

CALIFORNIA FIRE SERVICE

POSITION ON:

EMERGENCY MEDICAL SERVICES

STATUTORY ROLES AND

RESPONSIBILITIES

**July 22, 2009**

## ACKNOWLEDGEMENTS

This document is the result of collaboration among the members of the California Fire Chiefs Association, California Professional Firefighters, and the League of California Cities, Fire Chiefs' Department. The following committee members are acknowledged and thanked for their contribution of time and effort towards the development of this white paper.

Sheldon Gilbert, President  
California Fire Chiefs Association

Lou Paulson, President  
California Professional Firefighters

Demetrious N. Shaffer, Fire Chief  
City of Newark  
President, League of California Cities, Fire Chiefs' Department\*

Sabina Imrie, Past President  
CFCA, EMS Section

Kevin White  
California Professional Firefighters

Michael Antonucci, President  
CFCA EMS Section

Michael Pretz, Fire Chief  
City of Lodi  
Member, League of California Cities,  
Fire Chiefs' Department

Raymond Ramirez, Legislative Analyst  
CFCA, EMS Section, South  
Attorney at Law

Jim Hone, Fire Chief  
City of Santa Monica  
Member, League of California Cities,  
Fire Chiefs' Department

Mark Hartwig, Director  
CFCA, EMS Section, South

Steve Drowniany, Secretary  
CFCA, EMS Section, North

Dave Hafey  
CFCA, EMS Section, North

Jeff Eastman, Fire Liaison Chief  
CFCA, EMS Section Liaison, South

Ed Rodriguez  
CFCA, EMS Section, North

The California Fire Chiefs Association, California Professional Firefighters, and the League of California Cities, Fire Chiefs' Department would also like to give acknowledgement and thanks to Amy LaPan, Ph.D. of Napa Valley College and Sue Beville of Alameda County Fire who provided feedback and editorial assistance with this paper.

\*The opinions expressed in this paper are those of the League of California Cities, Fire Chiefs' Department, a sub unit within the League of California Cities, and should not be considered to be endorsed by the League's Board of Directors.

## EXECUTIVE SUMMARY

The California Fire Service is the primary provider of pre-hospital emergency medical care throughout the state. For over 40 years, fire agencies (city fire departments and fire districts) around the State of California have voluntarily and diligently provided dependable emergency medical services to California's visitors and residents. In a time before organized emergency medical services (EMS) even existed, the fire service stood at the vanguard of caring for California's sick and injured in the prehospital setting.

At the present time, the California Fire Service's role as an integrated part of the Emergency Medical Services System is being called into question. In some instances, our role is actually being eroded due to what the Fire Service believes to be misinterpretations of statutes by Local Emergency Medical Services Agencies (LEMSAs) regarding 9-1-1 dispatch and provider agreements. This doubt exists despite the adoption by the California Legislature of the *Emergency Medical Services System and Prehospital Medical Care Personnel Act of 1980* and the California Supreme Court decisions concerning the County and City of San Bernardino and Valley Medical Transport and Apple Valley Fire District. These state laws and court decisions clearly delineated the statutory roles and responsibilities of the Fire Service and LEMSAs. Now, differing interpretations of statutory roles and responsibilities and county concerns over reimbursement of indigent care presently are resulting in instances where cities and fire agencies are at odds with their LEMSAs (e.g., San Joaquin County and the City of Stockton Fire).

The California Fire Chiefs Association (CFCA), the California Professional Firefighters (CPF), and the League of California Cities, Fire Chiefs' Department (League Chiefs) convened a task force to discuss these issues and to make recommendations. These organizations collectively concluded that situations such as these can be avoided through the clarification of roles and responsibilities that governmental agencies hold under the California Health and Safety Code and the California Government Code. These codes are preeminent over all California regulations governing EMS.

Only by all government agencies understanding and performing within their scope of authority mandated under California statutes can future misinterpretations and subsequent strained relationships be avoided. It is the ultimate goal of the CFCA, CPF, and League Chiefs to reaffirm our commitment to excellence in prehospital care for California's communities and the people found within the state. In doing so, we also reaffirm our commitment to collaborating and cooperating with the California State EMS Authority and various LEMSAs who, conjointly with us, private ambulance providers and hospital emergency departments, play a critical role in ensuring economical and reliable emergency medical care to California's citizenry.

