

# 2011 Legislative Summit Preview



*Butte County Decision  
Over "Grandfathered"  
EOA Designations*



**Safe Ambulance  
Operations**



## Member/EMS News

### The New Man at the Helm: Where is He Taking State Fund?

Tom Rowe, State Fund's new CEO and President plans to ensure that California's largest provider of workers' compensation insurance remains true to its important role: providing all employers, including new ventures and small business, a strong and stable option for their workers' compensation needs.



Tom Rowe

As Chief Executive Officer, Rowe reports directly to State Fund's Board of Directors and is responsible for the day-to-day operations of the carrier. The Board named Rowe as President and CEO, effective August 2, 2010.

Rowe's industry experience includes almost 25 years with Fireman's Fund Insurance Company, where he was the President of the Commercial Insurance Division, as well as senior roles at Arthur J. Gallagher & Co. and Trilogy Insurance Services.

He also served on the board of directors for Fireman's Fund, Allianz Insurance Company, the American Insurance Association, and The National Council on Compensation Insurance.

### Dr. Tharratt Appointed Head of Prison Health Care Services

Dr. Robert "Steven" Tharratt, M.D. has been appointed the Statewide Medical Executive for California Prison Health Care Services. Dr. Tharratt served most recently as the Director for California Emergency Medical Services Authority in the Health and Human Services Agency. As the Statewide Medical Executive, Dr. Tharratt will coordinate all medical services within the California Department of Corrections and Rehabilitation 33 adult prisons.



Dr. Steven Tharratt

"Dr. Tharratt was chosen for his outstanding leadership ability, depth of experience, and ability to effectively implement statewide programs and initiatives. Dr. Tharratt is a well-respected health care leader in California and the University of California, and I am confident we will benefit from his considerable skills and talents," Kelso said.

### New Resource Helps Medics Obtain Patient's Medical History While Onscene

A viable solution has been introduced for what no doubt countless medics and EMTs have encountered when they arrive on scene only to discover a patient who is unable to communicate. Enter the Invisible Bracelet, an emergency ID that utilizes a unique 8-digit PIN number and a HIPAA-compliant secure web page to help EMS providers with vital information at the time of an emergency and



provide

notification to emergency contacts when patients are transported to a hospital.

The way it works is consumers visit [invisiblebracelet.or](http://invisiblebracelet.or) to create a secure online account. Their account includes their name, medical information (including allergies and medications) and up to ten emergency contacts. Once the account is created and patient profile is complete, members are emailed iB identifiers in the form of a wallet card, key chain fobs and stickers. During an emergency a medic can then look of the patient's medical information and if transport is necessary, notify emergency contacts through an automated phone call, e-mail or text message notifying them where and when an iB member was transported.

In order for the system to work to its full potential, Invisible Bracelet has partnered with EMS providers nationwide to provide free training

on the system. The training takes approximately ten minutes and is offered at no cost to the provider. Medics then have their own user name and password to access the iB members' read-only information via a HIPAA-compliant web page. Invisible Bracelet costs consumers only \$10 a year, per member.

Developed in partnership with EMSA in Tulsa, OK, the program has been adopted by the American Ambulance Association as the National Health Registry. For more information visit <http://www.invisiblebracelet.org>.



#### Pending Members

Aladtec, Inc.

Commercial Member

Thomas Chan, Marketing Coordinator  
Hudson, WI

Sacramento Metropolitan Fire District

Associate Member

Scott Clough, EMS Director  
Sacramento, CA

Metro West Ambulance

Out of State Member

J.D. Fuiten, President  
Hillsboro, OR

#### New Members

Premier Transport Ambulance (August 2010)

RAM Software Services (August 2010)

CHP Enterprises (October 2010)

Comments or questions about new member applicants should be directed to:

**Eb Muncy, Chair Ethics & Professionalism Committee**  
[info@the-caa.org](mailto:info@the-caa.org)



# Chairman's Message



## All Hands on Deck

by Bob Barry, Chairman of the Board

### 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.



Bob Barry

The election may be over, but the uncertainty as to what will happen next is still alive and well. State budget problems, legislative and regulatory initiatives and healthcare reform will still dominate the landscape in 2011.

In addition to our quest to gain a Medi-cal rate increase, several key issues will require our laser focus this year as we are presented with unprecedented challenges that may impact our industry.

We are working alongside other groups, including EMDAC and EMSAC, regarding potential

significant regulatory and legislative changes to the California EMS Act. The proposed changes contained in EMSA Guideline #141 along with issues related to grandfathering rights under Health and Safety Code 1797.201 and 1797.224 are just two issues that can have a direct effect on your business.

However, the greatest potential impact to our industry and your business will come through the implementation of Healthcare Reform. Make no mistake, it is not only coming, it is here. California leads the nation in implementation of National Healthcare Reform with the passage of several pieces of key legislation last year.

Earlier this month the federal government approved a Medicaid waiver request that will bring \$10 billion for healthcare reform initiatives. The issue here is to determine what it means and what effect it will have. There could be resources for a long overdue rate increase, or there could be further cuts in Medi-cal reimbursement while the state simultaneously expands the Medi-cal roles by millions of people.

As a member of this association, I ask you to make a commitment to get involved this year. Attend at least one more meeting this year than last, donate to the CAAPAC and ask questions. Become an expert in that part of our industry that impacts your business. Make your dues work for you by being part of the effort to effect public policy and ensure our voice is heard.

If you are not a member of the CAA, I ask you to give serious thought to joining. Would you consider it a good hire if a part-time employee you hired

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### CAA Leadership

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## Executive Director's Update

# A Glimpse at Healthcare Reform Implementation

by Brenda Staffan, Executive Director



Brenda Staffan

**On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (PPACA) and a companion bill, the Health Care and Education Reconciliation Act of 2010, was also signed into law a short time later.**

The CAA had two recent opportunities to gain insights into the implementation of the federal Accountable Care Act. Despite uncertainty from the 2010 election results, the state and federal agencies responsible for health policy have begun to roll out the framework for healthcare reform implementation. While initial steps focus on health insurance reform, a number of initiatives to contain cost and improve quality are also being formulated. The key for the CAA and its members is to unlock the impact of reforms on EMS systems and providers.

