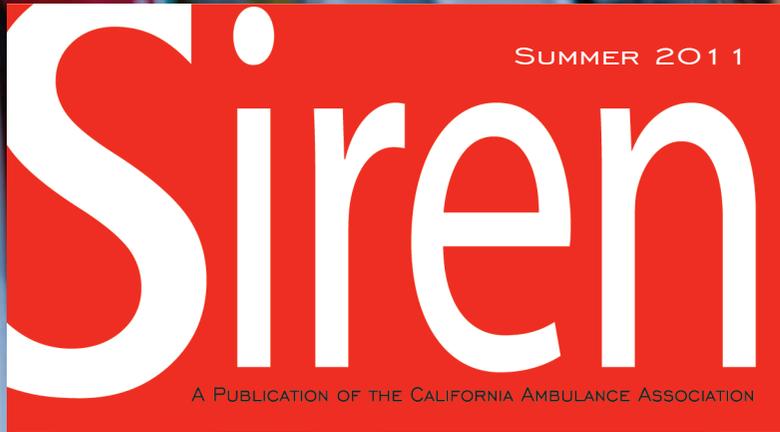


# Federal Court Opinion on Repetitive Transports



*New Medi-Cal  
Fiscal Intermediary  
Transition*

David Werfel  
Featured at Annual  
Reimbursement  
Conference in  
San Diego



## Emergency Medical Services Authority Welcomes Dr. Howard Backer



*Dr. Howard Backer  
Director, EMSA*

Howard Backer, MD, MPH, FACEP, has been selected to serve as Director of the California Emergency Medical Services Authority (EMSA). Diana Dooley, Secretary of the California Health and Human Services (CHHS) Agency, announced Dr. Backer's selection and held the swearing-in ceremony July 25th in Sacramento.

As Director, Dr. Backer will lead EMSA in establishing and enforcing standards for EMS personnel, coordinating with local EMS systems, overseeing the development of statewide specialty care systems, and preparing for and responding to disasters.

"I've had the opportunity to work closely with EMSA staff on disaster preparedness and public health issues over the past ten years, and I am well aware of their commitment to continually improving California's EMS system," said Dr. Backer. "As Director, I look forward to working with EMSA staff and with our public and private partners to support high quality and effective care to patients in the field and appropriate transport to definitive care."

Dr. Backer most recently served as the Interim Director of the California Department of Public Health (CDPH), where he served since 2000 in a variety of roles including as Chief of the Immunization Branch.

From 2008 to 2011, Backer served as Associate Secretary for Emergency Preparedness at CHHS where he worked closely with EMSA, CDPH, the Department of Social Services and other CHHS departments on plans to coordinate public health and medical disaster response as well as mass care and shelter issues. In that capacity, he served as a consultant to the Ukrainian Ministry of Emergencies and was part of a delegation to Chile following the devastating 2010 earthquake there. He will continue to coordinate the development of Emergency Function 8 (Public Health and Medical) for the California State Emergency Plan.

Prior to government service, Dr. Backer practiced emergency medicine full time for 25 years in rural, urban, and suburban settings. He received a Doctor of Medicine from the University of California at San Francisco, a

Master of Public Health from the University of California at Berkeley, a Bachelor of Sciences from the University of Michigan and is board certified in Emergency Medicine, Preventive Medicine and Public Health. He continues to work clinical hours in Urgent Care at the UC Berkeley Student Health Center.

Dr. Backer has a lifelong interest in wilderness and travel medicine. He is a founding member of the Wilderness Medical Society and a Fellow of the Academy of Wilderness Medicine. He also serves as medical consultant for an international adventure travel company and is a national expert in field water disinfection and infectious diseases of travelers.

Dr. Backer lives in Piedmont, with his wife, who is a registered nurse, and one of three daughters. In his time off, he likes to spend time in the Sierra Nevada mountains or do international travel to remote areas.

Daniel R. Smiley, who has served as EMSA Acting Director since November 2010, will resume his duties as Chief Deputy Director of EMSA, a position he has held since 1989.

The Emergency Medical Services Authority ensures quality patient care by administering an effective, statewide system of coordinated emergency medical care, injury prevention, and disaster medical response. Under statute, the Director of the Emergency Medical Services Authority is required to be a physician with experience in emergency medicine.

## Send Us Your Heroes!

EMSA is accepting nominations for the 2011 California EMS Awards through September 1. Paramedics, emergency medical technicians, administrators, trainers, volunteers, physicians, nurses, and first responders - together they are California's prehospital emergency medical care system. They ensure that in a medical emergency, a trained provider responds to a call for help and does what needs to be done. It's an act of courage every time. Win or lose. Each year, the Emergency Medical Services Authority (EMSA) honors their accomplishments through the California EMS Awards Program. These awards recognize meritorious acts, heroic acts, special advocacy, innovations or new approaches to improve EMS in the state.

An awards ceremony will be held in San Francisco on December 7, 2011. Nomination forms and additional information are available on the EMSA website at [www.emsa.ca.gov](http://www.emsa.ca.gov).