The CFCA, CPF, and members of the League Chiefs recommend the governing boards for cities, counties and fire districts understand rights and obligations provided by Health and Safety Code §1797.201. Representatives of cities, counties and special districts

must meet to discuss and reach an agreement concerning this statute. Until these discussions occur, CFCA, CPF, and League Chiefs are advising Providers to make certain that any written agreement with their respective LEMSA has no effect on 1797.201 rights and obligations. In the event that agreements cannot be reached, a formal dispute resolution and appeal process must be established.

## **INTRODUCTION**

Present tensions between the California Fire Service and some LEMSAs are undeniable. The court case between San Joaquin County and the City of Stockton Fire is ample proof of the debates surrounding various interpretations of California Health and Safety Code, Section 1797.201. The recent request by the Los Angeles County LEMSA to the California Attorney General for clarification regarding Section 1797.201 alone demonstrates the need for clarification. It is thus the objective of this paper to provide what the CFCA, CPF, and League Chiefs together believe should be the mutual understanding of the core issues involved in the present tensions. This paper will: 1) explain the statutory authority or “grandfathered” rights of the Fire Service under California’s Health and Safety Code, Section 1797.201; 2) clarify the statutory authority and responsibility of the LEMSA under the *Emergency Medical Services System and Prehospital Medical Care Personnel Act of 1980 (1980 EMS Act)*; 3) explain the differences in statutory interpretations concerning 9-1-1 dispatch and provider agreements that are resulting in current litigation between a fire agency and LEMSA; and 4) offer an explanation of the underlying financial motivations for why some counties do not wish to recognize Section 1797.201 rights. This paper will conclude with recommendations for resolving present divergences of statutory interpretations and subsequent tensions.

## **SECTION ONE: CITY AND FIRE DISTRICT STATUTORY RIGHTS AND OBLIGATIONS**

### *The Origins of City and Fire Service Involvement in EMS*

A seminal study was published in the *Lancet* in 1967. It discussed a pilot project in Ireland that aimed to reduce the incidence of death and disability from acute myocardial infarction (i.e., heart attack) through the provision of defibrillation in the field.<sup>1</sup> A year earlier, a study by the National Academy of Sciences discussed how returning Vietnam War Veterans concluded that they would have better chances of surviving trauma sustained in the combat zone than on the average American city street.<sup>2</sup> While the nation was only beginning to tackle these issues, the State of California in fact was.

The California Legislature in 1967 enacted the *Emergency Medical Care Services Act*, which created an Emergency Medical Care Committee in each county. A few days after this action, the legislature also enacted California Health and Safety Code § 219, which mandated that all California fire personnel and other public safety personnel meet

American Red Cross first aid training standards by July 1, 1969.<sup>3</sup> In 1969, three California physicians began not a *physician-based* prehospital mobile intensive care service, but a *firefighter-based* “mobile intensive care unit” pilot program.<sup>4</sup> This pilot program was based in “Los Angeles, California,” and was the first of its kind in the state. The pilot program utilized “eighteen” firefighters from the California fire services to introduce paramedic services to California’s residents. In 1970, in an effort to expand paramedic services statewide, California enacted the *Wedworth-Townsend Paramedic Act* (WTPA),<sup>5</sup> which mandated the development and evaluation of a program for emergency medical care similar to that discussed in the 1967 *Lancet* article. Importantly, no funds were provided by the California Legislature for WTPA program development. This cost was borne by California’s local agencies—city councils, fire district boards (including hospital districts), and sponsoring hospitals.<sup>6</sup> Along with other agencies, the California Fire Service and cities invested considerable resources in developing and implementing prehospital care programs.

The next significant milestone in the state was the enactment of the *1980 EMS Act* (Act).<sup>7</sup> This Act created the current California EMS Authority and the LEMSA. The Act aimed to continue the advances in prehospital care made in the state since 1967. This Act capitalized and leveraged upon the preexisting EMS infrastructure by enacting California Health and Safety Code, Section 1797.201.<sup>8</sup> In so doing, the Act recognized and preserved the significant commitment of time, money, staffing, and training made by the California Fire Service and cities for their fundamental role in developing and providing prehospital care over the preceding thirteen years.