### Federal Healthcare Reform Implementation Goals

On October 5, Herb Schultz, Regional Director for the federal Department of Health and Human Services (USHHS), made a presentation at the CAA Reimbursement Conference in San Diego regarding healthcare reform implementation subtitled, "Opportunities for Collaboration and Partnership." His agency will distribute regulations and provide guidance for quick, careful and efficient implementation. The framework will include three elements: private market reforms, health insurance exchanges and public program expansion. Nationally, near universal coverage will achieve 32 million more insured people by 2019 (92% of the non-elderly population) with 16 million more Americans in Medicaid by 2019.

A major objective if the PPACA is to contain costs and improve quality, now, and in the future, through the following initiatives:

- CMS Center for Innovation
- Accountable Care Organizations (ACOs)
- Bundling payments
- Incentives for better quality
- Independent Payment Advisory Board (IPAD)
- Reducing avoidable hospital readmissions
- Never events
- Administrative simplification for federal, state and private plans
- Driving down waste, fraud and abuse in Medicare and Medicaid

### State Healthcare Reform Implementation Goals

On October 18, California's Secretary of Health and Human Services (CAHHS), Kim Belshé, led a panel presentation and webinar titled, "Health Care Reform Implementation: Stakeholder Meeting." She set the tone for the presentation by stating "the PPACA gives considerable discretion" to the states in implementing healthcare reform and gave examples how her agency is working toward full, and in some cases, early implementation. For example, in 2010, the California legislature became the first state to pass legislation establishing a health insurance exchange. The Secretary presented the state's goals for healthcare reform implementation:

- Near universal coverage
- Delivery system reform and affordability
- Improvements in health status
- Principle of shared responsibility

The panel encouraged stakeholder input and announced that the "policy window is open." Specifically, the panel provided an overview of the state's implementation priorities:

- Pass legislation
- Obtain federal grants and policy guidance
- Launch website ([www.healthcare.ca.gov](http://www.healthcare.ca.gov))
- Develop implementation plans
- Generate foundation-commissioned policy papers

As has been widely reported, a key accomplishment of the PPACA is to achieve expansion of Medi-Cal program eligibility. In addition, the state has been recently successful in achieving CMS-approval of its Section 1115 Waiver. Collectively, these policies will result in:

- Managed care expansion
- Coverage expansion
- Delivery system reform
- Safety net transformation

Medi-Cal eligibility will be expanded resulting in approximately two million additional Medi-Cal enrollees by 2019. The CAA projects this expanded coverage will generate an estimated 25% increase in Medi-Cal ambulance transports. Because of severely below-cost

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## Legislative Summit Offers Members Opportunity to Deliver First Hand Information to Their Legislators



Assemblyman Jared Huffman, D-San Rafael visits with CAA board member Richard Angotti of St. Joseph's Ambulance during last year's Legislative Summit.

One of the highest priorities of the CAA is our legislative efforts in which we strive to educate our members and most importantly our elected officials about the legislative and regulatory priorities facing California's ambulance providers. Through the hard work of our lobbyist, leadership and the legislative committee (comprised of CAA members), great momentum was obtained in 2010. Most significantly, the CAA was successful in gaining Medi-Cal recognition of paramedic-level care.

While we are proud of legislative efforts for 2010, we know there is much work that lies ahead of us for 2011. As we ring in the New Year, CAA staff is busily preparing for its Annual Legislative Summit scheduled for January 31-February 2, 2011 at the Sheraton Grand Sacramento. We encourage you to join the CAA as we build upon our momentum and continue our successful strategies to reform the broken Medi-Cal payment system.

The Legislative Summit kicks off Monday afternoon with the Membership Development & Services Committee followed

by the Legislative & Agency Relations Committee/Payer Issues Subcommittee.

The Summit picks up Tuesday morning with a Legislative & Regulatory Briefing. While a Medi-Cal rate increase remains a priority issue, there are several other priorities that the CAA is monitoring, including: quality assurance fee, legislative options for achieving an ambulance rate increase and the status of federal and state Medi-Cal lawsuits.

Additionally information will be provided on the timing of state implementation of HCPCS Codes, Grandfather Status under EMS Act Sections 201 & 224, status of the State budget and its potential impacts, healthcare reform implementation in California. In closing, a presentation will take place on *EMS, an Essential Component of the Healthcare Safety Net* and how the success of ambulance issues depends on increasing awareness amongst the public, elected officials and policy makers.

Loaded with timely information, members will then make their way to the Capitol to attend scheduled appointments with legislators representing their service area.

The Summit concludes with a networking reception followed by dinner with a guest legislative speaker and committee meetings wrap-up on Wednesday morning.

The success of our lobbying efforts depends greatly on CAA member involvement. Not sure whether you should attend? Ask yourself if your elected officials know why Medi-Cal ambulance reimbursement is an essential priority? If not, make sure you are the one delivering this information to them first-hand.



### ANNUAL LEGISLATIVE SUMMIT January 31 – February 2, 2011 Sheraton Grand Hotel – Sacramento, CA

#### SCHEDULE

##### Monday, January 31, 2011

12:00 pm – 2:30 pm	Registration
1:00 pm – 2:00 pm	Ethics and Professionalism Committee (Closed)
2:00 pm – 3:30 pm	Membership Development & Services Committee
4:00 pm – 5:30 pm	Legislative & Agency Relations Committee / Payer Issues Subcommittee

##### Tuesday, February 1, 2011

7:30 am – 9:30 am	Registration
8:30 am – 9:30 am	<b>LEGISLATIVE &amp; REGULATORY BRIEFING</b>
	• Medi-Cal Rate Increase
	• Quality Assurance Fee
	• Legislation
	• Litigation
	• Medi-Cal Implementation of HCPCS Codes
	• Grandfather Status Under EMS Act Sections 201 & 224
	• Status of State Budget and its Potential Impacts
	• Healthcare Reform Implementation in California
	• EMS an Essential Component of the Healthcare Safety Net
9:30 am – 5:00 pm	LEGISLATIVE VISITS (lunch on your own)
5:00 pm – 6:00 pm	NETWORKING RECEPTION
6:00 pm – 7:30 pm	DINNER – Guest Legislative Speaker

##### Wednesday, February 2, 2011

7:30 am – 9:00 am	Registration
8:00 am – 8:30 am	CAAPAC Committee
8:30 am – 10:00 am	Education Committee / Safety Subcommittee
10:15 am – 1:00 pm	Board of Directors Meeting

#### **Early Registration Deadline is Friday, January 14, 2011**

For questions regarding the Annual Legislative Summit, please contact CAA at 877.276.1410 (toll free), [kingersoll@the-caa.org](mailto:kingersoll@the-caa.org), or [www.the-caa.org](http://www.the-caa.org).



