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BEFORE THE DIRECTOR OF THE

ARIZONA DEPARTEMENT OF HEALTH SERVICES

In the Matter of: RBR Management, LLC dba Community Ambulance, Applicant.	Docket No. 2017-EMS-0104-DHS (EMS No. 0283)

COMMUNITY AMBULANCE'S MOTION FOR REVIEW

1. INTRODUCTION

Applicant RBR Management, LLC, dba Community Ambulance ("Community Ambulance"), pursuant to A.R.S. § 41-1092.09 (A)(1), respectfully requests the Director of the Arizona Department of Health Service ("ADHS") review the final administrative decision in this matter and consider reversing course by granting Community Ambulance a CON to operate an interfacility ambulance service in Maricopa County. Careful review of the evidence as applied to the legal standards in statute and rule, and ADHS's decisional precedent in recent CON proceedings, more than support a reconsideration of the Director's wholesale adoption of Administrative Law Judge Tammy L. Eigenheer's ("ALJ") Recommended Decision[1] and grant a CON to Community Ambulance.

By adopting the Recommended Decision, the Director's final administrative decision (a) runs contrary to the weight of evidence establishing Community Ambulance is fit and proper to operate a successful ambulance company in Maricopa County, (b) appears to follow the long abandoned "unmet need" and "right of first refusal" standards from the Arizona Corporation Commission days under the public necessity factors, and (c) sets aside well-settled legal precedent this agency established through recent Certificate of Necessity ("CON") application decisions. To make matters worse, the Recommended Decision adopted by ADHS wholesale copies a substantial portion of the American Medical Response CON holders' ("AMR") (and other Intervenors') inaccurate, argumentative, inconsistent, misleading, immaterial and irrelevant findings of

[1] In citations, the ALJ's April 15, 2019 recommended decision will be referred to as "RD." Citations to Hearing Exhibits in this document will be in the following format: "ABC-__"; "ADHS-____"; "AMR-___"; "CA-___"; and "MA-___." Citations to the Hearing Transcript will be identified at "Tr.".

fact, typos and all.[2] Here are some material examples illustrative of the types of serious errors found in the Recommended Decision, though this is not intended to be an exhaustive list:

- The ALJ found the Applicant did not request the inclusion of interfacility arrival times through its Application, a misleading finding because Community Ambulance submitted its Application on June 10, 2016 – **almost seven (7) months before ADHS released a revised Guidance Document providing that "Applicants wishing to provide interfacility transports may propose 'Interfacility Arrival Times' and have those times measured for compliance purposes**."[3] Just like Maricopa Ambulance, LLC ("MA") proffered in its CON hearing, Community Ambulance **readily agreed – several times -- to subject its CON to interfacility arrival times**.[4]

- Intervenors refused to provide ambulance transport data to Community Ambulance despite subpoenas requesting that data – data which testimony proved was not the type that could be maintained by a hospital system.[5] In fact, the administrative hearing itself was significantly delayed precisely because the Court had not yet ruled on pending motions to compel responses and objections to these subpoenas. Without a decision on the subpoenas, Community Ambulance was forced to delay the hearing (and incur more cost) to give the Court an opportunity to rule on those motions and make relevant documents and data available. The ALJ never

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[2] RD at 47:22; 55:20; AMR's Proposed Findings of Facts and Conclusions of Law (OAH Docket No. 152) at 48:10.

[3] *Compare* ADHS-15 (2017 Guidance Document), AMR-82 (2010 Guidance Document); AMR-83 (2015 Guidance Document). Hearing Exhibits are located online at https://portal.azoah.com/oedf/documents/2017-EMS-0104-DHS/Omnibusindex.html

[4] Hearing Transcript Record ("TR") at 833:02-834:03; 1285:23-1286-4 (Q. [W]ould you be willing to agree to arrival times in your CON even though its not specifically set forth in the application? A. **Absolutely. I would expect we are held to arrival times**.") (Emphasis added.)

[5] Recommend Decision at 29:7-10; Tr. 2146:22-25 (AMR system status management employee and expert, Doug Jones ("Jones"), admitting "you know, most hospitals – hospital systems don't have a lot of detailed data")

ruled or applied to the Maricopa County Superior Court to enforce the subpoenas.[6]

- The ALJ adopted AMR's inaccurate and misleading finding that Richardson only met with two Fire Chiefs, when the testimony established on May 3, 2017, Richardson attended the Life Safety Council and gave a presentation on Community Ambulance to approximately 40-50 participants, including Fire Chiefs and their staff. From that meeting two Fire Chiefs asked for follow-up meetings as the rest were content with the presentation, and some of whom (among others) submitted letters of support to the Bureau of Emergency Medical Services & Trauma System ("BEMSTS").[7]

- The ALJ adopted AMR's misleading theory on Lyft and Uber replacing traditional ambulance transports by mischaracterizing Rogers' testimony about Lyft and Uber vehicles being used to transport victims in the nation's single worst shooting incident on October 1, 2017 in Las Vegas, Nevada. If that reasoning were accurate, then all of the taxis, trucks, cars, and other personal vehicles used to transport patients for that catastrophic event should all be considered suitable alternative for ambulance transports. Rogers' testimony was clear that Lyft and Uber are not replacing traditional ambulance transports.[8]

- The ALJ adopted Roy Ryals opinion that Community Ambulance cannot provide ambulance services – 11,315 transports in year one with 5 ambulances operating 24 hours, 7 days per week, plus one in reserve, even though Rogers (Community Ambulance's COO) plainly proved otherwise[9] and AMR's system status management employee and expert Jones – without even hearing Roger's testimony – agreed.

- The ALJ found Dignity Health only had a few examples of issues with IFT transfers when both Linda Hunt, CEO of Dignity Health

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[6] *Whitmer v. Hilton Casitas Homeowners Ass'n*, 245 Ariz. 77, 80–81, 425 P.3d 253, 256–57 (Ct. App. 2018)

[7] Hearing Transcript Record ("TR"); ADHS Hearing Exhibits 17-24.

[8] Tr. 1296:2-19.

[9] Tr. 1297:01-1299:20; 1305:12-1315:14; CA-149 (Community Ambulance Operational Plan)

Arizona ("Hunt"), and Jeff O'Malley, Vice President of Partnership Integration for Dignity ("O'Malley") testified they needed to find a new ambulance solution due to on-going and consistent valley-wide complaints from Dignity facilities about transport delays and service.

- Although the paramedic liaison for Arizona General Hospital – just one small hospital system in Maricopa County – testified that he fielded anywhere from **50 to 100 complaints per month** about interfacility service per month, the ALJ erroneously found he "**heard five to ten complaints per month about IFTs**."[10]

- The ALJ was dismissive of substantial evidence of Dignity's issues with AMR and their performance under the Dignity-AMR contract by understating issues with reporting (which O'Malley testified continues to be incorrect), delays, and the one-call system, a single number and dispatch center through which any Dignity Health facility could pick up the phone, dial one number straight to AMR.. For example, the ALJ dismissed issues with the one-call system and the requirement that AMR turn calls to other providers to ensure timely transports because "O'Malley was unaware whether AMR ever turned calls to other providers (if it could not do a transport in a timely fashion)" even though there was an exhibit submitted by AMR (that they suspiciously would not admit as evidence) that they had turned only four (4) calls to a non-911 provider in 3 years of having the preferred contract with Dignity Health. The testimony is undisputed that O'Malley asked for this data regarding turned calls, and AMR failed to address those requests.[11] Interestingly, Intervenor ABC Ambulance, LLC ("ABC") the recipient of those turned calls, is owned by Neal Thomas who happens to be the President of an AMR affiliate and Intervenor, ComTrans.[12]

- The ALJ found Applicant did not prove that it could be in the Phoenix Uniform Rate Group because it did not include the cost of supplies in its ARCR despite the fact that the cost of those supplies

[10] ALJ RD at 33:29-30
[11] Tr. 240:24- 242:6
[12] Tr. 1391:01-04

was in fact included in the ARCR. This finding ignored Applicant's revised ARCR and testimony on this issue, plainly set out in Applicant's closing argument and response to Intervenors' closing arguments, which clearly explained where that information was included in the ARCR and why. [13]

- The ALJ surprisingly characterized the ABC and MA service area "carve-outs" as good for the rural communities located in the "carve-out" areas while determining that Community Ambulance's rural plan would not serve those interests. Community Ambulance is expressly agreeing to do the same thing as ABC and MA by giving deference to the current provider in those areas while reserving the ability to serve residents in rural areas if the current provider needs help. Community Ambulance's plan is *better* than what is currently available because it provides rural communities with an added layer of protection and help when needed. Even AMR agreed this is a tangible public benefit.[14]

- The ALJ adopted AMR's misleading theory that Community Ambulance will transport ALL of Dignity Health's interfacility patients, whereas, Community Ambulance's ARCR and testimony was that ALL, if not most of Community Ambulance's 11,315 transports will be Dignity Health patients. This is different.

- The ALJ improperly applied the long-abandoned right of first refusal standard in its analysis of public necessity and need by concluding the current providers cobbled together can handle the transports set forth in the application[15].

- In an example of the ALJ improperly applying the right of first refusal standard, the ALJ found MA could scale its operations to meet Dignity Health's needs. Not only does this prove a need for

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[13] ADHS-12 (Revised ARCR); TR. 1349:10-1350:04; Written Closing Argument (OAH Docket No. 158); Response to Intervenors' Closing Arguments (OAH Docket No. 167).

[14] Tr. 2070:06 - 2070:12

[15] *See In the Matter of: Maricopa Ambulance, LLC*, 2015-EMS-0190-DHS, Director's Decision (May 17, 2016) ("MA Director Decision"), adopting *In the Matter of: Maricopa Ambulance*, LLC, 2015-EMS-0190-DHS, ALJ Recommended Decision ("MA ALJ RD"), at 21:15-25, Conclusions of Law, ¶5.

> additional ambulance transports, but this finding ignores undisputed evidence from MA's own personnel that it could not provide adequate service in the east valley and ignores the fact that MA has added an estimated 30,000 transports from contracts with the City of Scottsdale, City of Surprise, City of Goodyear and HonorHealth in the last several months.[16]

The Recommended Decision is not only inconsistent with the factual record[17] and the law, adopting the Recommended Decision prevents an ambulance company operating at the very highest standards, as its accreditation by the Commission on Accreditation of Ambulance Services ("CAAS") proves, and prevents exceedingly well-qualified, **nationally** recognized operators with over 70 years of combined experience, from providing 11,315 transports in the fastest growing county in the United States, with a recently reported population of 4,410,824.[18] Combined with undisputed evidence of an aging population with more acute medical conditions, and a year-on-year increase of ambulance transports, introducing a financially sound provider like Community Ambulance into the system to handle only approximately 3.5% of the total transports in Maricopa County – with no significant financial impact on incumbent providers – would benefit the public and the ambulance system ADHS oversees and regulates. There is low risk to the ambulance system overall, with huge benefits

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[16] Tr. 207:16-208:03; MA-39; 668:10-671:9; Tr. 1672:06-11; 1663:21-1664:15 (Bryan Gibson's testimony regarding growth of MA including the addition of 911 contracts with the City of Scottsdale, the City of Surprise, the City of Glendale, and through a preferred provider agreement with HonorHealth.

