Court Rulings Affect Medi-Cal Rate Cuts

Siren
Winter 2012
A Publication of the California Ambulance Association

The Safety Officer - Part 1

Member Profile on American Ambulance

Honorary CAA Member Earl Riggs Passes Away

Honorary CAA Member William E. "Earl" Riggs (1941 – 2012) passed away on January 11, 2012.

Earl Riggs founded Fremont Tri-City Ambulance Company in the mid-sixties and the company grew to become Regional Ambulance.

Earl Riggs was one of the original four founders of American Medical Response which was formed in 1992. He was very active at the state and national level and was instrumental in the forming of the American Ambulance Association, leading efforts to merge the two existing national associations into the AAA in 1979.

At the state level, he served as Chairman of the California Ambulance Association from 1978-1979 and was twice honored as the CAA "Man of the Year," first, for his work in gaining the 24-hour shift exemption for ambulance providers and, second, in the late eighties for founding the AzStar Insurance company.

Earl is survived by his wife of 50 years, Sharon; children Tracy Venable (Ron) of Brentwood and David Riggs (Sherrill) of Brentwood and eight grandchildren.

Funeral services were held on January 19 in Brentwood, CA and several ambulances from throughout the state participated in the funeral procession. Donations in the name of Earl Riggs can be made to the American Liver Foundation. ✢

Welcome New Members:

Trans Life Ambulance
Active Member
Mark Baird
Van Nuys, CA

Amwest Ambulance
Active Member
Boris Krutonog
Burbank, CA

Comments or questions about new member applicants should be directed to:
kingersoll@the-caa.org

CAA Members Honored at EMSA Awards

California emergency medical services providers and associates were recognized for exceptional acts of bravery and service to their communities and to the state at a luncheon ceremony in San Francisco December 7, 2011 hosted by the Emergency Medical Services Authority. Dr. Howard Backer, Director of the EMS Authority, and Commission Chair Colleen Kuhn, presented the 2011 EMS Awards.

Numerous CAA members were among those who received individual achievement recognition. At the award luncheon, EMSA Director Dr. Backer stated they have been selected in recognition of their excellence, motivation and service to EMS and he expressed his appreciation for their exemplary service. For more information and photos of the event, go the EMSA website at: http://www.emsa.ca.gov/about/awards/AwardPhotos_2011.asp

Dr. Backer (left) and EMS Commission Chair Colleen Kuhn (right) recognize Marilyn Dioszeghy (center). Photo courtesy of Art Hsieh.

The following individuals received Service Achievement Awards:

- George Baker, Hall Ambulance Service, 12 Years Service in EMS
- Sean Cox, Care Ambulance Service, 15 Years Service in EMS
- Sara Fitzpatrick, Riggs Ambulance Service, 10 Years Service in EMS
- Jennifer Mundy, Manteca District Ambulance Service, 20 Years Service in EMS
- Walter Parton, Riggs Ambulance Service, 26 Years Service in EMS

The following individuals received Meritorious Service Awards:

- Mark Leonard, Coast Life Support District, Gualala
- Jennifer Mundy, Manteca District Ambulance Service, Manteca
- Harrison Stewart, First Responder EMS, Chico

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Siren

Vision

Assure delivery of excellent pre-hospital care to the people of California by promoting recognized industry best practices.

Mission

- Serve as the voice and resource on behalf of private enterprise emergency and non-emergency ambulance services.
- Promote high quality, efficient and medically appropriate patient care.
- Advocate the value that pre-hospital care provides in achieving positive patient outcomes.
- Promote effective and fiscally responsible EMS systems and establish standards for system design.

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Opportunities and Challenges for California's EMS System

by Bob Barry, Chair of the Board

Bob Barry

Despite the ongoing debate about the federal Accountable Care Act, better known as Obama Care, some reforms have already been implemented and others are certain to be, especially in California. Most of the EMS providers and stakeholders that I have talked to admit they know very little about how healthcare reform will change or impact EMS. But just about everyone agrees that major changes are on the horizon.

I believe that EMS providers and stakeholders are going to need to act now if we are to be prepared for these changes or have any chance at influencing the policies that are shaping healthcare reform. To date, we have had several changes already take effect. Most of these have involved health insurance coverage and rate provisions. Others changes, due to state budget issues, have included recent provider rate cuts. We have also had close calls including proposals to abolish the EMS Commission, and to move the EMSA within the public health department. The EMS stakeholder community came together and successfully opposed both of these plans, and more proposals are sure to come.

While some of these changes may not directly affect your business or agency today, they will have a profound impact on our industry and EMS in general as full implementation of the PPACA takes effect in 2104. These changes will present challenges and opportunities for us as providers and stakeholder groups.

So, how do we prepare? First and foremost, as an industry and as members of the EMS system, we need to educate ourselves and engage in the process. There is a window of opportunity to help shape the reforms. For the EMS voice to be heard, however, we must get involved at the highest levels, demand inclusion in new state taskforces and policymaking committees, and educate policymakers before they make decisions without regard to our interests.

The CAA has taken a strong interest in healthcare reform and has placed this issue as a top priority. We are committed to serving as a clearinghouse for ideas

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Executive Director's *Update*

CMS Approves Medi-Cal Rate Cuts

CAA Challenges New Medi-Cal Access to Care Standard

by Brenda Staffan, Executive Director

Brenda Staffan

On November 2, 2011, the California Department of Health Care Services (DHCS) announced the federal Centers for Medicare and Medicaid Services (CMS) had approved the DHCS request to permanently reduce Medi-Cal ambulance rates by ten percent. As part of the CMS approval, the DHCS was required to develop a methodology which applies a federal access to care standard to every provider group which was subject to the Medi-Cal rate cut. According to the new DHCS policy, the access to care standard for emergency and interfacility ambulance transportation services has been combined with an identical standard for wheel chair and gurney van services, durable medical equipment suppliers, home health providers and dental services. The CAA analyzed both DHCS reports, *Medi-Cal Access Analysis (6 services)* and *Developing a Healthcare Access Monitoring System,* and found significant problems including errors, inaccurate data and policy flaws. Among other requests, the CAA recommended that DHCS develop unique measures for evaluating access to care for emergency services.