# Butte County Decision Clarifies the Power of the State EMS Authority Over “Grandfathered” EOA Designations

*R. Michael Scarano, Jr., Esq., Foley & Lardner LLP*

In a significant decision issued on August 27, 2010, the California Court of Appeal held that the state EMS Authority (the “Authority”) is empowered by the state EMS Act (the “Act”) to approve or reject determinations by local EMS agencies (“LEMSAs”) that providers qualify for “grandfathered” exclusive operating areas (“EOA”) under Section 1797.224 of the Act. The Court also held, however, that the criteria used by the Authority in determining whether a provider qualifies for grandfathering (i.e., whether it has operated in the same “manner and scope” since 1981) must be set forth in regulations formally adopted by the Authority under the California Administrative Procedures Act, rather than established informally by the Authority on a case by case basis. The Court further held that a county which designates a LEMSA may not reserve any of the LEMSA’s statutory powers, such as the ability to award EOAs, to the county itself, or divide LEMSA powers among multiple EOAs.

Although the facts of the case were complicated and involved a number of parties, the case primarily involved a dispute between the County of Butte (the “County”) and ambulance provider First Responder EMS (“First Responder”) on the one hand, and the Authority on the other hand, over whether the County or its designated LEMSA, Northern California Emergency Medical Services, Inc. (“Nor-Cal”), could grant First Responder and certain other providers grandfathered EOAs in the local EMS plan submitted for the County. The Court of Appeal, affirming the trial court’s decision, held that the Authority could properly reject the County’s grandfathering determinations by refusing to approve the local EMS plan. The Authority’s grounds for doing so were that the County and Nor-Cal had failed to provide the Authority with sufficient information supporting their determination that the providers in question qualified for grandfathering. However, the Court further held that in determining whether candidates for grandfathering meet the “manner and scope” test found in the Act, the Authority must establish regulatory criteria rather than relying on case by case guidelines.

The following sets forth the complex facts of the case and the legal grounds for the Court’s decision in more detail.

## BACKGROUND

In 1991, the County entered into an agreement with Nor-Cal to administer, as its LEMSA, certain specified LEMSA functions, such as submitting an annual local EMS plan. The agreement provided that the County reserved to itself certain other LEMSA functions not expressly granted to Nor-Cal, including the establishment and designation of EOAs.

In June 1992, the Butte County public health officer issued an order directing that the County’s local EMS plan be amended to establish EOAs pursuant to Section 1797.224 of the Act. In his order, the health officer found that the providers serving five operating areas in the County qualified for grandfathering within their respective service areas because they had been operating within those areas “in the same manner and scope since at least January 1, 1981,” as required by Section 1797.224. In accordance with these findings, the health officer ordered that “the current and present operators providing service within [their respective EOAs] be deemed the exclusive operators within each area.” Three of the five EOAs established by the County health officer were at issue in

the case ultimately decided by the Court of Appeal.

In July 1992, the health officer submitted to the Authority an amendment to the County’s EMS plan establishing the EOAs, along with copies of correspondence he had received from each of the providers in question, purporting to attest to their qualifications for grandfathered status. The health officer requested that the Authority approve the plan and confirm the County’s ability to grandfather the current providers into the EOAs.

The Authority responded by asking the health officer to provide more information about “the continuity of providers within the zones for which grandfathering is proposed” as well as additional information pertinent to grandfathering. The record in the case does not indicate whether the County responded to the Authority’s request for this additional information.

Although the health officer initially had requested the Authority’s approval of the EOA designations, the County subsequently took the position that the Authority’s approval was not required. In January 1994, the County Board of Supervisors passed a resolution which (1) formally adopted the findings and conclusions of the health officer set forth in his prior EOA order, and (2) purported to formally amend the County’s local EMS plan to create the EOAs set forth in the health officer’s order and to establish the current operators in those areas as exclusive operators. In addition, the Board’s resolution indicated that the installation of these operators within the EOAs was intended as an “interim measure,” pending a competitive process, and established a schedule for holding a competitive process for each of the County’s zones.

In March 1996, a new interim health officer for the County issued an order which changed direction by finding that the continued maintenance of the EOAs and the

<sup>1</sup> All references to the Act refer to the Emergency Medical Services System and the Prehospital Medical Care Personnel Act, Health and Safety Code Section 1797 et. seq.

<sup>2</sup> That section states: “A local EMS agency may create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider or providers of the services pursuant to the plan. No competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since January 1, 1981. A local EMS agency which elects to create one or more exclusive operating areas in the development of a local plan shall develop and submit for approval to the authority, as part of the local EMS plan, its competitive process for selecting providers and determining the scope of their operations. This plan shall include provisions for a competitive process held at periodic intervals. ....”

continued utilization of the current providers within those EOAs was proper and appropriate, and that a competitive bid process was neither required nor in the best interest of the County citizens at that time. The Board of Supervisors subsequently passed a second resolution which rescinded the schedule providing for a competitive process and affirmed the designation of the existing providers in their existing zones.

In March 2000, Nor-Cal submitted the County's EMS plan to the Authority, including the EOAs established by the first health officer and affirmed by his successor. In July 2001, the Authority approved the plan, except for the section grandfathering the existing providers into their respective EOAs. In the Authority's view, the previous expressions of intent by Nor-Cal and the Board of Supervisors to establish a competitive process "changed the scope and manner of operation," and therefore grandfathering the three zones at issue was no longer possible. The Authority also indicated that to establish EOAs and install the existing providers would require a clear determination of eligibility for exclusivity but that, to date, sufficient information had not been provided to the Authority to determine whether grandfathering was appropriate.