[17] A factual record, it must be noted, developed under the brand new statutory 10-day hearing restriction – in which Applicant only had five of those days to prove its case – unlike the seemingly endless hearing days available to previous applicants (including Intervenors) to develop a factual record. *See* A.R.S. 36-2234(B)(5). This limitation obviously required Community Ambulance to be expeditious in its presentation of testimony in its case and relied on documentary evidence to support its position.

[18] https://www.census.gov/quickfacts/fact/table/maricopacountyarizona/PST045218 (https://www.bizjournals.com/phoenix/news/2019/04/18/maricopa-county-still-fastest-growing-in-country.html).

to the public that system serves by granting Community Ambulance a CON.

What's more, the Recommended Decision, largely premised on AMR's slanted recitation of the evidence, is contrary to ADHS's long-held position that competition among private providers of ambulance service in a large market serves a public necessity.[19] The evidence (discussed below) clearly shows – well beyond a preponderance of the evidence – persistent systemic problems with timely and efficient interfacility transports in Maricopa County up through and including the dates of the administrative hearing.

Furthermore, the Recommended Decision cuts against what is now the clear public policy in the State of Arizona, as reflected by the recent HB2569 signed into law by Governor Doug Ducey on April 10, 2019 (A.R.S. §32-43020), encouraging well-qualified licensed and certified professionals (including doctors) to come to Arizona to ply their trade by recognizing reciprocity with licensing and certifying boards in other states.[20] Granting a CON to Community Ambulance will only improve ambulance service in Maricopa County. To be sure, Community Ambulance is requesting an opportunity to improve healthcare in Arizona by integrating with existing healthcare providers in new, innovative ways and by making ambulance service performance transparent:

- Community Ambulance seeks to dramatically innovate the ambulance transportation process by providing real time data

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[19] *See* MA Director Decision, adopting MA ALJ RD, at 25:14-17, ¶19.

[20] While the ambulance certification process is its own animal, the policy aim is the same—attract well-qualified licensed or certified professionals to this State. As Representative Peterson remarked in connection with his introduction of HB2569: "I'm proud to have introduced this bill to get government out of the way and let qualified individuals moving to our state get to work. Thank you to my fellow members of the House and Senate from both parties for their support, and a big thank you to Governor Ducey for signing this bill and making it a reality." https://azgovernor.gov/governor/news/2019/04/arizona-becomes-first-state-establish-universal-recognition-occupational

exchange between Dignity Health HIE systems, State of Arizona HIE, and ePCR systems during a Dignity Health patient transfer.[21]

- Community Ambulance would like to introduce ADHS to Online Compliance Utility for transparent and automatic arrival time reporting sent – untouched by the ambulance provider - directly from the CAD system data to the regulatory agency.[22] Community Ambulance pushed for this transparent system in Southern Nevada and it is now the standard.

- Community Ambulance will stock uniform medical equipment in all six (6) of its interfacility ambulances, including electric gurneys, heart monitors, IV pumps, ventilators, climate-controlled drug boxes to avoid transports being cancelled or delayed because the "wrong" ambulance was dispatched – an issue that was shown during the hearing to have caused transfer delays on multiple occasions.[23]

- Community Ambulance will launch a call center function, aligned with Dignity Health transfer center operations, to track and analyze Dignity Health ambulance transport requests and coordinate service requests to other CON providers.[24] This type of analysis and reporting is severely lacking with the current CON holders providing service to Dignity Health.

When innovation is embraced, patient care is expedited, access to care is improved and errors are reduced. These improvements will undoubtedly (1) reduce off-load and on-load times; (2) eliminate unnecessary redundancies; (3) reduce the potential for informational errors in transport; (4) improve the continuity of patient care and patient experience; (5) and ensure transparency and accuracy in CON compliance reporting. These are innovations Community Ambulance offers to the ambulance system that Intervenors have not brought to

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[21] *See e.g.* Tr. 815:11-820:6 (advanced ePCR systems)
[22] Tr. 1282:23 – 1285:7.
[23] CA-223; ADHS-1; Tr. 820:20-823:24 (uniform equipment on all ambulances, including IV pumps, vents, heart monitors, and climate-controlled drug boxes.)
[24] CA-149 (Community Ambulance Operational Plan)

this market – innovations that will no doubt provide a benefit to the public and to the ambulance system as a whole as other providers move to improve their own service to compete with Community Ambulance. That the current providers testified they would be willing to explore those innovations with Dignity Health is undeniable proof that just the threat of competition benefits the public.

The needs of the public in Maricopa County are vast and hospital systems should not be required to piece together interfacility responses from an unintegrated mix of three (3) different providers (one of whom – AMR – has tried and failed with Dignity Health and continues to lose transports from other providers) before an innovative and well-run company like Community Ambulance is given an opportunity. AMR has not been a good steward or partner and has already lost thousands of Dignity Health transports and tens of thousands of non-Dignity transports as a consequence. ABC admittedly cannot meet Dignity Health's needs, and MA is both currently unable to cover the entirety of Dignity's Health's transport needs and has added approximately 30,000 additional transports in the last several months with the addition of 911 and hospital system contracts that may result in Dignity Health receiving insufficient (and possibly substandard[25]) service just as it received from AMR under the preferred Customer Agreement. Health care systems "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."[26] Nor should hospital systems be forced to take risks with the delivery of care to its patient population through bad or unknown partners when it has already partnered with Applicant, a company it already trusts to deliver that care.

[25] Community Ambulance's Written Closing Brief (OAH Docket No. 158) at §2.5, 44:22-49:19)
[26] Tr. 1229:09 -1229:12

There is an unfortunate cycle in this market: ambulance companies grow monopolistically large in Maricopa County, leaving the system at risk. Over the years these companies have filed for bankruptcy, been acquired by private equity firms, and/or merged into bigger ambulance companies. These cycles result in periods of significant underperformance the public should not be required to endure. For almost ten years now, Dignity Health has solved similar systemic problems through its relationship with Community Ambulance in Nevada and expects Community Ambulance to help solve these issues 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 demonstrated inadequate service*, the needs of Maricopa County's growing patient population would benefit. Specifically, the addition of an ambulance provider willing to provide a dedicated interfacility ambulance service that cannot be pulled into a 911 system that becomes overloaded (like AMR testified occurs[27]) will benefit those sick and injured interfacility patients who would otherwise be left hanging. As the Fire Chiefs confirmed during the Life Safety Council meeting and confirmed through their letters of support, this is a problem not with the 911 system but with the interfacility system.[28]

What follows is Community Ambulance's effort to provide the Director a more complete picture of this case. But given the sheer length of the Recommended Decision and the fact that the majority of the factual findings are dubious at best, the Director and her team are encouraged to review the closing written argument and responsive argument filed by Community Ambulance as well as Community Ambulance's proposed findings of fact and law to better

[27] Tr. 2171:7-14
[28] AHDS-17 through ADHS-24

obtain that full picture.

One last word before diving into the factors. If at the conclusion of the Director's review, ADHS agrees Community Ambulance should receive a CON, but has lingering concerns about service in rural and wilderness areas and/or financial capacity issues, Community Ambulance is willing to accept certain restrictions in its CON and heightened financial reporting requirements that ADHS deems prudent and in the public benefit. Indeed, to avoid the costs an inevitable appeal will visit on Community Ambulance, Intervenors, and the taxpayers, and with the hope those funds could be better spent investing in improvements to the existing ambulance system to the benefit the residents of Maricopa County – Community Ambulance would be willing to agree to a narrowed scope for its CON, with more stringent reporting requirements, and/or arrival time requirements.

For example, if the Director finds segments of the public (e.g., Dignity Health) have needs that are currently underserved or poorly addressed and would benefit from the inclusion of Community Ambulance, limiting the CON to that population of patients might be most efficacious. Under that example, Community Ambulance would agree to a CON that permitted transports for patients under the care of a Dignity Health provider or affiliated provider, or where the patient or patient's physician has requested the care of a Dignity Health provider or affiliated provider. Alternatively, if the Director deems it in the public's best interests to have Community Ambulance available to back-up incumbent interfacility providers in Maricopa County, but has concerns about the overall impact of introducing Community Ambulance into the system without restriction, the Director may prefer a CON limiting the number of ambulances to six (6) in year one, as proposed through the CON, with room to increase the

number of ambulances by five (5) per year for the next 5 years.

Under any CON, if the Director has any lingering fit and proper concerns, Community Ambulance would readily submit operational and financial reporting[29] to ADHS/BEMSTS on a semi-annual or even quarterly basis.

2. THERE IS A PUBLIC NECESSITY FOR THE PROPOSED SERVICE

Throughout the hearing, Intervenors conveniently pushed the long abandoned "unmet need" and "right of first refusal" standards. Through the final administrative decision, the Director appears – maybe inadvertently – to have adopted that incorrect legal framework. This is an opportunity to revisit and clarify that standard. As ADHS knows, the public necessity requirement does not require evidence the existing CON holders are not meeting the needs of the community.[30] 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."

Moreover, the Recommended Decision fails to adequately apply or even consider the substantial and undisputed evidence Community Ambulance established during the hearing to the actual public necessity factors in statute.[31]

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[29] As the Director requires of MA, Community Ambulance understands such reporting would include arrival time compliance metrics and financials that include revenue collection and net collection figures.

[30] *In the Matter of American Medical Response of Maricopa, LLC*, 2014A-EMS-0305-DHS, Recommended Decision ("AMR ALJ RD")50:10-18, ¶38 (findings based on testimony of Terry Mullins regarding the Bureau's Guidance Document, GD-099-PHS-EMS), adopted by *In the Matter of American Medical Response of Maricopa, LLC*, 2014A-EMS-0305-DHS, Director Decision ("AMR Director Amended Decision").

[31] A.R.S. § 36-2233(B)(2); A.A.C. R9-25-903(A)(B).

As discussed below, the evidence is overwhelming, and certainly more than meets the mere preponderance threshold that Community Ambulance met all the necessary factors for a finding of public necessity.

As the Director understands, no single factor in the public necessity analysis is determinative. "The failure to provide information or establish any one factor does not, by itself, constitute grounds to deny an application."[32] The Director considers and balances these factors in the context of the Application and the proposed service area (i.e., a sparsely populated rural services area vs. a densely populated, fast growing urban county like Maricopa County). The weight of the evidence here establishes there is a public necessity for the proposed service.