*The Legal Basis of California Fire Service’s and City’s “Grandfathered Rights” - Section 1797.201*

The eligibility of rights granted to cities and fire districts to provide EMS is affirmed in legal judgments handed down by California’s Supreme Court. These judgments were the result of court cases that emerged over issues concerning the enactment of exclusive operating areas,<sup>9</sup> the advent of federal Medicare funding for ALS level transportation services,<sup>10</sup> and the Lomita I and II state court decisions regarding the financial responsibility for indigent transportation costs.<sup>11</sup> These issues resulted in conflict between LEMSAs, private providers, and the California Fire Service.

This conflict resulted in the historic case of *County of San Bernardino v. City of San Bernardino*, 15 Cal. 4<sup>th</sup> 909 (Cal. 1997), and its progeny *Valley Medical Transport, Inc. v. Apple Valley Fire Protection District*, 17 Cal. 4<sup>th</sup> 747 (Cal. 1998). In these two cases, the California Supreme Court confronted this basic fundamental question:

To what extent does the *1980 EMS Act* in general, and Section 1797.201 in particular, grant authority over the provision of EMS services to counties and local EMS agencies alone, and to what extent does the statutory scheme permit qualifying cities and fire districts to share this authority?<sup>12</sup>

The Court's answer, in sum:

Subject to the medical control provisions of the *1980 EMS Act*,<sup>13</sup> eligible Section 1797.201 cities and fire districts can continue to retain administration over the level of prehospital emergency medical services those entities have provided as of June 1, 1980,<sup>14</sup> and continuously thereafter, without interruption.<sup>15</sup> No written agreements are required as Section 1797.201 cities are authorized to provide prehospital emergency medical services by statute, and where written agreements are desirable, they are voluntary in nature.<sup>16</sup> Further, cities and fire districts may increase EMS services levels beyond what existed in June, 1980, so long as the city or fire district does not expand into a new type of EMS service.<sup>17</sup>

*A City's and Fire District's Scope of Authority under Section 1797.201*

As these legal decisions explain, fire agencies who provide or contract for EMS services like prehospital medical care, ambulance transport services, and 9-1-1 dispatch on or before June 1, 1980 (prior to when the *1980 EMS Act* took effect), can continue their preexisting services in perpetuity, without interruption, until such time as they *voluntarily choose* to enter into an agreement with a LEMSA. This is within their scope of authority.

Furthermore, Section 1797.201 stipulates that until such time as a city or fire district voluntarily requests to enter into a contract with a LEMSA regarding the provision of prehospital care services, the city or fire district will retain its administrative authority over these services. Also, there is no statutory deadline imposed for requesting or reaching an agreement. The statute reads:

Upon the request of a city or fire district that contracted for or provided, as of June 1, 1980, prehospital emergency medical services, a county shall enter into a written agreement with the city or fire district regarding the provision of prehospital emergency medical services for that city or fire district. Until such time that an agreement is reached, prehospital emergency medical services shall be continued at not less than the existing level, and the administration of prehospital EMS by cities and fire districts presently providing such services shall be retained by those cities and fire districts . . . .<sup>18</sup>

In other words, Section 1797.201 specifically makes cities and fire districts eligible to provide their preexisting EMS services that the fire agency contracted for or provided on or before June 1, 1980. This authorization to provide EMS services comes directly from statute and not from the local EMS agency. As the California Supreme Court stated in the San Bernardino case, the county cannot “contravene the authority of eligible [i.e., grandfathered] cities...to continue the administration of their prehospital EMS without the latter’s consent.”<sup>19</sup> Instead, the county must accommodate the city’s authority as the county creates an integrated EMS system.

There are also two important distinctions to be made regarding authority under Section 1797.201. The first distinction is “type” and the second is “level.”<sup>20</sup> A 1797.201 fire

agency does not have the authority to *expand* into new types of emergency medical services beyond those they provided on or before June 1, 1980.

An example of this is emergency medical dispatch (EMD). As a “type” of service, many California fire agencies have dispatched their own EMS resources and responses since the 1970s. However, they have improved dispatch by increasing the “level” of dispatch by including caller questioning and integrating 9-1-1 technology into dispatch procedures. Fire agencies are not assuming a new “type” of EMS function by improving the “level” of continuously provided services. They are simply *increasing* the level at which they provide them. This investment in EMS commitment of public resources benefits everyone and comes at no cost to the LEMSA.