The Authority was particularly concerned that three of the ambulance services in question had changed ownership, and, in one case, three different owners had operated the ambulance service since 1981. As discussed further below, the Authority's position was that although some changes of ownership permit grandfathering, others constitute a change in manner and scope which disqualify a provider from being grandfathered. In addition, the Authority was aware that a significant boundary change had been made in one of the areas, as a result of the incorporation of a college campus which added a day time population of over 10,000 students. The Authority indicated that if Nor-Cal wished to establish EOAs through grandfathering, the current providers would have to supply Nor-Cal with appropriate documentation regarding their eligibility, and Nor-Cal would have to amend the local EMS plan accordingly. The Authority also asserted, for the first time, that Nor-Cal, and not the County Health Department, was the LEMSA with statutory authority to establish EOAs.

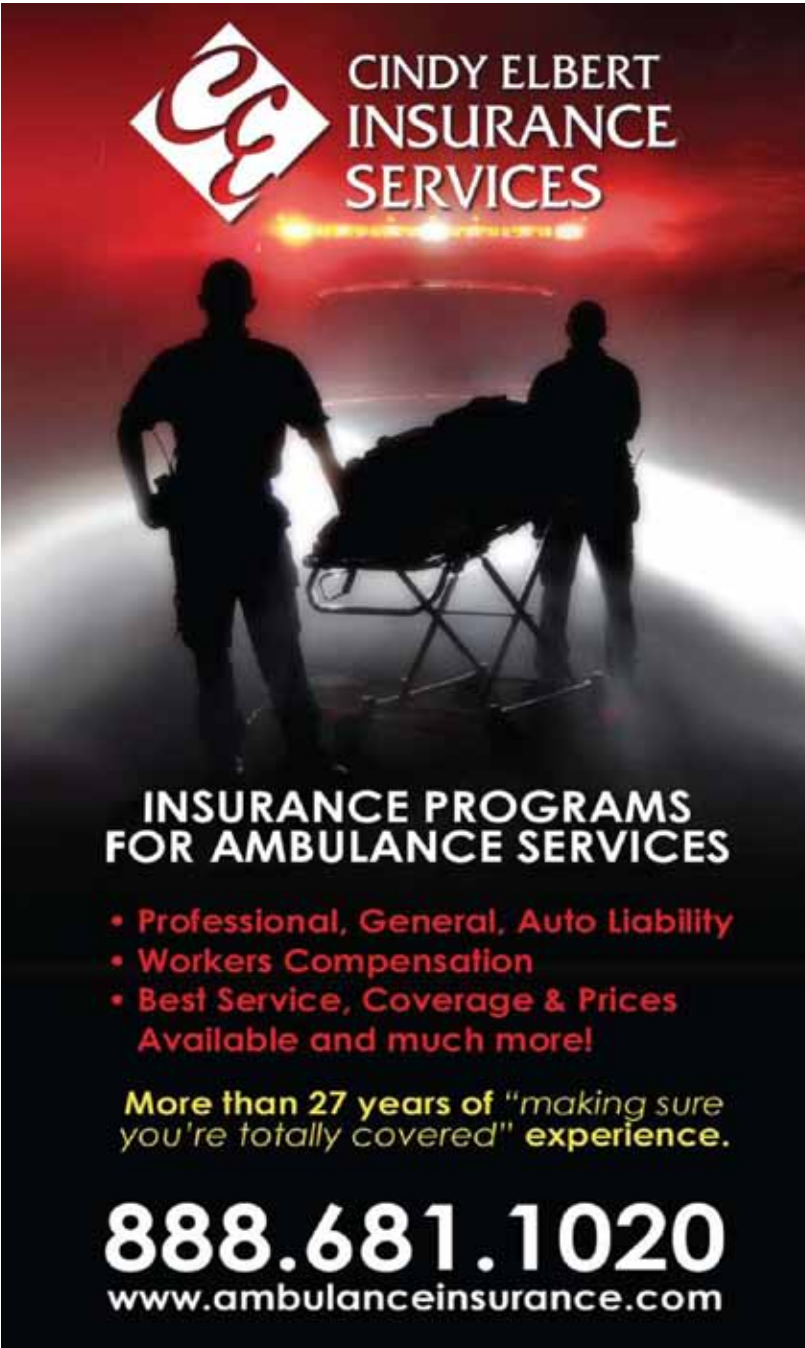
In June 2006, Nor-Cal approved a new provider, Priority One Medical Transport, Inc. ("Priority One") to provide EMS services in one of the three EOAs established by the County, subject to securing a base hospital and

determining the dispatch logistics of 911 calls. However, because Priority One was unable to secure a base hospital, it was unable to begin

operations within the County.

The three grandfathered providers, led by (and collectively referred to

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# Reimbursement Conference *Recap*

## Ed Norwood Featured at CAA Annual Reimbursement Conference in San Diego

Over 100 ambulance professionals enjoyed an outstanding workshop by Ed Norwood, recognized as a distinctive authority in administrative laws that govern the healthcare delivery process. He currently serves as the President of the National Council of Reimbursement Advocacy (NCRA, formally CCRA) and is also the Chief Compliance Officer for the Reimbursement Advocacy Firm.



Kathy Montoya from Palmetto GBA addressed a variety of Medicare issues and representatives from Medi-Cal presented an update on the claims processing. Herb Schultz, Regional Director for the Federal Department of Health and Human Services (DHHS), made a presentation regarding federal healthcare reform implementation subtitled, "Opportunities for Collaboration and Partnership." The conference also featured two special legislative speakers including continental breakfast with Senator-elect Juan Vargas and lunch with San Diego City Councilman Ben Hueso.