2.1. Competition serves a public necessity

Each of the Intervenor's testified and argued in their earlier successful efforts to obtain a CON (and in some instances in this case) that competition serves a public benefit.[33] More importantly, the stated position of the Director and ADHS has been and should continue to be that **competition among private providers**

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[32] AMR ALJ RD at 67:23-26, ¶11 (citing A.A.C. R9-25-903), adopted by AMR Director's Amended Decision, at 1:18-23.

[33]

- AMR advocated the benefits of competition when it applied for its CON, but now thinks the existing three providers are enough, implying the Director should shut the door. [Tr. 2064:24-25]
- ABC: Prehearing Legal Memorandum, 2012A-EMS-0101-DHS, 15:2-3; 15:24-16:1; ABC CON Hearing Transcripts, Volume 1, 10/1/2012, 2012A-EMS-0101-DHS, 289:9-291:11; CA-98.
- MA: 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.
  Q. Maricopa Ambulance believes in healthy competition amongst the ambulance providers in the system, right?
  A. That's correct. [Tr. 1695:07-23]

of ambulance service in a large market serves a public necessity.[34] Nevertheless, this well-settled issue was ignored in the Recommended Decision. But ignoring the importance of encouraging competition amongst ambulance service providers denies the public of the improved quality of ambulance service competition breeds. Economist David Argue, Ph.D. ("Dr. Argue") – whose opinion the Director agreed with in MA CON proceedings – again provided credible and enlightening testimony on the benefits realized by the patient population when there is competition in an ambulance market regulated by certificates of necessity. This evidence was not disputed:

> [T]he 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

[34] MA ALJ RD at 25:14-17, ¶19 ("Past history from the evidence that was submitted at the hearing in Case No. 2014A-EMS-0305-DHS [AMR's case] and MA's evidence that was submitted in the matter [Dr. Argue] establishes that competition among private providers of ambulance service in a large market serves a public necessity."), conclusion adopted by MA Director Decision.

force everyone to have higher quality services.[35]

If a provider is not living up to standards, healthcare systems and the public must have other options available in the marketplace.[36] This has proved true with MA recently replacing AMR as the 911 provider for several municipalities in Maricopa County, and as the preferred interfacility provider for the HonorHealth system. In fact, MA's rapid growth on the back of dissatisfaction with AMR reinforces the need for additional choice in interfacility ambulance providers in Maricopa County.

Competition serves the public need as the public policy behind HB 2569 demonstrates. It follows that competition amongst ambulance services in a large market like Maricopa County through the introduction of Community Ambulance would serve ADHS's mission to "promote, protect, and improve the health wellness of individuals and communities" in this county. [37]

2.2 The population demographics of Maricopa County favors awarding Community Ambulance a CON.

Maricopa County is growing. The evidence available at the time of the hearing was U.S. Census Bureau data as of July 1, 2017, reporting that Maricopa County has an estimated population of **4,307,033**.[38] Census figures for 2018 have recently been released and the U.S. Census Bureau reports Maricopa County is the *fastest* growing and 4th most populous county in the United States, with a current estimated population of **4,410,824**. These figures cannot be disputed. Both Hunt and O'Malley confirmed growth in Maricopa County continues apace,

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[35] Tr. 1222:10-1223:4
[36] Tr. 1208:23-1209:18
[37] AHDS Mission Statement at https://www.azdhs.gov/about.php
[38] MA ALJ RD, at 2:26 ¶2, adopted by MA Director's Decision; CA-150; this is a matter of public record of which the ALJ and ADHS can and should have taken public notice and weighs in favor of granting Community Ambulance a CON.

with the most growth being seen in the northwest and southeast portions of Maricopa County, including less densely populated areas of Maricopa County.[39] Hunt testified that based upon population data available to her that Maricopa County is seeing "2 to 3 percent cumulative growth over the next 5 to 10 years."[40] This is not in dispute.

Maricopa County "contains thousands of public and private healthcare facilities throughout the county"[41] and health systems in this county are building even more facilities to accommodate growth and an aging population. Dignity Health alone has 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 over 70 facilities and affiliated facilities located in Maricopa County.[42] Dignity Health plans to build and open several additional facilities, including a 50 bed Arizona General Hospital ("AGH") 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."[43] Hunt also testified that she is aware of plans for Dignity Facilities west or northwest of state route 303.[44] All of this was undisputed by any competent evidence.

When asked if she was aware of other health systems that are planning to

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[39] Tr. 77:18-21; 216:3-25
[40] Tr. 77:9-17
[41] MA ALJ RD, at 2:25-26, ¶2; CA-183-185, adopted by MA Director's Decision.
[42] Tr. 75:16-23; *see also* CA-28, CA-183
[43] Tr. 76:10-25; Tr. 638:1-639:23; ABC-28; CA-183
[44] Tr. 102:05-09

open new facilities in Maricopa County, Hunt testified: "[p]robably the better question is who's not going to open up more facilities."[45] 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, 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."[46]

The continued population growth across Maricopa County also includes areas of less densely populated sections of the County. Daisy Mountain Fire & Medical Fire ("Daisy Mountain") Chief Mark Nichols confirms that the community his department serves has seen continued growth over the past five (5) years.[47] Chief Nichols further testified HonorHealth's Sonoran free-standing emergency room located within that CON recently broke ground to expand into a full-service hospital.[48]

The current ambulance system is not fully meeting the current needs let alone the needs that will result from the population boom and undisputed expansion of these healthcare systems into previously less densely populated areas. O'Malley testified from AMR's own reporting data it provided to Dignity Health that the performance of existing ambulance providers gets *worse* the farther away from the city center you travel –in areas and for populations Dignity Health and other systems are trying to build healthcare services.[49] Meeting the needs of residents in these rural and less densely populated areas of Maricopa County is a significant reason awarding a CON to Community Ambulance serves

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[45] Tr. 77:22-25
[46] Tr. 77:24 – 78-3; 78:3-9
[47] Tr. 1451:9-19
[48] Tr. 1451:20-1542:03
[49] Tr. 251:18 - 252:10 (emphasis added)

the public benefit. This healthcare system expansion and continued population growth will require ambulance services and support to transport these critically vulnerable patient populations. The CON rules and regulations are designed to address the needs of these communities, and not to maximize the profitability, or protect the monopolies and territories of existing providers.

AMR's own data confirms continued growth in ambulance transports in Maricopa County since 2013.[50] There is also no dispute Maricopa County's aging population is on the rise and as this population ages, those residents require more acute levels of service.[51] 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."[52]

2.3. The Public's Best Interests are Served by Issuing a CON to Community Ambulance.

Contrary to positions taken by Intervenors, which were incorporated into the final administrative decision, there are only three ambulance providers, comprised of the Intervenors, to do the transports set forth in the Application. **The vast majority of the other CON holders in Maricopa County are public CON holders, most of whom only provide 911 ambulance service to all or part of the service area**.[53] Only a smattering of these public providers also provide interfacility and convalescent transports: Buckeye Valley Rural

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[50] 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)
[51] Tr 159:03-06; 215:13-216:13
[52] MA ALJ RD at 25:3-4, ¶17, adopted by MA Director's Decision
[53] *See e.g.* MA ALJ RD at 25:9-13, ¶18; adopted by MA Director's Decision.

Volunteer Fire District, North County Fire and Medical, Daisy Mountain, South County Fire and Medical District, and Mesa Fire and Medical Department.[54] *None of these public providers intervened to oppose Community Ambulance's Application*. In fact, a number of fire districts (including some of these listed) and municipalities, submitted letters of whole-hearted support for Community Ambulance's CON Application.[55] These fire departments cannot provide the county-wide service proposed by Community Ambulance and cannot provide an integrated county-wide system for health systems because of the geographic limitations on their interfacility CONs. Case in point, Daisy Mountain has an interfacility CON that is geographically restricted, and no Dignity Health facilities are located in its CON service area.[56]

In making these finding, the ALJ somehow dismissed the letters of support from various fire departments, fire districts, and municipalities as "form" letters, despite the fact Intervenors presented **no evidence** that any one the aforementioned community leaders did not knowingly and intentionally sign these letters of support voicing their full-throated support for Community Ambulance's Application. Such findings by the ALJ suggest these mayors and fire chiefs did not bother to read what they signed. The evidence, of course, is to the contrary. A total of six (6) Maricopa County Fire Chiefs, including the Chiefs

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[54] CON 8; CON 114; CON 105; CON 12; CON 140

[55] 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)

[56] Tr.1450:16-22; 1459:5-7; Daisy Mountain CON 105

of Phoenix Fire Department (the largest fire department in Maricopa County), Mesa Fire and Medical Department, City of Tempe Fire Medical Rescue Department, City of Chandler Fire, Health & Medical Department, Avondale Fire & Medical Department, and Daisy Mountain, a mayor (Hon. Jenn Daniels of Gilbert), and the former CEO of AGH all signed their names to letters agreeing there is a need for an additional interfacility provider in the Maricopa County service area to relieve the pressure on the 911 system and such a provider would benefit their constituency.[57]

Of course, Intervenors can provide interfacility and convalescent transports, but there are material issues and prohibitive limitations to their service the ALJ overlooked in the Recommended Decision. Certain of these CONs do not reach all of Maricopa County. MA 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). 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.[58] 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 give the public a another and better choice of ambulance service provider. Community Ambulance will also

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[57] ADHS 17-21; 23-24

[58] 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.)

be better positioned to enhance and improve interfacility service to otherwise underserved and identified rural areas of Maricopa County (as discussed below at §5). 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."[59]

2.4. A trivial financial impact on AMR weighs in favor of granting Community Ambulance a CON

Neither ABC nor MA will suffer a financial impact if Community Ambulance is granted a CON.[60] But, the ALJ generally concluded – without any apparent analysis – that there will be a financial impact on AMR. Community Ambulance asks the Director to revisit her adoption of this erroneous conclusion to the extent it is based on misleading and irrelevant evidence and fails to give proper deference to ADHS's articulation of the financial impact standard requiring evidence the incumbent will be driven out of business.[61] AMR presented no such evidence here.

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.[62] The fractional loss of

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[59] ADHS-19

[60] RD at 108:12-14

[61] *See* AM ALJ RD at 20:21-25, ¶20 ("[I]t does not appear that granting a CON to Maricopa Ambulance, without more, will drive any the current providers out of business. As noted above, protecting a current provider's monopoly is not a determinative or even a substantial factor under the current regulatory model"), adopted by MA Director's Decision at 1:16-20; ALJs' AMR ALJ RD Decision, 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."), adopted by AMR Director's Amended Decision.

[62] AMR-54 at 5

11,315 transports will have a negligible financial impact on AMR, and will not drive it out of business. AMR acknowledges – as it must – it will not go out of business or suffer a significant financial impact if Community Ambulance comes to market.