A coalition of public and private providers submitted a comment letter to DHCS, met with DHCS Director Toby Douglas in Sacramento on November 18, 2011 and submitted a follow-up letter on November 30th. In an effort to educate federal and state health officials regarding the unique care provided by emergency medical services, the EMS coalition also submitted a May 16th comment letter to CMS and met with CMS Medicaid officials in Baltimore on June 27th requesting a rejection of the Medi-Cal rate cut. In response to a Medicaid proposed rule (issued by CMS), on July 1st the CAA submitted a comment letter to the CMS Administrator recommending that "*any access to care analysis must address mandates to provide care regardless of reimbursement amounts.*" The CAA is awaiting a response from DHCS and is exploring the option of an EMS-specific federal access to care standard either through regulation or new statutory language.

The CAA believes the state's interpretation of the federal access to care standard has been inappropriately applied to emergency services. The Medicaid rate setting provision in Federal law which applies to ambulance services is from Section 1902(a)(30)(A) of the Social Security Act as follows:

A State plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

The DHCS standard is in conflict with other federal guidelines

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Ambulance Coalition Researching Alternative Medi-Cal Funding

While the legislative and legal battles over Medi-Cal funding are intensifying for health care providers, patient advocates and state finance officials, the CAA continues to argue that the State's severe inadequate financing of ambulance services places the statewide EMS system in a precarious position at the very time that the number of Medi-Cal enrollees will increase in 2014 due to health care reform implementation. Our long-term goal remains that Medi-Cal rates are increased to a level equal to Medicare rates. However, in the short term, we must research alternative local, state and federal funding sources.

A Medi-Cal Work Group (formed in 2009 with broad industry representation) hosted by the CAA has researched two additional policy options which have been successfully implemented for other health care safety net providers such as hospitals. Both programs involve counties as strategic partners and require the use of new or existing county funding for the federal match. Below are the ambulance-specific programs which are being researched to generate increased federally matched payments to providers:

- EMS-specific Section 1115 Waiver Demonstration Request – for federally-matched supplemental payments associated with uncompensated care costs attributable to the uninsured
- State Plan Amendment Request for an EMS-specific Intergovernmental Transfer (IGT) Program – for federally-matched supplemental payments or rate increase associated with Medi-Cal patients

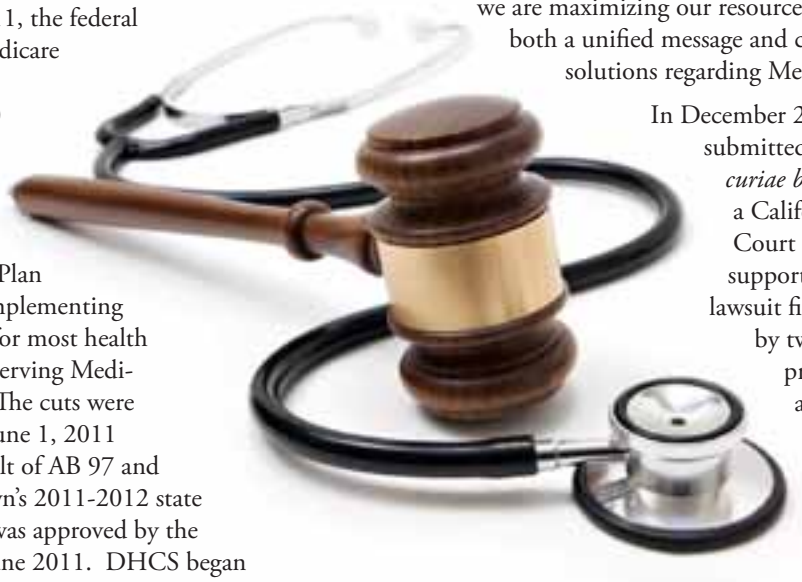
The CAA board of directors continues to pursue strategies that, as CAA Chairman Bob Barry says, will "leave no stone unturned." Of course, we will provide updates as we learn more details about the feasibility of these programs.

Several Court Rulings Affect Medi-Cal Rates

CAA Pursues Additional Legal Action

Over the last several weeks, federal courts have issued rulings on various lawsuits brought by health care provider groups regarding Medi-Cal rates and Medi-Cal rate cuts. A federal district court has awarded numerous preliminary injunctions to stop Medi-Cal rate cuts for a wide range of health care provider groups and the State has announced they will appeal the rulings to the U.S. Ninth Circuit Court of Appeals. Two of the court-ordered injunctions apply to ground ambulance services. In addition, the U.S. Supreme Court issued a long-awaited ruling on related Medi-Cal rate cases.

Federal Court Issues Injunctions Halting Medi-Cal Ambulance Rate Cuts



In October 2011, the federal Centers for Medicare and Medicaid Services (CMS) approved the Department of Health Care Services (DHCS) State Plan Amendment implementing 10% rate cuts for most health care providers serving Medi-Cal enrollees. The cuts were retroactive to June 1, 2011 and were a result of AB 97 and Governor Brown's 2011-2012 state budget which was approved by the legislature in June 2011. DHCS began implementing the rate cuts in early January.

The CMS approval of rate cuts triggered numerous lawsuits from a wide range of providers seeking injunctions. In early January 2012, U.S. District Court Judge Christine Snyder granted a temporary injunction request filed by the California Medical Transportation Association (CMTA) for *non-emergency medical transportation providers*. Then in late January, Judge Snyder included *all ambulance providers* in the temporary injunction request filed by the California Medical Association (CMA) covering numerous health care provider groups. While these court-ordered injunctions are temporary wins in the battle over Medi-Cal rates, additional legal steps are being pursued to both stop the Medi-Cal rate cuts in the short term and to achieve a permanent Medi-Cal rate increase.

Background

Over the past three years, the CAA has pursued a comprehensive effort to oppose Medi-Cal rate cuts and to reverse state policies that result in severe below-cost funding of ambulance services to Medi-Cal enrollees. The plan has included several parallel strategies: administrative, legislative, coalition-building, litigation, federal outreach, public relations and research of alternative funding sources. The CAA has collaborated with other key stakeholders to assure we are maximizing our resources and conveying both a unified message and consistent solutions regarding Medi-Cal funding.