### *Our sincerest thanks to our Conference Sponsors:*

- Care West Insurance
- King American Ambulance Service
- Critical Care Specialty Billing
- State Compensation Insurance Fund
- DerManual Insurance
- BoundTree Medical
- Cindy Elbert Insurance Services



*Top left: Jim McNeal, Schaefer Ambulance talks with Herb Schultz, Regional Director for the Federal Department of Health and Human Services; San Diego City Councilman Ben Hueso addresses a lunchtime crowd; Remy Turner HP Enterprise Services, the Medi-Cal Fiscal Intermediary; the Reimbursement Conference attracted billing and management representatives from across California; Kathy Montoya from Palmetto GBA.*





## Butte County Decision

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by the Court as) First Responder, subsequently brought an action against Nor-Cal and the County seeking declaratory and injunctive relief. First Responder asked the court to rule that (1) the agreement between Nor-Cal and the County did not grant Nor-Cal any authority with respect to the creation of EOAs; (2) the County retained the right as a LEMSA with respect to the creation and designation of EOAs; and (3) Nor-Cal had no authority to integrate an additional EMS provider into the EOAs set up by the County.

The County filed a cross-complaint against the Authority, seeking a judicial declaration regarding whether (1) the County had the authority to exercise powers under Section 1797.224 (i.e., the creation of EOAs), and (2) whether the current providers were eligible for EOAs. The County also sought an order prohibiting the Authority from rejecting the County's grant of grandfathered EOAs.

The trial court held that Nor-Cal, not the County, had exclusive authority to establish and award EOAs, and that the purported reservation of this right by the County was void. The court further found that it could not order the Authority to refrain from enforcing its determination that the current providers were not properly grandfathered. It reached this conclusion because the Authority had a "discretionary duty" to determine whether the local EMS plan for the county was acceptable, and the Authority's discretionary findings could not be overruled by the court, absent an abuse of discretion. Here, the trial court found no abuse of discretion.

### **THE COURT OF APPEAL DECISION**

On appeal, the Court of Appeal affirmed the trial court's findings. It addressed the three primary issues in the case as follows:

#### **1. Ability of the County to Reserve EOA Designations**

The first issue addressed by the Court was "whether a County may contractually designate a local EMS agency to administer some of the requirements of the EMS Act, while reserving for another local EMS agency [or itself] all of the remaining statutory powers and duties not covered by the agreement." The Court said that "the short answer is No." The Court based its conclusion on the plain language of Section 1797.200, which states that each county which has chosen to develop an EMS program "shall designate a local EMS agency". The Court observed that by using the words "a local EMS agency", Section 1797.200 "unambiguously requires a county to designate one local EMS agency, not two such agencies sharing the statutory powers and duties of [a LEMSA] under the EMS Act."

#### **2. Powers of the Authority to Approve or Reject Grandfathering Determinations**

The second issue addressed by the Court was "whether the Authority has the statutory power to disapprove a local EMS agency's designation of an exclusive operating area through the grandfathering provision of Section 1797.224 of the EMS." The Court said "the short answer is Yes."

The Court rejected the argument, put forth by the County and First Responder, that Section 1797.224 only requires approval by the Authority of a competitive

process. Although the plain language of the statute can be read in that fashion, the Court indicated that it is necessary to read that statute in the overall context of the EMS Act. The Act provides that a LEMSA "shall annually submit an emergency medical services plan for the EMS area to the Authority" (Section 1797.254), and, "among the mandatory subjects of the local EMS plan is transportation of emergency medical patients." (See Sections 1797.76, 1797.103, and 1797.70.)" The Act further provides that a LEMSA may implement a local plan, "unless the Authority determines that the plan does not effectively meet the needs of the persons served and is not consistent with coordinated activities in the geographical areas served, or that the plan is not concordant and consistent with applicable guidelines or regulations...established by the Authority." (Section 1797.105(a)(b)) Based on these factors, the Court concluded as follows:

The Authority has the statutory authority to review a local EMS agency's creation of an EOA as part of the transportation portion of the local EMS plan, regardless of whether the EOA was created through a competitive process or grandfathered, and then to reject the local EMS plan if it is not "concordant and consistent with applicable guidelines or regulations...established by the Authority."

#### **3. Requirement that the Authority Promulgate "Manner and Scope" Guidelines as Formal Regulations**

The third issue addressed by the Court was the validity of the criteria used by the Authority to determine whether grandfathering is appropriate. The County argued that, even if the Authority had the power to reject EOAs created via grandfathering, the Authority's disapproval of the County's EOAs was invalid because it was based on "invalid, underground regulations."

The California Administrative Procedures Act ("APA") provides that, if a policy or procedure falls within the definition of a "regulation" within the meaning of the Act, the promulgating agency must comply with the procedures for formalizing such regulation, which include public notice and approval by the Office of Administrative Law. A regulation that substantially fails to comply with these requirements may be judicially declared invalid. Such invalid regulations are often called "underground regulations."

A regulation subject to the APA has two principal identifying characteristics. First, the agency must intend its

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## Butte County Decision

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rule to apply generally, rather than only in a specific case. Second, the rule must implement, interpret or govern the agency's procedures.

In determining whether the Authority's criteria used in evaluating grandfathered EOAs constituted an underground regulation, the Court focused on a declaration submitted in the case by Dan Smiley, Chief Deputy Director of the Authority. Mr. Smiley's declaration stated, in pertinent part, as follows:

A change in manner and scope, defeating a County's ability to grandfather existing providers into EOAs, may occur in the following instances:

- (1) where there is a change in the number of providers in the area;
  - (2) where there are interruptions in the services provided by one or more providers in the area;
  - (3) where there is a change in the economic distribution of calls between providers in the area;
  - (4) where there is a change in ownership in one of the providers in the area;
  - (5) where there is a change in the geographical boundaries of the area;
  - (6) where areas or sub-areas are combined or splintered; and
  - (7) where there is an approval by the local EMS agency of a new provider in the area.
- A change in manner and scope will not occur in the following situations: (1) an upgrade in ambulance service from basic life support to advanced life support; (2) the subcontracting of a grandfathered provider with another provider for minor activities within an area that does not alter the manner and scope of operations, is approved by the local EMS agency and is part of the County's local EMS plan; and (3) the response of providers into an area for mutual aid or instant aid in the event of significant events or disaster situations.

Smiley's declaration also stated that "changes in ownership in EMS providers can result in a change in manner and scope." He elaborated that, "where one company purchases another, as evidenced by a stock transfer, purchase of goodwill, transfer of liabilities and transfer of accounts receivables, no change in manner and scope occurs. However, there is a change in manner and scope if one company purchases only the assets of another company."

