OAH 71-0913-35344

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE EMERGENCY MEDICAL SERVICES REGULATORY BOARD

In the Matter of the License Application of Children's Minnesota

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION

This matter came before Administrative Law Judge Jessica A. Palmer-Denig for a hearing on September 24-28, 2018. The record in this matter closed upon the filing of written closing arguments on October 15, 2018.

Gregory J. Schaefer, Assistant Attorney General, appeared on behalf of the Minnesota Emergency Medical Services Regulatory Board (Board). Gregory R. Merz, Gray, Plant, Mooty, Mooty & Bennett, P.A., appeared on behalf of Children's Minnesota (Children's). Christopher Heinze, Libby Law Office, P.A., appeared on behalf of the Minnesota Ambulance Association (MAA). Daniel D. Falknor, Dorsey & Whitney LLP, appeared on behalf of Mayo Clinic (Mayo) and Gold Cross Ambulance Service (Gold Cross). Konrad J. Friedemann and Teresa E. Knoedler, FriedemannFirm PLLC, appeared on behalf of North Memorial Health (North Memorial). Henry Parkhurst, Assistant Hennepin County Attorney, appeared on behalf of Hennepin Healthcare System, Inc. (Hennepin Healthcare). Randall S. Fischer participated on behalf of Stevens County Ambulance. Jake Howard participated on behalf of Bemidji Ambulance Service (Bemidji Ambulance). Mark Ebeling participated on behalf of Perham Area Emergency Medical Service (Perham Area EMS). James Ducharme participated on behalf of Meds-1 Ambulance Service Inc. (Meds-1).

STATEMENT OF THE ISSUES

1. Should the Board grant Children's an ambulance service license?

2. If so, should the license granted be modified in any way from the license Children's requested?

SUMMARY OF RECOMMENDATION

Based on the evidence in the hearing record, the Administrative Law Judge recommends that the Board grant Children's an ambulance service license. The Administrative Law Judge further recommends that the Board modify the license as explained herein.

FINDINGS OF FACT

I. Children's

1. Children's is a not-for-profit children's hospital with campuses in Minneapolis and St. Paul, Minnesota.[1] Children's also provides services in satellite locations and subspeciality clinics throughout the Twin Cities.[2]

2. The hospitals Children's operates are Level I trauma centers, meaning that they meet criteria established by the American College of Surgery for treating patients with the most severe injuries.[3]

3. Children's has roughly 250 physicians and 1,600 affiliated physicians, and also employs advanced practice nurses (APRNs), nurse practitioners, and neonatal nurse practitioners, as well as other healthcare professionals such as pharmacists and respiratory therapists (RTs).[4]

4. Children's draws patients from Minnesota, the Dakotas, Wisconsin, and Iowa.[5] Annually, Children's treats patients through approximately 100,000 pediatric emergency room visits, 300,000 ambulatory visits, 100,000 subspecialty visits, and roughly 14,000 to 15,000 admissions to its hospitals.[6]

5. Children's provides care to all children without regard to their ability to pay.[7] Its mission is to be an essential partner for families and to assist children by helping them to be healthy; to provide services as children grow, including by ensuring children receive the highest quality of care; and to advocate for the interests of children.[8]

6. Though there are other pediatric healthcare facilities in Minnesota, there are no other free-standing children's hospitals similar to the facilities operated by Children's.[9]

II. The Board and Regulation of Ambulance Service Licensing Generally

7. The Board regulates ambulance service licensing and operations. The Board licenses ambulance service personnel, including paramedics, emergency medical technicians (EMTs), and others.[10]

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[1] Hearing Transcript (Tr.) Volume (Vol.) I at 79-80 (Kharbanda).
[2] *Id.* at 80.
[3] *Id.* at 81-82, 135.
[4] *Id.* at 83-84.
[5] *Id.* at 84.
[6] *Id.*
[7] *Id.* at 79; Tr. Vol. V at 1136 (Hirschman).
[8] Tr. Vol. I at 79 (Kharbanda).
[9] *Id.* at 84-85.
[10] Tr. Vol. I at 30-31 (Spector); *see also* Minn. Stat. § 144E.01, subd. 6 (2018).

8. The Board licenses several different kinds of ambulance services: basic life support (BLS), advanced life support (ALS), part-time ALS, and specialized life support.[11] Each of these license classifications designates a different level of service provided; staffing and skill level requirements vary between the types of licenses, and certain medical procedures may only be performed at higher levels of licensure.[12]

9. Specialized life support services may be either basic or advanced, and are restricted by the Board to operating for less than 24 hours per day, providing services to designated segments of the population or for certain types of medical conditions, or are fixed-wing or rotor-wing air ambulance services.[13]

10. The Board also licenses scheduled ambulance services, which are basic or advanced ambulance services that operate under a schedule approved by the Board that restricts services to specified periods of time or to a specified group of people, or restricts the type of services to a specified medical category.[14]

11. The Board has authority to regulate the operations of air ambulance services in many respects, though initial licensure of those services is governed by federal law.[15]

12. Currently in Minnesota, there are 337 licensed ambulance services, including 184 BLS licenses, 5 BLS specialized licenses, 80 ALS licenses, 45 part-time ALS licenses, 15 ALS specialized licenses, and 8 air ambulance licenses.[16] There are currently 29,000 actively credentialed emergency medical services (EMS) personnel in Minnesota.[17]

13. Generally, licensed ambulance services are assigned to a primary service area (PSA), in which a particular ambulance service responds to 911 calls and may also provide interfacility transfers.[18]

14. A PSA is the geographic area that can reasonably be served by an ambulance service.[19] The Board has interpreted the statutes and rules establishing its regulatory authority to require PSAs for ambulance services that provide 911 services.[20]

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[11] Tr. Vol. I at 33-36 (Spector); *see also* Minn. Stat. § 144E.101, subd. 5 (2018).
[12] Tr. Vol. I at 33-36 (Spector); *see also* Minn. Stat. § 144E.101, subd. 6-9 (2018).
[13] Tr. Vol. I at 33-34 (Spector); *see also* Minn. Stat. § 144E.101, subd. 9.
[14] *See* Minn. Stat. § 144E.16, subd. 4 (2018); Minn. R. 4690.0100, subp. 30, .2800 (2017); *see also* Tr. Vol. V at 1240-1243 (Hirschman).
[15] Tr. Vol. I at 53, 61 (Spector); *see also* Minn. Stat. 144E.12, .121 (2018); *Hiawatha Aviation of Rochester v. Minn. Dept. of Health*, 389 N.W.2d 507 (Minn. 1986).
[16] Tr. Vol. I at 53 (Spector).
[17] *Id.* at 30.
[18] *Id.* at 36-38; Exhibit (Ex.) 137 (Minnesota PSA maps). Note that each hearing exhibit is identified by name on the first reference and, thereafter, identified only by number.
[19] Tr. Vol. I at 36 (Spector); *see also* Minn. Stat. § 144E.001, subd. 10 (2018).
[20] Tr. Vol. II at 583-584 (Spector).

The Board has granted licenses to certain basic and advanced ambulance services to operate without an established PSA.[21]

15. One statewide license for ground ambulance service exists, held by Life Link III.[22] This license is not actively used by Life Link III at this time.[23]

III. Procedural Background

16. On or about March 6, 2018, Children's submitted an application to the Board for a license to operate an ambulance service.[24]

17. The Board issued a Notice of Completed Application on March 20, 2018.[25]

18. The Board sent the Notice of Completed Application to each county board, community health board, governing body of a regional emergency medical services system designated under Minn. Stat. § 144E.50 (2018), ambulance service, and municipality in the area in which Children's would provide ambulance service.[26]

19. The Board submitted the Notice of Completed Application for publication in the *State Register* on March 20, 2018, and the notice was published in the *State Register* on March 26, 2018.[27]

20. The Board also contacted publishers of newspapers in the county seats of each Minnesota county to request publication of the Notice of Completed Application.[28]

21. The Board received 19 letters of opposition to Children's application and one letter submitting comments and questions.[29] The Board provided the letters to Children's by email on April 25, 2018.[30]

22. On April 27, 2018, Children's informed the Board that it would attempt to resolve the objections.[31]

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[21] *Id.* at 582-585.
[22] Tr. Vol. I at 71 (Spector); Tr. Vol. I at 231, 246 (Levi); *see also In re the Application of Life Link III, St. Paul, Minnesota, EMS License No. 359 to Change Their Current Schedule of Operations to Include a Substation for Ground Services in Willmar, Minn. to their Current Advanced Ambulance Specialized License,* No. 9-0900-8240-2, 1993 WL 852254 (Minn. Office Admin. Hearings Dec. 6, 1993) (discussing service provided by Life Link III).
[23] Tr. Vol. I at 74 (Spector).
[24] *Id.* at 32; Ex. 14 at ¶ 2 (Affidavit of Anthony Spector, Sept. 20, 2018); Ex. 1 (Children's License Application).
[25] Ex. 2 (Notice of Completed Application); Ex. 14 at ¶ 3, Ex. A.
[26] Tr. Vol. I at 40-41 (Spector).
[27] *Id.*; Ex. 2; Ex. 14 at ¶¶ 2-3, Exs. B, C.
[28] Tr. Vol. I at 40-41 (Spector); Ex. 14 at ¶ 5, Ex. D.
[29] Tr. Vol. I at 42-43 (Spector); Ex. 3 (letters received by the Board).
[30] Ex. 3 at 3A-3B.
[31] Tr. Vol. I at 43-44 (Spector); Ex. 4 (letter from Children's to the Board, Apr. 27, 2018).

23. On May 23, 2018, Children's notified the Board that the objections remained unresolved and requested that the Board initiate a contested case proceeding.[32]

24. The Board filed a Notice and Order for Prehearing Conference and Hearing on June 25, 2018.[33]

25. The Administrative Law Judge held a prehearing conference on July 27, 2018, at which Children's and the Board appeared.[34] On July 30, 2018, the Administrative Law Judge issued a Prehearing Order establishing the procedure and schedule for prehearing proceedings and the hearing.[35]

26. The Board issued a Notice of Public Hearing, dated August 13, 2018,[36] which was published in the *State Register* on August 20, 2018.[37]

27. On August 13, 2018, the Board sent certified letters to newspapers published in the county seats of all 87 Minnesota counties, enclosing the Notice of Public Hearing and requesting that it be published.[38]

28. The Board's letter addressed to the *Hastings Star Gazette* in Dakota County was not delivered to the newspaper.[39] The letter was not returned to the Board and the Board learned that it had not been delivered by tracking the letter.[40] The Board contacted the newspaper and arranged for two publications of the Notice of Public Hearing; the second publication occurred on September 19, 2018, which was not at least ten days before the hearing began on September 24, 2018.[41]

29. The letter addressed to the *Northern Light Region*, published in Baudette, Minnesota in Lake of the Woods County, also was not delivered.[42] The letter was not returned to the Board, and the Board learned through tracking that the letter was received at the U.S. Post Office in Baudette and processed there, but was not delivered.[43] Upon obtaining this information, the Board contacted the newspaper to arrange for publication of the Notice of Public Hearing; publication occurred once, on September 19, 2018, and there was no second publication.[44]

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[32] Tr. Vol. I at 44 (Spector); Ex. 5 (letter from Children's to the Board, May 23, 2018).
[33] *See* Notice and Order for Prehearing Conference and Hearing (June 22, 2018).
[34] Prehearing Conference Digital Recording (July 27, 2018) (on file with the Minn. Office Admin. Hearings).
[35] *See* Prehearing Order (July 30, 2018).
[36] Ex. 14 at ¶ 6, Ex. E.
[37] *Id.* at ¶ 7, Exs. F, G.
[38] Tr. Vol. I at 46 (Spector); Ex. 14 at ¶ 8, Ex. H.
[39] Tr. Vol. I at 46 (Spector); Ex. 14 at ¶ 9.
[40] Tr. Vol. I at 46 (Spector); Ex. 14 at ¶ 9.
[41] Tr. Vol. I at 46 (Spector); Ex. 14 at ¶ 9.
[42] Tr. Vol. I at 46-47 (Spector); Ex. 14 at ¶ 10.
[43] Tr. Vol. I at 47 (Spector); Ex. 14 at ¶ 10.
[44] Tr. Vol. I at 46-47 (Spector); Ex. 14 at ¶ 10.

30. The Administrative Law Judge finds that the deficiencies in publication of the Notice of Public Hearing in Dakota County and Lake of the Woods County were minor. There is no evidence in the record showing that any person was prejudiced by these deficiencies. Therefore, the Administrative Law Judge finds that the notice requirements for the hearing in this matter were satisfied in all material respects.

31. The Administrative Law Judge held a prehearing conference on September 17, 2018. All interested persons who wished to present evidence at the hearing were required to attend the prehearing conference in person.[45] If appearing in person at the prehearing conference imposed an undue burden upon any interested person, that person was permitted to submit a request for permission to appear by telephone. No person requested to appear by telephone.

32. A public hearing was held on September 24-28, 2018, at the Office of Administrative Hearings in Saint Paul, Minnesota.[46] The Board and Children's were parties to the proceeding, with the Board acting in a neutral capacity. Additionally, eight interested persons participated in the hearing: MAA; Gold Cross; North Memorial; Hennepin Healthcare; Stevens County Ambulance; Bemidji Ambulance; Perham Area EMS; and Meds-1.[47]

33. The Administrative Law Judge issued an Order for Post-Hearing Briefing on October 2, 2018, requiring that written closing arguments be filed by 4:30 p.m. on October 15, 2018, and indicating that the record would close at that time.

34. The Administrative Law Judge received written closing arguments on October 15, 2018, and the record closed on that date.[48]

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[45] *See* Prehearing Order at 2. Meds-1 did not appear at the prehearing conference, but had notified the Board that it wished to participate in these proceedings, and so the Administrative Law Judge permitted Meds-1 to participate at the hearing. *See* Ex. 11 (List of Interested Persons).

[46] Under Minn. Stat. § 144E.11, subd. 4(c) (2018), the hearing in an ambulance service licensing matter is to be held "in the municipality in which the applicant's base of operation is or will be located." As noted below, the Application identifies Minneapolis as the base of operations. Children's has facilities in the Twin Cities in both Minneapolis and St. Paul and seeks a license to provide ambulance service statewide. Additionally, no person objected to holding the hearing in St. Paul, rather than in Minneapolis. The Administrative Law Judge determines that the statutory requirement regarding the hearing location was satisfied under these circumstances.

[47] MAA filed a Petition for Intervention seeking to become a party to the proceeding. MAA's Petition for Intervention (Sept. 13, 2018). The Administrative Law Judge denied the Petition on September 19, 2018. Order Denying Petition to Intervene and Request for Continuance (Sept. 19, 2018).

[48] MAA submitted its closing argument by facsimile at 4:26 p.m. on October 15, 2018, but the filing was incomplete. MAA successfully filed a complete version of its closing argument at 4:41 p.m. on the same date, but because the filing was received after the Office of Administrative Hearings' filing deadline of 4:30 p.m., the complete closing argument is considered filed the following day. Based on MAA's clear attempt to file the document prior to the deadline, the Administrative Law Judge has considered MAA's closing argument timely filed and as part of the record.

