



Local and State Oversight of Emergency Medical Services in California

The California Ambulance Association (CAA) applauds the California Emergency Medical Services Authority, the state-wide stakeholder groups and other interested parties for committing to the improvement of emergency medical services (EMS) system coordination in the state of California.

In 2007, the Institutes of Medicine (IOM) of the National Academies of Sciences released its landmark publication titled, "Future of Emergency Care in the U.S." The publication encompassed three reports addressing hospital-based emergency care, emergency care for children and pre-hospital care. One of those reports, "*EMS at the Crossroads*," evaluates the development of EMS over the last 40 years resulting in the "fragmented system that exists today." The prestigious committee's findings and recommendations rest on three broad goals for the nation's "systems" of emergency care:

- improved coordination
- expanded regionalization
- increased transparency and accountability

Guided by these broad goals, local and state regulation of California's EMS systems should be evidence-based, fiscally responsible, uniformly administered and objectively enforced. To achieve these goals, the CAA offers the following solutions:

- Reinforce the essential principles which guide effective EMS system design
- Incorporate future impacts of national health care reform in EMS system coordination
- Strengthen the foundation and effectiveness of the relationship between counties and those cities and fire districts which are covered by HSC 1797.201

The CAA looks forward to working with our partners and colleagues in achieving high quality, efficient and medically appropriate care for our patients and communities.

Effective EMS System Design

Health and Safety Code Division 2.5, known as the EMS Act, establishes the framework for local and state regulation of EMS in the state of California. Within that legal framework, California's EMS systems should be designed to achieve improved coordination, expanded regionalization and increased transparency and accountability based upon the following principles.

1. County Authority. State law vests each county with the responsibility to organize the EMS system within its boundaries. The goal of EMS system coordination should be to achieve optimal quality service and economic efficiency. There are unique and often complex local factors which will affect the local EMS system design including demographics, geography and existing EMS system infrastructure, as well as funding for all of the components of the EMS system, including community tax support and patient billings. Within each respective county, there are other major issues which affect the process and substance of system design, including financial resources available to facilitate a competitive process, effectiveness of existing providers, status of medical indigents, local economic factors, the existence of hard to serve areas, and other dynamics within the local health care marketplace. The board of supervisors in each county is responsible for establishing EMS system policy and for creating or designating a local EMS agency (LEMSA) to administer such policies. The LEMSA is the appropriate entity to oversee local EMS system design, medical control and market allocation policies based upon unique local needs, financial responsibility and existing resources.

2. Accountability. A coordinated countywide or regional EMS system is essential to achieve optimal financial and clinical performance. *Performance accountability* should be accomplished through performance-based contracts, with oversight from independent LEMSAs. *Financial accountability* should be accomplished through systems of full cost accounting that accurately account for the sources of patient billings and community tax funding that are available to support all of the components to the EMS system. As health care reform will certainly continue to accelerate changes in the health care system at the national, state and local level, EMS administrators need to establish system-wide analysis and coordination mechanisms that are responsive and flexible enough to adapt to fast-changing external factors.

3. Quality and Efficiency. The residents of every community ought to be served by that organization, public or private, which can provide the highest quality service in the most economically efficient manner. All EMS systems, whether urban or rural, and regardless of provider type or system design, should regularly schedule evaluations of system performance via a structured benchmarking process. Benchmarking among systems of similar size and demographics will assist LEMSAs in determining opportunities for system improvements, will determine whether a competitive process is likely to deliver better economic value and optimal clinical performance; and will assist in determining the optimal intervals between competitive processes.

4. Objective Medical Oversight. Ultimately, EMS is the provision of medical care in the out-of-hospital setting. State statute vests the EMS agency designated by each county with the responsibility to assure medical control of the EMS system. Regardless of whether services are

provided by a public or private organization, the public deserves the protection of objective, informed, medically expert, and authoritative medical oversight of all EMS system components by personnel who are neither appointed nor compensated by the organization which is subject to the oversight. All of the EMS system's components are part of a "system of care" which refers to the organized delivery system for a specific type and level of care within a specified geographic area. For EMS systems of care, the components include 9-1-1 dispatch, emergency medical response, field triage, treatment, stabilization and transport by ground or air ambulance, either from a scene to a hospital or between health facilities. Further, it is critical to achieve continuity of care among all of the EMS system's patient care givers. This can be achieved through a number of mechanisms, including: evidence-based medical protocols, dispatch and pre-arrival instructions, personnel training, clinical performance measures, continuous quality improvement programs and use of medical technology under a unified county-wide medical control structure.