In December 2010, the CAA submitted an *amicus curiae brief* (amicus) to a California District Court of Appeal in support of the original lawsuit filed in state court by two ambulance providers (SEMSA and Riggs Ambulance Service) seeking to increase Medi-Cal rates. The amicus addressed several key issues: provided documentation regarding the cost of ambulance services; described the legal, moral and practical reasons that emergency ambulance services cannot "opt out" of the Medi-Cal program because of low rates; and provided the history of CAA's efforts to obtain adequate Medi-Cal rates. While the CAA was not an official participant in the original lawsuit filed in state court, the CAA's amicus formally established the CAA's position in support of the lawsuits goals. This was the first Medi-Cal lawsuit filed by a group of California ambulance providers in Los Angeles Superior Court in May

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In January 2012, the ambulance litigants and the CAA approved additional legal action to, first, secure a permanent injunction halting the 10% Medi-Cal rate cut, and, second, to remove the stay on the federal Medi-Cal ambulance lawsuit which is the legal path for a permanent Medi-Cal rate solution. It is critically important that the federal court consider the distinct circumstances of ambulance services and the unique ambulance-specific evidence.

The Legal Battles Over Medi-Cal Rates are Intensifying

Due to the ongoing budget crisis and cash flow problems, the State recently implemented short-term payment delays to universities, counties and *Medi-Cal providers*. The State vows to appeal the injunctions and has announced, "as the state's second largest general fund expenditure, Medi-Cal must be part of the state's budget solution." The CAA board of directors continues to pursue strategies that, as CAA Chairman Bob Barry says, will "leave no stone unturned."

Don't Let Meal Break Policies Take Your Lunch Money

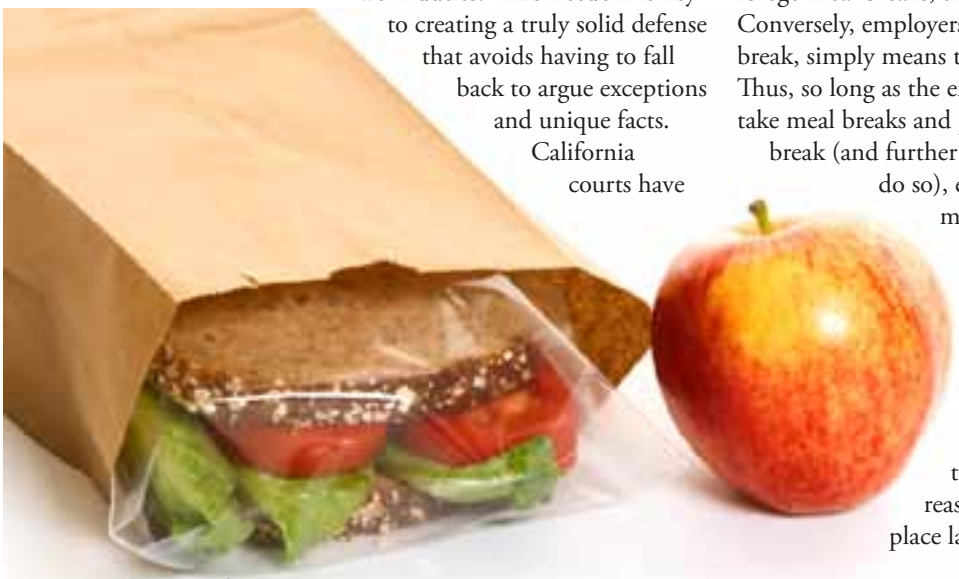
By John Yslas, Nan Chen and Michael Scarano

The ambulance industry has become a prime target in California for wage and hour lawsuits, especially with regard to meal breaks. The best defense against these lawsuits is to implement policies to ensure that meal breaks do not become an issue in the first place. Ambulance companies need to pay particular attention to the complicated meal breaks law in California to avoid becoming embroiled in expensive litigation.

California Law On Meal Breaks

California's Labor Code requires all employers to provide their employees with proper meal breaks. Although there often exist a number of solid and well-founded defenses, the consequences to employers for missed meal breaks may be expensive. Under California law, for every workday in which an employee misses a meal break, the employer must potentially compensate that employee with an extra hour of pay. As one might imagine, this adds up quickly. For example, if a company employs twenty employees at $20 per hour and has a poorly drafted or poorly implemented meal break policy, this may expose the company to up to $400 per workday in liability ($20 per worker every day).

To comply with California law, employee meal break policies should address (1) when meal breaks are provided, and (2) what constitutes a meal break. The first issue is simple enough. Barring defenses and facts, under California law, one meal break must be "provided" (which arguably means "made available") if the employee works for five hours. If the employee works 10 hours, then a second meal break must be provided. In order to count as a "meal break" (again, subject to defenses and facts), the meal break must be completely uninterrupted by work for at least 30 minutes and free from all work duties. This freedom is key to creating a truly solid defense that avoids having to fall back to argue exceptions and unique facts. California courts have characterized meal periods as "the right to be free of the employer's control." This means that if an employee responds to a call during his or her 30 minute meal break, this may not count as a meal break. Likewise, if an employee is required to stay within a very limited geographic area, or cannot conduct personal business, that time may not count as a meal break. For example, some courts have ruled that policemen who are "on-call" and cannot run personal errands during meal time or must respond to emergencies are not relieved of duty and, therefore, not on meal breaks. Thus, a best practice for employers is to endeavor to not interrupt an employee's meal period or place too many restrictions on an employee's activities during their meal period.



How To "Provide" A Meal Break

California law states that employers must "provide" their employees with meal breaks, but the courts have not definitively ruled on what "provide" means. Companies which are defendants argue that "provide" means simply to make meal breaks available, while employees who are plaintiffs argue that "provide" means that employers must ensure meal breaks are taken. The California Supreme Court will rule on this issue in a heavily anticipated case called Brinker Restaurant Corp. v. Superior Court. In Brinker, employees of a restaurant brought a class action alleging that their employer failed to "provide" meal breaks. The key issue in this case was what "provide" means.