IV. Ambulance Care Provided by Children's

A. Children's Collaboration with Licensed Services

35. Children's began providing transport care to neonatal patients more than 30 years ago, and 7 or 8 years ago it began staffing these transports with a dedicated team.[49] Neonates are any baby born preterm or at term through 1 month or 30 days of age.[50] A baby born at less than 37 weeks is preterm.[51]

36. Children's receives requests to provide neonatal transfers for babies that need a higher level of care than can be provided in their original facility, or because the baby needs treatment such as surgical procedures, IV access, a breathing tube, or mechanical ventilation management.[52]

37. For some time, Children's provided neonatal ground transport care through a collaboration with Life Link III, but several years ago Life Link III determined it would no longer provide statewide ground transport services.[53] Children's had a very short time to find an alternative partner through which to provide its services.[54]

38. Children's then entered into a collaboration agreement with Allina Health Emergency Medical Services (Allina) to provide transport care services.[55]

39. Under the agreement between Children's and Allina, Allina provides an ambulance crew, dispatch services, and regulatory oversight.[56] Allina trains its crew and provides one or two paramedics, or one paramedic and one EMT, while Children's trains and provides its medical care personnel.[57]

40. Allina staff drive the trucks and Allina selects the staff members it provides for the rigs; these Allina staff members have not participated in the training required by Children's and are not within Children's oversight.[58]

41. During ambulance runs handled jointly, Allina bills for the transportation services and Children's bills for professional services rendered during transport.[59]

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[49] Tr. Vol. II at 367 (Lampland).
[50] *Id.* at 332.
[51] *Id.*
[52] *Id.* at 333-334.
[53] Tr. Vol. I at 152 (Hirschman); Tr. Vol. I at 246 (Levi).
[54] Tr. Vol. I at 153 (Hirschman).
[55] Ex. 104 (Neonatal/Pediatric Intensive Care Transportation Collaboration Agreement).
[56] Tr. Vol. I at 151 (Hirschman).
[57] *Id*.
[58] Tr. Vol. I at 195 (Hirschman); Tr. Vol. I at 313 (Trocke).
[59] Tr. Vol. I at 187 (Hirschman).

42. Under the current agreement, when a call for service comes in, it may take 35 minutes for the Allina team to get to Children's and another 10 minutes to assemble the team from Children's, leading to a delay in providing the requested service.[60]

43. The collaboration agreement between Children's and Allina may be terminated by either party.[61]

44. Because Children's is not a licensed provider of ambulance services, it is not directly regulated by the Board.[62]

45. Allina did not participate in this proceeding, but it has been supportive of Children's decision to seek its own license.[63]

B. Children's Considers Whether to Change its Model for Providing Transport Care

46. Approximately three years ago, Children's began considering whether to change the way in which it provides transport services and to apply for an ambulance service license.[64] The process was started by the chief executive officer, chief nursing officer, and chief medical officer of Children's.[65]

47. Children's sought to determine whether a gap in service existed in the provision of ambulance service to children.[66] Children's reviewed its own internal data reporting system, spoke to other colleagues around the country, and conducted a literature review.[67]

48. During the literature review, a team at Children's collected peer-reviewed articles published over 25 years addressing issues related to specialized versus non-specialized interfacility transport in the United States and Europe.[68]

49. Children's reviewed whether a gap in care existed between certain types of facilities, if research was evolving on the provision of ambulance care to children, what the reasons for any differential in care might be, whether biomechanical differences impacted care, and the type of care providers that would provide the best services.[69]

50. Children's determined it could identify a gap in service relating to the knowledge that a provider might have regarding medical conditions that children

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[60] Tr. Vol. I at 302-303 (Trocke); *see also* Tr. Vol. II at 368 (Lampland).
[61] Tr. Vol. II at 404 (Maslonka).
[62] Tr. Vol. I at 158-159 (Hirschman).
[63] *Id.* at 158; Tr. Vol. I at 235 (Levi).
[64] Tr. Vol. I at 85-86 (Kharbanda).
[65] *Id.* at 86.
[66] *Id*. at 86-87.
[67] *Id.* at 87.
[68] *Id.* at 95, 122, 126; Ex. 1 at 1FF; Ex. 100 (Literature Summary and Articles Reviewed).
[69] Tr. Vol. I at 87-88 (Kharbanda).

experience, as well as a procedural gap based on the skill and experience providers had with performing procedures on children.[70] Children's believed that transporting children as quickly as possible from one place to another did not always result in the best outcomes.[71]

51. Children's also determined that a movement had developed toward using specialized teams of providers dedicated to providing medical care to children.[72] Children's believed that differences in care resulted from providers' lack of experience and exposure to children's medical issues.[73]

52. Children's examined statistics regarding the percentage of ground ambulance transfers that are involved in motor vehicle accidents, learning that 20 to 30 percent of EMS providers indicate that they have been involved in some type of accident over the course of their careers.[74] Children's considered appropriate restraint systems for children and biomechanical modifications to ambulances that would best suit children.[75]

53. Children's also reviewed guidelines from the American Academy of Pediatrics (AAP) regarding the mix of providers, and determined the best care for children would be provided by specialized transport teams of individuals who had experience performing procedures on and treating children.[76] The AAP guidelines establish recommendations for leadership and staff, training, and equipment for transport of pediatric and neonatal patients.[77]

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[70] *Id.* at 88-89.
[71] *Id.*
[72] *Id.* at 89-90; *see also* Tr. Vol. II at 529-539 (Sittig) (discussing the need for specialized service for neonatal and pediatric patients due to their different physiologic norms, heart rate, blood pressure, respiratory rate, and different physiologic conditions, and explaining exhibits 106 through 109); Ex. 106 (Orr, R., et al., *Pediatric Specialized Transport Teams are Associated with Improved Outcomes*); Ex. 107 (Duby, R., et al., *Safety Events in High Risk Prehospital Neonatal Calls*); Ex. 108 (Bingham, B. et al.. *Patient Safety in Emergency Medical Services: A Systematic Review of the Literature*); Ex. 109 (Hansen, M., et al., *Pediatric Airway Management and Prehospital Patient Safety: Results of a National Delphi Survey by the Children's Safety Initiative – Emergency Medical Services for Children*).
[73] Tr. Vol. I at 90-91 (Kharbanda).
[74] *Id.* at 91-92.
[75] *Id.* at 92.
[76] *Id.* at 93.
[77] Tr. Vol. II at 544-545 (Sittig).

54. Children's was motivated to extend its hospital care to children in rural areas of Minnesota.[78] For patients without ready access to the hospitals operated by Children's in the Twin Cities, Children's wished to extend access to subspecialists and intensive care level equipment and procedures so that such care could be provided to children en route to a facility.[79]

55. Children's determined that there were more than 80 specialized neonatal and pediatric transport teams operating in virtually every state.[80] Children's specifically examined the services provided by children's health care facilities in Milwaukee, Boston, Denver, Philadelphia, and Iowa City.[81]

C. Children's Adopts a New Model for Its Transport Services

56. Based on the factors it considered, Children's decided to move forward with a new model for its transport services.[82] In designing the specific service it would offer, Children's visited programs in other states to learn about their operations, including programs in Ohio, Washington, D.C., Kansas, Iowa, Florida, Texas, California, and Colorado.[83]

1. Staffing

57. Children's determined it would staff ambulance teams with nurse practitioners and RTs.[84] Children's chose to use nurse practitioners because they have significant training, they are licensed independent providers who can analyze data independently and act on that data, and they can provide care similar to that provided by a physician.[85] Children's chose to use RTs on its teams to enhance airway management for patients to address breathing problems.[86] Other staff on the teams are a paramedic and an EMT.[87]

58. Children's selected staff members for the teams who had experience in critical care working as nurses in intensive care unit (ICU) settings.[88] Some also had

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[78] *Id.* at 102 (Kharbanda).
[79] *Id.* at 101-102 ("So our hope is that when we go to those facilities we are brin[g]ing all of Children's expertise to their doorstep to help with their most critically ill kids, that we begin the care at that point, and that so when they get to Children's that care is already rendered and it will facilitate a higher quality of care overall, meaning they will leave the ICU quicker, there will be less antibiotic switches, there will be less complications in terms of the endotracheal tube being removed, and hopefully, what the literature would say, the patients would survive at a higher rate.")
[80] Tr. Vol. I at 107 (Kharbanda); Tr. Vol. I at 285 (Trocke); Ex. 131 (AAP Section of Transport Medicine Pediatric/Neonatal Transport Team Database).
[81] Tr. Vol. I at 147 (Kharbanda).
[82] *Id.* at 97-99 (Kharbanda).
[83] Tr. Vol. I at 203 (Hirschman); Tr. Vol. I at 270-271, 284-285 (Trocke).
[84] Tr. Vol. I at 98-99 (Kharbanda); Tr. Vol. I at 174-176 (Hirschman); Tr. Vol. II at 339-340 (Lampland).
[85] Tr. Vol. I at 174-175 (Hirschman); Tr. Vol. V at 1097 (Hirschman).
[86] Tr. Vol. I at 176-177 (Hirschman).
[87] Tr. Vol. I at 258 (Levi).
[88] Tr. Vol. I at 175 (Hirschman)

transport experience, including one staff person with more than 10 years of transport experience and another with 4 to 5 years of transport experience.[89]

59. The nurse practitioners Children's uses for transport teams are required to have critical care certification, such that they have completed nursing school and APRN schooling, and have spent time working in the ICU.[90] They further participate in a mentorship program, during which they rotate through the pediatric ICU (PICU), pediatric trauma program, pediatric emergency department, and operating rooms.[91]

60. Children's built on the existing training and experience of its transport team members by providing them with 16 to 18 months of additional training and extensive practice opportunities to build their skills in managing conditions in a transport setting.[92] Children's has established defined minimum competencies for transport staff based on the AAP guidelines for the number of intubations they perform and placement of central lines.[93] Training for team members is ongoing, including training on all aspects of airway care, circulation, insertion of chest tubes, insertion of IV catheters under ultrasound guidance, and other procedures.[94]

61. Before going on transport runs, team members participate in practice runs and simulation-based testing, and complete a written test.[95]

62. Staff members who serve on transport teams are also trained to service the ambulances.[96]

63. Children's uses dedicated transport teams, meaning that a team is available 24 hours per day and 7 days per week.[97] When the teams are scheduled for transport duty, they are not managing patients in the ICU.[98] When team members are not assigned to transport duties, they work in Children's neonatal ICU (NICU) and PICU units.[99]

64. Children's has three crews who are available to provide neonatal transports, and has managed to provide a fourth crew when needed on rare occasions.[100] Children's has one pediatric transport crew on standby and a second crew that is available on call.[101]

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[89] *Id.*
[90] *Id.* at 142 (Kharbanda).
[91] *Id.* at 142-143.
[92] Tr. Vol. I at 175-176 (Hirschman); Tr. Vol. V at 1089-1091 (Hirschman).
[93] Tr. Vol. I at 143 (Kharbanda); *see also* Tr. Vol. I at 277 (Trocke); Ex. 136 (Children's Training Competencies).
[94] Tr. Vol. I at 178 (Hirschman); *see also id*. at 220.
[95] Tr. Vol. I at 145 (Kharbanda).
[96] *Id.* at 144.
[97] Tr. Vol. II at 334 (Lampland).
[98] Tr. Vol. V at 1244-1245 (Hirschman).
[99] Tr. Vol. II at 334-335 (Lampland); *see also* Tr. Vol. II at 385-386 (Maslonka).
[100] Tr. Vol. V at 1098 (Hirschman).
[101] *Id*. at 1099.

65. When team members are not assigned to transport duties, they work in Children's NICU and PICU units.[102]

66. Children's staffs its rigs with the goal that low volume, high risk events will be easier to manage because team members perform necessary procedures routinely, and not sporadically, and team members are trained to operate with standardized rigs and procedures.[103]

67. Staff on the transport team are focused exclusively on care for neonatal and pediatric patients; Children's believes the familiarity of the team members with the different physiological needs of children, and their familiarity with disease process and management in children, optimizes patient outcomes.[104]

2. Ambulances and Equipment

68. Children's determined it would offer ground transport, rather than beginning a flight service, because weather can make the availability of air transport unpredictable.[105] Additionally, aircraft are limited in space and configuration, and in the number of staff that they can hold.[106]

69. Children's provides transport services by air in collaboration with Life Link III.[107] Children's receives patients for medical care by air and will continue doing so if its application is granted.[108] Children's does not intend for its ground service to take the place of air ambulance services.[109]

70. Children's purchased two ambulances, both of which are 2017 Kenworth T270s.[110] Children's used an advisory group to design the ambulances in accordance with patient needs, considering input from the NICU, PICU, cardiovascular ICU, and emergency department to determine the scope of care to be provided to patients during transport.[111]

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[102] Tr. Vol. II at 334-335 (Lampland); *see also* Tr. Vol. II at 385-386 (Maslonka).
[103] Tr. Vol. II at 335-336 (Lampland) ("Every second that you can't intervene or are looking for equipment that you can't find or are looking at med doses that you didn't know off the top of your head, that is the baby's body going downhill; and having a team that always knows exactly where everything is and does this on a day-to-day basis can deliver that more effectively."); *see also* Tr. Vol. II at 385 (Maslonka).
[104] Tr. Vol. I at 177 (Hirschman); Tr. Vol. II at 386 (Maslonka).
[105] Tr. Vol. I at 141 (Kharbanda).
[106] Tr. Vol. II at 338 (Lampland).
[107] *Id.*
[108] *Id.* at 376.
[109] Tr. Vol. I at 162 (Hirschman); Tr. Vol. II at 376 (Lampland) (Q: "Doctor, if it's in the best interests of a patient to be transported via air, considering the time, the special needs of the patient, the ability to deliver care more quickly, would it be Children's insisting that that patient be transported via its ground rigs as opposed to air?" A: "No, we always prioritize the patient in expediting the patient's care, but there [are] multiple variables that to play into that decision.").
[110] Ex. 1 at 1H; Ex. 101 (ambulance photographs).
[111] Tr. Vol. I at 166-167 (Hirschman).

71. Children's placed the rigs into service in approximately March 2018.[112]

72. Children's designed the ambulances to provide as close to an ICU level of care as possible during transport.[113] Children's seeks to initiate hospital-level care at the referring institution rather than waiting until the child arrives at Children's.[114]

73. Children's selected a variety of equipment for its rigs to meet this purpose.[115] Its equipment is stored in the trucks and in bags, ready to go when a call for service is received.[116] Children's brings its full complement of equipment on each run in the event that they arrive and discover a patient has a condition that they were unaware of or whose condition has worsened.[117]

74. The babies Children's transports have specific health concerns that require special equipment and procedures. In the first month, babies have issues with thermal regulation, which is the ability to control their own body temperature.[118] Preterm babies have an inability to control their respiratory drive, thermal regulation, blood pressure, or heart rate, because they were born too early and their organs are not fully functioning.[119] They may weigh less than one pound and be actively dying, or may have bowels that are not enclosed within their abdomens.[120]

75. Because premature or small newborn babies are at significant risk for temperature instability, Children's designed its rigs to have standard heat, along with a backup system that will run even when the engine is not running, and a third heating mechanism to provide heat if the ambulance will be off for a lengthy period or overnight.[121]

76. Neonates are impacted by noise, vibration, and light, because these inputs increase a baby's stress response.[122] Children's has developed an isolette, together with Bose Corporation and the University of Washington in Seattle, that attenuates close to 90 percent of the vibrations for neonates.[123] The isolettes are actively warmed by self-contained battery power.[124] Children's also uses a stabilizing stretcher.[125]

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[112] *Id.* at 200; Tr. Vol. I at 281-282 (Trocke).
[113] Tr. Vol. I at 167 (Hirschman); Tr. Vol. II at 335, 337, 365 (Lampland); Tr. Vol. V at 1095, 1127 (Hirschman).
[114] Tr. Vol. I at 182 (Hirschman); Tr. Vol. II at 382 (Maslonka).
[115] *See* Ex. 135 (Children's Equipment List).
[116] Tr. Vol. I at 303-304 (Trocke).
[117] *Id.* at 304.
[118] Tr. Vol. I at 333 (Lampland).
[119] *Id.*
[120] *Id.* at 363.
[121] Tr. Vol. I at 168 (Hirschman).
[122] *Id.* at 222-223.
[123] *Id.*; Tr. Vol. V at 1119-1120 (Hirschman).
[124] Tr. Vol. V at 1117-1118, 1209-1210 (Hirschman).
[125] *Id.* at 1118.