Another example is the delivery of prehospital medical care. A large percentage of fire agencies have provided this “type” of emergency medical care from non-transport vehicles at some continuous level (first aid through advanced life support) well before the implementation of the *1980 EMS Act*. Many jurisdictions have upgraded “levels” of care as the standard of care evolved and as directed by their respective governing bodies. These agencies did not expand into new “types” of service (i.e., transport); they simply increased the “level” of emergency medical care delivered from fire department apparatus within their jurisdictions. This example is supported by the concurring opinion in *County of San Bernardino v. City of San Bernardino*, 15 Cal. 4<sup>th</sup> 909 (Cal. 1997).

Any new types of services would be under the authority of the LEMSA to provide under contract with a city or private entity. The LEMSA may also choose to allow a fire agency to provide EMS services without a contract under *preexisting* jurisdictional authority granted by the Legislature via the California Government Code.<sup>21</sup> A 1797.201 fire agency, however, has the authority to *increase* the level of those EMS services they provided on or before June 1, 1980.<sup>22</sup> As techniques and technology have improved in EMS over the years, fire agencies have consequently improved and raised the level of their jurisdictional services.

The key points for cities and fire agencies to understand about the scope of authority for Section 1797.201 are:

- As the recent City of Stockton case illustrates, a fire agency must be vigilant and must adequately review proposed LEMSA policies and procedures for conflicts, especially dispatch policies and transportation related RFPs and exclusive operating areas (EOA) contracts. By accident and/or design, any intrusion upon a fire agency’s 1797.201 rights should result in an immediate written notification to the LEMSA that the fire agency objects to the proposal. Failure to do so may result in an assertion that the fire agency “acquiesced” to LEMSA control and thereby surrendered a previously conferred 1797.201 right or obligation.<sup>23</sup>
- Section 1797.201 fire agencies can continue delivering emergency medical services as offered or contracted on or before June 1, 1980, in

perpetuity and without interruption until such time as they *voluntarily* choose to enter into an agreement with a LEMSA.

- The LEMSA cannot mandate that 1797.201 fire agency enter into any agreement concerning prehospital emergency medical services, and there is no statutory deadline for a 1797.201 fire agency to enter into an agreement.
- The LEMSA cannot contravene the authority of any 1797.201 fire agency without the consent of the city and/or fire district.
- A Section 1797.201 fire agency may not unilaterally choose to provide new types of EMS services for that city or fire district without LEMSA approval, as this is the purview of the LEMSA; rather, the fire agency can only increase or reduce the level of EMS services that were provided on or before June 1, 1980.

## **SECTION TWO: LEMSA STATUTORY AUTHORITY AND RESPONSIBILITY UNDER THE 1980 EMS ACT**

The *1980 EMS Act* specifically outlines emergency medical services regulations reflecting a two-tiered policy of regulation, that is, regulation at the “state level” and at the “local level.” The EMS Act gives a local county board of supervisors the option to create a “local EMS agency” (LEMSA). The LEMSA has statutorily defined roles, duties, and two primary functions which are “administration” and “planning.”

To facilitate the administration and planning responsibilities, the *1980 EMS Act* was amended in 1984 to include Sections 1797.6, 1797.85 and 1797.224. Section 1797.6 gives the LEMSA immunity from prosecution under the federal antitrust laws for displacing the national competitive free market system by establishing “exclusive operating areas.” The stated intention of the legislature in adopting Section 1797.6 was for the statute to operate jointly with Sections 1797.85 and 1797.224. Section 1797.85 specifically defines the term “exclusive operating area,” and specifies the three types of service providers the EOA covers—emergency ambulance services, providers of limited advanced life support, and providers of advanced life support. Section 1797.224 authorizes a LEMSA to create an EOA as long as a competitive process is used to select the transport provider or providers and includes active state oversight.