The plaintiff employees in Brinker argue that to "provide" means to ensure that meal breaks are taken. Under this view, employers arguably must essentially make sure or "force" employees to take uninterrupted meal breaks and even if employees voluntarily forego meal breaks, the employers are still in violation of the law. Conversely, employers typically argue that to "provide" a meal break, simply means to make meal breaks available to employees. Thus, so long as the employer informs the employees that they may take meal breaks and provides the opportunity to take such a meal break (and further ensures that employees are not forbidden to do so), employers may not be liable for voluntarily missed meal breaks. Arguably it is only when employers force employees to forego their meal breaks that liability may occur. The Court of Appeals in Brinker adopted this position. The Brinker Appeals Court held (among other things) that "the employee must show that he was forced to forego his meal breaks as opposed to merely showing that he did not take them regardless of the reason." As oral argument on this issue took place late last year, the state Supreme Court will soon

decide this issue.

Even though the verdict is still out on how the Court will interpret "provide," ambulance companies would be well-advised to work with knowledgeable legal counsel in crafting policies that take the foregoing issues into account.

The On-Duty Meal Break Option

In some situations, as a practical matter, it may be difficult or arguably impossible for EMS employers to guarantee a completely duty-free meal period. In these cases, employers can consider using an "On-Duty Meal Break Agreement." When certain legal requirements are met, these agreements allow employers and employees to agree to a paid meal break that is not free from all work-related duties. In order to implement this meal break agreement, the employer and employee must have a written agreement which states that the employee may revoke the agreement at any time. The revocation language is critical to the validity of the agreement, and many employers expose themselves to risk by failing to include this language.

Additionally, an on-duty meal break agreement is allowed only if the "nature of the work prevents an employee from being relieved of all duty . Although no court has definitively ruled that the nature of EMS work qualifies ambulance providers for an on-duty meal agreement, a strong argument to that effect can be made in many cases. On-duty meal break agreements have been used with employees such as security guards, cement mixer drivers, and even retail store employees. Whether the nature of work justifies an on-duty meal break depends on several factors, including essentially: (1) the type of work, (2) the availability of other employees to provide relief to an employee during a meal period, (3) the potential consequences to the employer if the employee is relieved of all duty, (4) the ability of the employer to anticipate and mitigate these consequences, and (5) whether the work product or process would be destroyed by relieving the employee of all duty. One could argue that EMS employees qualify for on-duty meal breaks, because their work may require immediately responding to emergency calls and they cannot always take a completely duty-free lunch, although it should be noted that plaintiffs' attorneys have routinely made arguments to the contrary.

Don't Lose Your Lunch Money

As the foregoing indicates, it is important to draft effective meal policies. In the absence of an enforceable meal break agreement, policies should assure that employees receive uninterrupted breaks if at all possible. Failure to take the law and its nuances into account can be very expensive. ✢

John Yslas is a partner in the Labor & Employment Practice Group of Foley & Lardner, LLP, a national law firm with four offices in California. He represents employers in class action wage and hour litigation and a wide variety of other actions, including state and federal claims of discrimination, retaliation, harassment, breach of employment contract, wrongful termination, unequal pay, breach of fiduciary duty and unlawful interference. He is based in Foley's Los Angeles office.

Nan Chen is an associate in the Labor and Employment Practice Group, based in Foley's Los Angeles office. Nan also represents employers in a wide range of actions, including wage and hour claims

Michael Scarano is a partner based in Foley's San Diego office. He is co-chair of the firm's national Health Care Industry Team. He represents ambulance and EMS providers nationwide in a wide range of matters, including regulatory and reimbursement compliance, health facility and public agency contracting, and HIPAA privacy and security.

Unemployment Insurance Tax Hike on California Businesses

By Chris Micheli, CAA Legislative Advocate

While the Governor's budget is premised upon the success of his proposed tax increase initiative planned for the November 2012 statewide ballot, California businesses have begun paying higher employment taxes in the amount of $21 per employee, which is about a $290 million federal tax increase for 2011. This tax increase is the result of employers being required to repay the federal government for loans made to the California's Unemployment Insurance (UI) Fund. Since early 2009, California has been receiving a quarterly loan to cover the state's continuing UI deficit. The federal loans have been necessary so that the state Employment Development Department (EDD) could continue making uninterrupted payments to UI recipients.

This tax increase is the result of employers being required to repay the federal government for loans made to the California's Unemployment Insurance (UI) Fund.

California's UI Fund has been running an operating deficit since January 2009. California is one of 27 "credit reduction" states, according to the federal government. California has the largest balance at $9.2 billion. Pennsylvania, with a debt of $3.1 billion, has the second highest loan balance.