77. One of the ambulances is designed to transport two patients at one time in the event that twin newborns require NICU care.[126] This ambulance is able to transport both neonates with separate transport teams so that each baby has its own RT and neonatal nurse practitioner.[127]

78. The other rig is designed to transport patients needing a left ventricular assistance device, or LVAD, which is a heart bypass machine.[128]

79. Equipment for pediatric transport is sized differently than for transport of an adult.[129] A child's airway is smaller, shorter, and narrower than that of an adult.[130] The ambulances carry the same type of equipment for managing pediatric airways that Children's stocks in its emergency department, including fiberoptic laryngoscopes, video laryngoscopes, and other equipment and supplies.[131] The ambulances can also deliver high frequency ventilation to neonates.[132] Additionally, the ambulances carry RAM cannulas, which can deliver continuous positive airway pressure, potentially avoiding the need for an intubation.[133]

80. The ambulances can provide extracorporeal membrane oxygenation (ECMO), a technique that allows oxygenation of the blood via an external machine for patients whose lungs are not functioning.[134]

81. The rigs carry ultrasound equipment of the same type available in the ICU at Children's.[135] The transport team can also conduct laboratory testing onboard the ambulance as is necessary to stabilize and resuscitate a patient.[136]

82. The rigs have medical gases, including a large supply of oxygen suitable for longer transports, compressed air for an ECMO transport, heliox to be used for patients who have respiratory difficulties, asthma, or an airway obstruction, and which may prevent intubation, and inhaled nitric oxide for pulmonary issues and vasodilation.[137] The ambulances also have a blender that allows blending of oxygen to a certain percentage depending on the needs of the patient.[138]

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[126] Tr. Vol. I at 172 (Hirschman).
[127] *Id.*
[128] Tr. Vol. I at 297, 300-301 (Trocke).
[129] Tr. Vol. II at 382-383 (Maslonka).
[130] Tr. Vol. I at 181 (Hirschman).
[131] Tr. Vol. I at 220.
[132] Tr. Vol. I at 276 (Trocke).
[133] *Id.*
[134] Tr. Vol. I at 103 (Kharbanda).
[135] Tr. Vol. V at 1111, 1150 (Hirschman).
[136] *Id.* at 1150.
[137] Tr. Vol. I at 169 (Hirschman); Tr. Vol. I at 275 (Trocke); *see also* Tr. Vol. V at 1102 (Hirschman) (discussing heliox and heliox tanks).
[138] Tr. Vol. I at 275 (Trocke); Tr. Vol. V at 1101, 1107-1108 (Hirschman).

83. The ambulances contain a refrigerated cabinet and a warmer to warm fluids and blankets.[139]

84. The two ambulances are large enough to transport families.[140] There are four seats in the main cab of the ambulance so that patients' families are able to travel in forward-facing seats with standard seat belts.[141]

85. Children's selected the size of ambulance it uses to accommodate the equipment necessary for the service it provides.[142] The two ambulances are too large to fit into the facilities at some locations around the state.[143] Children's modified its ambulance garage to accommodate the vehicles.[144] Children's operated with the assumption that the rigs would not fit at any other facilities and designed its service around this issue.[145]

3. Telemedicine

86. The ambulances have telemedicine capability, allowing providers in the ambulances to connect via satellite or cellular phone to Children's hospitals and providers in the Twin Cities.[146]

87. By using telemedicine in the rigs, Children's is able to connect with specialized providers during transport to commence specialty care earlier.[147]

88. To ensure that it can maintain a connection for telemedicine, Children's obtained SIM cards from different cellular providers, including AT&T, Verizon, Sprint, and T-Mobile, so that the team can find the strongest signal as the rigs travel.[148] Children's drove around Minnesota testing the signal and have not identified an area in which they were unable to receive a signal.[149]

4. Quality of Care Analysis

89. Children's utilizes Ground and Air Medical Quality Transport (GAMUT) metrics, developed by the AAP and transport agencies, to measure the quality of care provided to patients and to determine quantifiable outcomes based on the quality of care.[150]

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[139] Tr. Vol. I 173 (Hirschman).
[140] *Id.* at 171.
[141] *Id.*
[142] Tr. Vol. V at 1207-1208 (Hirschman).
[143] *Id.* at 1124; Tr. Vol. II at 489-491 (Ducharme).
[144] Tr. Vol. I at 284, 300 (Trocke).
[145] Tr. Vol. V at 1124, 1208 (Hirschman).
[146] Tr. Vol. I at 104 (Kharbanda).
[147] Tr. Vol. I at 276 (Trocke).
[148] *Id.* at 292-293.
[149] *Id.* at 293-294.
[150] Tr. Vol. V at 1133-1134 (Hirschman).

90. Children's also performs case reviews, but unlike a case review, the GAMUT analysis allows Children's to assess specific quality measures regarding timing of services and procedures performed.[151]

D. Requests for Ambulance Care and Number of Transports

91. The process for a transport by Children's begins with a referral from a provider; the provider contacts Children's and, if the child will be transported to Children's, an accepting provider at Children's is designated.[152] The patient's referring health care provider determines where the child will go and determines the method of transport.[153]

92. The majority of patients Children's transports are brought to its own hospitals at the request of the referring physician.[154]

93. Children's uses its service to transport children to facilities other than its own.[155] Examples of instances when Children's will transport to another facility include a patient whose referring physician believes that a patient is best served by a burn center, or if a limb reattachment is required the patient will be transported to North Memorial.[156]

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[151] *Id.* at 1134-1135.

[152] Tr. Vol. I at 154 (Hirschman); Tr. Vol. I at 281 (Trocke).

[153] Tr. Vol. I at 153, 155, 163 (Hirschman); *see also id.* at 162 ("…when we receive a call from a referring facility, the provider making the telephone call is the one who determines the patient's needs. . . . We can explain the services that we provide, the provider can then decide whether the services are applicable for the patient that they are acutely managing. So they are best able to define whether the patient needs our services.").

[154] Tr. Vol. I at 153, 208 (Hirschman); Tr. Vol. II at 351-352, 356, 357-358 (Lampland); *see also id.* at 356 ("If the request from the provider who calls us to transport a baby is to transport them to Children's, we transport them to Children's."); Tr. Vol. V at 1142-1143 (Hirschman) (noting established referral patterns regarding NICU transfers and that "if they're calling us, most of the time they want the patient to be transferred to us."); *see also id.* at 1248.

[155] *See* Tr. Vol. I at 120 (Kharbanda) ("I personally as the chief of critical care would have no objection if they went to a local facility if they didn't need our care. I don't think there is any reason that they have to be brought back to Children's."); Tr. Vol. I at 153 (Hirschman) ("It's a medical [service] that we provide, and we would provide that service to any patient who would benefit from the service."); Tr. Vol. I at 252 (Levi) ("…we would take that patient to the most appropriate place, and there could be times where that is not going to be Children's."); Tr. Vol. I at 281-281 (Trocke) (Q: "If a child is picked up by Children's Minnesota's transport, will that child always end up at a Children's Minnesota hospital?" A: "No." Q: "How do you know that?" A: "You could look at our current practice and know that that is not the case. We do interfacility runs for HealthEast now where we pick up a child from one HealthEast hospital and drop the patient off at another HealthEast hospital. We transfer children that need transplant to Masonic. Hennepin County has their hyperbaric chamber so we have delivered patients for hyperbaric treatment to Hennepin County. Also eye care at Hennepin County. So we really do get the child to the specialty center that they need to get to like we do now."); *see id.* at 296 ("…our mission is to take care of the kids of Minnesota, and if that means that we transport a patient to Masonic for transplant, then we transport a child to Masonic for transplant."); *see also* Tr. Vol. II at 357 (Lampland); Tr. Vol. II at 395-396 (Maslonka).

[156] Tr. Vol. I at 207 (Hirschman).

94. Children's has received requests to provide pediatric transport services from several entities that object to its license application.[157] Between April 2018 and September 2018, Children's received two requests from Gold Cross, three requests from North Memorial, and ten requests from Hennepin Healthcare to transport patients using Children's rigs and services.[158]

95. Children's tracks the instances in which it is not able to provide transport and has never declined transport based on whether the patient will receive care somewhere other than at Children's.[159]

96. Children's provided care on 599 neonatal transports in 2016, 552 such transports in 2017, and had provided 370 neonatal transports in 2018 as of September 20, 2018.[160]

97. Children's began performing pediatric specialized runs in March 2018.[161] As of September 20, 2018, Children's provided care on 52 non-neonatal transports.[162] As of the hearing in this matter, it had performed one additional pediatric run, for a total of 53 such transports.[163] Approximately 15 of those pediatric patients were taken to a hospital other than Children's.[164]

98. Children's expects the number of transports it provides will be relatively stable from year to year.[165]

V. Children's Requests its Own License to Provide Ambulance Services

99. Children's seeks an ALS specialized license to operate an ambulance service statewide, with a base of operations in Minneapolis, Minnesota.[166]

100. Children's does not seek licensure to provide 911 response services.[167]

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[157] Tr. Vol. I at 278 (Trocke).
[158] *Id.* at 278; Ex. 134 (CHC PICU Transport Service Team).
[159] Tr. Vol. I at 209 (Hirshman).
[160] Ex. 13 at 13A (Children's Minnesota Response to EMSRB's First Set of Requests for Production).
[161] Tr. Vol. I at 281-282 (Trocke); Tr. Vol. V at 1225 (Hirschman).
[162] Ex. 13 at 13B.
[163] Tr. Vol. I at 281-282 (Trocke).
[164] Tr. Vol. V at 1143 (Hirschman).
[165] Tr. Vol. I at 137 (Kharbanda); Tr. Vol. II at 350-351 (Lampland).
[166] Ex. 1 at 1A.
[167] Tr. Vol. I at 105-106 (Kharbanda); Ex. 1 at 1F.

101. Children's plans to provide interfacility transport services to children, including neonatal and pediatric patients, who have conditions requiring transport of the type Children's currently provides.[168]

102. Children's identifies the parameters of its proposed transport population as follows:

> Children's Minnesota is applying for a state-wide license for specific, specialized services: inter-facility (not 911 scene response) transport dedicated to neonatal and pediatric patients (as those terms are defined by the American Academy of Pediatrics) including a tiny subset of older patients with pediatric conditions such as congenital heart defects.[169]

103. Children's does not use the terms "critical care" or ICU to define its potential patient population for transports.[170] In some instances, the term "critical care" is used to describe the level of care that such children need. For example, Children's identifies its ambulances as "critical care" ambulances, and its physicians may be board certified in "critical care."[171] However, Children's did not use this term in its application because the term "critical care patient" does not have a generally accepted meaning in the medical community.[172] The same issue is true for the term ICU and Children's felt it would be difficult to be compliant in its operations using this terminology.[173]

104. Children's anticipates its service will be used to transport children who "require a mobile ICU," and not children "who do not need subspecialized critical care type management."[174]

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[168] Tr. Vol. I at 112 (Kharbanda), *see also id.* at 131 ("…we wouldn't be doing this for every patient. This is for a select group of the sickest kids who need our help."); Tr. Vol. V at 1126 (Hirschman) ("Our intent is to provide services to pediatric patients of all ages, and as we've stated in our application, the rare, highly unusual older patient who has a pediatric-specific condition that we can address, who have unique needs for our services, which services are not currently being provided by other available EMS services locally.")

[169] Ex. 1 at 1CC.

[170] *Id.*

[171] Tr. Vol. I at 115 (Kharbanda).

[172] *Id.* at 115-116; Tr. Vol. I at 161-162 (Hirschman); Ex. 13 at 13C; *see also* Tr. Vol. IV at 1011 (Lyng) (Q: "Are you aware of any regulatory definition of the phrase "critical care?" A: "There is no such regulatory definition in the state of Minnesota under the EMSRB that defines critical care currently.")

[173] Tr. Vol. I at 161-162 (Hirschman); Tr. Vol. V at 1244 (Hirschman) ("…there's no consensus definition of or acceptable standard definition of ICU coverage. In our discussions with other EMS medical directors, they have indicated variable interpretations of what critical care means that was difficult to then implement. So if we accepted any such definition, then every patient that we carried would be subject to scrutiny and concern from the same directors.")

[174] Tr. Vol. I at 112 (Kharbanda); Tr. Vol. I at 183 (Hirschman) ("our transport program will be a limited resource, and it has to be used properly otherwise it will not be available for the patients who need it. Additionally, we would not be able to provide routine or non-critical care type of services or non-Children's specific types of services to all patients. So a patient with a fractured ankle, for example, who is being transported would not typically benefit from our specific services except for in some special circumstances.").

105. Children's also anticipates providing services to adult patients with pediatric conditions, but the number of individuals in this category is so small that Children's usually sees only one or two such patients per year in its emergency department.[175]

106. The medical director for the service will be Dr. David Hirschman, who currently serves as the medical director for critical care transport at Children's.[176] Dr. Hirschman specializes in emergency medicine, trauma care, and critical care transport.[177] Dr. Hirschman has been licensed as a physician since 1996 and serves as the medical director of the trauma program at the St. Paul campus and associate medical director of trauma at the Minneapolis campus.[178] Dr. Hirschman is trained in Advanced Cardiac Life Support and Advanced Trauma Life Support.[179]

107. The manager of the critical care transport team is Cheryl Trocke.[180] Trocke is also the manager of respiratory care services at Children's.[181] Trocke is an RT.[182] Trocke was an EMT in the 1990s but did not work in ambulance transport at that time.[183]

108. Children's wishes to provide its service statewide, and calculated its maximum response time to the farthest locations in the state, 380 miles away from its base of operation, to be 360 minutes, with an average response time of 30 minutes.[184]

109. The ambulance service will be available 24 hours per day.[185]

110. Children's estimates the population it may potentially serve at 1,286,149.[186] Children's arrived at this number based on census data from census.gov for the number of individuals in Minnesota who are under 18 years of age.[187]

111. Children's anticipates providing 805 total transport runs annually.[188] Children's determined this number by estimating that it would make 440 neonatal runs and 365 pediatric runs per year.[189] The calculation of neonatal runs was based on existing trends and the number of pediatric runs was estimated at one per day.[190] Children's arrived at the numbers through research and discussion with other facilities

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[175] Tr. Vol. I at 161 (Hirschman).
[176] *Id.* at 149-150; Ex. 1 at 1B, 1J.
[177] Tr. Vol. I at 149 (Hirschman).
[178] *Id.* at 149-150.
[179] Ex. 1 at 1B.
[180] Tr. Vol. I at 269 (Trocke).
[181] *Id.* at 269.
[182] *Id.* at 270.
[183] *Id.*
[184] *Id.* at 279; Ex. 1 at 1D.
[185] Tr. Vol. I at 163 (Hirschman).
[186] Ex. 1 at 1D.
[187] Tr. Vol. I at 196-197 (Hirschman); Tr. Vol. I at 280 (Trocke).
[188] Ex. 1 at 1D; Tr. Vol. V at 1137 (Hirschman).
[189] Tr. Vol. I at 281 (Trocke); Tr. Vol. V at 1181, 1184 (Hirschman).
[190] Tr. Vol. I at 281-282, 305-306 (Trocke).