AMR's financial impact analysis, which the ALJ appears to have relied upon, must be accorded no material weight. Despite the number of transports reported in the application (11,315), AMR developed its year-one (1) financial impact analysis using its own number – 13,023 transports.[63] 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, which is irrelevant because Applicant has acknowledged it will not be providing 100% of the Dignity Health transports in Maricopa County.[64] It has never been Applicant's contention that it is or will be staffed or equipped in year one (1) to run 100% of Dignity Health transports or do more than the 11,315 transports set forth in its Application.[65]

AMR's financial impact analysis further speculates that AMR will lose 18,941 transports in year two (2) if Community Ambulance is awarded its CON.[66] Setting aside the irrelevance and speculative nature of the supposed number of transports in years subsequent to Applicant's ARCR, AMR's figure is nevertheless overstated and unreliable because it includes all of AMR's 2017 transports from a non-Dignity facility to a Dignity facility.[67] **Neither Dignity Health nor Community Ambulance has any influence or input into the**

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[63] AMR-54
[64] Tr. 924:13-22
[65] *Id.*
[66] AMR-54; Tr. 2133:3-9
[67] Tr. 2133:3-9

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.[68]

More importantly, as Community Ambulance proved in the hearing, AMR's financial impact analysis fails to acknowledge that it has already lost thousands of transports to MA[69] 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. In addition to the migration of Dignity Health transports from AMR to a less than ideal patchwork of interfacility providers, AMR is also losing multiple 911 contracts and other interfacility business to MA and other providers. These are competitive market forces at work.

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 may lose if Community Ambulance is awarded a CON is significantly less than 11,315. Meaning, 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 result in any significant adverse financial impact on AMR.

Finally, Intervenors contend the addition of Community Ambulance in Maricopa County will cause rates and charges to increase due to infrastructure redundancy. That is a bold statement considering (1) the population growth and recent increase in new health system facilities to accommodate that growth, which necessarily equates to more transports and (2) no other private ambulance

[68] Tr. 182:22-183:13
[69] MA-37; Tr. 1631:13-20

provider has applied for a general rate increase as a direct result of any new CONs being issued, including the most recent entrants, AMR, ABC, and MA, or after losing 911 contracts and the 30,000 plus transports associated with those contracts.[70] Intervenors provided no evidence to quantify any alleged financial pressure on rates or to explain why patients would be facing higher rates and charges. The evidence is to the contrary. Not only is Community Ambulance not pressing rates up, Community Ambulance has proved it can be profitable at the Phoenix Uniform Rates even without charging patients for supplies.[71] Intervenors' contentions are pure speculation, unsupported by any actual data or analysis, and should not factor into the Director's review.

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

Under the old Arizona Corporation Commission regulatory scheme, "CON applicants not only had to prove that an unmet need existed, but the current provider had to be given the right of first refusal to satisfy the unmet need."[72] A current provider's right of first refusal, however, has been abandoned and replaced by the concept of public necessity and public's best interest.[73] Unfortunately, by adopting the Recommended Decision, ADHS erroneously reverted to this rejected standard in denying Community Ambulance's application on the public necessity factor.

As the decision currently stands, ADHS is requiring that Dignity Health use

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[70] Tr. 1694:18-22

[71] ADHS-12 (Community Ambulance's Revised ARCR)

[72] MA ALJ RD at 21:15-20, adopted by MA Director's Decision.

[73] *Id*. at 21:21-25; *see also* MA ALJ RD, adopted by MA Director's Decision; AMR ALJ RD, adopted by AMR Director's Amended Decision, ALJ Decision denying ABC application, In the Matter of ABC Ambulance, 2012A-EMS-0101-DHS [CA-97].

a hodgepodge of various private and public ambulance providers throughout Maricopa County. The weight of evidence, however, establishes this hodgepodge approach is not a workable solution for Dignity Health, which "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."[74] Nor should Dignity Health be forced to take risks with the delivery of care to its patient population when it has a ready and capable partner in Community Ambulance, an ambulance provider Dignity trusts and has proven capable of delivering quality and timely system-wide care.[75] Granting the Community Ambulance CON would embrace progress, innovation, and give the residents of Maricopa County the opportunity to enjoy the fruits of integration and innovation.

The Recommended Decision and final administrative decision suggest there was no detailed evidence about the ongoing issues with AMR's failed stint as Dignity Health's primary ambulance provider.[76] Any such finding, however, is inapposite when the weight of the indisputable evidence presented is considered. Dignity Health's witnesses from Hunt to paramedic liaisons Brandon Hestand, RN ("Hestand") and Matthew Karger ("Karger"), who work in the trenches with ambulance companies every day, confirmed repeated and regular problems with AMR, underscoring the need for an integrated provider like Community Ambulance.

The testimony of Linda Hunt, for example, was taken well out of context. Intervenors asked her questions knowing she has little specific knowledge about the day-to-day transport problems and the day-to-day operations of Community

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[74] Tr. 1229:09 -1229:12
[75] Tr. 37:16-39:18; 1221:24-1222:06
[76] Recommend Decision at 19:22-20:5

Ambulance and used that testimony against Community Ambulance. As CEO of Dignity Health, Hunt is decidedly not in the trenches, but she offered undisputed evidence that there were serious problems with interfacility ambulance service.[77] Although the ALJ at first states that Hunt only had knowledge about problems in 2014-2015 (which is not accurate); the ALJ later, and inconsistently, found Hunt knew about transport problems in later years (when AMR was well entrenched as the primary provider of transports for Dignity Health.)

The testimony about problems with the interfacility transport system is abundant. O'Malley testified that Dignity Health's hospitals and facilities were experiencing significant delays. In the case of AGH, these delays were upwards of three (3) to four (4) hours long. AMR, new to the market at the time, worked with Dignity Health to develop an interfacility focused solution – one it ultimately could not deliver. Contrary to the Recommended Decision, 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.[78] AMR agreed to a one-call number and dispatch center through which Dignity Health could pick up the phone, dial one number straight to AMR. This system was a failure. AMR agreed to use other ambulance providers in the community in cases where [AMR was] not able to provide timely response or service."[79] This didn't happen. In fact, 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, [80] even though such data exists. AMR refused to stipulate to the

[77] Tr. 207:04-209:23
[78] Tr. 231:15-232:14; 242:22-244:1; 234:23-235:19
[79] CA-24; Tr. 232.6-14; 239:12-24; 240:23
[80] Tr. 240:24- 242:6

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 **"well we just call 911."**[81] How is the misuse of valuable 911 resources cost effective or good for the ambulance system?

AMR also failed to provide accurate data and reporting to Dignity Health, as it contractually agreed to do.[82] In fact, AMR continues to provide inaccurate, incomplete, error-ridden, and unhelpful data reporting to Dignity.[83] These types of data reporting problems do not exist in the partnership between Community Ambulance and Dignity Health.[84]

Moreover, AMR's ambulance performance under the preferred Customer Agreement was deficient from the outset. 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.[85] Incredulously, AMR characterized these issues as isolated problems that never resulted in adverse patient outcomes, and the ALJ seems to have bought off on that excuse. But it can't possibly be that patients – the true focus of a necessity analysis – must die or have serious complications in order to grant a CON to improve ambulance service in Maricopa County.

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[81] Tr. 241 12-15 (emphasis added)
[82] CA-24; Tr. 244:4-245:23
[83] CA-24 (Customer Agreement); CA-195 (example of inaccurate reporting); Tr. 246:01-262:12
[84] Tr. 285:12-290:24
[85] CA-232B; 233E, 233H, 233J, 233R; Tr. 277:22-10; 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.[86] The credible and competent testimony of Hestand 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.[87] Any issues that may arise with respect to private ambulance companies including patient care, transfers issues and delays, Hestand steps in. 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.[88] No one can dispute air ambulance transport costs are significantly more expensive than ground ambulance costing payors, employers, and the public more.[89]

Hestand also testified about delays in patient care when an AMR unit was diverted from an interfacility call to a 911 call, and then the 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

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[86] 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.")
[87] CA-128 (Hestand Resume); Tr. 548:9-13; 548:20-549:03
[88] Tr. 552:16-553:13
[89] Tr. 553:06-13

> 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."[90]

Hestand further testified about a July 31, 2017 email he sent to Allison Skinner of AMR[91] 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."[92] Hestand explained that there is an inherent risk "any time you fly a patient, and it's also a cost."[93]

Hestand also testified about a significant delay caused by an interfacility unit being pulled into the 911 system.[94]

> 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.[95]

AMR employee and expert Jones confirmed that interfacility transports serve as

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[90] Tr. 554:13-21
[91] CA-214
[92] Tr. 583:2-25
[93] Tr. 583:25-584:6
[94] CA-233-J; 588:20-590:5; see also 2374:1-2374:9
[95] Tr. 589:9-20

back-up to "some of our 911 systems."[96]

Hestand testified about a significant delay in transporting an urgent patient on a vent and drip because AMR dispatched an ill-equipped ambulance for that patient.[97]

> 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.**[98]

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[96] Tr. 2171:7-14
[97] CA-233H; Tr. 593:18-595:15
[98] 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,[99] 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 cannot 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[100] 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

[99] Tr. 820-20-823:24
[100] CA-233R

> unusual that a sending facility or a receiving facility will pay -- pay for that type of transport.[101]

Hestand testified about 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.[102] A stroke patient transport originating from CRMC is an *urgent* transport – and there was a 45-minute ETA for that patient.