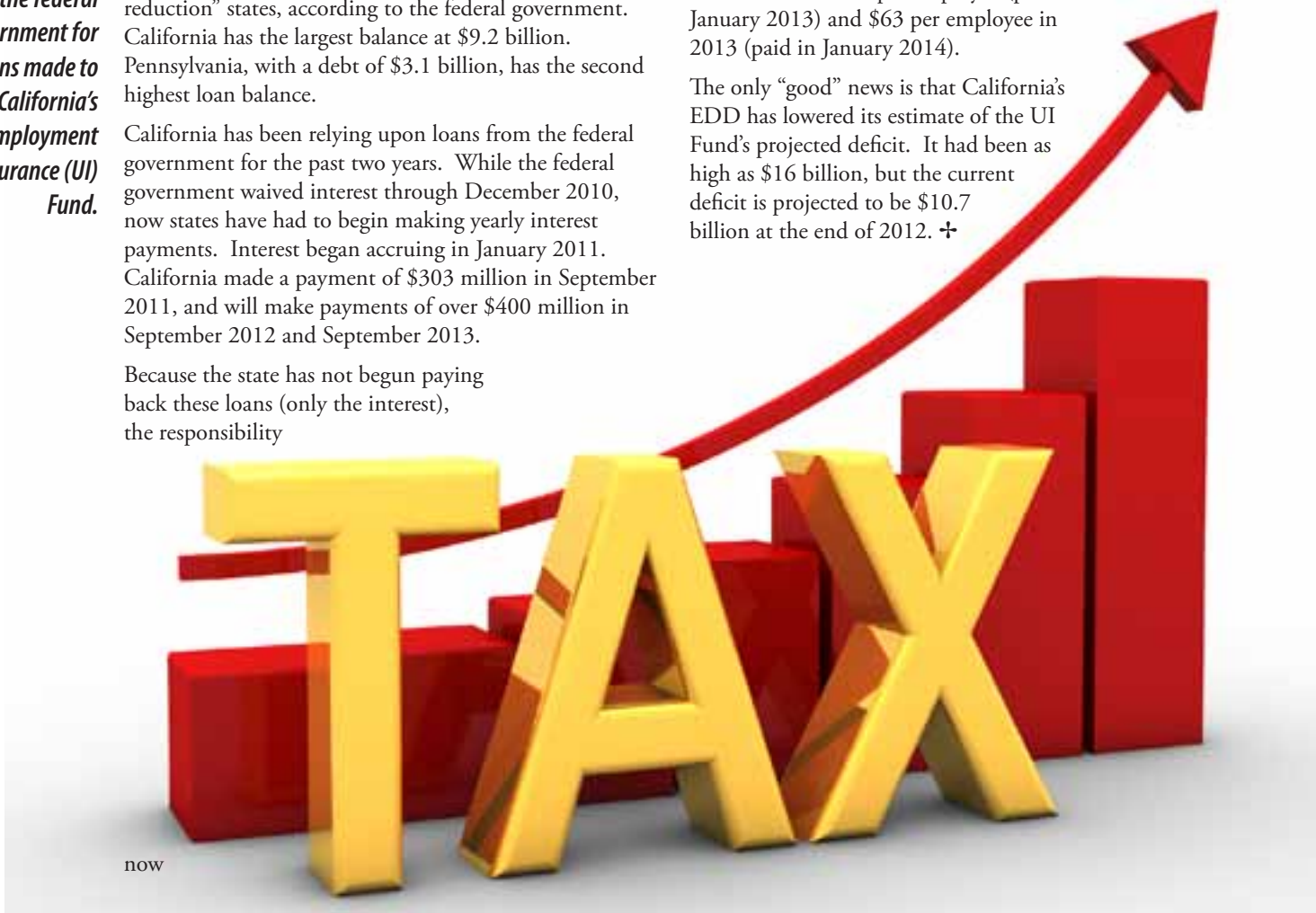
California has been relying upon loans from the federal government for the past two years. While the federal government waived interest through December 2010, now states have had to begin making yearly interest payments. Interest began accruing in January 2011. California made a payment of $303 million in September 2011, and will make payments of over $400 million in September 2012 and September 2013.

Because the state has not begun paying back these loans (only the interest), the responsibility now falls to businesses in California. Employers have begun paying back these loans by means of a reduced credit in paying their Federal Unemployment Tax Act (FUTA) taxes. The credit is being reduced for the employers' credit in the amount due on January 31, 2012, relating to FUTA taxes paid in calendar year 2011. California's employers will face another reduction in their FUTA credit for 2012 (paid in January 2013).

The FUTA taxable wage base is the first $7,000 in wages paid to employees in California. There are five states including California that have a taxable wage rate at the federal minimum level. As such, California's current maximum state tax per employee is $434 per year, while the national average is $995 per employee per year.

Absent legislative action in 2012, the amount of the tax increase will be $42 per employee (paid in January 2013) and $63 per employee in 2013 (paid in January 2014).

The only "good" news is that California's EDD has lowered its estimate of the UI Fund's projected deficit. It had been as high as $16 billion, but the current deficit is projected to be $10.7 billion at the end of 2012. ✢



Annual Stars of Life Celebration & Legislative Summit

"One of the most exciting association events of the year"

April 16-18, 2012
Sheraton Grand Hotel
-Sacramento-

The CAA's Annual Stars of Life Celebration recognizes and honors the dedicated field EMS professionals in the ambulance services industry.

The program also features meetings with Members of the Legislature at the State Capitol where the Stars of Life themselves, along with a host from your ambulance company, will provide a shining example for your Assembly Members and Senators of the value of quality ambulance services as an *essential component of the health care safety net*.

Your participation also ensures wonderful memories for your employees and valuable local exposure and recognition for your ambulance operation.

The program will include:

- ★ Buffet breakfast and orientation
- ★ Legislative Certificate of Recognition for each Star of Life
- ★ Individual meeting with your members of the Assembly and Senate
- ★ Networking reception
- ★ Dinner with award presentation ceremony and distinguished guest speaker
- ★ Numerous opportunities for local and state recognition.

Program Overview

Monday, April 16
9:30 am – 12:00 pm
Committee Meetings

1:00 pm – 5:00 pm
EMS Health Care Reform Think Tank

Tuesday, April 17
All Day
Stars of Life Celebration

Wednesday, April 18
8:30 am – 10:00 am
Committee Meetings

10:15 am – 1:00 pm
Board of Directors Meeting

Legislative & Regulatory Briefing

During committee meetings, the CAA will address the association's legislative and regulatory priorities:

- Medi-Cal Rate Increase
  - Section 1115 Waiver & IGT – Assessment of these new funding options
  - Legislation – Options to achieve ambulance rate increase
  - Litigation – Status of federal Medi-Cal lawsuit and rate cut injunction
- Medi-Cal Implementation of HCPCS Codes – Timing of state implementation
- Grandfather Status Under EMS Act Sections 201 & 224 – Proposed legislative and regulatory changes to the "grandfather" clauses of the EMS Act under Sections 201 & 224
- California EMS Commission – Current issues and priorities
- Status of State Budget – Potential impacts on ambulance providers
- Healthcare Reform Implementation – Ongoing roll-out of the state and federal framework

CALIFORNIA AMBULANCE ASSOCIATION

For hotel and registration information, go to www.the-caa.org
Schedule subject to change.

Court Rulings Affect Medi-Cal Rates

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2008. The case was denied by a superior court judge in late 2009 and the subsequent appeal was also denied by the District Court of Appeals, thus ending the state level litigation.

The state case was immediately followed by a parallel federal petition filed with the U.S. District Court in Los Angeles in June 2010 by a now much larger group of providers (consisting of 28 litigants including both members and non-members of the CAA). In 2011, the CAA officially joined the 28 other ambulance plaintiffs in the federal lawsuit also intended to address severe below-cost Medi-Cal ambulance reimbursement (SEMSA et. al. vs. Toby Douglas, CDHCS).