In addition to establishing EOAs and selecting providers through a competitive process, Section 1797.220 gives the LEMSA limited medical control authority over providers in the local EMS system. “Medical control” is defined as the process of performing actions to ensure that care taken on behalf of ill or injured patients is medically appropriate, and medical oversight is provided by a medical director who is a physician, who by experience or training, handles the clinical and patient care aspects of the EMS system.<sup>24</sup>



Section 1797.220 describes the kinds of matters that are properly within the scope of medical control (e.g., dispatch, patient care guidelines, and patient destinations), but the statute fails to clarify the depth of that medical control in relation to these matters. Under the 1988 amendments, the depth of medical control is to be properly limited by subsequent enacted state regulation.<sup>25</sup> Section 1797.220 LEMSA authorities thus comes from Section 1798 which states that medical control of the EMS system comes from the local EMS agency medical director but must be pursuant to state regulation.<sup>26</sup> This means that medical control is the medical management of an EMS system, but it has nothing to do with determining *who* provides the EMS service; rather, medical control is about determining *how* a type or level of EMS is to be performed. For instance, a LEMSA has medical control oversight responsibilities to ensure that a fire agency that provided emergency medical transport services on or before June 1, 1980 does so in a medically appropriate manner. The LEMSA cannot singly decide that a new agency will provide emergency transport in lieu of the fire agency which had done so on or before June 1, 1980.

In respect to medical oversight, the California Fire Service accepts the appropriate role that LEMSAs play in the development, implementation and oversight of medical standards and practices for all emergency service personnel, public and private. Hence the primary responsibilities of the LEMSA include:

- Plan, implement and evaluate an emergency medical services system.
- Approve EMT-P and EMT-II<sup>27</sup> service programs.
- Provide for oversight of EMT-P, EMT-II and EMT-I training programs.
- Provide for the medical management of the development, implementation, and evaluation of the *clinical aspects* of an EMS system *consistent with the standards established by the State EMS Authority*.

Further, discretionary responsibilities that a LEMSA may implement include:

- Establishing an EOA that covers three specific types of providers: emergency ambulance services, providers of limited advanced life support, and providers of advanced life support. If an EOA is established, additional requirements include:
  - The LEMSA must establish a competitive process to select providers unless the “grandfather” provisions are met (public or private provider was continually providing specified services without interruption since January 1, 1981); and,
  - Submitting to the EMS Authority a local EMS plan that establishes a competitive process for selecting providers at periodic intervals; and,

- This local EMS plan concerning EOAs cannot supersede Section 1797.201.
- Requiring additional medical qualifications requirements (e.g., “accreditation” requirements) for EMT-P and EMT-II personnel.

### **SECTION THREE: DIFFERING STATUTORY INTERPRETATIONS**

Tensions presently exist among cities, fire agencies, and LEMSAs because of differences in interpretation of statutes and the authority permitted to governmental agencies under those statutes. Specifically, it is the opinion of the CFCA, CPF, and League Chiefs that some LEMSAs are not recognizing some cities’ Section 1797.201 rights for the following reasons: 1) the LEMSAs interpretation of their authority in regards to medical control, and 2) the belief that some cities have waived their 1797.201 rights through past paramedic provider agreements.

#### *9-1-1 Telephone and Emergency Medical Dispatch*

An example of how a LEMSA is not recognizing the statutory authority of a city is the case between the City of Stockton and San Joaquin County EMS. This case involves the San Joaquin County EMS Agency and the City of Stockton Fire. The LEMSA in San Joaquin County has made a new, overly broad interpretation of its authority to regulate 9-1-1 dispatch by taking the secondary public safety answering point (PSAP) from fire for EMS related calls. The LEMSA medical director ordered all cities within San Joaquin County to transfer medical 9-1-1 calls to a for-profit ambulance provider located in a different county. The Fire Service believes this action oversteps the boundaries of medical control permitted under the *1980 EMS Act* and Section 1797.201 of the California Health and Safety Code. Moreover, this new action upsets the voluntary coordination and collaboration that existed undisturbed for over ten years.

In March 2003, the State EMS Authority issued the *Emergency Medical Services Dispatch Program Guidelines* (EMSA #132). The Emergency Medical Dispatch (EMD) guidelines were developed and vetted through a process that included an expert writing group, multi-disciplinary review, refinement through the public comment period and finally approval by the EMS Commission. The EMD guidelines were developed to provide a consistent, statewide standard for emergency medical dispatch agencies and dispatchers that choose to *voluntarily* implement an EMS program.”<sup>28</sup> These voluntary guidelines also were to provide a means to improve emergency medical dispatch services, if the city and its fire agency elected to so do.