The Court agreed with the County's assertion that these statements constitute a generally applicable interpretation of the "manner and scope" language of Section 1797.224. Consequently, the Court held that the establishment of

"manner and scope" criteria requires formal rule-making through the APA. The Court stated:

We thus conclude that the Authority's interpretation of the "manner and scope" language of Section 1797.224 is a generally applicable policy subject to the rule-making procedures of the APA. Because the Authority did not comply with those procedures, this interpretative regulation is void and not entitled to any deference.

The Court nevertheless held, however, that the Authority had the power to reject the local EMS plan submitted for the County, and the grandfathering designation found in it, "based on a lack of information provided by Nor-Cal," rather than on the merits of whether the "manner and scope" test was in fact met. The Court did not determine "whether the changes in ownership and boundary change in this case amounted to a change in manner and scope." Rather, the Court simply concluded that the Authority had not abused its discretion in requiring additional information to make that determination.

### CONCLUSION

The Butte County case has not been appealed and is significant for three primary reasons. First, it affirms that the Authority has the power to approve or disapprove grandfathered EOAs. While it has been widely assumed that this was the case, counties, their LEMSAs and providers have argued that the Authority should in most cases defer to the LEMSAs' findings on this issue. The case indicates that the Authority is under

no obligation to do so.

Second, the case will require that the Authority promulgate regulations defining what constitutes a change in manner and scope, rather than relying on its own case by case guidelines. Perhaps in response to early developments in the case, the Authority had recently circulated draft guidelines on this and other EOA-related issues for public comment. Those draft guidelines may be the Authority's starting point for drafting regulations. The EMS Act and the APA require that the draft regulations be circulated for public comment, reviewed at a public hearing and ultimately approved by both the EMS Commission and the Office of Administrative Law. This process will take several months, at a minimum.

Finally, the Court's finding that a county may not reserve any of a LEMSAs' statutory powers to itself is significant for counties that have designated outside agencies as their LEMSAs.

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## Chairman's Message

*Continued from page 3*

were responsible for saving you thousands of dollars in fees by helping defeat AB 511 last year? Well that's the approximate annual cost of dues for the CAA's largest member companies. If you keep it in perspective, the CAA is an outstanding value for your company and the CAA cannot represent the interests of the entire industry without the support of its members.

The threats remain. If we do not join together to represent the interests of our industry, others will make decisions that impact our businesses for us. The potential impacts on your business, makes these challenges your business. Now is the time to get involved.

I am looking forward to seeing you at our Legislative Summit in January.

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## Executive Director's Update

*Continued from page 4*

Medi-Cal reimbursement rates, this increase in Medi-Cal coverage and transports has the potential to have a major impact on California's EMS systems.

Clearly, there are now many more questions than answers, yet there are many opportunities to collaborate with other areas of healthcare to contain cost and improve quality. While health insurance reform will increase coverage and reduce the number of uninsured by creating "near universal" coverage, cost containment and quality improvement will surely impact providers.

### **Resources**

The CAA has created a members-only section of the CAA website to provide resources to CAA members regarding the various issues which will impact ambulance providers as both healthcare providers and as employers. After entering their password, members can access the Healthcare Reform page by clicking on the link.

For information about healthcare reform implementation in California, go to: <http://www.healthcare.ca.gov/>.

For information about federal healthcare reform implementation, go to: <http://www.healthcare.gov/>.

The CAA is a statewide leader in promoting quality, efficient and medically appropriate patient care within California's local EMS systems. With healthcare reform implementation accelerating in California, it is essential to assure the state's EMS systems continue to serve the medical transportation needs of our patients and communities.



## Legislative Update

# 2010 California Legislative Session Overview CAA Gains Medi-Cal Recognition of Paramedic-Level Care

Chris Micheli, CAA Legislative Advocate

The California Legislative Session came to a conclusion on August 31, 2010, although a nearly 24-hour session occurred in early October to conclude the 100-day late state budget. The California Ambulance Association had another busy year working on legislation on behalf of its member companies. The following is a description of the major bills the association worked on during this past year. The new two-year session begins on December 6, 2010.

A highlight for the CAA and its members in 2010 was the tremendous momentum generated in the legislature emphasizing the critical need to modernize the Medi-Cal payment system for ambulance services. AB 1932 (Hernandez), the Ambulance Payment Reform Act, addressed both the archaic Medi-Cal coding and claims processing system as well as severe below-cost reimbursement levels. While the state budget crisis was an insurmountable hurdle for the rate increase provisions of AB 1932, the Department of

***“DHCS as agreed to accept the bill’s provision to implement the HCPCS coding system (utilized by Medicare and required by federal law) to reimburse ambulance services provided to Medi-Cal beneficiaries.”***

Health Care Services (DHCS) has agreed to accept the bill’s provision to implement the HCPCS coding system (utilized by Medicare and required by federal law) to reimburse ambulance services provided to Medi-Cal beneficiaries. The targeted implementation date is June 2011.

Two other key bills opposed by the CAA in 2010 were defeated. First, following intense opposition from many entities in the state-wide EMS community, including the CAA, AB 2456 was vetoed by the Governor. Second, the CAA retained its oppose position on AB 511 and the bill was held on suspense. AB 511 would create a quality assurance fee (QAF) for ambulance providers. Based upon CAA’s analysis, the bill had too many flaws and negative impacts for CAA members. The CAA continues to model a QAF and is soon launching a data survey of all ambulance transportation providers in the state, both public and private. Below is a summary of all of the bills CAA monitored in 2010.

### CAA Priority Bills

**AB 511 (De La Torre - D) Medi-Cal: ambulance transportation services providers: quality assurance fees.**

This bill, as a condition of participation in the Medi-Cal program, commencing July 1, 2010, would have imposed on each public and private ambulance transportation services provider that bills and receives patient care revenue from the provision of ambulance transportation services, as defined, a quality assurance fee for each transport provided, as specified.