Judge Orders Stay in Federal Medi-Cal Ambulance Lawsuit

The federal Medi-Cal ambulance lawsuit accuses the State of violating federal law and the U.S. Constitution's Fifth Amendment which protects against the illegal taking of property. The *illegal taking of property* is a result of simultaneous requirements for ambulance providers serving Medi-Cal enrollees: 1) ambulance providers are statutorily mandated to respond to all 9-1-1 calls and are prohibited from denying non-emergency Medi-Cal services; and 2) the State's Medi-Cal reimbursement for those services is not a reasonable (cost-based) amount. The state Attorney General's office has indicated that the federal ambulance lawsuit was the first Medi-Cal rate case filed in California based upon a Fifth Amendment violation. The federal ambulance lawsuit was transferred to the same federal judge (Christine Snyder) hearing the well-known *Independent Living Center* case. This is also the same federal judge which has recently granted numerous temporary injunctions preventing Medi-Cal rate cuts. Because the U.S. Supreme Court was reviewing related Medi-Cal cases, Judge Snyder ordered a stay in the federal ambulance lawsuit.

U.S. Supreme Court Issues Major Decision on Medi-Cal Rate Cases

On February 22, 2012, the U.S. Supreme Court issued a decision in three related lawsuits all challenging Medi-Cal rates (Independent Living Center, California Pharmacists Association and Santa Rosa Memorial Hospital). The U.S. Supreme Court decision sends all three Medi-Cal cases back to the federal Ninth Circuit Court of Appeals, citing the complexity of the Medicaid challenges and the changes that the federal Health and Human Services Department has enacted since the lawsuits were first filed. In an opinion written by Justice Breyer, the court vacated the Ninth Circuit's original court decision and said the Ninth Circuit could rehear the case.

Next Step: Secure a Permanent Injunction & Lift Stay on Ambulance Case

In January 2012, the ambulance litigants and the CAA approved additional legal action to, first, secure a permanent injunction halting the 10% Medi-Cal rate cut, and, second, to remove the stay on the federal Medi-Cal ambulance lawsuit which is the legal path for a permanent Medi-Cal rate solution. It is critically important that the federal court consider the distinct circumstances of ambulance services and the unique ambulance-specific evidence. The petition will request Judge Snyder to lift the stay on the federal ambulance lawsuit. The petition will also assure that the temporary ambulance injunction is not overturned.

Clearly, the legal and policy issues surrounding Medi-Cal reimbursement are complex. Regarding the various lawsuits, there are significant differences in their respective legal approaches. First, there is a *difference in intended outcome.* A temporary injunction will only stop the Medi-Cal rate cut in the short-term. A temporary injunction does not solve the underlying problem of severe below-cost Medi-Cal rates. The federal Medi-Cal ambulance lawsuit is intended to permanently correct low Medi-Cal rates and, therefore, requires a much more detailed legal strategy, evidence and arguments.

Second, there is a *difference in legal strategy*. Some of the Medi-Cal rate lawsuits filed by other health care groups are based upon violations by the State of federal regulations (i.e., *the Supremacy Clause*). The federal ambulance lawsuit is based upon violations by the State of several federal laws and the constitutional rights of ambulance providers. The federal ambulance lawsuit is intended to permanently correct severely low Medi-Cal rates that do not cover the actual cost of ambulance service. In addition, the federal ambulance lawsuit employs a legal strategy that is specific to the delivery of statutorily-mandated emergency ambulance service. This approach incorporates ambulance-specific statutes, regulations and supporting documentation to challenge the State's Medi-Cal rates as a violation of constitutionally protected Fifth Amendment rights (an illegal taking) and of other federal statutes. ✢

This approach incorporates ambulance-specific statutes, regulations and supporting documentation to challenge the State's Medi-Cal rates as a violation of constitutionally protected Fifth Amendment rights (an illegal taking) and of other federal statutes.

Brenda Staffan is the Executive Director of the California Ambulance Association.

EMSA Awards

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- Scott Wood, Medic Ambulance Service, Sacramento

The following individuals received Clinical Excellence Awards:

- Alberto Alvarez, Hall Ambulance Service, Bakersfield
- Claudia Andrade, Hall Ambulance Service, Bakersfield
- Sebastian Chavez, Hall Ambulance Service, Bakersfield
- Mike Grissom, Hall Ambulance Service, Bakersfield
- Kevin McClanahan, Hall Ambulance Service, Bakersfield
- Brandon McNamara, Hall Ambulance Service, Bakersfield
- Shaun Navarra, Medic Ambulance Service, Sacramento
- Sean Cox, Care Ambulance Service, Orange
- Sara Fitzpatrick, Riggs Ambulance Service, Merced
- Sandra Whaley, Medic Ambulance Service, Sacramento
- Stephanie Melton, Care Ambulance Service, Orange
- James Recto, Medic Ambulance Service, Sacramento
- George Baker, Hall Ambulance Service, Bakersfield

The following individual received Community Service Award:

- Marilyn Dioszeghy, First Responder EMS, Chico

The following individuals received Lifesaving Awards:

- Jessica Batz, First Responder EMS, Chico
- Matt Wolfe, First Responder EMS, Chico

The following individual received a Distinguished Service Award:

- Louis K. Meyer, Retired, Stockton ✢

Chair's Message

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and information on healthcare reform for our members, our industry, and the entire EMS system so we all can better anticipate and prepare for what lies ahead.

The question is, what outcomes do we wish to achieve? Are we looking at evidence-based medicine, or maybe new medical necessity criteria that may reduce transports? Do we need to prepare for more federal, state and local funding cut backs, or will there be new payment incentives tied to quality and cost savings? We may even have to prepare for a single payer system.

What can we do? We need to work together as providers, and EMS stakeholders to better understand and identify the challenges we face, and the opportunities that may present themselves. To this end, I invite all of you to attend and participate in the inaugural "EMS Health Care Reform Think Tank" that we will be hosting April 16, 2012 at the CAA Legislative Summit in Sacramento.

The *think tank* will bring together a group of leaders representing California's key EMS system stakeholders—including ambulance providers, representatives from EMSAAC, EMDAC, EMSA, Cal Chiefs, and labor—to confront tough issues on potential opportunities and challenges of health care reform. The *think tank* is sure to discuss controversial issues in a frank and, at times, difficult, conversation intended to generate creative solutions that will help shape your organizations' strategy going forward.