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

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



# The Benefits Of Stakeholder Collaboration

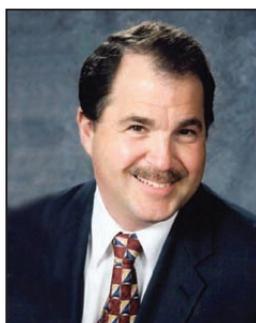
by Bob Barry, Chair of the Board

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Bob Barry

*“The challenge of every organization is to build a feeling of oneness, of dependence on one another... because the question is usually not how well each person works, but how well they work together.”*

— Vince Lombardi

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Circulation among California's private ambulance providers, elected officials and EMSA administrators.

Cover photo: Stefano Lunardi | istockphoto.com



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One of the CAA's goals over the past few years has been to enhance our working relationships with the other EMS agencies and become the "go to" source for information on our industry.

During the course of meeting this objective, I discovered that the benefits of engaging with these other agencies are exceedingly clear. Consequently, we have found ourselves collaborating together with agencies we previously had always viewed as competitors.

This process started initially with the QAF Work Group where we began working together with the California Fire Chiefs Association and the California Association of Fire Districts. This collaboration has now grown through our representation on several key taskforces and work groups, including the current AB 210 stakeholder workgroup and EMSA's

Chapter 13 Task Force, which are both working to solve the long-standing .201/.224 issues that have plagued the state EMS system for the past 30 years.

Over the years, I have seen EMS stakeholders routinely compete with each other in an unrelenting fashion. You could chart the competition and inefficient struggle between stakeholder groups and each would have a hostile attitude toward the others.

For example, contentious relationships seem to persist between our industry and fire departments which at times view each other as direct competitors. And, there is another layer of interaction that these provider entities have with their own county LEMSA and the state EMSA.

I believe greater collaboration among

*Continued on page 15*

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## Executive Director's Update

# CAA Continues to Seek Rejection of 10% Medi-Cal Cut

by Brenda Staffan, Executive Director



Brenda Staffan

Since Governor Brown signed the Medi-Cal rate cut legislation into law in the spring, the CAA has continued to advocate that a Medi-Cal rate cut will harm access to patient care. As we have previously reported, Governor Brown signed AB 97 (Committee on Budget, Chapter 3, Statutes of 2011, among other provisions) which directs the Department of Health Care Services (DHCS) to implement a permanent 10% reduction in Medi-Cal rates for emergency and non-emergency medical transportation effective June 1, 2011.

Even after months of lobbying by the CAA, our members and other stakeholders, the legislature did not exempt ambulance services from the cut.

### California ambulance provider representatives travel to Baltimore to meet with CMS.

Following extensive research, the CAA team determined that the rate cut requires federal authorization in the form of CMS (Centers for Medicare and Medicaid Services) approval of a State Plan Amendment (SPA). On May 16, the CAA, along with other ambulance providers (California Fire Chiefs Association and AMR) sent a letter to Medicaid officials at CMS requesting that CMS reject the 10% Medi-Cal rate cut for ambulance services. The letter included evidence that a rate cut would reduce patient care access to medically necessary ground ambulance transportation. In late June, representatives from the three provider groups met with Medicaid officials at the CMS headquarters in Baltimore, MD to further advocate for an exemption from the rate cut. We also sent a similar letter to the DHCS in response to their proposed regulations.

### Ambulance providers are urged to prepare for potential cash flow interruption.

As of the writing of this article, CMS has not taken action on the Department request for a rate cut and our request to reject the rate cut. Further, while the Department has not yet announced how the rate cut would be implemented, we have confirmed that if CMS approves the 10% rate reduction, the rate cut will be applied retroactively to June 1, 2011. One possible scenario is that Medi-Cal will hold payments for a period of time until the equivalent value of the rate cut has been achieved. We will provide an update to members once we can confirm the method. We also expect the DHCS to issue a bulletin which will provide instructions on how the rate cut will be implemented.

### CAA joins federal Medi-Cal ambulance rate lawsuit.

Also this spring, the CAA board of directors voted to officially join a federal lawsuit which seeks to increase Medi-Cal ambulance rates to levels that cover the cost of services. After being suspended for a period of months with other federal cases related to Medi-Cal reimbursement, the federal

## **Severe Below-Cost Medi-Cal Rates Impacts Access to Patient Care**

### **Lowered quality of care**

Below-cost Medi-Cal rates prevent and slow the delivery of necessary and innovative treatments, drugs and technologies to the patient's side due to reductions in training, supply and capital expenditures. Ambulance providers are now deferring capital equipment purchases and lengthening capital equipment replacement schedules.

### **Decreased access to care**

Below-cost Medi-Cal rates cause longer paramedic response times, reduced paramedic response capacity and fewer staffed paramedic ambulances available to respond to 9-1-1 emergency requests for service. Ambulance providers are cutting back on the number of "unit hours" and ambulances "on duty" to respond to requests for service, and are closing or "browning out" fire and ambulance stations.