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

> 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.[103]

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

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[101] Tr. 587:16 - 588:7
[102] Tr. 575:07-576:07
[103] Tr. 576:13 - 577:02

about a stroke patient at CRMC, a Level 1 emergency room, who required an urgent transfer to the Barrows Neurological Institute at St. Joseph's hospital, a higher level of care.[104] AMR unilaterally activated the 911 emergency system to CRMC to transfer that patient.[105]

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, an issue the ALJ seemed to have ignored in her recommended decision. 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,[106] 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.[107]

Karger, a paramedic liaison for the AGH system,[108] 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 "anywhere 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 [100] complaints [per month] regarding interfacility transports out of our

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[104] CA-233E; Tr. 561:05-22; 590:21 - 593:01
[105] Tr.592:11-593:01
[106] Tr.472:18-473:8; Tr. 473:18-474:1
[107] Tr. 473:2-17
[108] CA-175; Tr. 635:1-637:7

facilities."[109] Despite this undisputed testimony, the ALJ somehow erroneously found: "Since starting his current role at Dignity, in May 2018, Karger states he heard five to ten complaints per month about IFTs."[110]

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."[111] 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."[112]

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.[113] Karger immediately notified all AGH staff of the new policy that the 911 system was no longer to be utilized and that patients would be transferred by way of interfacility ambulances.[114]

After the policy implementation, on May 24, 2018, Karger met with AMR representatives Todd Jaramillo ("Jaramillo") and Alex Lopez to explain that AGH would "no longer be utilizing the 911 systems and that we were expecting faster

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[109] Tr. 640:2-8
[110] ALJ RD at 33:29-30
[111] Tr. 646:1-7
[112] AMR-46; Tr. 1953:10-1955:10
[113] Tr. 647:15-648:5
[114] Tr.648:13-649:08

response times."[115] Karger testified that Jaramillo was "extremely dismissive" and "didn't seem to really care too much."[116] 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 – without warning – to a freestanding emergency room in the east valley on **October 22, 2018** for a non-urgent patient, while first week of hearing for Community Ambulance's CON was under way.[117]

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 because the crew decided to take a snack break when they arrived at the facility.[118]

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.[119] 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?,"[120] despite the clear directive from ADHS not to utilize the 911 system, which Karger relayed to Jaramillo during their earlier meeting. He further testified that AMR's representatives at that meeting were dismissive of these concerns he and facility administrator Brenda Lopez raised and were "borderline aggressive."[121] As AMR's representatives, including Jaramillo, were going back

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[115] CA191; Tr. 649:12-651:21
[116] Tr. 651:14-19
[117] Tr. 661:24 – 665:02; ABC-28
[118] Tr. 659:23-660:17
[119] Tr. 651:23-655:25
[120] Tr. 652:12-19; 654:2-22
[121] Tr. 654:13-22

and forth with Karger and Lopez, 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."[122]

Though Karger would prefer not to use AMR at all, particularly in light of this June 20, 2018 meeting, AGH has no choice. MA 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 MA has a very limited presence.

2.6 ABC and MA alone also cannot meet the need

ABC admitted it cannot provide Dignity Health with the systemwide preferred interfacility provider solution it will have with Community Ambulance. Neal Thomas's testimony makes this point clear:

> "[M]y preference would not be to try to take all of [Dignity's] 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.[123]

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 in uncontested testimony:

> 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

[122] Tr. 655:4-12
[123] Tr. 1417:9-4

> 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.[124]

ABC's view is regressive and would not best serve the public benefit. Not to mention, ABC continues to resist voluntarily agreeing through its CON to arrival time standards.[125] 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, and is admittedly incapable of being the preferred provider Dignity Health needs in Maricopa County and surrounding areas.[126] Not to mention, ABC is geographically restricted through its CON from entering a number of areas in Maricopa County, including (1) Buckeye Valley Rural Volunteer Fire District and (2) North County Fire and Medical, except for the campus of Banner Del Webb Hospital.[127] These areas include the following communities: Sundad, Buckeye (which is west of State Route 303), Salome, Arlington, Hassayampa, Palo Verde, Tonopah, Wintersburg, Liberty, Rainbow Valley, Goodyear, Surprise (west of

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[124] Tr. 1213:17-1214:09

[125] Tr. 1504:05-14 (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."); *see also* ABC-89

[126] Tr. 1417:9-4

[127] ABC-1 (CON 139); Tr. 1485:4-1487:5

Citrus), Sun City West (except the campus of Del Webb Hospital), Cold Water Ranch, Wittmann, Morristown, Wickenburg, Aguila, and Sunflower.

MA 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 MA still has its limitations in its reach. Like ABC, there are geographic restrictions baked into its CON, which restrict MA from serving patient populations in (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)], which encompasses similar communities such as Wickenburg, Black Canyon City, New River, Sun Lakes, and areas west of State Route 303 where Dignity Health has indicated it plans to potentially expand.[128] Furthermore, MA has admitted it does not have a strong presence in the east valley, which has required Dignity Health continue to rely on AMR as the only real option in that part of town.[129] Couple that with the over 30,000 transports it just received by winning contracts throughout the Maricopa County and it becomes difficult to understand how the ALJ so matter-of-factly states MA can scale its operations to meet the need. The recognition that MA would have to scale its operations is further evidence that there is a need for an additional provider in Maricopa County.

2.7. A "Needs Assessment" is not a requirement for Interfacility Application.

Based on Intervenors' arguments, ADHS adopted the ALJ's denial of the Application, in part, on the basis that Community Ambulance did not obtain a

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[128] CA-43; Tr. 102:05-09

[129] Tr. 207:16-208:03; MA-39; 668:10-671:9

needs assessment.[130] This, however, is appealable error. The regulations **do not require the Director to consider a "needs assessment" for the issuance of a convalescent and interfacility only CON**.[131] Under the ambulance regulations, a "needs assessment" bears only on the Director's consideration of whether to issue a certificate of necessity to more than one ambulance service for **911 transport service**, and even then, it is not a requirement. *See* A.A.C. R9-25-903(C) (1-4). To be sure, even though AMR and MA both applied for and obtained CONs that include both interfacility and 911 service, **neither presented a needs assessment at their hearings.** That no needs assessment was obtained is entirely irrelevant for this Application and, if unchanged on review, would be another basis for appeal.

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

The ALJ failed to rule on pending objections to responses to subpoenas after Intervenors refused to provide ***any data or information*** requested through those subpoenas that would give insight into the numerous reports of inadequate performance under the Dignity Health preferred agreement. Despite the fact AMR represented that it needed to intervene to provide relevant information for the Director's consideration, AMR (and the other Intervenors) did their best to avoid doing just that. And the Director's adoption of the Recommended Decision will only encourage less transparency in the CON process, not more. This can't be the aim of the ADHS.

One of the bogus reasons AMR gave for not providing this data – and which the ALJ adopted in the Recommended Decision – is that hospital systems should

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[130] Recommended Decision at 25:1-4; 104-21-23
[131] A.A.C. R9-25-903 (B) (1-4)

be able to collect this ambulance transport data. This is simply not supported by the weight of evidence.[132] Even AMR's own in-house system status expert agrees this is the kind of data only an ambulance company would have.[133]

As a consequence, there was minimal data evidence that any one of the Intervenors had demonstrated substandard performance. But that is not dispositive of Community Ambulance's CON Application. To be sure, the Director granted MA's CON despite an express finding of no substandard performance by the incumbent CON holders.[134] That said, testimony from the hearing established that consumers of interfacility ambulance services in Maricopa County are dissatisfied with AMR's level of service and are moving business away from the company. Moreover, the data reporting AMR did produce to Dignity Health cast serious doubts about whether AMR is compliant with its CON arrival time standards on transports AMR handled for Dignity Health.[135]

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 definition of "fit and proper" set forth at A.R.S. § 36-2201(21) requires a

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[132] Tr. 2181:22-2182:25; Tr. 1686:11-1687:2.
[133] Tr.2186:09-2188:01
[134] MA ALJ RD at 11:21-12:19, ¶¶48-52, adopted by MA Director's Decision at 1:15-3:9
[135] Community Ambulance's Written Closing Argument for detailed discussion of this issue.

determination by the Director that "an applicant for a certificate of necessity … has the expertise, integrity, fiscal competence and resources to provide ambulance service in the service area." As it currently stands, by adopting the Recommended Decision, the Director's final administrative decision found that Community Ambulance has both the integrity and resources to operate an ambulance service in Maricopa County but does not have the necessary expertise or fiscal competence to operate in Arizona. These conclusions are factually and legally erroneous and are contrary to the weight of the evidence. The result deprives Maricopa County and this State's ambulance system of a *nationally* recognized and Commission on Accreditation of Ambulance Services ("CAAS") accredited ambulance service that regularly outperforms other providers and exceeds the stringent compliance standards required in Southern Nevada. Community Ambulance would bring that expertise to Arizona.

3.1. Expertise

On the issue of expertise, by adopting the Recommended Decision, the final administrative decision ignores the sheer weight of evidence establishing the vast expertise of Community Ambulance and its operators, focusing instead on irrelevant issues that cannot possibly stand as a barrier to a fit and proper finding. It is difficult to understand how a CAAS accredited ambulance service – which Chief Operations Officer of AMR, Glenn Kasprzyk, considers "the gold standard for ambulance services to achieve,"[136] run by owner/operators with nearly 70 years of combined experience as emergency medical technicians, paramedics, emergency medical service instructors, and ambulance company operators do not have the requisite expertise to operate an ambulance service in

[136] CA-163; Tr. 763:1-4; 1996:1-8

Arizona.[137]

Richardson is the Chief Executive Officer of Community Ambulance and a 50%-member of AMG, LLC ("AMG") – the minority owner of Community Ambulance.[138] Richardson has worked in emergency medical services since 1985, beginning his career as a paramedic, a certification that is still active today.[139] 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.[140] 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.[141] In 1995, Richardson was elevated to Operations Manager of American Med Tech located in Bellevue, Washington.[142]

In 2000, Richardson moved into the public sector as a firefighter and paramedic for the City of Henderson.[143] 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.[144] Richardson retired early from the Henderson Fire Department as Division Chief in 2012 to dedicate all of his time to Community Ambulance.[145]

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[137] CA-125 (Richardson resume); CA- 173 (Rogers resume)
[138] Tr.775:5-7
[139] CA-125; Tr. 737:16-738-2
[140] *Id.*; Tr. 733:22-25
[141] Tr.734:1-7-734:9-21
[142] Tr.735:7-25-736:1-13
[143] Tr. 738:20-25
[144] Tr.742:2-19
[145] 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. 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.[146]

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.[147] Richardson has also been certified in various aspects of Emergency Medical Services and regularly recognized for his exemplary service.[148]

Rogers is the Chief Operating Officer and the other 50%-member of AMG.[149] Rogers has worked in the ambulance industry for over 35 years.[150] Starting out at 18 years old as an emergency vehicle operator[151], Rogers has worked as an EMT, EMT intermediate, paramedic, and eventually became the Director of

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[146] Tr.753:2-25:754:1-25:763:5-25
[147] CA-164
[148] 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).
[149] Tr. 1254:20-1255:04
[150] CA-173
[151] Tr. 1256:01-16

Operations for an AMR company in Southern Nevada before becoming the Chief Operating Officer for Community Ambulance.[152] Rogers has effectively worked and managed every aspect of an ambulance service and has a particular expertise in system-status management and operations.[153]

In 2001, recruited by John Wilson and Bob Ramsey, Rogers helped launch Southwest Ambulance, now known as MedicWest.[154] 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.[155]

In July 2007, AMR purchased MedicWest, and by February 2008, Rogers left AMR MedicWest to join the Henderson Fire Department.[156] 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.[157] In that position, Rogers was responsible for EMS training of approximately 200 employees, including clinical education, quality assurance, quality improvement, and research.[158] In addition, Rogers acted as a liaison to the Southern Nevada Health District and as an advisor to Henderson's Fire Chief.[159] In addition, the Clark County Fire Chief tasked Rogers with

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[152] Tr.1256:01-1269:13
[153] Tr. 1297:01-1299:11
[154] Tr. 1263:5-20
[155] Tr. 1264:2-22
[156] Tr. 1264:22-1266:09
[157] Tr. 1266:10-15
[158] Tr. 1266:16-22
[159] Tr. 1266:22-1267:02

developing a system status management plan for 911 response and transport in the event AMR employees carried out their threats to strike.[160]

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.[161] 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.[162]

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.[163] Additionally, Rogers is still an active certified paramedic.[164]

Rogers has also been recognized at the county, state, and federal level for his exemplary service in EMS.[165] 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.[166]

More recently, Richardson, Rogers, and Community Ambulance's paramedics and EMTs were locally and nationally recognized for their tireless efforts during

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[160] Tr. 1267:03-10
[161] Tr. 1269:14-1271:01
[162] CA-225; Tr. 1286:05-1294:22
[163] CA-155; CA-237
[164] CA-237; Tr. 1274:15-22
[165] CA-236 (Congressional awards); CA-152 (letter of recommendation from Clark County Deputy Fire Chief, Jon C. Klassen); CA-153 (Healthcare Headliner Award)
[166] Tr. 1255:14-24

the harrowing and tragic mass-casualty event on October 1, 2017 at the Route 91 Festival in Las Vegas.[167] Not only have 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.[168] No one from AMR's operations in Nevada were asked to participate in this program.

