**Legislative Budget and Finance Committee**

# A Performance Audit of the Emergency Medical Services Operating Fund

**Report Presentation by Elizabeth Voras, Project Manager, February 26, 2014, Meeting of the House Veterans Affairs and Emergency Preparedness Committee**

Good morning, Mr. Chairman and members of the Committee. House Resolution 2012-315 called on the LB&FC, in conjunction with the Joint State Government Commission, to study the financial and administrative effectiveness of Pennsylvania's emergency medical services system. Under HR 315, the LB&FC was responsible for reviewing the financial aspects of the Emergency Medical Services Operating Fund (EMSOF), therefore our presentation focuses on this aspect of the program. Our Committee released this report in October 2013.

Pennsylvania's EMS system receives financial assistance from the Commonwealth through an annual special fund appropriation from the EMSOF. The EMSOF receives its funding from a $10 fine assessed on all traffic violations and a $25 dollar fee assessed on all ARD (Accelerated Rehabilitation Disposition) admissions. The Pennsylvania Department of Health's Bureau of Emergency Medical Services is responsible for administering these funds, which are used to support the Commonwealth's 15 regional councils and the Pennsylvania Emergency Health Services Council, otherwise known as PEHSC. The regional councils, whose creation and duties are found in state statute, are either nonprofit organizations or units of

local government. Exhibit 9 on page 54 of the report shows the current configuration of our regional council boundaries. There are no General Funds utilized for EMS purposes in Pennsylvania except for funding the operation of the Department of Health's Bureau of EMS.

During the course of this study, we found that EMSOF funding for the Commonwealth's EMS system has been declining in recent years, from $11.3 million in FY 2007-08 to $10.0 million in FY 2011-12. This decline is primarily attributable to a decline in the revenues generated by the fines on traffic violations and fees on ARD admissions due to a steady erosion on the payment of fines by those on whom they have been assessed, particularly at the Common Pleas level. If no remedial action is taken, it is anticipated that expenditures will continue to exceed revenue for the foreseeable future, and the portion of the EMSOF fund available to emergency medical services will be nearly depleted by FY 2016-17. Several options for increasing EMSOF funding are discussed in the report, including raising the fines and fees, and establishing professional credentialing and ambulance inspection fees as many other states have done.

Our report also addresses how EMSOF funds are allocated to the various regional councils. Although Act 2009-37 requires the Department of Health to consider the availability of other funds and the priorities set forth in the statewide EMS plan when making EMSOF funding allocation decisions, we found this is not

done. Instead, the department allocates EMS funding solely on the basis of total population (50 percent), rural population (30 percent), and the EMS region's square mileage (20 percent). This formula has resulted in per capita allocations for the rural areas of the state that are three or four times that of their urban counterparts.

While there is widespread recognition that rural areas need relatively more financial assistance for emergency medical services than urban areas, we recommend the department work with its advisory council to incorporate additional factors into regional council allocation decisions. We also recommend that the department reconsider imposing restrictions on the use of income from the regional council's secondary activities, such as conferences and communications centers, as a way to help ensure that EMSOF-related funding is used only for emergency medical service purposes.

We also found that the current statewide EMS Plan, although required in statute and intended to be used to help drive funding allocation decisions, is of limited use because it does not include specific timeframes to accomplish objectives, often does not identify the parties responsible to achieve the objectives, and does not include cost estimates to achieve the plan's priorities. We recommend that the DOH and PEHSC add greater specificity (e.g., timeframes, accountability, and cost estimates) to the state EMS plan.

Since 1998, when we did our last review of the EMSOF, the regional councils have become much more dependent on EMSOF funds to cover their expenditures. Although this varies significantly from council to council, EMSOF funding now covers an average of 59.3 percent of the regional council expenditures, compared to only 29.6 percent of expenditures in 1998.

We also found that the percentage of EMSOF funds used for pre-hospital provider equipment—meaning the equipment used by ambulance companies—has decreased from 23.5 percent in FY 1997-98 to about 15 percent in FY 2011-12. The impact of this decrease may not be particularly significant, however, because state EMSOF funds comprise only a small fraction of total PA ambulance company revenues (estimated at $461 million statewide).

In FY 2011-12, the PA Emergency Health Services Council expended $491,949, or about 4.5 percent, of the total spent from the EMS portion of the EMSOF account. PEHSC is designated in law as the state's official EMS advisory council, although in recent years the department has used them primarily to help prepare the statewide EMS plan.

We found that the Bureau of EMS still maintains a manual filing system for regional EMS council records, and this lack of automation makes it difficult to monitor EMS council expenditures. We recommend that the BEMS work to computerize

EMS records, which would not only improve BEMS's ability to monitor the regional councils, but would also allow regional council staff to submit paperwork more efficiently through electronic documents. At the meeting when we released this report, Mr. Gibbons, the new Bureau director, agreed on the need to computerize these files and indicated it was one of their higher priorities.

We also found that the Department of Health does not evaluate the performance and effectiveness of the regional EMS councils on a periodic basis as required by departmental regulations. The Bureau does however appear to be doing a good job in monitoring and communicating with the regional EMS councils. We recommend that the Bureau systematically perform an in-depth review of each of the regional council's efficiency and effectiveness, perhaps on a rotating basis. The department does have the right to contract with another entity if a council's performance is deemed unsatisfactory, so this would be a meaningful exercise.

HR 315 specifically asked us to perform an analysis of the total compensation packages, including benefits, provided to employees of the regional councils and PEHSC. We found that, for the most part, the salaries and benefits the regional EMS councils and PEHSC offer their employees appeared reasonably in line with what might be expected if they were Commonwealth employees. However, there is quite a bit of variation among councils, and due to the decreasing revenue in the EMSOF fund, we recommend that DOH establish parameters on the use of EMSOF

funds for EMS council and PEHSC salaries and benefits, which now comprise about 55 percent of the councils' EMSOF expenditures (up from 43 percent in 1998).

Thank you for your attention and I would welcome any questions you may have at this time.