Additional details about the "EMS Health Care Reform Think Tank" will be sent to you soon, but I encourage you to save the date, and make plans to attend. The future of your business is at stake. ✢

Executive Director's Update

Continued from page 4

on how access is to be evaluated, such as a MACPAC report to Congress which identified three areas of evaluation: 1) appropriateness of services and service setting, 2) efficiency, economy and quality of care, and 3) impact on health care outcomes. California's statewide EMS system assures universal access to 9-1-1 emergency medical services regardless of the patients' insurance status or ability to pay. Utilization of 9-1-1 services is driven solely by need. Therefore, Medi-Cal rates could be zero and there would be no change in the utilization of or the need for services. Below are the specific recommendations to DHCS:

- Segregate medical transportation data into accurate and distinct categories
- Remove emergency ground ambulance services from provider participation and utilization trend analysis
- Convene a work group to develop unique measures for evaluating access to emergency ground ambulance services
- Expand the literature search to include emergency health care and emergency medical services research
- Implement an early warning system to assess shifts in the EMS system's financial infrastructure
- Correct data errors and comply with HIPAA regulations by implementing long-delayed uniform system of claims processing

While additional legal efforts continue to secure a permanent injunction which halts the 10% Medi-Cal rate cut, we will continue to advocate that the state's access to care analysis must address mandates to provide care regardless of reimbursement amounts.

For a copy of the CAA's letters, send a request to info@the-caa.org. For more information about the Medi-Cal rate cut, including the DHCS *Medi-Cal Access Analysis (6 services)* and the DHCS *Developing a Healthcare Access Monitoring System*, go to http://www.dhcs.ca.gov/pages/RateReductions.aspx. ✢

The Safety Officer, Part 1: Core Competencies

By Steve Melander, Operations Supervisor & Safety Officer, Riggs Ambulance Service

The ideal safety officer is a confident leader, and someone who has walked the walk and can talk the talk with their fellow EMTs and paramedics.

The role of a safety officer will vary depending on the size of your organization and your budget restrictions. The optimum would be a dedicated, full time position staffed by an experienced, safety specialist with advanced degrees and training. For smaller agencies with less financial resources, it could be a full or part-time field employee functioning as safety officer under the "other duties as assigned" clause. Safety programs focusing on prevention, when implemented correctly, will pay back many times over. I would caution you not to be frugal when it comes to staffing this position. The safety officer must have a genuine interest and should be given at least one or two days per week dedicated to safety duties and training.

When I think of an officer, it brings images of a person in a starched uniform, toting a gun, a badge, and whose responsibility is to lay down the law in no uncertain terms. An officer commands authority and the fear of consequence (tickets, fines, arrest, and imprisonment) is the motivating factor to behavior modification. While the safety officer is a position of authority and should be taken seriously, I would like to share a different perspective—less of an officer and more of a leader, liaison, and critical thinker.

The person functioning in the role of safety officer must first and foremost be a competent leader. They need to have the qualities required to lead such as courage, determination, motivation, and dedication. This person needs to be fully invested in the process. The safety officer, when selected and trained correctly, will be your catalyst for culture change. It is critical that they lead by example, and are actively involved in the processes that they are overseeing while making recommendations for change. The agency employees will not embrace the changes if they view the safety officer as someone who is completely out of touch with their job duties. Someone who has walked a mile in his or her shoes will establish more credibility. The safety officer must be willing to roll up their sleeves and get their hands dirty. If the safety officer hides in their office sending out periodic emails and memorandums they will not be respected, nor taken seriously. Most often, the best ideas develop when you are working side-by-side with your employees and encountering problems and discovering solutions together.

In addition to being a competent leader, the safety officer must be an effective communicator and liaison. One of their primary responsibilities will be to open the lines of communication among the employees and management. The safety officer needs to be able to balance representing the needs of the company and at the same time be an advocate to all employees. This is important to establishing a successful safety culture even though it is a difficult part in the role of a safety officer.

One of the goals of a safety officer is helping employees understand the reasons behind safety polices. Effectively communicating the policies and answering employees' questions about the policies will result in a "buy-in" attitude from the employees. They may feel better about complying if they understand the need for the safety policy as opposed to being told to follow it because management said so. Through effective communication, a safety officer can develop an understanding with employees and change their thinking process when it comes to following safety policies.

When selecting a person to be the Safety Officer, they must be able to look at all the angles, take the time to make good decisions, and listen to the different perspectives from employees.

The safety officer must be able to identify and determine the best course of action to improve safety in an organization on many complex issues daily in EMS. For example, early in my career in EMS, I discovered there were many safety policies that I needed to follow but was unable to due to varying circumstances, such as, I did not have the necessary tools available for me, I lacked the appropriate training, other policy changes voided the current policy, and current advances in equipment and technology made the existing policy obsolete. While working as a flight paramedic at a California-based air ambulance company, the director of quality and safety brought

this conflict into perspective for me and illustrated critical thinking in a safety improvement. He visited my base for an inspection and asked me to explain how I did things on the aircraft. Many times during the visit, he would stop me and asked me bluntly if what I was explaining was a policy or practice?

His questioning made me very uncomfortable at first, but after the fourth time, a light bulb went on over my head. His questioning was intended to determine whether I was able to follow the policy with the equipment, resources and training currently provided by the company; or, was the policy obsolete and required change. If a policy is not practical, it creates a hole in your safety system that requires immediate attention to prevent an accident from happening.

When selecting a person to be the safety officer, they must be able to look at all the angles, take the time to make good decisions, and listen to the different perspectives from employees. The safety officer must be well thought out in his/her actions and not make decisions too quickly. Many times, making decisions too quickly will only compound any issues affecting the safety culture of an organization.

In the next issue of the Siren, look for the next article in the series - The Safety Officer, Part II: Training & Education.✢

American Ambulance 911 Team: Paramedics Jeremy Kern, Mark Pisching, James Garza and EMT's Leann Folia and Adam Carreon.

American Ambulance: Providing Exemplary Care Through Innovation

Company: American Ambulance
Founded: 1975
President & Owner: Jim Kaufman
General Manager: Todd Valeri
Number of employees: 550
Number of ambulances: 90
Services Provided: ALS, BLS, Interfacility, CCT
Service Areas: Fresno & Kings Counties

American Ambulance was founded in 1975, by four EMTs in Fresno, with the purpose of providing non-emergency transports and medical supply delivery. In 1984, American Ambulance competed in a joint, exclusive operating bid in the area and was awarded their first contract to be the emergency paramedic provider in Fresno County.