5. Cost of Readiness. Health insurance is a major source of funding for the EMS system, primarily funding the ambulance transportation component; however, ambulance transport revenues are more often supporting other system components. There are certain aspects of the EMS system that may be appropriately funded by community tax support using population-based funding models and other components of the EMS system that may be appropriately funded by user fees which are covered by health insurance. In both models, it is essential there is adequate funding of the cost of readiness—the availability of medically appropriate resources for immediate emergency response. Adequate funding is necessary for both day-to-day emergency medical services and the surge in patients that occurs when EMS systems respond to large scale homeland security incidents, public health emergencies and natural disasters.

6. Grandfathered Existing Local Providers. County EMS agencies, with guidance provided by the California EMS Authority, are responsible for allocating market rights within locally designated exclusive operating areas (EOA). HSC 1797.224 specifically authorizes and facilitates the use of existing local providers, public and private, operating within a designated EOA, if they have been performing services in the same "manner and scope" since 1981. A different statute, HSC 1797.201, authorizes certain cities and fire districts which have performed EMS since 1980 to continue the administration of EMS within their boundaries, subject to medical control by the applicable LEMSA, until they enter into an agreement with the LEMSA for system administration. These so-called "201" entities may not expand into a new "type" of EMS (such as expanding from non-transport first response to ambulance transport) without the LEMSAs approval. Both statutes essentially permit the use of "grandfathered" providers in lieu of a competitive process if certain conditions prescribed in the respective statutes are met.

Use of financially stable "grandfathered" providers has proven to be effective as long as the provider can demonstrate that services are cost-effectively meeting the community's needs. Many of these providers, both public and private, have served their communities for decades with quality and efficient services. Any changes to the framework established by HSC 1797.201 or 1797.224 should be designed to achieve the goals of improved coordination, expanded regionalization and increased transparency and accountability.

7. Effective Competitive Processes. When the conditions for grandfathering under either HSC 1797.201 or 1797.224 are not met, state law requires a competitive process in order to establish EOAs. The threat of being replaced is one of the most powerful performance incentives, yet, competitive processes are not without risk for communities. When competitive processes are implemented via requests for proposals, EMS administrators must assure the following:

- The goal is to achieve *effective EMS system design* and to gain the best value and quality for patients and the community;
- The *competitive process* is objective, transparent, pro-competitive, without conflicts of interest and efficiently managed;
- *Benchmarking* is employed as a rational and data-driven method to determine if the cost of a request for proposal process will benefit the community and deliver better value; in the interim between periodic competitive processes, market studies have been successfully used to assess the most optimal timing of periodic competitive processes and determine if a request for proposal process is warranted;
- Every eligible ambulance provider, public or private, is assured a *fair opportunity to compete* for ambulance service market rights;
- The *concerns of incumbent providers* and incumbent workforce are addressed and there is fair opportunity for input into the EMS system design;
- A *level playing field* is established and maintained through an evaluation process that achieves “apples to apples” comparisons, especially in cases where one or more agencies of local government are potential participants along with private providers in the competitive process; a local governmental agency does not administer a competitive process under HSC 1797.224 in which it is also one of the proposers;
- The *integrity of financial comparisons* is achieved via application of sound accounting principles including full cost accounting, full allocation of shared costs, effective rate regulation, impact of uncompensated care and equal access to available public assets and community tax support when needed;
- Competitive processes incorporate a comprehensive analysis of the new requirements of *national health care reforms* which may have significant impacts on each EMS system’s financial infrastructure;
- *Local rate regulation* assures adequate funding for the ambulance transportation component of the EMS system and policies assure revenues from patient billings are not leveraged as a commodity;
- *Proposal evaluation panels* have diverse representation by individuals from business, medical, accounting and consumer backgrounds; panel members are without conflicts of interest and proposal evaluation processes utilize fair and transparent scoring methods; and
- To *prevent cavalier proposals*, failure by any provider selected via a competitive process, public or private, to deliver its financial and service commitments will result in forfeiture and reallocation of those same market rights, in addition to other appropriate penalties.

Impacts of National Health Care Reform

Health insurance is a major source of funding of emergency systems of care in the state of California. With President Obama signing sweeping health care reform legislation into law, emergency health care systems are certain to be impacted. Once a comprehensive analysis is completed, EMS systems may find both challenges and opportunities. There may be fewer uninsured patients, but more patients insured at below cost, such as current Medi-Cal rates. There may be an increase in patients covered by commercial insurance, but also increased efforts to constrict the definition of medically necessary care.

While current Medicare rates are below the national average cost of ambulance transportation service, health reform includes plans for substantial cuts in total Medicare program spending which may impact ambulance reimbursement. As CMS broadens its use of value-based purchasing tools to apply to all health care providers, covered ambulance transportation services are expected to be impacted. Increased use of coordinated care models may include new bundling of health care services, similar to how certain non-emergency ambulance services are bundled under the skilled nursing facility prospective payment system.