### **Reduced supply of care**

Below-cost Medi-Cal rates reduce services especially in hard hit communities with vulnerable populations: suburban and rural areas, depressed economic areas, and areas with high numbers of uninsured and Medi-Cal patients. Unlike the Medicare ambulance fee schedule, Medi-Cal payment policy does not address the higher cost per transport experienced by rural ambulance services. In lower population density rural areas, the fixed cost of readiness is spread across a lower volume of transports, resulting in a higher cost per transport compared to urban services.

### **Barriers to access to care**

Below-cost Medi-Cal rates penalize 9-1-1 patients covered by commercial health insurance. These patients shoulder an unfair and inequitable burden in the form of extremely high co-pays and deductibles, and these high out-of-pocket expenses create a personal financial consequence for dialing 9-1-1.

Continued on page 14



# New Medi-Cal Fiscal Intermediary Takes Over September 30

by Jody Soule, Chair, Payer Issues Committee

A new fiscal intermediary will be processing all of our Medi-Cal claims beginning in the fall of 2011. At our Annual Convention in June at Harrah's in Tahoe we had the pleasure of meeting with Cynthia Garrett our current fiscal agent from Hewlett Packard, Blanca Castro from ACS or Affiliated Computer Services (our new fiscal agent), and Bonnie Kincaid from the Department of Health Services (the agency that oversees Medi-Cal). Issues addressed by this panel included the transition timing, computer system conversions, customer service and claims support processes.

Hewlett Packard has been the fiscal agent for Medi-Cal since 1987. The Assumption of Operations for HP to transition to ACS is on or around September 30, 2011. They will be developing a long needed replacement system with modern hardware and software architectures that is compliant with federal requirements.

During the takeover phase the hopefully painless transition will first be a hardware/network update, application software re-host from HP to IBM data center, configuration of other data centers for backup redundancy and to replace call center and document management. ACS has hired experienced HP staff to help when they assume operations from HP.



Cynthia Garrett, HP; Bonnie Kincaid, Department of Health Services and Blanca Castro, ACS explain the transition to ambulance providers during the CAA's Annual Convention.

We have been told that the key focus and goal is to ensure a seamless transition through Provider communication. DHCS and ACS will be measuring their success on the minimal impact to Providers and Beneficiaries. I know that as Providers we are hoping for their success also.

For more information about the Medi-Cal Fiscal Intermediary Transition, see the FAQs flyer at: [http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom\\_20005.asp](http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_20005.asp).

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# Federal Court Issues Opinion Favorable to Repetitive Transport Providers

By R. Michael Scarano, Jr., Partner, Foley & Lardner, LLP



Image courtesy of Sierra Ambulance

On July 11, 2011, a federal trial court in Tennessee issued a significant decision favorable to ambulance providers who perform scheduled repetitive transports for dialysis and other types of chronically ill patients. The decision, in the case of *MooreCare Ambulance Service, LLC vs. Department of Health and*

*Human Services*, addressed the standard to be applied by the Medicare administrative contractors (“MACs”) in determining whether scheduled repetitive transports are medically necessary. In a nutshell, the court held that providers need only demonstrate that the trip was, in fact, a scheduled repetitive transport, and that a physician has signed a timely physician certification statement (“PCS”) indicating that the trip was medically necessary. In other words, the court held that MACs should not look behind the PCS to determine whether other information in the record establishes medical necessity. The decision may be appealed and, even if that does not occur, it is binding only on the MAC for Tennessee. However, it could be persuasive on ALJs, other administrative review bodies and the courts.

## **Background**

In May, 2007, AdvanceMed, the Medicare safeguard contractor for Tennessee, requested all medical records and supporting documentation from MooreCare Ambulance Service for claims with dates of service from January 1, 2005 through September 30, 2006. AdvanceMed reviewed a random sample of 60 claims and found “a high level of payment error.” Specifically, 89.32% of the claims examined were determined to have been improperly billed by MooreCare. AdvanceMed determined that this resulted in overbilling in the total amount of \$19,131.59, which was extrapolated to a potential recoupment of \$2,114,613.

MooreCare appealed through the standard administrative appeals process, first seeking a redetermination by CIGNA, the MAC for Tennessee at the time. Not surprisingly, CIGNA determined that the “assessed overpayment” decision by AdvanceMed was “fully valid” and affirmed the overpayment amount. MooreCare then appealed to the Qualified Independent Contractor (“QIC”), which

issued a “partially favorable” ruling, reducing the overpayment amount from \$19,131.59 to \$11,170.33. Not satisfied with this partial victory, MooreCare appealed the ruling to the next level, an administrative law judge (“ALJ”). The ALJ reviewed 23 claims that had been found non-payable and reversed the decision as to 13 claims. Still not satisfied, the plaintiff appealed to the Medicare Appeals Council (“Appeals Council”), the highest level of administrative appeal. The Appeals Council again reviewed all 23 claims that had been reviewed by the ALJ and affirmed some of findings but also reversed some of the cases that had been decided favorably to MooreCare by the ALJ.