which had added pediatric capabilities to their transport services after having an existing NICU transport team.[191] Based on its current operational experience, Children's believes that it will likely provide fewer runs than initially projected.[192] The estimated number of 805 runs amounts to approximately 1.4 percent of the total number of requests for ambulance service in Minnesota in 2017.[193]

112. Ninety staff members will be actively rostered to provide ambulance services, including 10 EMTs, 40 EMT-Paramedics, and 40 nurse practitioners and RTs.[194]

113. The application includes protocols for various medical conditions, including pulmonary, cardiovascular, gastrointestinal, hematologic, neurological/altered mental status, trauma, and multi-system conditions, as well as conditions resulting from special situations such as poisoning, drowning, ECMO, and isolation precautions.[195] Children's has also adopted policies for its operations identified in its application.[196]

114. The application identifies medications that will be carried on the ambulances.[197] Children's has adopted a policy titled "Medication Administration, Storage, and Discard While on Transport."[198] Children's developed the list of medications based on its determination of the most common or most likely medical conditions of patients it would transport, and the best initial management of those patients from an ICU perspective.[199] The doses Children's carries are pediatric and weight specific.[200]

115. Children's has identified the equipment its ambulances will carry, consistent with its practices on the ambulances it currently operates.[201] Children's based the list submitted with its application upon the conditions it anticipated it would see in transport and in consultation with staff in various departments regarding the type of equipment they would want to have for patients in transport.[202]

116. Children's has a mutual aid agreement with Allina.[203]

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[191] *Id.* at 281.
[192] *Id.* at 281-282; Tr. Vol. V at 1138 (Hirschman) (testifying that 805 runs would be a mature level for the service after it is fully developed with regard to pediatric care transports).
[193] Tr. Vol. I at 242-243 (Levi).
[194] Ex. 1 at 1F; Tr. Vol. I at 291 (Trocke).
[195] Ex. 1 at 1K-1L.
[196] Ex. 1 at 1L-1M.
[197] Ex. 1 and 1N.
[198] Ex. 1 at 1P-1Q.
[199] Tr. Vol. I at 165 (Hirschman).
[200] Tr. Vol. I at 99 (Kharbanda).
[201] Ex. 1 at 1R; *see also* Tr. Vol. I at 273-276 (Trocke); Ex. 132 (Equipment Comparison List).
[202] Tr. Vol. I at 166 (Hirschman).
[203] Ex. 1 at 1C, 1U-1W; Tr. Vol. V at 1148-1149 (Hirschman).

117. Children's anticipates that 98 percent of ambulance service revenue will come from third-party insurance payors and 2 percent from charges directly to patients.[204]

118. Children's estimates the amount billed for an ambulance run will be $4,294, but that generally only about $1,900 will be collected.[205]

119. Children's anticipates its total revenue from ambulance services will be $1,555,650.[206] This number was calculated using the amount that Children's expects to collect for each run, approximately $1,900, times the anticipated 805 runs.[207] Children's expects its annual expenses for the service will be $2,367,157.[208] Children's anticipates that the service will operate at a financial loss.[209] Children's conducted a break-even analysis, determined that the program would not break even, and decided to proceed with offering the service because the benefit outweighed the cost.[210]

120. Children's submitted three letters of support with its application, from CentraCare Health,[211] HealthEast,[212] and WGH Group.[213] The letters of support noted the high degree of specialization and standard of care provided by Children's,[214] the lack of neonatal/pediatric dedicated critical care transport in Minnesota,[215] and improved health outcomes for patients.[216]

121. On August 29, 2018, Fairview Health Services, which merged with HealthEast, withdrew HealthEast's support for the Children's application and declared its "strong opposition" to the proposed license.[217]

122. On September 10, 2018, CentraCare Health withdrew its letter of support based upon its "thought, consideration, and subsequent reviews" of the license application.[218]

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[204] Ex. 1 at 1E.
[205] Tr. Vol. I at 282-283, 317 (Trocke).
[206] Ex. 1 at 1D.
[207] Tr. Vol. I at 283 (Trocke).
[208] *Id.* at 283-284; Ex. 1 at 1E.
[209] Tr. Vol. I at 179-180 (Hirschman).
[210] *Id.*; Tr. Vol. V at 1246-1247 (Hirschman); Ex. 200 (Charts and Presentation Materials).
[211] Ex. 1 at 1Y (Letter from Gordon Vosberg to Board, June 7, 2017).
[212] Ex. 1 at 1Z (Letter from Keith Wesley to Board, June 2, 2017).
[213] Ex. 1 at 1AA (Letter from Michael Wilcox to Board, June 12, 2017).
[214] Ex. 1 at 1Y; Ex. 1 at 1Z; Ex. 1 at 1AA-1BB.
[215] Ex. 1 at 1AA.
[216] Ex. 1 at 1Y; Ex. 1 at 1Z; Ex. 1 at 1AA-1BB.
[217] Ex. 8 at 8A (Letter from Robert Beacher to Tony Spector, Aug. 29, 2018).
[218] Ex. 9 at 9A (Letter from Gordon Vosberg to Tony Spector, Sept. 10, 2018).

123. Bernard Jungmann, fire chief for the City of Burnsville, Minnesota, testified in support of the license application at the hearing.[219] Jungmann directs the ambulance service for Burnsville.[220]

VI. Opposition to the Application

124. During the public comment period on the application, the Board received 19 letters in opposition.[221] The objecting entities were: Meds-1;[222] Eveleth Ambulance Service;[223] Virginia Fire Department;[224] City of Nashwauk;[225] City of Cottonwood;[226] Perham Area EMS;[227] Lamberton Ambulance Service;[228] F-M Ambulance Service;[229] Hennepin Healthcare;[230] Sanford AirMed;[231] MAA;[232] Bemidji Ambulance;[233] Gold Cross;[234] Lakes Region EMS;[235] North Memorial;[236] Rock County Ambulance Service;[237] Stevens County EMS;[238] Thief River Falls Area Ambulance;[239] and Sanford Wheaton Ambulance Service.[240]

125. F-M Ambulance, Sanford Health, Sanford Wheaton, Thief River Falls Ambulance, and Rock County Ambulance are all Sanford-affiliated entities.[241] These entities' objections were all coordinated by Sanford.[242]

126. On August 28, 2018, the City of Eveleth withdrew Eveleth Ambulance Service's objection, noting that the person who submitted the objection did not have

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[219] Tr. Vol. II at 426-452 (Jungmann); *see id.* at 430 ("I believe it's important that the kids that are in need, the specialized kids get the teams and specialized resources. I met with the Children's staff about this after I saw the application on public notice and understanding their capabilities compared to what a 911 paramedic or a paramedic without that specialized training would have, I believe that specialized team for that specialized subset of patients is important.")
[220] *Id.* at 427.
[221] *See* Ex. 3.
[222] Ex. 3 at 3C (Letter from James Ducharme to Tony Spector, Mar. 23, 2018).
[223] Ex. 3 at 3E (Letter from Nicole Sopp to Tony Spector, Apr. 4, 2018).
[224] Ex. 3 at 3F (Letter from Allen Lewis to Tony Spector, Apr. 4, 2018).
[225] Ex. 3 at 3H (Letter from Greg Heyblom to Tony Spector, Mar. 26, 2018).
[226] Ex. 3 at 3J (Letter from Dane Meyer to Tony Spector, rec'd Apr. 13, 2018).
[227] Ex. 3 at 3L (Letter from Mark Ebeling to Tony Spector, rec'd Apr. 16, 2018).
[228] Ex. 3 at 3N (Email from Tanner Berris to Tony Spector, Apr. 19, 2018).
[229] Ex. 3 at 3Q (Letter from Tim Meyer to Tony Spector, Apr. 19, 2018).
[230] Ex. 3 at 3S (Letter from Kelly J. Spratt to Tony Spector, Apr. 16, 2018).
[231] Ex. 3 at 3U (Letter from Mike Christianson to Tony Spector, Apr. 19, 2018).
[232] Ex. 3 at 3W (Letter from Mark Ebeling to Tony Spector, Apr. 19, 2018).
[233] Ex. 3 at 3Y (Letter from Andrew LaCoursiere to Tony Spector, rec'd Apr. 23, 2018).
[234] Ex. 3 at 3BB (Letter from Tom Fennell to Tony Spector, Apr. 19, 2018).
[235] Ex. 3 at 3DD (Letter from Aarron Reinert to Tony Spector, Apr. 23, 2018).
[236] Ex. 3 at 3EE (Letter from Patrick Coyne to Tony Spector, Apr. 23, 2018).
[237] Ex. 3 at 3II (Letter from Harlan Vande Kieft to Tony Spector, Apr. 19, 2018).
[238] Ex. 3 at 3KK (Letter from Randall S. Fischer to Tony Spector, Apr. 5, 2018).
[239] Ex. 3 at 3NN (Letter from Kali Muchow to Tony Spector, Apr. 23, 2018).
[240] Ex. 3 at 3PP (Letter from Cheryl Shekleton to Tony Spector, Apr. 24, 2018).
[241] Tr. Vol. IV at 963 (Vande Kieft).
[242] *Id.* at 962 ("Sanford, as a whole, put up the letter, there. They all read it over and agreed to that letter and sent it in.")

authority to do so and that the city took no position on the application.[243] On September 13, 2018, the City of Lamberton withdrew Lamberton Ambulance Service's objection, also noting that the person who submitted the objection lacked authority to do so and that it did not take a position on the application.[244]

127. The Board received one letter of correspondence, from Gillette Children's Specialty Healthcare (Gillette Children's), providing comments and seeking answers to specific questions.[245] Gillette Children's requested that data be provided as to the claim in the application that Minnesota was one of the few states without designated pediatric transport and requested Minnesota-specific data on the need for such transport.[246] Additionally, Gillette Children's letter made several general comments and more specific comments regarding the impact on existing services.[247]

128. Objecting entities contended that Children's had not shown that the proposed license was supported by a compelling need or would improve public health, though one, the Virginia Fire Department, noted "the necessity of the specialized service provided by Children's Minnesota is almost beyond debate."[248]

129. Objecting entities further asserted that granting the license would take revenue from existing ambulance service providers, existing ambulance providers are already offering the type of service Children's seeks to provide, and duplication in services would lead to deleterious effects.[249]

130. The City of Nashwauk indicated that its ambulance service was able to provide ALS interfacility transfers for adult and pediatric patients, and critical care air transport was also available to the region for neonatal transfers, but that if specialized neonatal ground transport was needed, it "most definitely will utilize Children's Hospital ground transport unit."[250]

131. The City of Cottonwood opposed the application because it believes that granting Children's a license will destroy the current PSA laws, opening the door for Children's to establish bases throughout the state and take revenue from local providers, and will allow out-of-state ambulance services to enter the market and open up the issue of fire departments taking over ambulance services.[251] Cottonwood also asserts that not every child needs to go to Children's due to time and location, and these patients can be served somewhere closer to them.[252]

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[243] Ex. 7 (Letter from Mitchell J. Brunfelt to Tony Spector, Aug. 28, 2018).
[244] Ex. 10 (Letter from Paul N. Muske to Tony Spector, Sept. 13, 2018).
[245] Ex. 3 (Letter from Karen Brill and Dennis Jolley to Board, Apr. 24, 2018).
[246] *Id.* at 3RR-3SS.
[247] *Id.* at 3SS-3TT.
[248] *See, e.g.*, Ex. 3 at 3F; Ex. 3 at 3FF.
[249] *See, e.g.*, Ex. 3 at 3C, Ex. 3 at 3J; Ex. 3 at 3W; Ex. 3 at 3BB; Ex. 3 at 3FF-3GG; Ex. 3 at 3KK.
[250] Ex. 3 at 3H.
[251] Ex. 3 at 3J.
[252] *Id.*

132. Two entities contended Children's application did not meet the statutory requirements under Minn. Stat. § 144E.101, subd. 9, because they believe Children's did not limit the service according to statutory criteria.[253]

133. Several entities objected to allowing Children's a statewide license, noting that Children's is able to provide services now, as needed. Perham Area EMS noted that "every medical facility and/or service is free to contact Children's Minnesota to request their services at any time."[254] Bemidji Ambulance noted that "[i]f Children's is providing a service that cannot be provided by any other entity they will likely be summoned when and where they are needed regardless of the existence of a formal PSA."[255] Lakes Region EMS opined that the Children's service is best accomplished by "partnering with local ambulance providers to provide these services within the existing PSAs and PSA law."[256] North Memorial argued that a statewide license is not necessary because Children's can already provide its services via its mutual aid agreement with Allina Health.[257]

134. Bemidji Ambulance expressed concerns that creating a statewide PSA could set a "troubling precedent" that could lead other entities to seek statewide licenses for specific subsets of patients.[258] North Memorial argued that granting the license "would set precedent" that "could lead to additional applications for other niche service line offerings," which would lead to the "erosion" of the PSA system and financial instability for existing services.[259]

135. Bemidji Ambulance asserted that the proposed patient population, as Children's defined its PSA, was "poorly defined" and requested "very specific parameters be outlined as to which patients fall under this specialty PSA;" Bemidji Ambulance Service noted that, when considering "this and future specialized PSAs it is best to be as specific as possible when detailing the parameters of the demographics of the specialized PSA to avoid misunderstandings."[260] North Memorial contended that, by seeking to serve "pediatric" patients, when the term "pediatric" may encompass people over the age of 21, Children's seeks a license that "is not tailored to serve" only the population of neonates and pediatric patients.[261]

136. Gold Cross objected that granting a statewide license would allow Children's an "unjust opportunity . . . to market their ambulance service across the entire state," which would "erroneously imply to referring facilities . . . that Children's Minnesota would be the closest, most-appropriate facility, thereby bypassing closer,

[253] Ex. 3 at 3L; Ex. 3 at 3W.
[254] Ex. 3 at 3L.
[255] Ex. 3 at 3Y.
[256] Ex. 3 at 3DD.
[257] Ex. 3 at 3EE.
[258] Ex. 3 at 3Y.
[259] Ex. 3 at 3CC.
[260] Ex. 3 at 3Y.
[261] Ex. 3 at 3FF.

equally capable providers, and result[ing] in longer out of hospital times and potentially compromis[ing] patient care."[262]

VII. Ambulance Service in Minnesota

137. Rural ambulance services in Minnesota may cover large PSAs.[263]

138. Some ambulance services in Minnesota achieve a profit.[264] Some ambulance services, however, particularly in rural areas of Minnesota, operate with extremely small profit margins or at a loss.[265]

139. Payment for ambulance services is based upon a base rate plus a loaded mile fee, making interfacility transfers more lucrative than 911 transports.[266] Medicare and Medicaid reimbursement does not cover the total cost of 911 runs.[267] Ambulance services may have bad debt that they are required to write off due to inadequate reimbursement.[268]

140. Some ambulance service providers do not achieve sufficient revenue from 911 calls and need revenue from interfacility transfers to remain financially viable.[269]

141. Ambulance services without sufficient revenue from transport services have developed additional business lines to support their operations and they also may rely on community fundraising activities.[270] For example, Granite Falls Ambulance in Granite Falls, Minnesota, holds multiple fundraisers throughout each year, including a golf tournament, a burger and brat feed, and a pancake feed.[271] Granite Falls Ambulance manages additional businesses within its operation providing teaching and