A chronic problem in the emergency health care system is that ambulances are frequently diverted from receiving hospitals due to a shortage of nurses and physicians to treat incoming patients. Ambulance crews are forced to wait in emergency rooms, often for several hours, while the patient waits on an ambulance stretcher before the facility will accept responsibility for patient care. These diversions and wait times endanger the patient and lead to increased EMS system costs. Will health care reforms make these patient flow patterns better or worse and what mechanisms will EMS systems and emergency departments employ to address these challenges?

Currently, ambulance services provide significant levels of uncompensated care, including charity care provided to the uninsured and below-cost reimbursement from Medi-Cal, Medicare and other government insurers. Below are the statistics about how Medi-Cal currently severely underfunds ambulance services:

- Medi-Cal rates cover about one quarter of the cost of service (EDS, 2008; GAO, 2007)
- Medi-Cal rates are about one third of Medicare rates (EDS, 2008; CMS, 2007)
- 88% of Medi-Cal ambulance transports were emergencies in 2008 (EDS, 2008)
- Medi-Cal funding does not recognize paramedic level care, even for heart attack and trauma patients
- Medi-Cal is underfunded by approximately \$165 million per year (CAA, 2010)

With a certain increase in Medi-Cal eligible beneficiaries, probable Medicare cuts, the individual insurance mandate, and potential for changes in medical necessity requirements, there is the potential for significant impact on the delivery of emergency health care. Payer mixes will certainly shift and the net impact to the EMS systems' financial infrastructure is yet to be determined.

Strengthen Relationship between Cities and Counties Covered by 1797.201

An important question in achieving improved EMS system coordination is: why county level control? There is significant evidence provided in the Institutes of Medicine landmark report published in 2007 titled, “*EMS at the Crossroads*,” to support the existing legal, economic, medical and demographic framework established by the EMS Act to designate counties as the responsible entity for establishing a local emergency medical services program (HSC 1797.200). Effective planning and oversight of emergency medical services by the LEMSA designated by each county is the primary and most fundamental means of achieving sound EMS system design—and delivering optimal quality and value to patients and communities.

As the most populous state in the country, California is a unique mix of diverse and dynamic regions: densely populated urban areas, expansive suburbs, rural agricultural regions and a vast frontier landscape. In establishing the most effective geopolitical entity responsible for planning and oversight of emergency medical services “systems of care,” simply stated, city-based oversight is too narrow and state-based oversight is too broad due to the state’s diversity.

EMS planning and oversight should align with each region’s “medical trade areas,” defined as the geographic areas which reflect the use patterns of medical resources by the population. California’s counties have the most direct relationship and alignment to the state’s medical trade areas. For this reason, and for other legal, economic, medical and demographic reasons, counties are the most appropriate geopolitical entity to provide local planning and oversight of EMS. Further, as is already the case in many rural areas, groups of counties with similar demographics and resource patterns are jointly establishing LEMSAs with the goal to achieve better economies of scale in delivering effective planning, oversight, medical direction and quality assurance activities.

There are other examples of county responsibility and authority, especially in the area of disaster preparedness. For example, FEMA and the state office of emergency services recognize counties as operational areas for the purpose of preparedness, mitigation, response and recovery operations. In addition, counties have the authority to declare a local emergency.

Conclusion

The EMS Act creates a sound legal framework for effective governance of California’s EMS systems. Article 1 of the EMS Act provides authority to the California EMS Authority to develop planning and implementation guidelines for EMS systems, receive and approve local EMS and trauma system plans and provide technical assistance. Article 1 of the EMS Act also assigns authority to each county to develop a local emergency medical services program, designate a local EMS agency and assure medical control of the EMS system.

There is significant evidence to support the existing legal, economic, medical and demographic framework established by the EMS Act to designate each county’s board of supervisors as the responsible entity for establishing an emergency medical services program (HSC 1797.200).

EMS system coordination will be improved as the foundation and effectiveness of the relationship between cities and counties created by HSC 1797.201 and HSC 1797.224, as applicable, is strengthened—assuring the delivery of optimal quality and value to patients and communities. Any proposed changes to the EMS Act, therefore, should be designed to achieve improved coordination, expanded regionalization, increased transparency and accountability.

Sources

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About the California Ambulance Association

Founded in 1948, the California Ambulance Association (CAA) represents the interests of emergency and non-emergency ambulance service providers serving nearly every county of the state of California. As healthcare’s first responders, the association is dedicated to assuring the delivery of excellent pre-hospital care to the people of California by promoting recognized industry best practices.

This position paper was approved by the California Ambulance Association Board of Directors on April 8, 2010.