The central issue addressed by the Appeals Council was whether MooreCare had provided sufficient evidence that the ambulance trips under review were medically necessary. MooreCare largely relied on the PCS’s from the patients’ physicians stating that the patient could only safely travel by ambulance, and on the “run reports,” which constituted provider’s own medical record of the trips. Relying on its interpretation of the Code of Federal Regulations and the Medicare Benefit Policy Manual, the Appeals Council concluded that “a signed PCS alone is insufficient to support Medicare coverage.” The Appeals Council then went on to examine each claim and whether the record supported the use of the ambulance. The MAC found that, in 20 cases, the claim was not properly covered by Medicare, usually because the necessity for an ambulance had not been clearly demonstrated.

## **The Court’s Decision**

MooreCare appealed the Appeal Council’s findings to the federal district court in Tennessee. The court carefully reviewed the pertinent Medicare ambulance fee schedule regulation and interpreted it differently than the Appeals Council, the ALJ, the QIC and the MAC. The court recognized that there is a “basic” rule governing whether ambulance services are covered by Medicare, but there is also a “special for scheduled repetitive transports.” The “basic” rule is that ambulance services are covered “where the use of other methods of transportation is contraindicated by the individual’s condition. Under the Basic Rule, the beneficiary’s condition must require both the ambulance transport itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation via ambulance is appropriate if either the beneficiary is bed-confined, and it is documented that the beneficiary’s condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement . . . is one factor that is considered in medical necessity determinations.” 45 C.F.R. § 410.40(d)(1)).

However, the court interpreted the regulation as creating a separate “special rule” for “non-emergency, scheduled, repetitive ambulance services.” Under this special rule, Medicare covers medically necessary non-emergency, scheduled, repetitive ambulance services if the ambulance supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary’s attending physician certifying that the medical necessity requirements . . . are met. The physician’s order must be dated no earlier than 60 days before the date the service is furnished.” Thus, if the service is “scheduled” and “repetitive” and a valid PCS is signed, additional review of the record to determine medical necessity is not required under the regulations.

After reaching this legal conclusion, the court asked MooreCare to point to evidence in the administrative record showing, for each challenged claim, that the service at issue was “scheduled and repetitive” and that a valid PCS existed. Where such evidence was lacking, the court stated that MooreCare could establish medical necessity under “general rule.”

The court then proceeded to evaluate each of the 23 claims at issue by first attempting to apply the “special rule,” and, if the special rule did not resolve the issue, by applying the “general rule.”

As noted above, the “special rule” requires that the provider submit a timely PCS signed by a physician. This is consistent with the ambulance fee schedule regulations, which require that,

for repetitive scheduled transports, a PCS must have been signed by physician before the transport. However, the court showed some latitude here, permitting payment for transports run between August 16, 2006 to October 16, 2007, even though the PCS was not signed until August 23rd, after the service began. The court did not articulate the reason for this leniency, but it may have recognized that providers may not be aware that a series of trips are repetitive and scheduled until the definition of repetitive transports is met. That definition provides that transports are deemed to be repetitive if they are required more than three times in any ten day period or once a week for three consecutive weeks for a chronic condition.

As noted above, this decision will likely be appealed. Even if that does not occur, it is only binding on the MAC in Tennessee, which is now CAHABA. However, the decision maybe persuasive on administrative tribunals and courts in addressing the same issue in other jurisdictions. The decision is very significant because it establishes a much “lower bar” for scheduled repetitive transport providers to meet in establishing medical necessity. Historically, the medical necessity of such trips have been very difficult to justify, and numerous providers have been prosecuted, fined and even jailed for overly aggressive application of the medical necessity rules. Under the rule articulated in this decision, the PCS alone is sufficient to establish medical necessity for a scheduled repetitive trip.





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General Manager, American Ambulance of Fresno

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# Annual Convention Recap

## 63rd Annual Convention Concludes Productive Year for the CAA

Over 104 EMS leaders from across the state of California gathered June 15-17 at Harrah's Lake Tahoe for the CAA's 63rd Annual Convention.

Serving as the perfect kick-off, attendees enjoyed a round of golf during the Annual Ray Lim Memorial Golf Tournament, followed by a lake-side welcome dinner and reception at the spectacular Edgewood Tahoe Golf Course.

This year's program, themed, "Preserving & Strengthening the Ambulance Safety Net," featured outstanding speakers and topics, including state specific issues to protect and help providers grow their ambulance companies.

### CAA Marketplace

This year's Marketplace featured several vendor booths, showcasing the latest innovative business and technology solutions for the ambulance industry. The CAA Marketplace was the perfect place for attendees to connect with other industry leaders between sessions.

*Continued on page 15*

### Thanks to Our Annual Convention Sponsors:



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Kim Ingersoll, Chair Barry, and Jennifer Blevins

Sara McEntee, CAAS



## Reimbursement Conference *Preview*

# Registration Now Open for 2011 CAA Annual Reimbursement Conference

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It's only at the 2011 CAA Annual Reimbursement Conference that California's ambulance service providers receive state-specific information and resources to update your compliance program and to maximize your billing revenue.