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[262] Ex. 3 at 3CC.
[263] Tr. Vol. III at 662 (Ebeling); Tr. Vol. III at 829 (Fischer); Tr. Vol. IV at 948 (Berends-Sletten); Tr. Vol. IV at 954-955 (Vande Kieft).
[264] *See* Tr. Vol. IV at 913-915 (Fennell); Ex. 144 (Gold Cross Supplemental Response to Subpoena); Tr. Vol. IV at 1066 (Wagner); Ex. 146 at 10-11 (North Memorial's Supplemental Response to Subpoena). The Administrative Law Judge notes that much of the detailed financial information admitted into the record in this proceeding is sealed pursuant to a Sealing Order issued on November 16, 2018. The objecting entities' financial information is well established in the record available to the Board and the Board may examine and evaluate these records in its consideration of the case. However, the Administrative Law Judge has not expressed specific numbers regarding the financial performance of the objectors in these findings of fact because doing so would have required redaction to prevent public disclosure. The Administrative Law Judge determined that preparing an order that permits full disclosure of its reasoning to the public was more consistent with the public notice requirements of Minn. Stat. § 144E.11 (2018). Additionally, the Administrative Law Judge determined that consideration of this matter, based upon its particular facts, does not require affirmatively stating financial data regarding the objecting entities in the findings of fact.
[265] Tr. Vol. II at 513-514 (Parrish); Tr. Vol. III at 632, 673 (Ebeling); Tr. Vol. III at 776 (Croston); Tr. Vol. III at 793 (Fischer); Tr. Vol. IV at 1037 (Wagner).
[266] Tr. Vol. II at 480 (Ducharme); Tr. Vol. III at 796 (Fischer).
[267] Tr. Vol. III at 630 (Ebeling).
[268] *Id.* at 667.
[269] Tr. Vol. II at 480 (Ducharme); Tr. Vol. III at 631 (Ebeling); Tr. Vol. III at 825-826 (Fischer).
[270] Tr. Vol. IV at 933 (Berends-Sletten).
[271] *Id.* at 933, 937.

training,[272] non-emergency wheelchair transports, a community paramedic program, and mental health transportation.[273] North Memorial relies on public subsidies in some of its smaller PSAs.[274]

142. Some providers feel that the lost revenue of even one run will negatively impact their businesses.[275] If revenue is not adequate to maintain operations, ambulance service providers may put off buying new equipment or vehicles, and may not be able to maintain staffing at desired levels.[276]

143. Some providers feel that neonatal and pediatric transport needs are already being met in the areas they serve.[277] At least one provider disagrees that adults with pediatric conditions may require specialized transport.[278]

144. Around the state, some providers do not offer the type of service that Children's provides, or they perform these services rarely. For example, Burnsville Ambulance Service does not regularly provide interfacility transfers.[279] It does not maintain a neonatal or pediatric specialty team.[280] Perham Area EMS performs only a handful of neonatal transfers, with most such patients served by Sanford AirMed or another provider.[281] On average, Perham EMS performs approximately 20 pediatric interfacility transfers per year.[282] Bemidji Ambulance performs few neonatal and pediatric critical care interfacility transports.[283] Stevens County Ambulance would usually utilize air transport or some other specialty service for transporting neonates.[284] Hennepin Healthcare's ambulance service is not generally in the business of providing interfacility transfers,[285] and from 2015 to present, it provided no neonatal interfacility transfers.[286] Granite Falls Ambulance does not perform any neonatal transfers,[287] and

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[272] *Id.* at 935.
[273] *Id.* at 936-937.
[274] Tr. Vol. IV at 1039 (Wagner).
[275] Tr. Vol. II at 469 (Ducharme); Tr. Vol. III at 656 (Ebeling); Tr. Vol. III at 793 (Fischer) ("Every dollar of revenue lost is critical to rural ambulance services. . . ."); Tr. Vol. IV at 933 (Berends-Sletten); Tr. Vol. IV at 960 (Vande Kieft).
[276] Tr. Vol. III at 631-633 (Ebeling); Tr. Vol. IV at 1038 (Wagner).
[277] Tr. Vol. III at 634, 636 (Ebeling); Tr. Vol. III at 685 (Howard); Tr. Vol. IV at 886-887, 888 (Fennell); Tr. Vol. IV at 956 (Vande Kieft).
[278] Tr. Vol. IV at 1004-1005 (Lyng).
[279] Tr. Vol. II at 428-429 (Jungmann).
[280] *Id.* at 429.
[281] Tr. Vol. III at 645-646 (Ebeling).
[282] *Id.* at 631.
[283] Tr. Vol. III at 682 (Howard) ("So the vast majority of the patients that we're arguing over the last few days -- the vast majority of those patients that originate out of Bemidji, I will never see because the determination will be made by the physicians at those facilities, to overgeneralize -- maybe not "overgeneralize" -- but to generalize: Is this patient sick or not sick? And if they're sick, they're not going to send them by my service; they're going to fly them. And if they're not sick, they're not going to call your service to come up -- or proposed service to come up and transport them, so these calls -- as far as I'm concerned, this isn't an issue.")
[284] Tr. Vol. III at 813 (Fischer).
[285] Tr. Vol. IV at 857-858 (Spratt).
[286] *Id.* at 873-870; Ex. 125 at 2 (Hennepin Healthcare's Response to Subpoena).
[287] Tr. Vol. IV at 928 (Berends-Sletten).

does not have a specialty team performing pediatric interfacility transports.[288] Rock County Ambulance, operated by Sanford Luverne Hospital in Luverne, Minnesota, has done one neonatal transfer, but usually contacts other providers for these transports.[289] Rock County Ambulance performs around 20 to 40 pediatric interfacility transfers each year,[290] and it does not have a specialized crew for these transports.[291]

145. Other providers, including Sanford[292] and Gold Cross,[293] do offer specialized neonatal and pediatric transport.

146. Mayo has been performing specialized neonatal transports for over 25 years.[294] Mayo's ambulance service, Gold Cross, currently staffs its specialized transport teams with NICU and PICU certified registered nurses with a minimum of three years of experience, a pediatric or NICU RT, and if the patient is on ECMO, a perfusionist accompanies the team.[295] When not performing a transport run, the Gold Cross specialized team staff are working in their units at Mayo, wearing flight suits, and without a patient load so that they can leave if needed.[296] The team maintains prepackaged equipment for these specialized runs at the helipad.[297] In the event of a rotor-wing transport, the team takes an elevator to the helipad and gets on the helicopter.[298] If the team is called to do a fixed-wing or ground transport, the team retrieves the equipment and loads it for transport by fixed-wing or ground.[299] Gold Cross has one neonatal crew and one pediatric crew available 24 hours per day, 7 days per week.[300] All NICU trips are performed by specialty teams, whereas use of a pediatric specialty transport team is determined by the referring and accepting provider.[301]

147. Ambulance service providers maintain that, if a referring physician requested service from Children's, they would not seek to prevent Children's from making the interfacility transfer.[302] Generally, ambulance service providers participating in these proceedings agree that some patients benefit from a specialized neonatal or

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[288] *Id.* at 940.
[289] Tr. Vol. IV at 955-956 (Vande Kieft).
[290] *Id.* at 954, 956.
[291] *Id.* at 964.
[292] Tr. Vol. III at 646 (Ebeling) (discussing Sanford's use of NICU staff for neonatal runs, including NICU nurses, RTs, or a nurse practitioner).
[293] Tr. Vol. IV at 880 (Fennell); Ex. 131 at 7.
[294] Tr. Vol. IV at 883-884 (Fennell).
[295] *Id.* at 880-881, 907.
[296] *Id.* at 881.
[297] *Id.* at 882.
[298] *Id.*
[299] *Id.*
[300] Tr. Vol. IV at 916-917.
[301] Tr. Vol. IV at 918-919.
[302] Tr. Vol. II at 463 (Ducharme); Tr. Vol. III at 700-701 (Howard) ("Children's, if you get this license and you want to establish a relationship with me and if you call me and say, 'Hey, we've been asked to come into your hospital and take this patient,' I will welcome you with open arms. I will send a crew up there to assist you, if you request it, in any way possible."); Tr. Vol. III at 806 (Fischer).

pediatric transport, and they agree Children's is currently providing a valuable service.[303]

148. At the same time, some ambulance services are "protective of their PSAs and the way [they] control [their] PSA."[304] Some ambulance service providers believe that a service operating outside a PSA must "call the service that has that PSA and ask permission to come into it."[305] Meds-1 has denied a request from another service to enter its PSA for a transport in the past.[306]

149. Some ambulance services carry equipment to accommodate pediatric patients' specific needs.[307] Gold Cross can accommodate patients on ECMO during transport.[308] Gold Cross also stocks prepackaged medications dosed for neonatal or pediatric transport.[309] Gold Cross further stocks pediatric backboards, resuscitation masks, and small intravenous catheters in all of its ambulances in all locations.[310] Gold Cross utilizes isolettes to secure neonates during transport, and it uses a weight-based system of restraints for pediatric patients starting at nine pounds.[311] Rock County Ambulance has telehealth capabilities allowing a physician to remain on camera for runs.[312]

150. Some ambulance services in Minnesota do not carry the same equipment that Children's carries on its rigs.[313]

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[303] Tr. Vol. II at 463-464 (Ducharme); Tr. Vol. III at 690 (Howard); Tr. Vol. III at 794 (Fischer) ("Just because we have opposed this license application does not mean that we oppose the use of the services when they're necessary and when we need them.")

[304] Tr. Vol. II at 455 (Ducharme).

[305] *Id.*; *see also* Tr. Vol. III at 719-720 (Howard) (Q: "In order for Children's to come pick up a patient in your PSA, you have to give your permission for them to do that, right?" A: "At this point, yes."); Tr. Vol. III at 804 (Fischer) (Q: "My question is: When the referring physician and the receiving at Children's agree that Children's transport is the most appropriate, do you believe that the local EMS provider should have the ability to veto that judgment by those two doctors?" A: "To discuss it, yes."); *but see* Tr. Vol. IV at 1009-1010 (Lyng) ("[I]f that conversation has occurred between those two physicians, then the transport resources have already been -- are being arranged between those physicians, so there would not be an opportunity for the local service to actually be called into question during that episode of care as to whether or not that transport was appropriate for them to take, or appropriate for the retrieval team to take. Now, after the fact, there may be questions that occur.")

[306] Tr. Vol. II at 462 (Ducharme).

[307] Tr. Vol. III at 637 (Ebeling) (discussing restraint systems for pediatric patients).

[308] Tr. Vol. IV at 889 (Fennell).

[309] *Id.* at 890.

[310] *Id.* at 898-899.

[311] *Id.* at 899.

[312] Tr. Vol. IV at 964 (Vande Kieft).

[313] Tr. Vol. IV at 945-946 (Berends-Sletten) (discussing that Granite Falls Ambulance has a high-flow nasal cannula, but does not have a blender for mixing oxygen concentration, a backup generator, telemedicine capability, medical gases, or LVAD or ECMO capabilities); Tr. Vol. IV at 966-967 (Vande Kieft) (discussing that Rock County Ambulance lacks a blender, generator, and capability to administer medical gases or provide ECMO or LVAD, it but can obtain a high-flow nasal cannula from the hospital for transport; *see also* Ex. 132.

151. Ambulance services generally staff their transports with a mix of paramedics and EMTs or two paramedics.[314] Granite Falls Ambulance staffs pediatric interfacility transports with a mix of paramedics, registered nurse paramedics, registered nurse EMTs, and EMTs.[315] For ALS runs, Rock County Ambulance uses a paramedic and an EMT, or depending on the patient's condition, may take a nurse and an RT who would be taken from the floor or unit at the hospital.[316] In some rural areas in Minnesota, ambulance service providers have difficulty finding trained staff for open positions.[317]

152. Training for ambulance service staff around the state varies. Perham Area EMS staff receive pediatric trauma life support training and training on neonatal resuscitation, audit S.T.A.B.L.E. newborn training, and four hours annually of pediatric airway training.[318] Gold Cross trains its specialized teams in neonatal airway management.[319]

153. Medical directors for ambulance services around the state may be family practice or emergency room physicians.[320] Though some have EMS experience, others may lack this experience.[321]

154. Ambulance services that participated in these proceedings received feedback on runs and performed case reviews, but have not adopted GAMUT standards for quality control.[322]

155. The number of transports provided by any particular ambulance service varies from year to year.[323]

156. Certain ambulance providers who participated in this matter have not experienced a decline in interfacility runs since Children's began providing pediatric interfacility transports in March 2018.[324]

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[314] Tr. Vol. III at 645 (Ebeling); Tr. Vol. III at 807-808 (Fischer).
[315] Tr. Vol. IV at 940 (Berends-Sletten).
[316] Tr. Vol. IV at 964 (Vande Kieft).
[317] Tr. Vol. III at 664 (Ebeling); Tr. Vol. IV at 949-950 (Berends-Sletten); Tr. Vol. IV at 1040-1041 (Wagner).
[318] Tr. Vol. III at 660 (Ebeling); *see also* Tr. Vol. III at 814-815 (Fischer) (discussing Stevens County Ambulance's training requirements).
[319] Tr. Vol. IV at 898 (Fennell).
[320] *See* Tr. Vol. III at 688-689 (Howard); Tr. Vol. III at 729 (Lilja); Tr. Vol. IV at 942 (Berends-Sletten); Tr. Vol. IV at 965-966 (Vande Kieft); Tr. Vol. IV at 984 (Lyng).
[321] Tr. Vol. II at 495 (Ducharme); Tr. Vol. III at 728-729 (Lilja).
[322] Tr. Vol. II at 482 (Ducharme); Tr. Vol. III at 661 (Ebeling); Tr. Vol. III at 811-812, 813-814 (Fischer); Tr. Vol. IV at 943-945 (Berends-Sletten); Tr. Vol. IV at 966 (Vande Kieft).
[323] Tr. Vol. II at 500-501 (Ducharme); Tr. Vol. III at 656-657, 659 (Ebeling); Tr. Vol. III at 823 (Fischer).
[324] Tr. Vol. III at 649-655 (Ebeling); Ex. 145 at 4 (Perham Area EMS Profit and Loss Statement); Ex. 145 at 17 (Perham Area EMS Inter-Facility Transports); Ex. 145 at 19-26 (Perham Area EMS Inter-Facility Transports by Age Group); Ex. 145 (Perham Area EMS Annual Transport and Financial Statistics Chart); Tr. Vol. IV at 1062 (Wagner); Ex. 146 at 8 (North Memorial non-neonatal transports chart).

