and Rogers both look forward to continuing to attend and participate in regional and state EMS meetings in the coming years.

**11. CONCLUSION**

Under the applicable statutes, regulations and rules set forth above, the record in this matter will show that Community Ambulance is fit and proper and that issuing Community Ambulance a CON will benefit the public and fill a public need in Maricopa County for an additional interfacility and convalescent ambulance service. As such, Community Ambulance respectfully requests that this Court recommend the issuance of the CON to Community Ambulance.

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RESPECTFULLY SUBMITTED this 28th day of January, 2019.

**HENDRICKS MURPHY, PLLC**

By: */s/ Brendan Murphy*
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**ORIGINAL** filed this 28th day of January, 2019 via the OAH electronic document filing system https://portal.azoah.com/oedf, with copies provided to all parties on the approved mailing list by posting through the designated OAH website at https://portal.azoah.com/oedf/documents/2017-EMS-0104-DHS/index.html, in accordance with Case Management Order No. 1.

/s/ *Brendan Murphy*

# Exhibit 1

Arizona Care Network

A Better State of Care

Abrazo Community Health Network | Dignity Health. | Phoenix Children's Care Network

November 8, 2018

Adriane Hofmeyr
Hofmeyr Law, PLLC
31 N. 6th Avenue, Suite 105-466
Tucson, AZ 85701

Dear Ms. Hofmeyr:

Thank you for inviting Arizona Care Network to share information for consideration in the OAH proceedings (2017-EMS-0104-DHS) involving your client, ABC Ambulance LLC.

Arizona Care Network is an accountable care organization operating as a 50/50 joint-venture between Tenet Healthcare, conducting business locally as Abrazo Community Health Network, and Dignity Health. The organization is governed by a 21-member Board of Managers consisting of 15 physicians representing medical groups in the network, 4 appointed representatives from Tenet and Dignity Health, our CEO, and a patient representative. All 21 board members share equal voting rights.

Arizona Care Network has entered in to arrangements with various payers to improve care for patients treated by ACN providers, including an arrangement with Mercy Care that has been in place since 2014. Mercy Care does not delegate provider network contracting or credentialing functions to Arizona Care Network. As a result, Mercy Care retains its right and authority to contract with and credential physicians and other health care providers to be considered in-network for all members, including those patients covered under ACN's arrangement with Mercy Care.

Arizona Care Network's Board of Managers determines which medical groups and other provider organizations participate in the network, which includes primary care clinicians, specialists, ancillary providers and facilities. ACN strives to coordinate the delivery of health care services within this selected network of providers to maximize opportunities to effectively diagnose, treat and rehabilitate as necessary patients served by the network.

Arizona Care Network does not contract with or otherwise credential/certify ambulance companies. Ambulance companies provide a vital service to patients; however, ACN does not coordinate or participate in the arrangement of interfacility transport services for any patient covered under our various payer agreements. Rather, we believe it is most appropriate for these arrangements to be made by and between the patient and his/her family, and the physicians, nurses and other capable support staff representing the involved facilities.

I appreciate the opportunity to share the above information. If you have any questions, please contact me through my assistant, Susan Laufenberg, at susan.laufenberg@azcarenetwork.org or (602) 406-2237.

Sincerely,

David S. Hanekom, MD, FACP, CMPE
Chief Executive Officer

cc: Scott Bennett, Coppersmith Brockelman PLC
Andrew Morgan, Coppersmith Brockelman PLC