This year's conference will include a Medicare Update and other hot topics featuring: David Werfel and an update from Palmetto GBA by Kathy Montoya. A forum regarding CAA's Medi-Cal rate initiative will also be provided to conference attendees.

Early bird registration ends September 30, and you can register on line at <http://www.regonline.com/caa2011reimbursementconference>.



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## Legislative Update

# CAA Legislative Effort Continues in Three Major Areas

By Chris, Micheli, CAA Legislative Advocate

There has been a fair amount of continued activity by the California Legislature prior to its scheduled summer recess in late July and early August. CAA staff has worked in three major areas of legislation during the past few months: Quality Assurance Fee, AB 678, and AB 210. CAA's Board adopted

oppose, unless amended positions on both AB 678 (Pan) and AB 210 (Solorio), but emphasized its commitment to work with the authors and proponents of both of these bills in an effort to address the concerns expressed in CAA's opposition.

As a result of our lobbying against AB 678, Senate staff and others asked CAA to re-examine its opposition to a proposed quality assurance fee (QAF). CAA continues to host the Medi-Cal Work Group calls and meetings in our efforts to devise a system that will enable California to secure additional federal funds to compensate emergency and non-emergency ambulance providers in this state for Medi-Cal patient transports without creating financial "losers" in such a funding scheme. This continuing effort requires work with funding models, consultations with federal program experts, and discussions with state officials. While CAA remains opposed to a QAF at this point, based upon feedback and suggested program changes by the state, staff are re-examining the proposals to determine if a different approach could create a sufficient amount of funding and resolve the issue of financial losers to justify legislation in this effort. In addition, CAA has been looking at alternatives to create federal funding opportunities based upon feedback from federal CMS officials.

In the meantime, pending legislation (primarily AB 678 and AB 210) has kept CAA staff very busy with ongoing meetings and negotiating sessions. Both of these bills are sponsored by the California Professional Firefighters.

AB 678 would allow a certified public expenditure (CPE) program to be utilized by public fire departments in California to draw additional federal matching funds to be provided to fire districts and fire departments in the state that complete the federally required CPE cost report forms. The CAA has worked for the past two years to create a funding scheme that benefits both private and public providers. This bill, on the other hand, would create a Medi-Cal funding system that treats providers unequally and would give the public sector additional funds for serving Medi-Cal patients. CAA has asked the author and sponsor to amend the bill to allow both public and private providers to receive the new federal funding that may be obtained via a CPE program. Those requests have been rejected. As of the date of this article, AB 678 is on suspense at the Senate fiscal committee. The

Continued on page 14

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# State Budget Adopted with No Further Health Care Cuts

## *California EMS Commission Saved from Budget Ax*

By Chris, Micheli, CAA Legislative Advocate

The Legislature adopted a second budget in late June prior to the start of California's fiscal year on July 1. Although the budget adopted in March attempted to deal with many of the cuts in state services desired by interested parties, Governor Brown and Democratic leaders continued their push for additional revenues.



When no deal was reached with Republican legislators for a vote on potential revenues, Democrats adopted an "all-cuts budget" that was not dependent upon new revenues. However, in a surprise move, Governor Brown vetoed the budget less than 24 hours after it was adopted and Controller John Chiang withheld over \$400 in daily payments normally owed to legislators. With the lack of a budget and after losing over \$4,500 each, a new budget deal (based primarily upon \$4 billion in new estimated revenues being received by the state over the course of the next fiscal year) was reached and signed shortly thereafter. No additional health and human services cuts were adopted. However, if the additional revenues are not collected by the end of 2011, then the Department of Finance will have the authority to proceed with triggered cuts, primarily in education funding.

### California EMS Commission Saved from Budget Ax

CAA did work diligently for several weeks to defeat the Governor's proposal to eliminate the Emergency Medical Services (EMS) Commission. The Governor's May Revision had proposed elimination of over 40 boards and commissions, including the EMS Commission, which finally had its CAA representative join the Commission in January (Jaison Chand). Upon learning of the Governor's proposal, CAA formed a coalition of opponents, primarily the California Fire Districts Association and the California Professional Firefighters. Those groups commenced a heavy lobbying campaign to save this important

*Our collective lobbying efforts were successful and led to the two houses ultimately rejecting the Governor's proposed elimination of the EMS Commission.*

commission and the groups sent letters and testified before the budget subcommittees. Our collective lobbying efforts were successful and led to the two houses ultimately rejecting the Governor's proposed elimination of the EMS Commission. Only a few boards and commissions were ultimately saved and the vast majority of the Governor's cost-cutting efforts were approved by the Legislature and signed into law by Governor Brown. As such, the EMS Commission will continue to exist.