3.1.1 Rote Memorization and Recitation of the BEMSTS Statutes and Rules is not a perquisite to a finding of expertise.

Despite the unrivaled *bona fides* of Community Ambulance and its operators' nationally recognized expertise in ambulance service, the final administrative decision adopts the Recommended Decision which appears to have found that Community Ambulance lacks expertise because its operators could not cite page, line, and verse of the controlling statutes and rules governing ambulance service in Arizona. Absolutely nowhere in the fit and proper standard, however, are operators of an ambulance company required to have the legal acumen to recite and parse the ambulance regulations and statutes – which as the Director knows is a 237 page volume.[169] ADHS/BEMSTS recognizes this reality and through the Guidance Document offers applying *and* ***existing CON holders*** "technical assistance to ambulance services in order to obtain or to amend a certificate of

[167] Tr. 1299:2-1303:22; CA-166-169
[168] Tr.1304:2-1305:6
[169] BEMSTS STATUES AND RULES, APRIL 2019, https://www.azdhs.gov/documents/preparedness/emergency-medical-services-trauma-system/statutes-rule-book.pdf.

necessity" and "created and posted a 'CON General Information and the Ambulance Revenue and Cost Report (ARCR) webinar."[170] It also ignores the testimony that Community Ambulance currently provides services pursuant to several franchise agreements in Nevada, each with its own set of particular rules and requirements, including response time tolerances similar to the current Arizona framework.[171] That Community Ambulance meets and always exceeds expectations in Nevada is ample evidence alone that Applicant is fit and proper to operate in Maricopa County.

3.1.2 Utilizing Off-Duty Firefighters to partially staff ambulances

By adopting the Recommended Decision, the final administrative decision also suggests Community Ambulance lacks expertise because it intends to hire off-duty firefighters as part of its workforce if awarded a CON. While true that off-duty firefighters are a ***part*** of the employment plan, how would these hires be problematic if the off-duty firefighters are paramedics or EMTs? It isn't. In fact, MA employs off-duty fire fighters.[172] More troubling is that the decision assumes that 100% of the ambulances Community Ambulance puts in operation will be staffed by off-duty firefighters despite undisputed testimony that part-time firefighters are just "one of the options we would like to look at."[173] 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

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[170] ADHS-15

[171] Tr. 1281:23-1282:22; 1293:01-1295:18; CA-225 (Ambulance Franchisees Performance Report – Percentage Compliance, January-December 2017)

[172] Tr. 1676:20-24

[173] Tr. 1001:13.

> 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.[174]

3.1.3 Richardson and Rogers will be actively involved in the Maricopa County operations.

Despite ample testimony to the contrary, the final administrative decision adopted the Recommended Decision's finding that Richardson and Rogers will not be running the operation in Arizona. This is wrong. The actual and undisputed evidence is that Richardson and Rogers would lead Community Ambulance's operations in Maricopa County. Rogers testified that he would be involved in all aspects of operations, including oversight of dispatch, as well as preparation of the demand analysis and system status management plan for the contemplated Maricopa County operations.[175] Richardson, in response to questions by Mr. Kevin Ray, counsel for ADHS/BEMSTS, testified as follows:

> Q. And you would be absentee managers for RBR or Community Ambulance or whoever the applicant is? You would remain in Nevada and you would hire managers in Arizona for the Arizona operation?
>
> A. The anticipation is I would be spending a lot of time down here for the operations to -- for the start-up and the oversight until we get people into position. So as a management group, that's what we would provide is the oversight to different operations. So we would do that here just like we would in Nevada.

Roger's and Richardson's testimony is entirely consistent with the Operation Plan,[176] through which Community Ambulance represents:

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[174] Tr. 823:1-824:14
[175] Tr. 1305:7-1315:14
[176] CA-149

> Robert Richardson and Brian Rogers, working closely with their consultant group EMS Advisors, will lead the operational startup.
>
> Robert Richardson plans on spending most of his time in Maricopa County with EMS Advisors to ensure a smooth and successful startup.

There is no evidence to dispute the evidence Rogers and Richardson fully intend to be present in Maricopa County, participate directly in the operations of the proposed ambulance service here in Maricopa County, and participate more broadly in Arizona's EMS community.

3.1.4 Community Ambulance has the medical oversight and clinical experience necessary to operate in Maricopa County.

By adopting the Recommended Decision, the final administrative decision also found that Community Ambulance was not fit and proper because it did not prove that it had the medical oversight or clinical experience necessary. Again, this ignores the evidence. Richardson not only discussed Anne Burns, MD, the intended Medical Director for Community Ambulance, but her resume was admitted as an exhibit in the hearing.[177] A brief review of that resume reveals an emergency medicine physician who clearly has the clinical expertise necessary to provide clinical oversight and direction. Dr. Burns has been the attending physician in the Emergency Department at Dignity Health's largest facility in Maricopa County, St. Joseph's Hospital and Medical Center ("St. Joe's"), since 2004, and the **Chairman and Medical Director of the Emergency Department** at St. Joe's since 2016. Similarly, Dr. Burns has been an attending physician at and the Medical Director of the Emergency Department at Dignity Health's Westgate hospital ("Westgate") since 2016. Dr. Burns has also been an Assistant Clinical Professor of Medicine for Creighton University School of Medicine since 2013. Intervenors offered no evidence to challenge Dr. Burns'

[177] CA-176

credentials. When you consider her other previous experience, education and training, a finding that questions her expertise and ability to provide clinical direction is inexplicable.

3.2. Community Ambulance more than established fiscal competence

The conclusion on fiscal competence is also perplexing. On this issue, the final administrative decision adopted the Recommended Decision, which vaguely concludes that because there is no evidence of the fiscal health of Community Ambulance's operations in Nevada, it did not demonstrate that it has fiscal competence.[178]

The Recommended Decision and the final administrative decision appear to have based this finding at least in part on the fact that Community Ambulance did not submit its Nevada financial statements during the Hearing. As an initial matter, those documents are not required under Arizona law. To be sure, R9-25-902(A)(3)(f) and R9-25-1101 plainly provide that an applicant for a CON – including applicants who have not yet provided ambulance services in Arizona – can submit ***either*** "a copy of the applicant's most recent financial statements ***or*** an Ambulance Revenue and Cost Report." (Emphasis added.)

It was not until after the Hearing that the Intervenors argued that the Nevada financial statements should have been provided. In response and while the record was still open, Community Ambulance submitted for the Court's consideration its most recent three-years of financial statements, including reviewed financials for 2015, and *audited* financials for 2016 and 2017. These financial statements were not even considered. Given the Court's liberal

[178] Recommended Decision at 6:21-22.

approach to evidence in this setting, the financial statements should have been admitted as evidence and the information therein should have been given substantial weight, especially the audited financials for 2016 and 2017.[179] The fact is the financial statements show quite clearly Community Ambulance is a profitable, well financed and well-run ambulance service with sufficient financial capacity and resources to operate its proposed services successfully as proposed under the revised ARCR.

Even without these financials, the weight of the evidence is contrary to the findings on this issue. Community Ambulance more than demonstrated it has "sufficient financial strength and volume of business to continue operations to provide Arizonans with reliable service."[180] Community Ambulance provided overwhelming evidence to support its fiscal competence. As an initial matter, Community Ambulance has demonstrated through substantial evidence it will realize a year one profit on 11,315 transports by over $596,924, (using Phoenix Uniform Rate Group rates) or over $742,870 if the rates proposed through the second Findings Letter are applied.[181]

Community Ambulance's majority partner, Dignity Health, continues investing in Maricopa County and its residents as demonstrated through the building of a number of new facilities to care for patients in this growing market.[182] Dignity Health currently has approximately **$1.6 billion dollars** invested in 110 different collaborative partnerships, like Community Ambulance,

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[179] The 2015 reviewed and 2016 and 2017 audited financials were submitted as Exhibit B to Applicant's Response to Intervenors' Closing Arguments, filed on February 21, 2019, OAH docket no. 167.

[180] ADHS-15 (2017 Guidance Document).

[181] ADHS- 13 Second Findings Letter

[182] Tr. 76:10-25 (development of new Dignity Facilities addressed in detail in section 3.1 below); Tr. 157:24-158:02.

throughout its system.[183] For Community Ambulance, Hunt has the independent discretion – without seeking any further corporate approval –to contribute up to **$1,000,000** to Community Ambulance operations.[184] While the Recommended Decision and final administrative decision recognized this material fact, the decisions ignored additional undisputed evidence Community Ambulance has (1) between **$500,000 and $700,000** in operating cash, which can be readily accessed for Maricopa County start-up operations and (2) **$1,700,000** in available capital lines from which to draw for its Maricopa County operations.[185] 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.

Surely, the undisputed facts that Community Ambulance has between **$500,000** and **$700,000** in available cash and banks are willing to extend **$1.7 million dollars** in credit to support its operations is indisputable evidence of a vitally healthy and fiscally competent company. To be sure, banks don't offer lines of credit to financially incompetent organizations.

3.3 Maricopa Ambulance was fit and proper despite undisputed evidence that its ownership shuttered an ambulance company without notice.