157. The Board collects data on the number of particular types of patients transported by ambulance providers to a particular facility, and on total transfers performed by ambulance services, which data is available through a database called MNSTAR.[325]

158. From 2016 through approximately the hearing date in 2018, several entities that have objected to Children's application performed no interfacility transfers to bring neonatal or pediatric patients to Children's.[326] Other objecting entities provided few interfacility transfers of patients to Children's.[327]

159. In 2016, Bemidji Ambulance made 906 interfacility transfer runs; it made no neonatal transfers to Children's and four pediatric transfers to Children's that year.[328] In 2017, and through approximately the hearing date in 2018, Bemidji Ambulance performed 511 interfacility transfer runs, but made no neonatal or pediatric interfacility transfer runs to bring patients to Children's.[329]

160. Stevens County Ambulance made 292 interfacility transfer runs in 2016, and transported 3 pediatric patients to Children's and no neonatal patients.[330] From 2017 through approximately the hearing date in September 2018, Stevens County Ambulance made 440 total interfacility transfer runs, but made no neonatal or pediatric interfacility transport runs to Children's.[331]

161. Meds-1 made 743 interfacility transfers in 2016, of which 7 were pediatric transfers to Children's, 804 interfacility transfers in 2017, 6 of which were pediatric transfers to Children's, and through approximately the hearing date in 2018, it made 488 interfacility transfers, bringing 4 pediatric patients to Children's.[332]

162. Other ambulance services performed more interfacility transfer runs to Children's, but those runs were a small portion of the total number of interfacility transfers made by those entities.[333]

163. Lakes Region EMS performed 1,254 total interfacility transfer runs in 2016, of which 27 were pediatric transfers to Children's.[334] In 2017, Lakes Region EMS

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[325] Tr. Vol. I at 286 (Trocke); Ex. 133 (MNSTAR Data Summary). Exhibit 133 is a compilation of transfer statistics for entities that opposed Children's application for licensure. Tr. Vol. I at 286 (Trocke).
[326] Ex. 133 at 52-53 (chart), 4-6 (Cottonwood Ambulance Service), 7-9 (F-M Ambulance), 10-12 (Hennepin County Medical Center Ambulance Service), 25-27 (Nashwauk Ambulance), 34-36 (Rock County Ambulance), 43-45 (Thief River Falls), 49-51 (Wheaton Ambulance).
[327] *Id.* at 52-53.
[328] Tr. Vol. I at 286-287 (Trocke); Ex. 133 at 1.
[329] Ex. 133 at 2, 3.
[330] *Id.* at 40.
[331] *Id.* at 41-42.
[332] *Id.* at 22-24.
[333] *Id.* at 52-53.
[334] *Id.* at 13.

made 1 neonatal interfacility transfer and 9 pediatric interfacility transfers to Children's, out of a total of 351 interfacility transfers.[335]

164. Gold Cross made 1 neonatal transfer and 41 pediatric transfers to Children's in 2016, out of 6,683 interfacility transfers it performed that year.[336] It made no interfacility transfers to Children's from 2017 through approximately the hearing date in 2018, though it performed 18,849 interfacility transfers during that time.[337]

165. North Memorial made 5,276 interfacility transfer runs in 2016, bringing 1 neonatal patient and 266 pediatric patients to Children's.[338] In 2017, North Memorial made 1 neonatal transfer and 25 pediatric transfers to Children's, out of a total of 15,970 interfacility transfers.[339] As of approximately the hearing date in 2018, North Memorial had performed 9,295 interfacility transfers, of which none were to Children's.[340]

166. From 2016 through 2018, entities owned by Sanford made a total of 3,306 interfacility transfers, with 4 neonatal transfers and 25 pediatric transfers to Children's.[341]

VIII. Issues Related to Whether a Duplication of Services Will Result from Granting Children's a License

167. Providers recognize that Children's offers transport care now, without a license, through its collaboration with Allina.[342]

168. Some ambulance service providers do not anticipate harm to their businesses arising from the service Children's currently undertakes, even if it were licensed to provide that service. Burnsville Ambulance Service does not believe that granting Children's a license will cause harm to other EMS providers.[343] Bemidji Ambulance recognizes that Children's current service does not cause it financial harm and that it can lose four interfacility transfers made to Children's without a detrimental

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[335] *Id.* at 14.
[336] *Id.* at 19.
[337] *Id.* at 20-21.
[338] *Id.* at 28.
[339] *Id.* at 29.
[340] *Id.* at 30.
[341] *Id.* at 37-39.
[342] Tr. Vol. II at 463, 493 (Ducharme) (Q: "I mean isn't it your real concern here, sir, not about Children's service, but about some later application that we don't yet have before us?" A: "Yes, absolutely, because they can do the job that they want to do now." . . . "I think they provide the service now without the license."); Tr. Vol. IV at 925 (Lyng) (noting no reason exists that would prevent Children's from continuing to provide its current service).
[343] Tr. Vol. II at 432 (Jungmann) ("When I looked at the application, it's 805 runs what they project over the entire state. It has a very minimal impact. If you look at the number of EMS calls in the State or EMS calls at least in our service area and the colleagues that I am familiar with, every year the volume continues to rise, and it seems like a very small and specialized subset of patients that they are looking to take care of that are in need of specialized care.")

impact.[344] Hennepin Healthcare has a high volume transport service that is less likely to be impacted by Children's provision of transport services.[345] North Memorial would lose few interfacility transport runs if Children's continues providing specialized critical care transports.[346]

169. Some ambulance services are concerned that a detrimental impact could occur if Children's is licensed to provide services statewide, if Children's expanded the service it provides at some time in the future to take other types of transports, or if other ambulance providers decide to apply for more expansive licenses.[347]

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[344] Tr. Vol. III at 684 (Howard) ("It won't hurt me financially if it stops there, if it happens as it is written."); *see also id.* at 687 ("I chose to be here, not because I'm worried about losing the four calls that it shows went to Children's on MNStar in 2016. I'm not worried about that.").

[345] Tr. Vol. IV at 858 (Spratt).

[346] Tr. Vol. IV at 911 (Fennell) (acknowledging that, if Children's were licensed, Gold Cross would not lose all of its neonatal transfers to Children's and indicating the witness did not know how many transfers it might lose); Tr. Vol. IV at 1017 (Lyng) (Q: "How many does North expect to lose to Children's?" A: "I would say that would be speculation. It depends very much on exactly how broadly Children's intends to interpret the scope of their license. If the scope of their license as it is approved is specific to critical-care-level needs, then it would be a very small portion."); *see also* Tr. Vol. IV at 1056-1057 (Wagner) (acknowledging North Memorial does not know how many transports it may lose to Children's if Children's obtains a license).

[347] Tr. Vol. II at 463 (Ducharme); Tr. Vol. III at 634-635, 641 (Ebeling); Tr. Vol. III at 691-692, 717 (Howard), *see also id.* at 701 ("I don't believe that you are going to be a financial detriment to my service, but I do believe that changing this precedent will."); Tr. Vol. III at 777-778 (Croston) (expressing concerns about future license applications for specific conditions and stating, "my understanding is that if Children's simply applied for a small PSA, they could have a PSA-to-PSA interaction, and they could still do the same things that they're already doing right now, as far as I can tell. I'm not – I really don't understand the reason for the license."); *see id.* at 781 ("And if a doctor in one facility thinks that's the best way to transport that patient, I'm all for it. I'm under the belief that they can do that now. I'm not opposed to them having an operating rig; I just think the statewide license is the issue for us."); Tr. Vol. III at 792 (Fischer) ("If it is approved, the -- it would create a -- one of -- one-of-a-kind sole-provider in the state of Minnesota to service that population of pediatric patients -- pediatric-plus patients in the state of Minnesota, which then could contract with any payor group as a sole-provider and eliminate every other ambulance service from any contractual arrangements in the state of Minnesota."), *see also id.* at 825 ("the application, as it's written, would allow you to take any pediatric patient for any purpose and any reason. It could be a fractured finger, if you determined -- you and the local physician determined that you wanted to use your transport."); Tr. Vol. IV at 867 (Spratt) (Q: "With a statewide license approved, would there be any limitation in Children's ability – legal limitation in Children's ability to open a substation in any location in Minnesota?" A: "No. There should be no lim[it]ation to opening across the state."); Tr. Vol. IV at 901 (Fennell) ("This is -- if this license were granted, this would start the erosion process of the PSA law. Other people, other services, would carve out a niche market and say that this is the target market that they want to go after. They'd be treated the same as Children's is treated if they're granted the license."); Tr. Vol. IV at 932 (Berends-Sletten) ("if Children's is granted it, that opens up a whole new can of worms, if you will, for other agencies to come into our state. And once the wheel has been greased, so to speak, by Children's, you know, then -- then who else?"); Tr. Vol. IV at 958, 961 (Vande Kieft) ("So if they start giving out statewide licenses, no one can show us how that's going to affect us. . . . They're just giving out a statewide license. Now everybody gets a statewide license. So now, all of a sudden, somebody puts an ambulance service in Luverne that wants to do our transfers."); Tr. Vol. IV at 981 (Lyng) ("the language in the license application could be interpreted to apply to any pediatric interfacility transport, whether it's for a 'rule out appendicitis' or a broken wrist that can very easily be taken care of by the standard ALS resources that exist across the state."); *see also id.* at 989 ("By opening the Pandora's box of allowing a statewide license holder in Minnesota, that can potentially open

IX. Incorporation of Facts

170. Any conclusion of law more property adopted as a finding of fact is incorporated herein.

171. Any fact discussed in the Memorandum that is not specifically identified within a finding of fact is incorporated herein.

Based on these Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Board have jurisdiction over this matter pursuant to Minn. Stat. §§ 14.50, 144E.001-.52 (2018).

2. The Administrative Law Judge and the Board have complied with all procedural requirements of law and rule and this matter is properly before the Administrative Law Judge and the Board.

3. The Board has authority to grant licenses for ambulance services.[348] The legislature has established licensing categories for BLS, ALS, part-time advanced ALS, and specialized life support.[349] The legislature also directed the Board to adopt rules regulating scheduled ambulance services.[350]

4. A specialized life support service provides basic or advanced life support as designated by the Board, and shall be restricted by the Board to: (1) operation less than 24 hours of every day; (2) designated segments of the population; (3) certain types of medical conditions; or (4) air ambulance service that includes fixed-wing or rotor-wing.[351]

5. The Board has defined a scheduled ambulance license to include "basic or advanced ambulance service that restricts its services to specified periods of time or to a specified group of people, or restricts the type of services it provides to a specified medical category."[352] Scheduled ambulance services operate pursuant to a schedule

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the door for those types of companies, for a profit, to come into Minnesota, to apply for a license, and get a foothold to start taking over some of the smaller rural services that are having a tough time making ends meet."); Tr. Vol. IV at 1036 (Wagner) ("I feel like it's a duplication of services, if they were able to transport all pediatric patients in interfacility transfers. It also opens up the door to other license applications to PSAs for a statewide PSA which could quickly degrade the ability for the ambulance services to survive and also to guarantee ambulance coverage that the primary service laws enable the state to have."); *see also id.* at 1053 (Q: "So you're assuming, with that 25 percent number, that North Memorial will lose 100 percent of its neonatal and pediatric interfacility transports if Children's license is granted; is that right? A: "The potential is certainly there, if they get a statewide license.")

[348] Minn. Stat. § 144E.11.
[349] Minn. Stat. § 144E.101, subd. 5.
[350] Minn. Stat. § 144E.16, subd. 4(9).
[351] Minn. Stat. § 144E.101, subd. 9.
[352] Minn. R. 4690.0100, subp. 30.

approved by the Board defining the time the service may operate, and group or medical category the service will serve.[353]

6. A PSA is the "geographic area that can reasonably be served by an ambulance service."[354]

7. The legislature has directed the Board to "adopt rules defining [PSAs] under which the Board shall designate each licensed ambulance service as serving a [PSA]."[355]

8. A license granted by the Board "shall specify" the PSA for which the licensee is licensed.[356]

9. Under the Board's rules, "[a]n applicant for a new license . . . must declare the [PSA] that it intends to serve and seek designation of that area."[357] An applicant must show the reasonableness of the PSA it has designated, with regard to response times, distances traveled, the specific service to be provided, and the applicant's intention to be responsible to the population of that PSA or to a specified group of persons.[358]

10. The Board has established a maximum PSA size for communities of varying populations based upon the travel time from a licensee's base of operations or substation.[359]

11. Scheduled ambulance services are exempt from the maximum PSA size restriction.[360]

12. The Board and the Administrative Law Judge must analyze four factors in considering whether to grant an application for licensure:

> (1) the recommendations or comments of the governing bodies of the counties, municipalities, community health boards, and regional emergency medical services system designated under section 144E.50 in which the service would be provided;
>
> (2) the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license;
>
> (3) the estimated effect of the proposed service or expansion in primary service area on the public health; and

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[353] Minn. R. 4690.2800, subp. 2.
[354] Minn. Stat. § 144E.001, subd. 10.
[355] Minn. Stat. § 144E.06.
[356] Minn. Stat. § 144E.10, subd. 1.
[357] Minn. R. 4690.3400, subp. 1 (2017).
[358] *Id.,* subp. 2 (2017).
[359] *Id.,* subp. 3 (2017).
[360] Minn. R. 4690.2800, subp. 3.

(4) whether any benefit accruing to the public health would outweigh the costs associated with the proposed service or expansion in primary service area.[361]

13. The Administrative Law Judge must review and comment on the application and make written recommendations as to its disposition by the Board.[362] The Administrative Law Judge "shall recommend that the board either grant or deny a license or recommend that a modified license be granted," setting forth the reasons in detail.[363]

14. Children's bears the burden to establish by a preponderance of the evidence that a license should be granted.[364]

15. The Administrative Law Judge concludes that Children's has established by a preponderance of the evidence that it should be granted a license to provide ambulance service.

16. The Administrative Law Judge recommends that the license granted to Children's be modified to a scheduled service license with a statewide PSA in order to comply with the requirements of statute and rule.

17. Any finding of fact more properly considered a conclusion of law is adopted as such.

18. Any statement in the Memorandum below that is more properly considered a conclusion of law is incorporated herein.

Based upon these Conclusions of Law, and for the reasons explained in the accompanying Memorandum, which is incorporated herein, the Administrative Law Judge makes the following:

[361] Minn. Stat. § 144E.11, subd. 6.
[362] *Id.*
[363] *Id.*
[364] Minn. R. 1400.7300, subp. 5 (2017); *see also Matter of Rochester Ambulance Serv.*, 500 N.W.2d 495, 498 (Minn. Ct. App. 1993).

RECOMMENDATION

The Administrative Law Judge concludes that Children's has established by a preponderance of the evidence that it should be granted an ambulance service license. The Administrative Law Judge further concludes that the license granted should be modified from the license requested. The Administrative Law Judge recommends that the Board grant Children's a scheduled service license with a statewide PSA permitting Children's to provide interfacility transfers, 24 hours per day and 7 days per week, to neonatal and pediatric patients, and adult patients with pediatric conditions, as described in Children's application, upon request of a referring provider or ambulance service.

Dated: November 16, 2018

JESSICA A. PALMER-DENIG
Administrative Law Judge

Reported: Transcript Prepared by Kirby Kennedy & Associates
Five Volumes

NOTICE

This Report is a recommendation, not a final decision. The Board will make the final decision after a review of the record. Under Minn. Stat. § 144E.11, subd. 7, the Board must approve or deny the application and grant the license within 60 days if the application is approved. Under Minn. Stat. § 14.61 (2018), the Board shall not make a final decision until this Report has been made available to parties to the proceeding for at least ten calendar days. Parties may file exceptions to this Report and the Board must consider the exceptions in making a final decision. Parties should contact Anthony Spector, Executive Director, 2829 University Avenue SE, Suite 310, Minneapolis, Minnesota, 55414, (651) 201-2806 to learn the procedure for filing exceptions or presenting argument.

The record closes upon the filing of exceptions to the Report and the presentation of argument to the Board, or upon the expiration of the deadline for doing so. The Board must notify the parties and Administrative Law Judge of the date the record closes. If the Board fails to issue a final decision within 90 days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a (2018).

Under Minn. Stat. § 14.62, subd. 1 (2018), the Board is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

I. Introduction

It is undisputed that Children's currently provides high-quality, life-saving ambulance transport care to neonatal and pediatric patients throughout Minnesota through its collaboration with Allina. The dispute in this case instead centers on whether Children's should be granted a license to provide transport services on its own. The Administrative Law Judge concludes that the Board should grant Children's a license.