### State Budget Impacts on Healthcare

- Assumes savings of \$1 billion General Fund from a potential shift of Proposition 10 (First 5) funds that the Legislature approved in the March budget. The Governor and legislative Democrats opted to approve the shift without seeking voter approval, which resulted in seven county First 5 commissions filing lawsuits. The Governor removed the \$1 billion savings from his May Revision because of the lawsuits, but the Democrats' budget assumes the savings will be achieved.
- Assumes \$700 million in new one-time federal reimbursement resulting from repayment of costs incurred by the Medi-Cal Program in prior years that should have been paid by the federal Medicare Program.
- Assumes nearly \$100 million in Medi-Cal savings resulting from an extension of the current Medi-Cal managed care plan tax, which is currently set to expire June 30, 2011.
- Instead of simply eliminating the Medi-Cal Adult Day Health Care program, as proposed by the Governor's January budget, provides \$85 million General Fund for a replacement program. This also represents an increase of \$60 million compared to the Governor's May Revision, which proposed \$25 million General Fund for a transitional program.
- Reflects erosions of \$172 million in various health budget solutions due to a month delay in enacting the March budget solutions.
- Assumes savings of \$31 million in 2011-12 by shifting the Healthy Families Program into Medi-Cal.



# The Safety Zone

## Who's Responsible for Safety

By Don Vonarx, General Manager, Riggs Ambulance Service

Depending on your role within your organization the answer to this question may vary. Frontline employee's may acknowledge their role in a culture of safety, but also may quickly place blame on management in the event of an accident, injury or exposure. Most managers would probably agree that safety is everyone's responsibility, but they also realize the company owns the lion's share of responsibility when it comes to unsafe working conditions, preventable accidents, injuries, and exposures.

In our industry, responsibility and requirement for safety is well-defined in many areas, such as, the provision of specialized safety training, personal protective equipment, prophylactic vaccinations, health screenings, and post-exposure follow-ups. While your organization is likely compliant in all of these state and federal regulations, you may be missing opportunities to develop a culture of safety that benefits everyone in the organization.

### Safety Committees

A culture of safety is created by participation at all levels, yet, this can be easier said than done. The obvious and most common method for this participation is through the company Safety Committee. Most organizations have Safety Committees but the experiences and successes of these committees vary widely. Successful Safety Committees share common characteristics:

- Well-represented by a cross section of the organization. Be careful of the perception that management has "hand-picked" those to be included.
- Members that willingly participate and are enthusiastic for improvement.
- Committee activities which incorporate methods of

timely follow up and reporting of process improvement to all stakeholders.

- A very high level of support and participation from management.

The last item is critical and can make or break the entire process. If management does not wholly support and buy-in to the commitment

of a safe culture, the process will most likely fail to be sustainable in the long term. This means that all issues brought by the Safety Committee are thoroughly and openly discussed with all members. Safety Committee members are also given the responsibility and opportunity to state their point of view without risk. Managers participating in the process must resist the impulse to shut down ideas they deem to be frivolous or too expensive.

### Safety Observations and Reporting

An important component of the company-wide culture of safety is to insure everyone understands the expectation that when safety issues are encountered, they are reported promptly. Of equal importance is management's timely review and follow-up to address the issue. Once the safety issue has been comprehensively resolved, reporting to stakeholders keeps everyone involved in the process and supports future participation. Employees who know their concerns will be addressed are more likely to report them.

A culture of safety sets the expectation that everyone is actively involved and responsible for a company's safety; however, supervisors and managers have additional responsibilities. Management is legally required to know and enforce the applicable safety laws and regulations. They are also ethically required to go further and proactively look for

issues. One method adopted by Riggs Ambulance Service (RAS) in Merced is the development of an online Supervisor Safety Observation form. It is

Observation Matrix	Yes	No	Not Observed
Wears DOT vest on MVC scene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses safe lifting principles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety glasses readily available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wearing restraint in back of ambulance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient has shoulder restraints in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proper use of break-away flat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has PCR mostly complete upon arrival at hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safely transports Toughbook	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STARCARE practiced in dealing with all customers during observation period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safe Lifting / Ergonomics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Road Safety Box intact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proper restraint of pediatric patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proper use of PPE's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Proper use of StairChair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monitor Clock is correct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RAS implemented a Health & Safety Observation Form to provide an extra measure of safety for the crews and the patients they serve.



# The Safety Zone

the expectation that Operations Supervisors assist crews on scene and while doing so they are to document their safety-related observations of the crew. The Supervisors are encouraged to both reward crews "caught doing the right thing" with gift certificates, or occasionally provide remediation to crews cutting safety corners. This

***"A culture of safety sets the expectation that everyone is actively involved and responsible for a company's safety; however, supervisors and managers have additional responsibilities."***

information is captured electronically on the observation form and archived in a database. This data provides valuable historical information when dealing with repeat safety policy offenders.

As managers, we understand the advantages of a safety-conscious workforce and want to cultivate one, but may feel challenged in exactly how to achieve this. The first step is to essentially, take the first step; get your employees and yourself involved. Reward them for their involvement and support them in their efforts

while giving all their ideas genuine consideration. Make it "ok" to report safety issues, follow up in a timely manner and share the progress with all.