**Position:** Oppose

**Outcome:** Held in Senate Health Committee

**AB 1932 (Hernandez - D) Medi-Cal: ambulance transportation services: reimbursement: service levels.**

This bill would have authorized the HDCS to utilize certain service levels

for purposes of determining billing codes for emergency and nonemergency basic life and advance life support transportation and specialty care transportation. If the department utilizes the aforementioned service levels to determine billing codes, this bill would have required the department to, by June 30, 2011, adopt the definitions and Healthcare Common Procedure Coding System codes for those service levels that have been established by the federal Centers for Medicare and Medicaid Services, and to determine the above described billing codes in a revenue-neutral manner.

**Position:** Sponsor / Support

**Outcome:** Held on Senate Appropriations Committee Suspense File

**AB 2456 (Torricco - D) Emergency medical services: regulation.**

This bill would have specified that the regulations of the authority shall include policies and procedures applicable to the functions, certification, and licensure of all emergency medical technician personnel, as defined, and would have required the local EMS agencies to adhere to these standards. The bill would have authorized the authority to develop and adopt a related county. This bill would have specified that the regulations of the authority shall include policies and procedures applicable to the functions, certification, and licensure of all emergency medical technician personnel, as defined, and would require the local EMS agencies to adhere to these standards. The bill would have authorized the authority to develop and adopt a related fee schedule and fee increases to support the authority’s actual costs to promulgate the additional regulations. The bill would have provided that any policies and procedures implemented by a local EMS agency that are not in accordance with the standards required under the bill are subject to review by the Director of the EMSA, as specified, and that a local EMS agency that is notified of a policy or procedure that is not in compliance is required to stop implementation of the policy and procedure or submit a revised policy or procedure that complies with the regulations developed by the authority to the director within 90 days of notification. The bill would have allowed the authority to assess penalties on a local EMS agency that fails to respond to a notification of noncompliance.

**Position:** Oppose

**Outcome:** Vetoed by the Governor



## Other Bills of Interest to CAA

### **AB 424 (Torres - D) Warren-911-Emergency Assistance Act: public education campaign.**

This bill would have required the office of the State Chief Information Officer to develop and implement a public education campaign to instruct the public on the appropriate and inappropriate uses of the 911 emergency telephone number system.

**Position:** Oppose

**Outcome:** Vetoed by the Governor

### **AB 438 (Beall - D) Medi-Cal: treatment authorization requests.**

This bill stated the intent of the Legislature to enact legislation that would implement reforms to the Medi-Cal TAR process, as specified.

**Position:** Support

**Outcome:** Held in Assembly Rules Committee

### **AB 1272 (Hill - D) Emergency medical services: trauma center: helicopter landing pad.**

This bill would have permitted an EMS agency to submit a request of notification to a city, county, or city and county for notice of any zoning variance, permit, amendment, or entitlement for use that would permit the construction or operation of a heliport or helipad on the property of a general acute care hospital.

The bill would have also permitted the local EMS agency, or an EMS agency from a county adjacent to the proposed heliport or helipad, after receiving the notice, to prepare a report, as specified, to consult with representatives of the city, county, or city and county regarding that report, and to provide written comments and appear at a hearing regarding the proposed construction or operation of a heliport or helipad.

**Position:** Support

**Outcome:** Held in Senate Rules

Committee

### **AB 1503 (Lieu - D) Health facilities: emergency physicians: emergency medical care: billing.**

This bill provides that uninsured patients or patients with high medical costs who are at or below 350% of the federal poverty level are eligible to apply to the emergency physician, as defined, who provides emergency medical services in a general acute care hospital for a discount payment pursuant to a discount payment policy. The bill requires the emergency physician to limit expected payment for services provided to a patient at or below 350% of the federal poverty level and who is eligible under the emergency physician's discount payment policy, as specified.

**Position:** Support

**Outcome:** Signed into law by the Governor

### **AB 1999 (Portantino - D) Underage drinkers: immunity from prosecution.**

This bill grants limited immunity from criminal prosecution for any person under the age of 21 years who is subject to prosecution under specified provisions where the person under the age of 21 years called 911 and reported that either he or she or another person was in need of medical assistance due to alcohol consumption

**Position:** Support

**Outcome:** Signed into law by the Governor

### **AB 2153 (Lieu - D) Emergency room crowding.**

This bill would have required every licensed general acute care hospital with an emergency department to determine the range of crowding

scores that constitute each category of the crowding scale, as provided, for its emergency department. The bill would have required every licensed general acute care hospital with an emergency department to calculate and record a crowding score every 4 hours, except as specified, to assess the crowding condition of its emergency department.

The bill would have required, by January 1, 2012, every licensed general acute care hospital with an emergency department to develop and implement a full-capacity protocol for each of the categories of the crowding scale.

**Position:** Support

**Outcome:** Held on Senate Inactive File

### **AB 2245 (Hill - D) Vehicles: aftermarket horns: decibel levels.**

This bill would have prohibited a motor vehicle from being equipped with an aftermarket horn that emits a sound greater than 110 dB(A).

**Position:** Support

**Outcome:** Vetoed by the Governor

### **AB 2506 (Carter - D) Mental health: medical transportation services.**

This bill would have required each mental health board or commission to facilitate the development and implementation of a written memorandum of understanding (MOU) between emergency and nonemergency medical transportation entities, local law enforcement, Medi-Cal managed care mental health plans, general acute care hospitals, and acute psychiatric hospitals, to provide for the delivery of emergency and nonemergency medical transportation services for individuals with mental illness. This bill would have required that the MOU be developed and implemented not later than one year after the date that this measure becomes effective.

**Position:** Oppose

**Outcome:** Held in Assembly Health Committee

### **SB 1281 (Padilla - D) Emergency medical services: defibrillators.**

This bill would have repealed provisions that authorize the Emergency Medical Services Authority to establish minimum training and other standards for the use of automatic external defibrillators (AED) and requires persons or entities that acquire the AEDs to comply with maintenance, testing, and training requirements, which are scheduled to change on January 1, 2013.

**Position:** Support

**Outcome:** Defeated in Senate Judiciary Committee



## The Safety Zone

# Safe Ambulance Operations

Don Vonarx, General Manager of Riggs Ambulance Service

“Medic 5 has just been involved in a collision” says the voice on the other end of the phone. Your mind immediately races, needing answers that aren’t available yet; “is anyone hurt?”; “what happened?”; “do we have our management responding?”; “what will the crew involved need and what will their families need?”; “what do others involved need?” As an ambulance service manager your mind also instinctively and immediately screams, “Who was at fault?” Over the coming days another question will loom, “How could this have been prevented?”