Finally, the finding that Community Ambulance and its operators are not "fit and proper" appears to be based on a heightened standard not seen before in a CON hearing. Certainly not the standard that was applied in the hearing for Maricopa Ambulance's CON. The finding is puzzling when one considers that Maricopa Ambulance and its principals were found to be "fit and proper" even though there were serious adverse facts, circumstances and allegations swirling

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[183] Tr.85:17-22.
[184] Tr. 85:17-86-13
[185] Tr.835:09-835:23

around the Maricopa Ambulance management and ownership team during and immediately after its hearing. In that case, there were serious allegations of personal misconduct, including fraud, against the individuals that testified at the hearing and the private equity fund that owned Maricopa Ambulance. In the bankruptcy proceeding, the trustee filed an adversary complaint against the FirstMed management team (substantially the same individuals that manage Maricopa Ambulance) for a (1) breach of duty of care to FirstMed entities and their creditors; (2) breach of duty of loyalty to FirstMed entities and their creditors; (3) misappropriation of corporate opportunities; (4) aiding and abetting breaches of fiduciary duties, misappropriation of corporate opportunities, conversion and fraudulent transfer; (5) respondeat superior; (6) conversion; (7) alter ego; (8) fraudulent transfer; (9) unjust enrichment, (10) constructive fraud; (11) breach of contract; (12) fraudulent misrepresentation; and (13) unfair and deceptive trade practices. The impact of the complete shuttering of the FirstMed operations without any advance notice to customers, employees or regulatory agencies was breathtaking yet not enough for ADHS to reject the CON application on the basis that the Maricopa Ambulance team was not fit and proper. Instead, it appears that heightened financial reporting requirements were imposed on Maricopa Ambulance.[186]

Here, there are no allegations of wrongdoing on the part of the principals. They have operated Community Ambulance in Nevada with year on year growth and have earned the highest honors and awards for their service. Community Ambulance is financially independent and can, but does not have to, rely on Dignity Health for financial support. Based on its ARCR, Community Ambulance shows a profit of hundreds of thousands of dollars. Witness testimony showed

[186] MA Director Decision at 7:4-22.

access to an $3,200,000 in available cash. Yet it was found not to be fit and proper because it did not provide its Nevada financials, something that is not required by Arizona law, rule or regulation. Additionally, Maricopa Ambulance was found to be fit and proper even though its ARCR only showed a net profit of $1,500 in its first year of operations. It, like Community Ambulance, had a large financial backer that could support start-up operations yet the likelihood of having to tap into that resource was much higher for Maricopa Ambulance given its scant profit in year 1. In light of Community Ambulance's ARCR, its own financial resources, as well as its ability to utilize the resources of Dignity Health makes the finding difficult to understand.

On the evidence established at hearing, there is no question Community Ambulance exceeds the fit and proper criteria required by the statute and is precisely the type of professionals Arizona should eager to attract.

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

The final administrative decision adopted the Recommended Decision's clearly erroneous finding regarding rates and charges. 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[187], and is willing to accept the financial impact, if any, of placing Community Ambulance in that rate structure.[188] It is Applicant's understanding that participation in the Phoenix Uniform Rate Group is

[187] ADHS-10; ADHS-12; ADHS-25. Current Phoenix Uniform Rate Group rates: ALS Base Rate: $952.81; BLS Base Rate: $848.73; Mileage: $19.75; Waiting Charge: $212.18. There can be no dispute these rates are just and reasonable because ADHS has approved this rate group for Intervenors MA and AMR, as well as other ambulance providers who have not intervened.
[188] Tr. 826:6-9; 832:7-18; ADHS Ex. 25; CA Ex. 9

voluntary and participation is granted by the Director so long as Applicant's financial modeling using the uniform rates continues to show sustained profitability, which Community Ambulance proved true here.[189]

Nevertheless, the final administrative decision adopts the Recommended Decision, which found "RBR did not offer an explanation of how it could successfully use the Phoenix Uniform Rate Group's rate when it does not plan to charge for supplies like other providers charge." This conclusion makes little sense in view of the ARCR.

Through the ARCR, Community Ambulance reported costs of goods sold as zero dollars ($0.00) because, unlike Intervenors, Community Ambulance is **not** charging its patients for the use of medical supplies, thus reducing overall costs to the patients.[190] As explained through its Closing Argument and as clearly set forth in the ARCRs, Applicant accurately and appropriately reported the cost of its medical supplies on its revised ARCR at page 6 under line 25 "Ambulance Supplies – Nonchargeable." Applicant's ARCR has clearly accounted for the costs of medical supplies – costs it will not recoup – and shows a more than sufficient profit from year one operations even without charging for medical supplies. This red herring issue was repeatedly espoused by Intervenors and was erroneously adopted by the Recommended Decision and final administrative decision.

Similarly, the Recommended Decision and final administrative decision – misled by Intervenors' arguments – misconstrued evidence concerning the contractual discount provided for under the anticipated customer agreement between Dignity Health and Community Ambulance and its impact on the ARCR.

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[189] Tr. 1010:8-25

[190] Tr. 826:14-16; 827:6-24; ADHS-12 at 15

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.[191] 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.[192] 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 Recommended Decision and final administrative decision appear to apply the discount to all 11,315 transports proposed by Community Ambulance in year one.

When viewed correctly, it is clear from well-established and substantial evidence the rates and charges proposed by Community Ambulance are just, reasonable, and sufficient. After dissection and analysis of the ARCR during the hearing (as set forth in Community Ambulance's Closing Written Argument at 59:6 to 62:10) if ADHS permits Community Ambulance to use the uniform rates and charges, in year one on 11,315 transports, Applicant's first-year net revenue on

[191] ADHS-1; ADHS-12; CA-17
[192] Tr. 274:20-275:6; Tr. 366:21-367:5

11,315 transports at the Phoenix Uniform Rates would still be $596,924, after taking contractual discounts and non-chargeable supplies into account.[193]

5. COMMUNITY AMBULANCE'S PROPOSED RURAL PLAN MEETS ADHS'S EXPRESSED PUBLIC POLICY AS SET FORTH IN THE GUIDANCE DOCUMENT

The ALJ's findings on the proposed rural plan misconstrues Community Ambulance's earnest proposal to ensure that ambulance service to those residing in rural and wilderness areas will not be negatively impacted by the entry of Community Ambulance but improved. Both Rogers and Richardson readily and openly acknowledged CON holders in rural areas need to be able to transport non-emergency calls to offset the 911 expense.[194]. They are sensitive to these issues because Community Ambulance provides interfacility and 911 transports in urbanized and rural services areas in Southern Nevada and understand the challenges of operating and maintaining a full ambulance service in sparsely populated rural and wilderness areas.[195] The ALJ – relying on AMR's conveniently incomplete recitation of the evidence – entirely ignored Roger's testimony 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

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[193] It is clear from previous CON hearings that mistakes in an ARCR do not preclude the Applicant from receiving a CON. MA 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. MA ALJ RD at ¶¶ 28, 30, 33, adopted by MA Director's Decision.

[194] Tr. 837:1-20; 1180:21-1181:2; 1181:5-7

[195] Tr. 837:20-20; 842:1-17

> CON holders] need those transports in order to fortify the 911 system in that rural area. [196]

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." [197]

Community Ambulance's proposed rural plan will not interfere with AMR's ongoing service to those residents and also improves service to patients residing in rural areas and communities. The plan is simple: any transports in a declared rural area, AMR would continue to provide the service unobstructed by Community Ambulance.[198] The residents in these rural areas benefit because Community Ambulance would be available to respond to any calls when the CON holder in that area (1) cannot respond to a call or (2) needs help to clear extremely long ETA's that are having an impact on patient care and welfare.[199] Glen Kasprzyk of AMR agrees this would benefit the public in those rural areas:

> 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.[200]

The rural plan ABC and MA arrived at was to simply carve out rural areas, like Wickenburg, from their CONs, which leaves AMR as the primary provider of service to those people living in rural and less densely populated areas. While that

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[196] Tr. 1180:21-1181:2; 1181:5-7
[197] Tr. 1181:13-24
[198] Tr. 1181:13-24
[199] Tr. 1181:2-5
[200] Tr. 2070:06 - 2070:12

plan conveniently ensures AMR will suffer no financial impact from other providers in the area, the carve-out method entirely ignores the needs residents of rural and less densely populated areas of Maricopa County. Community Ambulance's plan does not ignore these residents, but also respects AMR's operations in those area. That's because the Community Ambulance plan that would only be triggered if the CON Holder in the rural areas need help to transport patients.

There is little guidance in the rules, regulation and Guidance Document about what an actual rural plan should look like. But, based on what is available, it seems that Community Ambulance's plan is precisely what the Guidance Document contemplates by (1) ensuring the existing provider will continue to provide its existing service in those rural areas unabated and (2) providing an added layer of protection to vulnerable residents in those rural areas if the existing provider cannot respond to a call or needs help to clear extremely long ETA's that are having an impact on patient care and welfare.[201] Indeed, the proposed rural plan squarely addresses the public policy concerns raised in the Guidance Document and, as Dr. Argue opined, "would eliminate the possibility of cream skimming issues in rural areas."

This is what Community Ambulance credibly proposed and proved at the hearing. This plan is good for the residents of rural Maricopa County and improves the system overall without threatening in any way AMR's ability through LifeLine to continue providing services in those rural areas. If, however, ADHS still has reservations that this rural plan would negatively impact LifeLine's ability to provide service in rural and wilderness areas within Maricopa County and

[201] Tr. 1181:2-5

surrounding areas, Community Ambulance would be amenable to certain geographic restrictions in its CON to address these concerns.

6. CREAM SKIMMING AND CHERRY PICKING IS A RED HERRING THAT DOES NOT APPLY TO DENSELY POPULATED URBAN AREAS.

A corollary contention has been made that Community Ambulance is going to cherry pick transports based on its access and evaluation of patients' Protected Health Information ("PHI"). This is utterly false and quite shocking when you consider it flies in the face of Community Ambulance's commitment and adoption of Dignity Health's non-profit mission, values, and charity care initiatives.[202] Community Ambulance is committed to operate and manage its ambulance service "in a manner that furthers the existing charitable, religious and community-based healthcare purposes, mission, vision and values of [Dignity Health] by promoting health and providing or expanding access to healthcare services for a broad cross section of the community."[203] This includes a commitment to provide medical transportation services regardless of the payor source or ability to pay.[204] To cast aspersions that Dignity Health would place an ambulance service, of which it owns 50.1%, above the health and welfare of its patients is irresponsible and defamatory. The truth is all ambulance providers have access to PHI when they transport a patient.

Yet, the ALJ adopted Intervenors' false claims – without any evidence whatsoever – that Community Ambulance will screen transports that pose a risk of no reimbursement and collect 100% of its billable transports. And now the Director has adopted this same position through the final administrative decision. If this were true – which it is not and there is no evidence to suggest it is –

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[202] CA-13 (Community Ambulance Operating Agreement at §5.2)
[203] *Id.*
[204] *Id.*

Community Ambulance would have no "Bad Debt" reflected on its revised ARCR. Yet, it is clear from the revised ARCR, specifically the "Bad Debt" line item, collecting anything near 100% of billable transports is an impossibility. The lack of hard evidence to support Intervenors' false and disparaging smears and the fact that Community Ambulance fully anticipated and reported uncollectable transports in its revised ARCR, exposes this PHI-cherry picking argument for what it is – a fallacy.