While a LEMSA must provide medical oversight to the 9-1-1 dispatch system, and while dispatch providers are obligated to coordinate the implementation of EMD guidelines with the LEMSA medical director, the San Bernardino decision made clear that LEMSA medical control policies and procedures affecting dispatch and patient treatment cannot interfere with a city’s “internal, administrative matters.” In other words, a city may

determine for itself how it will handle dispatching emergency calls concerning public safety. The addition of 9-1-1 to the system in the 1980s was a purely administrative response by cities to the statutory mandate in the *Warren 9-1-1 Act*, and is consistent with a city's 1797.201 rights under the *1980 EMS Act*. A city's decision to have its PSAP answer telephone requests for medical emergency calls is an internal administrative matter. City and fire agency coordination with EMD guidelines was a conscious choice on the part of cities and their respective fire agencies to enhance the level of service they offer, not relinquish a type of service they provide. In addition, EMS medical directors do not have the statutory authority to designate an exclusive medical dispatch provider. They can only do this if the city or fire district voluntarily relinquishes this right to the LEMSA.

### Provider Agreements

In 1986, California Code of Regulations Title 22, Section 100161, now Section 100167, required an "EMT-P service provider" to have a written "ALS Provider Agreement (Provider Agreement)" with a county LEMSA to participate in the advanced life support or paramedic program. These ALS provider agreements covered engine-based and/or ambulance transport advanced life support services. Some fire agency paramedic providers chose not to sign a provider agreement with a county LEMSA, as no written agreements are required under Section 1797.201. Others were told that there was no choice in the matter – the fire agency must sign the provider agreement under state regulation in order to upgrade to paramedic level or retain existing paramedic services (this intent is reflected in the preamble section of many of those agreements). In the spirit of cooperation, or yielding to coercive pressure because the community deserved paramedic level care, many fire agencies did in fact sign written agreements at the direction of their LEMSA. However, in signing these provider agreements, cities cannot be construed to have waived their Section 1797.201 rights unless they *voluntarily* and *with intent* chose to so do.

Today, some county LEMSAs now believe that these provider agreements supplanted or waived grandfathered rights. This belief is not justified as these "agreements" do not mention Section 1797.201, or language specifically waiving rights. It is important to note the elements of a waiver are as follows: (1) both parties must be apprised of the rights being waived; (2) the party waiving his or her rights must intend to waive his or her rights; and, (3) the party waiving his or her rights must voluntarily intend to so do. In the case between San Joaquin County and City of Stockton Fire, the LEMSA asserted that the City of Stockton Fire Department waived its 1797.201 rights when it entered into a provider agreement with the county LEMSA. Nowhere, at any point in the correspondence between the fire department and the LEMSA did anyone representing the city or the county mention the fire service waiving their Section 1797.201 rights. It was asserted by the LEMSA that the provider agreement was required under state regulation. Hence, it is arguable that the fire service was not apprised that part of the agreement was to waive its rights or that by signing the agreement did voluntarily and with intention relinquish their 1797.201 rights. What's more, this LEMSA chose not to

assert this purported right until 2006, one year before the 2002 Medicare rules took full effect. The implication of these Medicare changes will be discussed in the next section.

The California Fire Service is not aware of any other fire agencies within California that have been forced to institute EMD services or relinquish a portion of their EMS services without their voluntary cooperation. To the contrary, fire agencies who have not signed provider agreements have willingly offered to provide indigent care at no cost to the county or increase EMS system resources at no county expense. Moreover, the benefit of full system integration through voluntary means has been proven time and again through the California Fire and Rescue Mutual Aid System. This unduplicated strategic response capability is based upon an “organized pattern of readiness and response services based on public and private agreements and operational procedures” that are wholly voluntary in nature.