Operating an ambulance is, by far, the most dangerous aspect of the Paramedic and EMT’s job<sup>1</sup>, compounded by high daily mileage operations, code 3 driving and vehicles that are not designed for occupant safety by the same standards as the family car. According to a 2002 meta-analysis of EMS fatality data<sup>1</sup>, 74% of EMS on-duty fatalities were related to motor vehicle operations. Accident statistics indicate the risk of being involved in a collision in an ambulance is 5 times higher than in a personal vehicle and the motor vehicle fatality rate for EMS personnel is more than double the national average of on-the-job vehicle related mortality<sup>1</sup>.

With these sobering statistics in mind, the concept of collision prevention may seem daunting, but it does not have to be. Let’s look at the components of a comprehensive safe vehicle operation program.

### Personnel

One important and highly variable component in the composition of safe vehicle operations is the people you employ that operate the ambulance. You may want to ask yourself the following:

1. What is your driving record criterion for applicants (see Policies below)?
2. Do you participate in the California DMV Employer Pull Notice (EPN) program<sup>2</sup> in which you will automatically be notified of any driving record infraction?
3. Does everyone know the consequences of serious driver infractions?
4. Do you uniformly enforce those consequences, such as, automatic termination for a DUI conviction?
5. Do you have ongoing methods for updating your employees on driving-related policies, best practices (see Policies below), as well as a method to routinely monitor each driver (see Driver Monitoring below)?

6. Do your employees know what to do, and not do, in case they are involved in a collision?

### Policies

Comprehensive policies are critical to your organization’s safe vehicle operations program. Policies set the expectations of performance and behavior, but are only as good as they are uniformly enforced and as they are reasonably enforceable. Examples of safe vehicle-related policies include Code 3 operations, maximum vehicle speeds, minimum following distances, navigating intersections, cell phone use, patient’s family/friend riders, patient restraints, crew restraints, equipment restraints, etc.

### Training

If your agency is already CAAS-accredited, you know Emergency Vehicle Operations training is required annually, yet many companies conduct this important course only during orientation or, at best, sporadically. While conducting a full-fledged EVOC course is time intensive, logistically challenging to plan and execute and is also expensive, it is the perfect time and place to insure that all employees know your company’s expectations (policies) and to demonstrate safe low-speed vehicle operations.

### Vehicles and Equipment

As previously stated, ambulances have not been designed to meet the same rigid crash dynamics as most motor vehicles in the United States. While the chances of surviving a catastrophic collision in the front seats of the ambulance are good (thanks to airbags, reinforcement areas, front crumple zones, etc.), the likelihood of serious injury or death is dramatically higher in the patient compartment. The

restraint systems in the back are not adequate for a high speed collision or rollover, assuming the crewmember is even wearing a seatbelt in the back at



the time of the collision. The multiple pieces of equipment in the patient compartment of the ambulance (i.e., jump bags, O2 cylinders, monitors, etc.) become high-mass projectiles during a collision and can, by themselves, cause devastating injuries.

At a minimum, all equipment must be secured in the patient compartment; patients must be fully restrained including shoulder harnesses; and crewmembers must be restrained with only few exceptions.

### Driver Monitoring

You have now implemented several major components of a safe vehicle operation program. You carefully screen your new employees, receive regular DMV driver reports, have reviewed and revamped all vehicle operation policies, enforce the policies uniformly, have conducted thorough EVO training and made sure everything and everyone in the ambulance is tied down. Do you sleep better at night resting assured that all of your operators are out there 24/7/365 carefully abiding by all company policies and driving regulations, never driving in an aggressive or erratic manner, and treating the ambulances as



## The Safety Zone

they should?

The reality is that all the previous components of safe vehicle operations are important, but they still do not fully reflect the actual every day behavior by the human beings driving our ambulances. And what you don't know can be deadly and very, very expensive. Enter the driver monitoring system.

There are currently two primary systems used throughout EMS in the United States today: DriveCam and Road Safety. Both systems use g-force sensors that translate the signals into digital outputs. The DriveCam signal triggers an onboard video camera placed on the inside windshield under the rearview mirror to record the high-forces event. The video clip, with audio, is then downloaded at a later date and reviewed to determine driver culpability, whether it's a collision, a high speed turn or rapid deceleration. The video records both the forward view from the windshield as well as a fish-eye view of the driver's compartment. DriveCam works very well for collision reconstruction and can provide irrefutable evidence of your driver's actions, good or bad. DriveCam can also be effective for driver remediation and as a deterrent from high forces driving when your operators know that "big brother is watching." However, DriveCam may have a couple of opportunities for improvement in my opinion. For example, post-incident feedback is not

provided to the employee in a timely manner as it may be days before the supervisor meets with the driver to review the video footage. Further, DriveCam does not have a pre-incident warning system, a critical tool to avoid a high forces driving event in the first place.

The Road Safety Safe Force Driving System does not provide video recording capability; however, it does provide real-time driver feedback and warns of impending high forces and high speed driving. The Road Safety system also records high forces/speed driving events and converts these into a points system based on the number of miles driven by each employee and then assigns a 1 to 10 score. Drivers above level 4 are considered to be compliant with the company standard. The system also records seat belt usage when the vehicle is placed in drive and the use of a vehicle spotter, an important

feature.

The risk and liability of emergency vehicle operations is extreme and mitigation must be of the highest priority to any ambulance service. Through development, implementation as well as consistent and constant oversight of a safe ambulance operations program, we can take some satisfaction that we have done everything possible to minimize the risk to our crews, patients, and all other stakeholders when our ambulances travel the roads of the communities we serve.

<sup>1</sup>Maquire, et al (December, 2002) Occupational Fatalities in Emergency Medical

Services: A Hidden Crisis. Annals of Emergency Medicine. 625-632.

<sup>2</sup>California Department of Motor Vehicles Employer Pull Notice, <http://www.dmv.ca.gov/vehindustry/eptn/epngeninfo.htm>

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