II. Legal Standards

The Board and the Administrative Law Judge must analyze four statutory factors in considering whether an application for licensure should be granted:

> (1) the recommendations or comments of the governing bodies of the counties, municipalities, community health boards, and regional emergency medical services system designated under section 144E.50 in which the service would be provided;
>
> (2) the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license;
>
> (3) the estimated effect of the proposed service or expansion in primary service area on the public health; and
>
> (4) whether any benefit accruing to the public health would outweigh the costs associated with the proposed service or expansion in primary service area.[365]

Children's, as the applicant, must establish by a preponderance of the evidence that the license should be granted.[366] To establish a fact by a preponderance of the evidence, "it must be more probable that the fact exists than that the contrary exists."[367] If the evidence is equally balanced, then that fact or issue has not been proven by a preponderance of the evidence.[368]

III. The Board May Grant Children's a License to Operate Statewide, Serving the Population Identified in its Application

In these proceedings, interested persons argue that the Board lacks authority to grant Children's a license to operate without a PSA or that it cannot grant Children's a license to operate statewide. The Board has interpreted the license application

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[365] Minn. Stat. § 144E.11, subd. 6.
[366] Minn. R. 1400.7300, subp. 5; *see also Matter of Rochester Ambulance Serv.*, 500 N.W.2d 495, 498 (Minn. Ct. App. 1993).
[367] *City of Lake Elmo v. Metropolitan Council*, 685 N.W.2d 1, 4 (Minn. 2004).
[368] *Id.*

submitted by Children's as a request for a specialized ALS license without a designated PSA.[369] The Board has interpreted its authority to permit it to grant specialized licenses that are not tied to a primary service area.[370] Analyzing this issue requires parsing the statutes and rules governing the Board's authority.

When interpreting statutes, a court's task is to determine the intent of the legislature.[371] If the legislature's intent can be discerned from the plain and unambiguous language of the statute, "the letter of the law shall not be disregarded under the pretext of pursuing its spirit."[372] A statute is ambiguous if it is susceptible to more than on reasonable interpretation.[373] In determining whether a statute is ambiguous, words and phrases are to be given their plain and ordinary meaning.[374] A statute is considered as a whole and various parts are harmonized to give effect to all of the statute's provisions.[375]

Administrative agencies are "creatures of statute" and may exercise authority granted to them by the legislature.[376] An agency's authority may be expressly indicated in a statute or may be implied from the expressed powers.[377] When a statute is ambiguous, courts will defer to an administrative interpretation of the statute by an agency with authority to apply the statute on a statewide basis, if its interpretation is reasonable.[378] If the meaning of a statute is doubtful, courts give great weight to the construction of the agency charged with its interpretation.[379] Interpretations by an administrative agency are not entitled to deference when the interpretation contravenes plain statutory language or where compelling indications suggest that the agency's interpretation is wrong.[380] Agencies articulate policy by promulgating administrative rules under the Minnesota Administrative Procedure Act (APA).[381] Courts interpreting administrative rules determine whether a rule is ambiguous by looking to the text of the

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[369] Tr. Vol. I at 37 (Spector); Tr. Vol. II at 576 (Spector).

[370] *See* Tr. Vol. I at 36-37 (Spector) (discussing PSAs in relation to 911 response services and in contrast to specialized licenses); Tr. Vol. II at 580 (Spector) (discussing the Board's interpretation of its authority to grant specialized licenses that are not tied to a PSA); *id.* at 583 (discussing certain licenses issued by the Board); *see also* Tr. Vol. I at 228 (Levi) ("A specialized license, as I understand it, is a license that does not have a prescribed PSA. It is designed for a special purpose and a defined population."); *id.* at 236 (noting confusion regarding the Board's application form, which required PSA information, and Children's understanding of the nature of a specialized license.)

[371] *State v. Riggs*, 865 N.W.2d 679, 682 (Minn. 2015); Minn. Stat. § 645.16 (2018) ("The object of all interpretation and construction of laws is to ascertain and effectuate the intention of the legislature.")

[372] *Riggs*, 865 N.W.2d at 682.

[373] *State v. Struzyk*, 869 N.W.2d 280, 285 (Minn. 2015).

[374] Minn. Stat. § 645.08(1) (2018).

[375] *Riggs*, 865 N.W.2d at 683.

[376] *In re Hubbard*, 778 N.W.2d 303, 318 (Minn. 2010).

[377] *Id.*

[378] *Minn. Transitions Charter Sch. v. Comm'r of Minn. Dept. of Educ.*, 844 N.W.2d 223, 231 (Minn. Ct. App. 2014).

[379] *Id.*

[380] *In re Claim for Benefits by Meuleners*, 725 N.W.2d 121, 124 (Minn. Ct. App. 2006).

[381] *In re PERA Salary Determinations*, 820 N.W.2d 563, 570 (Minn. Ct. App. 2012); Minn. Stat. § 14.01-.69 (2018); *see also St. Otto's Home v. Minn. Dep't of Human Servs.*, 437 N.W.2d 35, 42-43 (Minn. 1989) (rules must be adopted in accordance with the APA and agencies may not rely on an interpretation that constitutes an unpromulgated rule).

rule and the apparent purpose of the regulation as a whole.[382] If the rule is not ambiguous, the court must interpret the rule according to the rule's plain language.[383]

The Board obtains its authority to regulate ambulance service licensing from chapter 144E of the Minnesota Statutes and its own rules promulgated in chapter 4690 of the Minnesota Rules. Under Minn. Stat. § 144E.06, the Board "shall adopt rules defining [PSAs] under which the Board shall designate each licensed ambulance service as serving a [PSA]."[384] A license issued by the Board "shall specify" the PSA for which the licensee is licensed.[385] PSA has a specific statutory definition; it is the "geographic area that can reasonably be served by an ambulance service."[386] The Board's rules require that "[a]n applicant for a new license . . . must declare the [PSA] that it intends to serve and seek designation of that area."[387] An applicant "must show the reasonableness" of the PSA it has designated, with regard to response times, distances traveled, the specific service to be provided, and the applicant's intention to be responsible to the population of that PSA or to a specified group of persons.[388]

Under the plain language of these statutes and rules, designation of a PSA is required. Both the statutes and the rules repeatedly use the terms "shall" and "must," which are interpreted as imposing a mandatory requirement.[389] The legislature expressly directs the Board to adopt rules under which it "shall" designate a PSA for "each licensed ambulance service," that the licensee can reasonably serve, and the PSA is to be stated in the license. The Board imposes mandatory requirements through its rules for applicants to designate a PSA and establish that it is reasonable. None of these provisions differentiate between categories of licenses or suggest that they are applicable only to ambulance services offering 911 response.

The Administrative Law Judge recognizes that, in many instances, the Board would be entitled to some deference regarding its interpretation of these statutes and rules. The Administrative Law Judge has carefully considered the authority expressly delegated by the legislature, as well as whether the Board may have implied authority to support its interpretation. The Administrative Law Judge also recognizes that, as a matter of public policy, it might be better to distinguish between various types of service and to apply the PSA requirements only to ambulance services that respond to 911 calls for service. But the Administrative Law Judge can find no part of the statutes or rules under which specialized life support licenses are exempt from the general requirements established for all licensees.[390] Interpreting the statutes and rules, as

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[382] *J.D. Donovan, Inc. v. Minn. Dept. of Transp.*, 878 N.W.2d 1, 5 (Minn. 2016).
[383] *Id.* at 5-6.
[384] Minn. Stat. § 144E.06.
[385] Minn. Stat. § 144E.10, subd. 1.
[386] Minn. Stat. § 144E.001, subd. 10.
[387] Minn. R. 4690.3400, subp. 1.
[388] Minn. R. 4690.3400, subp. 2.
[389] Minn. Stat. § 645.44, subd. 15a, 16 (2018).
[390] At the hearing, the Board did not identify the specific language upon which its interpretation rests, though it referenced Minn. Stat. §§ 144E.101, .11, and chapter 144E as a whole. Tr. Vol. II at 579-580, 582 (Spector).

currently written, to insert such a provision would go beyond the direction of the legislature and the Board's authority as promulgated in its rules.

Notwithstanding this, the Board does have authority to grant Children's a statewide license to provide ambulance services. The legislature and the Board have designated two categories of licenses that permit ambulance services to assist specific groups of patients. The first is a basic or advanced specialized license, which is restricted to operation less than 24 hours of every day, designated segments of the population, certain types of medical conditions, or air ambulance service that includes fixed-wing or rotor-wing.[391] The Board has defined a scheduled[392] services license similarly, as a "basic or advanced ambulance service that restricts its services to specified periods of time or to a specified group of people, or restricts the type of services it provides to a specified medical category."[393] These definitions contain significant overlap, but there is an important difference between the two licenses. The Board has expressly excluded scheduled ambulance services from the maximum PSA size provided by Minn. R. 4690.3400, subp. 3.[394]

Therefore, the Board may grant Children's an ALS scheduled service license with a statewide PSA to permit it to serve the patient population identified in its application. As discussed in further detail below, the Administrative Law Judge recommends that the Board do so.

IV. The Statutory Factors Favor Granting Children's a License

A. Recommendations and Comments

The first statutory factor requires the Board to consider the recommendations or comments of the governing bodies of the counties, municipalities, community health boards, and regional emergency medical services system in which the service would be provided.[395] Children's points out that this factor requires consideration of the views of "governing bodies" of specific entities. Children's notes that few of the recommendations and comments submitted in the record are from such governing bodies, and that the majority of the objections to its license were submitted by private or quasi-public EMS providers. Children's is correct.

The Board must give broad notice of an application for an ambulance service license; notice recipients may comment on the application and, if interested in doing so,

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[391] Minn. Stat. § 144E.101, subd. 5, 9. The Administrative Law Judge notes that a specialized license is defined using the disjunctive "or," which is typically interpreted as requiring only one of the possible factual situations to be present. *State v. Bakken*, 883 N.W.2d 264, 268 (Minn. 2016).

[392] In this context, "scheduled" does not simply connote a designation as to the timing of the service, but is best understood as a "statement of supplementary details appended to a legal or legislative document," or a "list, catalog, or inventory." *Schedule*, MERRIAM-WEBSTER.COM, https://www.merriam-webster.com/dictionary/schedule (last visited Nov. 13, 2018). The definition of a scheduled services license is broad enough to encompass the type of service Children's intends to provide.

[393] Minn. R. 4690.0100, subp. 30.

[394] Minn. R. 4690.2800, subp. 3.

[395] Minn. Stat. § 144E.11, subd. 6(1).

may participate in the hearing.[396] Once the record is developed, however, the statute prescribes a narrower category of commenters whose views the Board must consider.[397] Ambulance services operating in the area the applicant seeks to serve are in the category of persons who must receive notice and who may participate in the proceedings, but they are not included under the first statutory factor requiring the Board's consideration. This is not to say that the Board should disregard the views of ambulance service providers; indeed, the Administrative Law Judge has devoted substantial attention to their concerns. Under the statute, however, the Board may evaluate recommendations differently depending on the source and is ultimately required to give greater consideration to the recommendations and comments of the specified governing bodies.

The statute does not articulate any standard regarding how the Board should evaluate or weigh the recommendations or comments of governing bodies. The statute does not indicate that the Board is bound to abide by these comments, but rather that the Board must consider the comments along with the other statutory factors.

In this case, the few comments submitted by governing bodies are negative. For example, the City of Nashwauk believes its ambulance service is able to provide ALS interfacility transfers and that critical care air is already sufficiently available in its region.[398] The City of Cottonwood opposes the application because it foresees Children's licensure as destroying Minnesota's PSA system; it believes that Children's may establish bases throughout the state and then take revenue from local providers, that out-of-state ambulance services will enter the market, and that consideration of fire departments taking over ambulance services will also result.[399] Cottonwood also asserts that children can be seen in a location closer to them than Children's.[400] These comments echo the objections submitted by other commenters.

Various aspects of these comments are based on speculative concerns, misunderstand the scope of the license at issue, or are contradicted by the record established at the hearing. Nashwauk's comment, in particular, expresses a dichotomy, in that it argues that there is no need for a license to be issued, but also that if specialized neonatal ground transport is needed for a patient in its area, it "most definitely will utilize Children's Hospital ground transport unit."[401] The Administrative Law Judge respectfully recommends that the Board should not accord these comments greater weight as compared to the other statutory factors, and should evaluate these comments in light of the record as a whole, considering the reasoning expressed below. Ultimately, the Administrative Law Judge concludes that the other statutory factors weigh in favor of licensure.

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[396] Minn. Stat. § 144E.11, subd. 2, 3, 5(f)(2).
[397] Minn. Stat. § 144E.11, subd. 6(1).
[398] Ex. 3 at 3H.
[399] Ex. 3 at 3J.
[400] *Id.*
[401] Ex. 3 at 3H.

B. Deleterious Effects on the Public Health From Duplication of Services

In determining whether to grant Children's a license, the Board must consider "the deleterious effects on the public health from duplication, if any, of ambulance services that would result from granting the license."[402] This factor engendered the greatest degree of dispute during these proceedings.

Ambulance services in Minnesota do not operate in a free market system.[403] The Minnesota Supreme Court has held that:

> Ambulance service is essential to a community. It is also a service for which demand is inelastic and expenses largely fixed. Where the demand is insufficient to support additional services, either quality is sacrificed or rates and public subsidies increased, but in either event, the taxpayer-consumer suffers.[404]

In areas where demand for services is inelastic, any competition will be deleterious.[405] An applicant for an ambulance service license may show that duplication will not have a deleterious effect upon the public health by establishing an increased demand for service in the area it wishes to serve,[406] or by establishing that a need exists that is not currently being met.[407]

Children's has established that a demand for its service exists. Together with Allina, Children's currently performs over 500 neonatal transports per year, and from March to September 2018, performed 53 pediatric, non-neonatal transports.[408] This is not a hypothetical demand, but rather is the status quo. Objectors recognize that the demand for this service exists, and some have clearly indicated they have no objection to the service Children's currently provides.[409] They object, however, that granting Children's a license to meet this demand independent of Allina will have deleterious effects. These objections fall into several categories.

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[402] Minn. Stat. § 144E.11, subd. 6(2).
[403] *Twin Ports Convalescent, Inc. v. Minn. State. Bd. of Health,* 257 N.W.2d 343, 348 (1977) (interpreting prior governing statute as manifesting "a legislative determination that the ambulance service business is one in which the public welfare is not promoted by free enterprise.")
[404] *Id.*
[405] *N. Mem'l Med. Ctr. v. Minn. Dept. of Health*, 423 N.W.2d 737, 739 (Minn. Ct. App. 1988).
[406] *Id.* at 740.
[407] *Matter of Rochester Ambulance Serv.*, 500 N.W. at 498.
[408] Ex. 13 at 13A (Children's Minnesota Response to EMSRB's First Set of Requests for Production); Tr. Vol. I at 281-282 (Trocke); Tr. Vol. V at 1225 (Hirschman).
[409] Tr. Vol. II at 463, 493 (Ducharme); Tr. Vol. IV at 925 (Lyng); Tr. Vol. III at 777-778, 781 (Croston); Ex. 3 at 3F ("the necessity of the specialized service provided by Children's Minnesota is almost beyond debate"); *see also* Tr. Vol. II at 512 (Parrish) ("I mean they are doing the job right now, I don't understand what the -- I guess I am trying to understand why they need the license if they are already doing the job."); *see also* MAA's Written Closing Argument at 9 (noting that as to neonatal transports "this need is already being met by [Children's] itself."); North Memorial Closing Argument at 14 ("If there is any measurable public health benefit to the use of Children's rigs, then there can be no doubt that the citizens of Minnesota are already reaping that benefit.").