#### **SECTION FOUR: THE INCENTIVES FOR DENYING 1797.201 RIGHTS**

It is the observation of the California Fire Service that the basis for the debates regarding eligibility for rights under Section 1797.201 ultimately has to do with reimbursement issues. Counties are presently mandated under California law to provide and pay for indigent emergency care. However, changes in Medicare reimbursement rates have made it questionable that a county has the ability to meet this obligation without taking control of 9-1-1 emergency dispatch, eliminating fire ambulance programs, and bringing these programs’ coverage areas directly under county control.

##### *The Mandate to Provide Emergency Indigent Care*

The indigent medical care question has been visited by the California courts many times. In the 1969 *Viloria*<sup>29</sup> case the California Appeals Court held that the County, as a California political subdivision, was financially responsible for the cost of indigent medical care. Subsequent court cases (e.g., *Lomita I*<sup>30</sup> and *Lomita II*<sup>31</sup>) extended this obligation for a county to provide and pay for *emergency* prehospital care to all persons found within the county. Specifically in *Lomita II*, the Appeals Court said that a county could fulfill its legal mandate to indigents using either of the following, or any combination thereof:<sup>32</sup>

- The county may create a separate county department to provide emergency ambulance service, equipping such department with the necessary vehicles and other equipment, as well as personnel in such department and pay the expenses of operation such departments as it staffs and operates other county departments;
- It may assign the duty of providing emergency ambulance services to residents of the county to such existing county department as it may choose and provide that department with the necessary equipment and trained personnel;

- It may contract with cities or local agencies located within the county to provide necessary emergency ambulance service to the residents of the county found within such city or cities; or,
- It may contract with private ambulance companies.

### *Paying for Indigent Care: The Private Provider and the EOA*

The California Fire Service has watched as California counties used their medical control authority, along with the option to contract with for-profit private ambulance companies, to discharge their legal duty towards indigent patients. Selecting this option, in and of itself, is not improper. However, it is the *means* by which counties have chosen to tackle this problem that raises the specter of impropriety. By asserting unconstrained medical control authority<sup>33</sup> and contracting with private ambulance companies, California counties have succeeded in shifting the county's financial obligation for indigent patients to the private industry and Medicare. In exchange, a private provider is given the exclusive authority to provide emergency ambulance services within a California county, which includes the right to all emergency and non-emergency ambulance calls originating within the county, except for those areas served by qualifying cities and fire districts are outside of the exclusivity agreement.<sup>34</sup>

What made EOAs initially profitable for private companies was a loophole which existed in Medicare reimbursement rates and transportation ordinances. Medicare historically paid only for necessary ambulance transports at the lowest level based on medical condition. However, the federal government, around the time of the *Lomita II* case, began paying for ALS transportation services at an increased rate under Medicare.<sup>35</sup> Under a loophole in the Medicare reimbursement rules, an ALS provider could bill for paramedic level services, even when a lower level ambulance and hence lower level reimbursement cost would have sufficed *if* an ambulance provider was required to have only paramedic level services via county ordinance. Several California counties enacted such transportation ordinances<sup>36</sup> or transportation plans<sup>37</sup> that required the private provider to supply only paramedic level emergency ambulances.<sup>38</sup> The end result was that counties were able to pay for indigent prehospital emergency care, as well as finance rural ambulance service, from the surplus profit generated from lower level emergency care that was billed for at the higher-level of service rates under Medicare. The formation of EOAs by LEMSAs made this whole scenario more appealing for a private provider since the EOA prevented outside competition from entering the market in the territory covered by the EOA. Thus, a private monopoly was created in the territory covered by the EOA. It is this otherwise anticompetitive conduct that requires the immunity from federal antitrust laws.

### *Changes in Medicare Reimbursement*

Medicare reimbursement loopholes would eventually be identified and closed. Warning signals from the Federal Office of Inspector General (OIG) surrounding the payment practices engaged in by California counties and others began as early as 1987.<sup>39</sup> The

OIG noted that Medicare ambulance costs went from \$34 million dollars in 1974 to \$350 million dollars in 1985.<sup>40</sup> California was one of eight states selected for review.<sup>41</sup> The 1987 OIG report identified the two practices of significance – 1) the inability of the “reasonable costs” system to control cost, and 2) the shift of “public provider costs to Medicare.” The second finding was described as resulting from the practice of local governments to “bid out” EMS ambulance transports to private enterprise.<sup>42</sup> It is worthy to note that prior to 1982, fire department ALS services were not reimbursed by Medicare and constituted the majority of ALS transportation ambulance service providers.<sup>43</sup> The California Legislature expressly acknowledged this non-reimbursement situation for fire department ALS transportation services in 1980.<sup>44</sup>