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## Legislative Update

*Continued from 10*

proposal must be approved by CMS before being implemented.

AB 210 attempts to clarify numerous provisions of California’s EMS Act, which was adopted in 1980 and has been subject to numerous legal challenges and regulatory activities. CAA has been an active participant in both the “Chapter 13 Task Force” hosted by EMSA, as well as the AB 210 Stakeholder Work Group, in an effort to address numerous concerns that have been identified with proposed changes to the underlying statute. CAA has also

made numerous requests to make AB 210 a two-year bill so that the negotiations and proposed regulatory changes can be made without the pressures of the legislative calendar. While those requests have been rebuffed, CAA and several other groups have continued to participate in the weekly meetings of the AB 210 Work Group in a good faith effort to represent the CAA’s members’ interests regarding proposed changes to the EMS Act. Numerous in-person and weekly conference calls have been ongoing for the past few months and will continue during the legislative recess in an effort to finalize this legislation prior to the Legislature’s adjournment in mid-September. As of the date of this article, AB 210 is scheduled for a hearing at the Senate Appropriations Committee.

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## Executive Director’s Message

*Continued from 4*

ambulance lawsuit was re-filed with the federal court this summer. The plaintiffs are a group of nearly 30 California ambulance providers that include both members and non-members of the CAA, out-of-state ambulance providers and now includes the CAA.

### **CAA continues to educate officials that Medi-Cal ambulance funding must be a priority.**

We have recently been requested to re-evaluate the Quality Assurance Fee (QAF) and we have gained new information from CMS regarding alternative programs to generate increased federal matching funds which we will explore. Regardless of the funding source, severely underfunded Medi-Cal rates impact patient care and we urge both public and private ambulance administrators to increase their efforts to track the impact of these funding shortfalls on patient care.

In addition to our work on Medi-Cal, the CAA leadership has been active participants with other EMS stakeholders on two very critical initiatives which will shape future standards for EMS system design in California: the EMSA-hosted **Chapter 13 Task Force** and the proposed **AB 210** authored by Assembly member Solorio (D-Santa Ana). As CAA leaders represent our members on both of these initiatives, we are guided by the association commitment to promote fair, effective and fiscally responsible EMS systems and we will keep our members informed of their progress.



## Annual Convention Recap

*Continued from 8*

### Annual Chair' Banquet

The Chair's Banquet served as the perfect platform to reflect on this year's accomplishments due in large part to the tireless work of the several dedicated volunteers. Jody Soule of San Luis Ambulance Service was presented the Chair's Award of Excellence for her outstanding leadership as Chair of the Payer Issues Committee, and for her tremendous guidance and contributions on the association's Medi-Cal work group.

Brian Hartley of Boundtree Medical received the Commercial Member of the Year Award for his outstanding contributions as an engaged member of the CAA.

Gerry Hart was bestowed an Honorary Lifetime Member designation for his distinguished service to the science and art of ambulance services.

### Election Results

The results of the 2011 election were announced at the general membership meeting:

#### **2011/2012 Board of Directors**

Bob Barry, Chair  
Helen Pierson, Vice Chair  
Alan McNany, Secretary/Treasurer  
Richard Angotti  
James McNeal  
Dana Solomon  
Fred Sundquist  
Josette Mani, Sgt-at-Arms

#### **2011/2012 Ethics & Professionalism Committee**

Eb Muncy  
Byron Parsons  
Klark Staffan

#### **Thank you to the 2010/2011 CAA Leadership Team**

At the Chairman's Banquet, Bob Barry recognized that all of the association's members have contributed to making this

association remarkable and he personally thanked the banquet attendees for their tremendous support of the association.

### **Board of Directors**

Bob Barry, Chair  
Dana Solomon, Vice Chair  
Helen Pierson, Secretary Treasurer  
Richard Angotti  
Jim McNeal  
Fred Sundquist  
Alan McNany  
Josette Mani, Sergeant-at-Arms

### **Management Team**

Brenda Staffan, Executive Director  
Chris Micheli, Legislative Advocate  
Mark Corum, Siren & Website Editor  
Jennifer Blevins, Meeting Planner  
Tricia Schrum, Accountant  
Kim Ingersoll, Membership Services

### **Committee Chairs**

Eb Muncy, Legislative & Agency Relations Committee  
Ed Guzman, Nominating Committee  
Gerry Hart, EMS Commission Subcommittee  
Alan McNany, Ethics & Professionalism Committee  
Jim McNeal, CAAPAC Committee  
Eb Muncy, Nominating Committee  
Helen Pierson, Education Committee  
Stewart Slipiec, Safety Subcommittee  
Jody Soule, Payer Issues Subcommittee

Chairman Barry offered special recognition and thanks to the management team at California Advocates Management Services, specifically, Jennifer Blevins and Kim Ingersoll, for the quality and efficient services they provide to our association.