Since that first contract, American Ambulance has developed additional services to serve the people of Fresno County with a commitment to the core values of service, excellence and integrity.

In addition to being the sole paramedic provider for the Exclusive Operating Areas of Fresno and Kings Counties, American Ambulance has implemented several specialized programs with exemplary patient care in mind. Their STAR (Specialized Trauma ALS Rescue) team trains for wilderness, swift water, and open water SCUBA rescues. The rescue team also supports local law enforcement agency SWAT teams with tactical medics. Air transportation services under the name Skylife were expanded to Kings County and added fixed-wing transports for long distance needs. American Ambulance offers classes for the community including EMT training, CPR, First Aid, ACLS, PALS and PHTLS. They also offer free basic CPR courses in the rural communities in both English and Spanish.

American Ambulance Paramedic Clark Sumner and EMT Carlene Blair display tools of their trade in 1980.

American Ambulance is a part of the community and participates

in holiday toy drives and staff volunteer days with Habitat for Humanity and the Community Food Bank. American Ambulance also provides ambulances to local charity cycling, walking, and running events. To support a healthier lifestyle for employees, American Ambulance added a "health and wellness program" which has regular courses on healthy eating, exercise, finance management, and emotional development.

As with all private ambulance companies, American Ambulance faces the same challenges as other companies providing a high level of care to all residents while balancing the challenges of a difficult economy, low reimbursement and increased population requiring medical aid. American Ambulance utilizes the CAA as a way to connect with other providers to share solutions to industry problems and to network.

American Ambulance recognizes the need to integrate technology into the daily operations of the company in order to succeed. Ambulance transportation services succeed by providing high quality service to every person regardless of the ability to pay and technology has always proven to be a way to make a small investment up front that pays long term dividends. In 2001, American Ambulance developed patient care reporting software because the documentation software available on the market was too constrained. Since its implementation, the Simon ePCR software, developed by American Ambulance, has captured over 1.5 million patient care reports. In addition, they provide that software (including installation and training) at no cost to their neighboring EMS providers to help them streamline documentation. In 2003, American Ambulance implemented a customized ambulance billing software, again choosing to develop the software rather than sacrifice by working around the constraints of an aftermarket product.

American Ambulance is continually expanding to meet the needs of the company and its employees. In 2002, their Fresno headquarters moved into a state-of-the-art building designed to house headquarters, provide training, and maintain the fleet of ambulances. The building included three mechanic's bays, a car wash and a fueling station. Another facility with a training room was built in Kings County in 2007, so employees who live in that area could train near home. In 2010, they evaluated and expanded their mechanic facilities. Their Fresno headquarters added 5 mechanic bays which improved the mechanic needs of their facility and added a storage center for mechanic maintenance supplies to cut costs. Another mechanic's garage was built in Kings County so ambulance repairs and scheduled maintenance could be done in Kings County, cutting costs and additional wear and tear on the vehicle.

Paramedic Anna Martinez and EMT Dan McCoy responding to a call.

911 Call Takers at the Fresno County EMS Communications Center.

The training department was relocated to a remodeled Clovis facility and was designed with employee continuing education in mind. The facility includes a bay where an ambulance can be driven into the building to provide hands on training of the equipment. Training is provided for employees and the general public and includes First Aid, CPR, ALCS, PALS, and PHTLS. In addition, the training department developed an EMT course to meet local needs and 5 EMT courses a year are provided to the public.

American Ambulance added an expanded scope, critical care transport paramedic position in 2011, to meet the growing inter-facility medical transport needs. ✢

American Ambulance Milestones:

1991	Partnered with Rogers Helicopters to provide critical air transportation services
1994	Partnered with Fresno County to build state of the art EMS communications building
1999	Developed a Basic Life Support division to provide non-emergency transportation
2000	Awarded a contract to be the Emergency Paramedic provider in Kings County

CALIFORNIA AMBULANCE ASSOCIATION
2520 Venture Oaks Way, Suite 150
Sacramento, CA 95833

EMS Health Care Reform Think Tank: Opportunities and Challenges for California's EMS System

Monday, April 16, 2012 – 1:00 pm – 5:00 pm | Sheraton Grand Hotel – Sacramento, CA

Despite the ongoing debate about modifications to the federal Accountable Care Act—with proposals ranging from outright repeal to modest changes—some reforms are certain to be implemented, especially in California. Many EMS providers admit they know very little about how health care reform will change EMS. The majority expect that major changes are on the horizon. Most also predict that EMS providers will need to act now to be prepared. Is your service prepared for:

- Evidence-based medicine?
- Reimbursement tied to care reliability?
- Federal, state and local funding cut backs—simultaneously?
- New payment incentives to increase quality and reduce cost—simultaneously?
- Unconventional sources of new revenue?

Join a group of leaders representing California's key EMS system stakeholders—including provider organizations, medical directors, regulators, and workforce—to confront tough issues on potential opportunities and challenges of health care reform. The think tank is sure to discuss controversial issues in a frank and, at times, difficult, conversation intended to generate creative solutions that will shape your organizations' strategy going forward.

Participants will also:

- Learn about Triple Aim, Impacting Cost & Quality and other health care reform initiatives
- Receive a follow-up report based on the think tank's deliberations
- Gain on-line access to EMS quality improvement resources
- Shape how the California EMS profession might need to action

The best way—the only way—to predict the future is to create the future.

-Peter Drucker

Program Overview

1:00 pm – 1:30 pm
Welcome

1:30 pm – 2:30 pm
EMS System Opportunities to Contain Cost and Improve Quality – David Williams, PhD
Improvement Advisor at www.truesimple.com and Faculty at the Institute for Healthcare Improvement

3:00 pm – 5:00 pm
Opportunities and Challenges for California's EMS System
A panel representing California's key EMS system stakeholders facilitated by David Williams, PhD will discuss the possible impacts of health care reform on California's EMS systems and pre-hospital care providers, share perspectives on potential threats and opportunities and explore the public policy issues that affect our patients, providers and communities.

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For hotel and registration information, go to www.the-caa.org

Space is limited, so register early! Registration preference will be given to CAA members. Schedule subject to change.