When asked whether cream skimming is an issue for Community Ambulance's application, particularly in a highly populated and mostly urban service area like Maricopa County, Dr. Argue testified:

> No. I don't think it is. I think there are a couple of reasons for that. One is that, as we referred to -- as I referred to a while ago, Maricopa County is a -- is a big county. It's got 300,000 or so transports, and Community, I believe the number is 11,300 -- it's talking about 11,300 IFTs. That's 3 or 4 percent of the total, so 96, 97 percent of the total transports in the county are not affected by this arrangement here. And what that means is that the cost of serving -- of providing the -- the services for the remainder of the county are spread among large numbers of -- of transports and, you know, 911 and IFTs. And it's -- As long as those costs are spread, then the company -- adequately, then the company providing the service will continue to do it. What we don't want to have happen is the company to go out of business because so much of the cream has been skimmed away that it cannot operate. But with the -- it may be the case – it probably will be the case that the company will earn less money -- the incumbent company will earn less money. But unless that company is being pushed out of business, then there's no real impact on -- on the hospital -- I'm sorry -- on the community, in this case the patient, which is what we've got going here in Maricopa County.[205]

Of the over 300,000 transports in Maricopa County, neither MA nor AMR presented evidence to support any straight-faced argument that Community Ambulance's 11,315 transports in Maricopa County will have any negative impact

[205] Tr. 1226:16-1227:16

on its ability to provide 911 service in Maricopa County. Put simply, there are so many transports in predominantly urban Maricopa County that the small percentage of contemplated transports does not implicate cream skimming as an issue.

Furthermore, neither MA nor AMR submitted any data or statistical evidence its interfacility transports are necessarily more profitable than 911 transports. On the other hand, Mike Evans, CPA testified this is no longer the case:

> Q. Mr. McGoldrick stopped you from elaborating on reimbursements for interfacility transports versus 911 calls. Do you mind just finishing or starting over and telling us what you were about to say?
>
> A. Certainly. And I believe I've fairly summarized your question, Paul, in that you asked me whether or not I believed that reimbursement for 911 calls would be greater -- or, excuse me -- reimbursement for interfacility calls would be greater than inter- -- than 911 calls, and I said that that's historically been the conclusion by most people. But I believe that in today's environment, that may not be the case simply because interfacility transports are, if not all, nearly all nonemergent, and the reimbursement rates for Medicare for nonemergent transports are significantly less than they are for emergent transports. And with the growing Medicare population as a percentage -- excuse me – the growing number of ambulance transports as a percentage of total transports, that may -- and I believe it's not true that interfacility transports are higher simply because of the lower nonemergent Medicare allowable rates in comparison to the urgent Medicare allowable rates. The emergent would apply to 911 transports whereas nonemergent Medicare allowables apply to interfacility transports.[206]

Nor was there any data or statistical evidence that the interfacility transports have higher rates of reimbursement than 911 transports in Maricopa County. Instead, all Intervenors rely on is the opinion of Roy Ryals, who relied on no data or statistics to reach his broad conclusions on the alleged impact of cream-skimming in a densely populated county with over 300,000 transports per year. In

[206] Tr. 1110:20-1111:18; CA-132 (Evans Resume)

Community Ambulance's experience, non-911 interfacility transports are more closely scrutinized by all payors for medical necessity resulting in an increased number of payment denials.

The impact of alleged cream skimming on residents of rural areas and incumbent CON holders servicing those areas, however, is an issue of obvious concern for the Director and is an issue Community Ambulance has directly addressed in this case. The Director's public policy concerns about cream skimming as expressed through the Guidance Document are focused not on urban areas, but on residents of rural and wilderness areas.[207] Those policy concerns are largely focused on ensuring continued and improved ambulance service to individuals living in rural and wilderness areas, and safeguarding the incumbent's ability to provide service in those areas. Community Ambulance's Application and plan entirely avoids any risks to the incumbent provider in rural areas while proving back up services for the benefit of those living in rural areas and encouraging healthy competition that benefits the residents of Maricopa County living in the mostly urbanized areas of the county.[208]

7. COMMUNITY AMBULANCE'S MAPPING AND CAPABILITY TO PROVIDE THE PROPOSED SERVICE IN MARICOPA COUNTY

The Director should also be aware during the review process that the characterization of the mapping presented by Community Ambulance as "basically useless"[209] inappropriately relied on the testimony of AMR's Jones and necessarily adopts AMR's false claim that Jones "reviewed and analyzed Beery's

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[207] ADHS-15

[208] Considering AHDS (eventually) granted ABC an interfacility only CON for most of Maricopa County suggests the Director has already considered and rejected so-called cream skimming arguments for the mostly urban Maricopa County service area.

[209] RD at 68:13-17

mapping[210] and found those projections to be "overly optimistic representations," overly generous, and a "very positive outlook" of real traffic conditions. The problem, of course, is that this inappropriately argumentative "finding" contradicts Jones' own testimony and that of other witnesses. Jones testified that he did ***not*** do a thorough review and analysis of the maps created by Mr. Beery:

> Q: You did an assessment and analysis of these maps, correct?
> A: Well, in that I reviewed the documentation on the approaches taken to come up with those results and did some comparisons with our work, similar – similar type approaches. So some, yes.[211]

Relying on Jones' "analysis" is even more problematic when you understand that Jones' maps[212] and "analysis" used entirely different assumptions. Specifically, Jones' analysis was based on AMR's arbitrary assumption that Community Ambulance would be providing approximately 18,000 transports with only 4.5 ambulances.[213] This assumption is summarily disproven by the actual CON Application and undisputed witness testimony that Community Ambulance anticipates running 4.5 ambulances to perform 11,315 transports, with capacity to utilize 5 ambulances 24 hours per day, 7 days per week if necessary.[214] When pressed to give an opinion about whether Community Ambulance could do 11,315 transports with five (5) ambulances, **Jones agreed**.[215] And, he further stated that if the transports needed to "be on time" he

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[210] CA-186-189
[211] Tr. 2176:6-11
[212] CA-124 (Mapping Methodology); CA186-189 (Beery Maps)
[213] Tr. 2188:12-2189:13
[214] Intervenors mischaracterize the operating model once again even though Brian Rogers ("Rogers") clearly testified that it would run five (5) ambulances until a demand analysis is completed and Community Ambulance can accurately assess how to best meet that demand.
[215] Tr.2185:24-2186:09

would require more data - the kind of data Jones testified only an ambulance company would have (and AMR conveniently refused to produce in this case.)[216]

As Rogers testified and Intervenors' witnesses, Gibson and Jones, confirmed, without the data that AMR refused to produce, it would take approximately 20 weeks of actual transport information to be able to develop a complete demand analysis. As was clearly stated during the hearing, the mapping was only for a demonstration of availability of driving distance from post location and not meant to be any kind of a 911 or IFT plan because applicant did not have the data to conduct that level of analysis. Without that data, Beery used rush hour traffic during the week utilizing actual posted speed limits and intersection controls as well as adjusting for the fact that the ambulances would have to slow down to make turns and to stop.[217] Beery used Google maps and Waze – well accepted platforms in the industry – to determine what speeds could be expected during rush hour so that he could develop a model that was adjusted for the worst traffic that occurs each day.[218] Google maps and Waze use fixed sensors, roadway sensors, roadway cameras and crowdsourcing to predict drive times and would necessarily include areas of construction and other factors that Beery could not predict.[219] The maps that were produced are reliable predictions of drive times from the post locations identified by Applicant and show that it can cover the service area, and certainly more than handle year one transports for its only current customer, Dignity Health. Jones agrees.[220] Once a complete demand analysis could be completed, Brian Rogers testified that more reliable and

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[216] Tr.2186:09-2188:01
[217] CA-124
[218] *Id.*
[219] *Id.*
[220] Tr. 2185:24- 2186:9

accurate mapping could be developed, and operational adjustments could then be made to ensure adequate response times if such response times were problematic.

Furthermore, Community Ambulance wholeheartedly disagrees with the ALJ's universal adoption of Roy Ryals' unit hour utilization ("UHU") analysis and ultimate conclusion that Community Ambulance cannot transport 11,315 patients within the Maricopa County service area based on its operational model.

As Rogers testified, Community Ambulances is going to start with 4 ambulances 24 hours a day, seven days a week and 1 ambulance placed in service for 12 hours during high demand times. The 6th ambulance will be held in reserve. Once accurate data is collected a demand analysis will be developed and a more strategic deployment ambulance plan will be developed where ambulances are placed in service based on the actual demand analysis. However, initially based on 11,315 transports and 4.5 ambulances in service, each twelve (12) hour ambulance shift will transport between 3-4 patients for a UHU (transports / unit hours) of .287 (31/108). If we assume that each transport takes 2 hours, which is longer than Community Ambulance anticipates, the on-task time would be 6.88 hours leaving 5.11 hours available. The math is simple. Community Ambulance will successfully operate at a .287 UHU based on its over 70 years combined experience and its current operations in an expansive service area in Henderson/Las Vegas, NV where it routinely runs an average UHU of .37.

If Community Ambulance is unable to service the transports at a .287 UHU like Ryals suggests, Community Ambulance can put the 5th ambulance into 24-hour service as contemplated by its ARCR to cover the additional transports, a point that Ryals and the ALJ ignored. If all five ambulances are used, it would create 10 shifts and the UHU would drop to a .258 (31/120) UHU. This would

further reduce the number of required ambulance transports per shift, and consequently would reduce the on-task time for each ambulance allowing more available time for unexpected calls. Jones, AMR's system status management expert, agreed that 11,315 transports could be done with 5 ambulances.

8. CONCLUSION

With over 4.4 million people in Maricopa County, many of whom rely on quality ambulance service in their time of need, the urban and rural residents the CON process is designed to protect will reap the benefits from the addition of a well-qualified and dedicated interfacility ambulance provider. When weighed against the proven facts that none of the existing providers will suffer any significant financial impact if Community Ambulance is introduced into this large market, awarding a CON to Community Ambulance is in the best interests of the public. Based on the record in this proceeding and ADHS's decisional precedent in matters involving Maricopa County ambulance services, Community Ambulance respectfully requests the Director enter a Decision (1) rejecting the recommended decision and (2) granting Community Ambulance a CON to provide interfacility and convalescent transports in Maricopa County in a manner ADHS believes best serves the needs of the public

RESPECTFULLY SUBMITTED this 18th day of June, 2019.

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