## Chair's Message

*Continued from 3*

EMS stakeholders, including EMSAAC, EMDAAC, the Fire Chiefs and Fire Districts, Professional Firefighters, CAA, and EMSA can help to solve many of the problems that challenge EMS, especially as we grapple with the challenges posed by health care reform.

Multi-stakeholder collaborations are tasked with challenges, problems or opportunities that individual groups or organizations cannot achieve alone. While each organization may agree to the need for a shared direction or a common decision, each group also calculates the costs and benefits of collaboration based upon their group's specific needs.

Collaboration works best when:

- The objective cannot be accomplished alone.
- There are shared goals among stakeholders such as providing comments on government regulations.
- There are mutual cost benefits which result from efficiently working together.
- There are opportunities to maximize the collective voice of the EMS community in the broader health care arena.

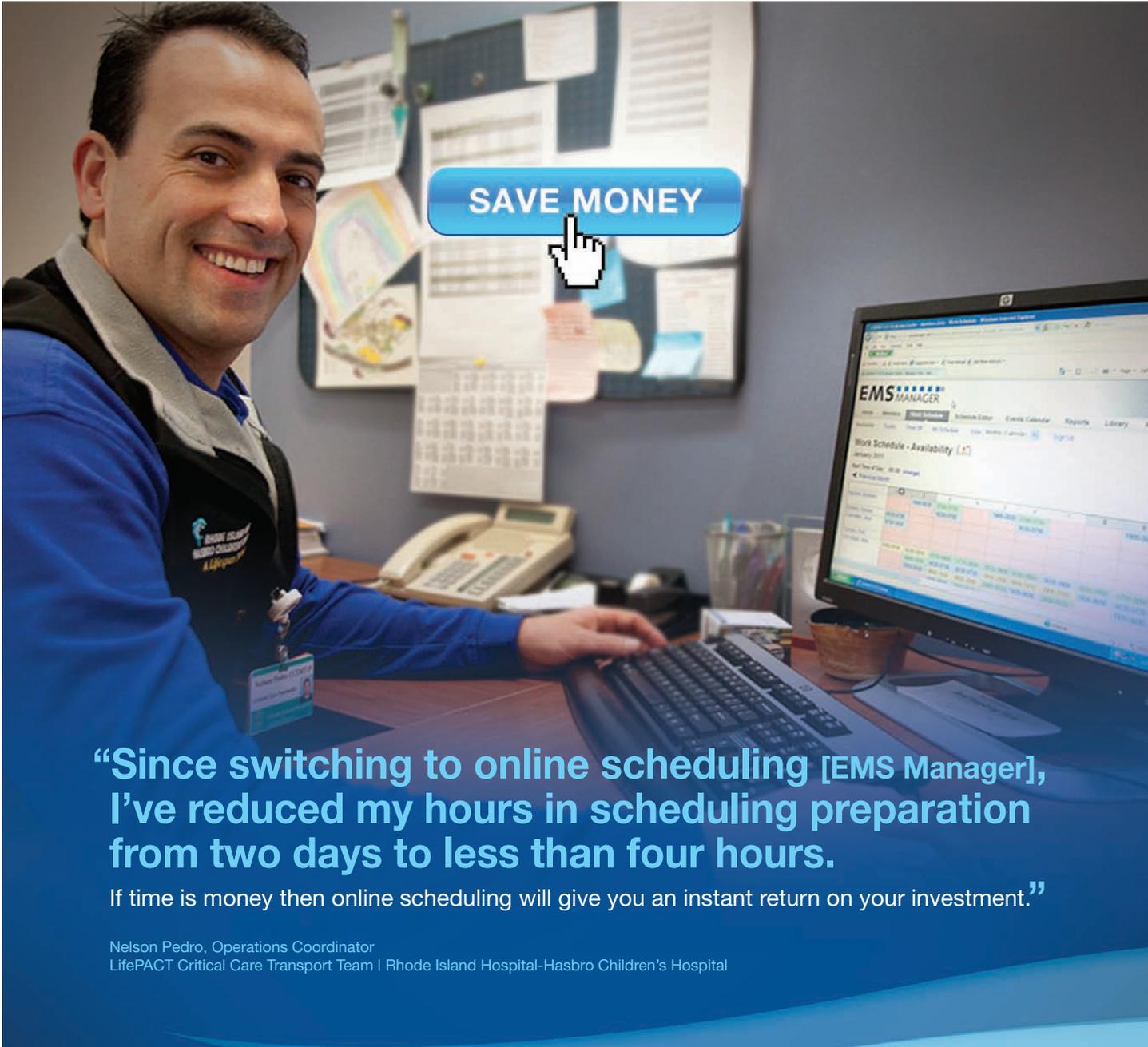
As an association, we must stay open to working with all other stakeholders that can impact our industry. We cannot isolate ourselves or disengage to the point where others have an opening to dictate policy changes to our industry just because we do not trust or understand other groups.

To this end, we must continue to reach out and establish relationships with each group, so we can understand their points of view and can communicate ours to them. Your leadership team is committed to continuing to collaborate with other organizations and represent your interests at the state level at the highest levels of effectiveness.



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