First, some objectors contend that granting Children's a statewide license will open the door to statewide licensure of other entities, including non-Minnesota and for-profit entities, leading to destruction of Minnesota's current PSA system. The Board is required to analyze each application for licensure on its own merits to determine whether the statutory factors in Minn. Stat. § 144E.11, subd. 6, weigh in favor of licensure. These statutory factors do not contemplate analyzing the impact of future license applications that may be submitted by unknown entities. This would be a speculative endeavor. If Children's is granted a license, and subsequently another entity determines it wishes to seek a statewide license, the Board will be required to address the merits of that license application and determine its impact on the public health, at the time that issue arises.

Second, some objectors note Children's specification of a patient population for its service, which they fear will lead to applications for service to other specific populations or for particular medical conditions. But, the legislature and the Board have already established that a license may be granted to serve a specific population or persons with particular medical conditions. The definitions for specialized life support and scheduled ambulance service expressly contemplate these categories.[410] This argument also relies on speculation about actions that may be undertaken by other entities at a later date. The Board cannot deny Children's a license that is expressly allowed because others might also seek that type of licensure.

Third, some objectors contend that deleterious competition will result because Children's may expand its service beyond the confines of the care it currently provides by opening bases throughout the state, and that it will ultimately seek to perform all pediatric interfacility transfers statewide, as well as adult transfers for individuals who suffered an illness as a child.[411] Objectors rely on several aspects of Children's application to support this premise: (1) Children's has applied for a statewide license; (2) Children's indicated it would transport adults with pediatric conditions; (3) Children's designates the population it seeks to serve as 1,286,149 people; and (4) Children's has not limited its application by clearly stating it intends to provide critical or ICU care to the children it transports.

This argument is also speculative. There is no actual evidence in the record to support a conclusion that Children's intends to expand its service in the manner contemplated by the objectors. Children's has credibly explained that its service will be limited to the patients whose conditions require the level of transport care it now provides. Children's does seek to provide transfer services statewide; this is the service it currently offers and is not an indication that it intends to alter the nature of its transport operations. Next, the Board's application form expressly required Children's to state a population it would serve, and it chose to use a figure from the U.S. Census for the population of Minnesotans under the age of 18. This is a limitation of the form used by

[410] Minn. Stat. § 144E.101, subd. 9; Minn. R. 4690.0100, subp. 30.
[411] Tr. Vol. II at 518-519 (Parrish) (noting belief that a license will allow Children's to provide "transfers of any kind of patients throughout the state of Minnesota.")

the Board,[412] not an assertion that Children's actually intends to provide service to nearly 1.3 million Minnesotans. Children's further explained that it did not use the term critical care or designate its patients as ICU transports because the terms are not well-defined and it did not want to use imprecise terms in establishing its regulatory obligations. Finally, Children's explained that it sees a handful of adult patients with pediatric conditions at its facilities annually, suggesting that the number of transports that would be involved for such patients would be extremely minimal.

Fourth, some objectors contend that Children's seeks a statewide license so that it can advertise its services across the state and divert patients from other hospitals for treatment at Children's. Children's credibly explained at the hearing that, in most instances, referring physicians request a transport by Children's for neonatal patients because the referring physician wishes for the child to be treated at Children's. Children's rarely is called to provide transport for a neonate to a different facility, but if requested it would do so. Children's has transferred a much larger percentage of pediatric patients to facilities other Children's. Witnesses from Children's repeatedly, emphatically, and credibly testified that they see their transport service as a resource for all children regardless of the facility in which the child will ultimately receive treatment. Children's marketing and informational materials, which do discuss transport of patients to Children's and not to other facilities,[413] do not counteract this testimony. Such materials are not comprehensive business plans tailored to address all eventualities. The internal financial analysis Children's conducted, which contemplated return on investment and increased admissions,[414] also does not show that Children's intends to keep all transport patients for itself. Instead, this analysis considered a variety of factors as Children's refined its business plan for transport services.

Fifth, some objectors assert that the license application is an effort by Children's to skim the most profitable payors, or the "cream," from the mix of insurers, leaving other providers at a disadvantage. Some objectors contend that Children's may even enter into exclusive provider agreements in which it corners the market on transport services for some payors. There is no evidence in the record to support this argument. Children's provides services as requested without regard to whether a transport patient has insurance, or the type of insurance, or whether the child's family can pay.

Sixth, rural providers object that they rely on interfacility transfers to make up for inadequate 911 reimbursement rates and that losing transports, or even one run, to Children's will have a deleterious effect on them. The Administrative Law Judge does not discount the difficult financial pressures that face rural ambulance service providers and does not doubt their sincere concerns. At the same time, the Administrative Law Judge does not find these arguments persuasive.

The second factor for the Board's consideration requires analyzing whether a deleterious effect *on the public health* will arise from duplication of services, not whether

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[412] Tr. Vol. I at 71 (Spector) (noting that a development opportunity exists to consider changing some aspects of the Board's application form).
[413] *See* Ex. 103.
[414] *See* Ex. 200.

there is a deleterious effect on an ambulance service provider. Rural providers discussed the challenges they face in replacing equipment and in hiring qualified staff, and noted that a decrease in revenue from lost runs impacts their ability to address these issues and may ultimately lead to lower quality services for the public. They also argue that if Children's is licensed to provide interfacility transfers, a complete cessation of 911 response could result in some areas. Some objectors contend that, by taking runs that other providers might offer, Children's will be depriving them of opportunities to practice and develop skills with procedures that could aid children in transport.

The record does not suggest that such circumstances will result from licensure for Children's. The record clearly establishes that the number of transports any ambulance service may provide varies from year to year. The record also establishes that some rural providers do not provide neonatal transport or specialized pediatric transports, meaning that the overlap between their services and Children's is very small or possibly non-existent. Children's has established that most transport patients are brought to Children's at the request of a provider, and that many objecting entities had few, if any, transports to Children's over the last several years. Additionally, as Children's seeks to provide services statewide, the number of transports from any particular area of the state will be small and the transport runs spread over a wide number of providers. Children's will not be providing 911 services, which is the most common type of run accomplished by ambulance service providers, and the number of interfacility runs that will overlap with any particular provider will be too small to be of consequence for skill development. Importantly, Children's and Allina together can provide these transports now, even without a license for Children's.

Finally, the objectors argue that Children's has not established that an unmet need exists, and that other providers offer the same service by ground or air that Children's offers. Therefore, the objectors argue that licensure is not warranted. The record belies this argument. To be sure, there are other ambulance services that offer high-quality pediatric and neonatal transport, including a few providers that operate specialized teams serving these patients. None of them provides exactly the same service operated by Children's, however, based upon a combination of staff, equipment, and treatment options available during transport. The record also shows that some of the objectors have, themselves, utilized Children's pediatric transport services since these services became available in March of this year. Additionally some objectors argue that Children's has not shown an unmet need, claiming Children's cannot point to evidence of an adverse event suffered during transport by a child in Minnesota, other than anecdotally. This argument presupposes that it is necessary for a child to be harmed, to suffer, or possibly to die before Children's can show an unmet need. Such a showing is not required by the statutory factors.

As the situation now stands, Children's provides specialized transport services for neonatal and pediatric patients upon request of a referring physician. Under its current arrangement with Allina, it could perform the number of anticipated runs it might make if licensed, estimated at 805, or take on even more if able to do so. In fact, the entity most clearly impacted by Children's licensure would be Allina. Allina currently staffs the very same runs Children's makes and bills for its services; this is revenue

Allina will lose if Children's performs these runs on its own. Yet, Allina did not object to licensure for Children's and has been supportive of Children's as it explored obtaining its own license. There is no evidence showing that allowing Children's to provide transport care as a licensed entity will have a deleterious impact upon the public health.

C. The Estimated Effect of the Proposed Service on the Public Health

The record supports finding that the third factor weighs in favor of licensure. Children's has credibly shown that, in some instances, neonatal and pediatric patients may benefit from specialized transport services. This is not in serious dispute, as Children's, and others, already provide this service. Therefore, the question before the Board is not whether Children's should be able to provide such care, but whether the public health will benefit from granting it a license to do so.

Children's articulated several reasons why the public health will benefit from its licensure. First, if the contract between Children's and Allina is terminated, Children's would not have a partner through which to offer transport care and would be required to seek out another entity quickly to keep its operations running. While there is no evidence in the record showing that the collaborative relationship is endangered, the concern is not an idle one. Children's experienced this very situation when Life Link III suddenly ceased providing ground transportation services. Second, Children's has established training protocols for members of the transport team it provides, but Allina provides its own transport staff for the rigs who do not have Children's training; they are not under Children's oversight and Children's does not choose the specific employees Allina will provide. If Children's were licensed, it could determine training requirements for these other staff positions and would be able to select specific staff for its teams. Third, Children's established that runs are sometimes delayed because it takes time for Allina staff to convene together with Children's staff and the rigs to start the run. Finally, as Children's notes, it is not currently directly regulated by the Board, but instead is under Allina's regulatory umbrella.

Some interested persons commented that licensing Children's is unnecessary because children with critical medical needs are better served by air transport. Children's agrees that some patients should be transported by air. Children's receives patients at its hospitals who are transported by air and provides transport care itself by air. Children's does not seek for its service to replace air transport, but instead it hopes to complement other transport options to meet patient needs, as determined by the patient's physician. Additionally, Children's ground transport services are available in inclement weather that might make air transport unavailable. To the extent that Children's ground service competes with air services, air transport occupies a different market than ground transport, in which competition is permissible.[415]

Granting Children's a statewide license benefits the public health. Children's provides its current service statewide. Neonatal and pediatric patients throughout the

[415] Tr. Vol. IV at 904 (Fennell) (agreeing that air transport is subject to competition and that Mayo's air transport service completes with air services offered by North Memorial and Sanford).

state may benefit from a transport by Children's if their medical condition requires that level of care. At the hearing, the Board's counsel asked whether Children's could accomplish its goals with a scheduled service license to transport patients between its two facilities, and Children's expressed that it could.[416] The Administrative Law Judge respectfully proposes that granting such a license is not well-supported by the record. Children's service is not an internal facility-to-facility mode of transport. Though it is possible Children's service could be used in this manner if a particular patient required it, the service Children's offers clearly is a statewide transport service. To speak plainly, if the Board intends for Children's to have a license under which it offers statewide service, the Board should grant it a license to offer statewide service.

Granting such a license, with a statewide PSA, would alleviate any concern that a local ambulance service provider would prevent Children's from performing a run deemed necessary by a referring and accepting provider based on their medical judgment. Many ambulance services expressed that they would not stand in the way if a patient's physician determined that Children's service offered the best transport option, and some noted they would provide strong support to Children's if such a transfer did occur in their area. Yet, some providers interpret Minn. Stat. § 144E.101, subd. 13, to permit them to prohibit a provider operating outside their PSA from performing a transport if they believe they can provide it, and that their permission for the transfer must be granted before it can be accomplished. Minn. Stat. § 144.101, subd. 13, provides that

> A licensee may provide its services outside of its primary service area only if requested by a transferring physician or ambulance service licensed to provide service in the primary service area when it can reasonably be expected that:
>
> (1) the response is required by the immediate medical need of an individual; and
>
> (2) the ambulance service licensed to provide service in the primary service area is unavailable for appropriate response.

The Administrative Law Judge notes that the interpretation given to the term "unavailable" by these providers may not be an accurate one. This question of statutory interpretation is not squarely presented in this proceeding, however, and so the Administrative Law Judge does not offer analysis on that point. Rather, the Administrative Law Judge notes that granting Children's a license to operate statewide, as it currently does, with a scheduled service license and statewide PSA is consistent with the record and avoids this concern.

Finally, the Administrative Law Judge recommends that the Board reject limitations suggested by interested persons to limit Children's to 805 runs per year, to limit the number of trucks Children's can operate, or to limit its ability to advertise.

[416] Tr. Vol. V at 1242-1243 (Question by counsel for the Board to Dr. Hirschman).

Limiting the care Children's can provide to a certain number of runs does not benefit the public health if a physician determines that patient number 806 would benefit from care by Children's. Additionally, limiting Children's to two trucks may hamper its ability to further refine and improve the physical assets through which it provides care and may impair its capacity to serve children who are in need. Finally, limiting Children's ability to advertise a service it offers would make it difficult for Children's to educate providers around the state about the options its service presents. These restrictions are not required by the statutory factors.

D. Whether Any Benefit Accruing to the Public Health Would Outweigh the Costs Associated with the Proposed Service

The Administrative Law Judge determines that the fourth factor also weighs in favor of licensure. As noted earlier, Children's currently provides care on hundreds of transport calls annually. Children's can continue to provide these transport services, and take as many transport runs as it can handle, without having a license. Yet, the intent of the legislature is for ambulance services to be licensed and to operate directly under the oversight of the Board, which oversight benefits the public health.

Additionally, as discussed above, there is no evidence showing that any particular provider, other than Allina, will lose money to Children's if it is licensed. There is no evidence in the record showing that the neonatal runs Children's has long performed resulted in losses to any other provider, and several providers who participated in this hearing had no detrimental changes in their number of pediatric runs since Children's began performing this service.

There also is no evidence that the public will bear increased costs if Children's is licensed. There is no evidence in the record suggesting that other providers will charge more for their services if Children's is licensed, or that transport runs provided by Children's will become more expensive once it is licensed.

The record shows that the greatest costs of this service will be borne by Children's. Children's estimates that this service will lose money, potentially a substantial sum annually. Children's determined that the benefit of providing this service to children outweighed the financial losses it will incur.

V. The Board May Modify the License Granted Based on the Current Record

Some objectors argue that the Board should deny Children's a license instead of modifying the license granted to meet the statutory requirements. Objectors contend that the license should not be modified because the public did not have an opportunity to address potential modifications through the comment period before the Board and at the hearing. The Board should reject this argument.

Minn. Stat. § 144E.11, subd. 6, expressly contemplates that the Administrative Law Judge may "recommend that the [B]oard either grant or deny a license *or*

recommend that a modified license be granted."[417] Therefore, a modification may be proposed based upon the record of the hearing. The record in this case is extensive and reflects that issues raised regarding the application, and the contours of the service Children's will provide if licensed, were fully vetted during the pre-hearing portion of the process and through the hearing. The license the Administrative Law Judge recommends is essentially the same license Children's requested, with a shift in terminology and explicit recognition of a statewide PSA. There is no reason for the Board to determine it cannot modify the license.

VI. Conclusion

There is a recognition, throughout the statutory factors, that the public health is the Board's primary concern in making its licensing determination. Minnesota's PSA system provides the state with a substantial public health benefit. But while "best possible care" is not a statutory factor,[418] the law should not be applied to stifle innovation in transportation services or care delivery. Children's has shown that making its transport service available as a licensed provider benefits the interests of the public health.

The Administrative Law Judge determines that Children's has met its burden to show by a preponderance of the evidence that it should be granted a license to operate an ambulance service. The Board should grant Children's an ALS scheduled service license with a statewide PSA, to operate 24 hours per day and 7 days per week, allowing Children's to provide neonatal and pediatric interfacility transports, as well as interfacility transports of adults with pediatric conditions, upon request by a referring medical provider or ambulance service.

J. P. D.

[417] Emphasis added.
[418] *Life Star Ambulance Sys., Inc.* v. *Ashton*, 363 N.W.2d 895, 897 (Minn. 1985).