After the federal government conducted six lengthy civil investigations covering a ten year period,<sup>45</sup> changes to reimbursement rules were implemented. On “August 5, 1997,” the Congress mandated a Medicare national fee schedule to replace the “reasonable cost” reimbursement structure by 2000.<sup>46</sup> This mandatory cost structure was to be in place by “January 1, 2000,”<sup>47</sup> but was delayed until “April 1, 2002.”<sup>48</sup> The mandatory Medicare ambulance fee schedule was not without effect. Not only were emergency ambulance reimbursement rates to be significantly decreased,<sup>49</sup> but ground ambulance revenues were to be significantly redistributed to rural air ambulance suppliers.<sup>50</sup> The surplus profits formerly seen would diminish, yet counties were still responsible for the provision and funding of indigent emergency care. Hence, profit streams from other sources would need to make up the losses incurred from changes to Medicare.

### *Making up the Difference: Looking to 9-1-1 Dispatch and Provider Agreements*

In the face of changes to the Medicare fee schedule, some private providers may now face genuine cost issues – this is an area of uncertainty. If truly present, local EMS agencies are now faced with the very real prospect of making up this shortfall in profits. For some reason, however, local EMS agencies continue to perceive that *Lomita II's* option #4 remains the only viable salvation. Thus, if one is going to rely on private, for-profit transport services, then counties must find other avenues to make up the shortfalls incurred from changes in Medicare reimbursement policies. In light of this, it logically follows that a county can do this through two means: 1) accessing the *Warren 9-1-1 Emergency Assistance Act of 1982*, and/or 2) eliminating fire ambulance programs and bringing those programs’ service areas under direct county control.

Acquiring control of 9-1-1 dispatch from a city and sourcing it to a private provider would allow counties to indirectly access a tax supported revenue stream, as emergency dispatch is funded through taxpayer dollars under the *Warren 9-1-1 Emergency Assistance Act of 1982 (Warren 9-1-1 Act)*. This may be the basis for a LEMSA’s insistence, based upon its “medical control” authority, to transfer 9-1-1 dispatch from a city to a private for-profit provider.

Thus, counties are now asserting that under “medical control” a California *regulation*<sup>51</sup> is empowering them to *command* the remaining public emergency medical service

providers (including those retaining transportation rights) to enter into written agreements with the LEMSAs. Once this compelled agreement is signed, some counties assert that the county may then unilaterally terminate the ALS provider agreement without cause,<sup>52</sup> even where the alleged agreement contains no waiver language whatsoever. The public provider is then asserted to be *unlawfully* providing prehospital paramedic level services.<sup>53</sup> If San Joaquin County is successful in its legal case against the City of Stockton Fire Department, the outcome would be: 1) the county could compel the public provider to turn over the dispatching of emergency ambulances and the revenues associated therewith for the processing of those calls;<sup>54</sup> and, 2) as an illegal provider of prehospital care services, the public provider could be compelled to cease providing existing paramedic level services. If cities can be forced to sign these agreements, the county can force cities to turn over EMS ambulance dispatching and terminate a fire department's statutory authority to provide ambulance service. The primary justification for this action is the county's assertion of their authority given them through "medical control." By allowing a county EOA provider to become the sole supplier of emergency ambulance dispatching services, paramedic intercept services, and transportation services, the county is able to leverage the revenue for these services in exchange for discharging county indigent emergency care obligations. At the present time, what appears to stand in a county's path to unilaterally exercise this authority is California Health & Safety Code, Section 1797.201.

Finally, the argument asserted that private, for-profit emergency dispatch and transport services are less expensive to the taxpayer or removes the cost for indigent care from the taxpayer by absorbing the cost through a for-profit system are suspect for the following reasons: 1) the Medicare reimbursement system is a tax supported reimbursement system; 2) the *Warren 9-1-1 Act* reimbursement stream is a tax supported reimbursement system; and 3) counties are generally not willing to conduct an independent financial audit to validate the financial solvency of an EOA. In short, the taxpayer is supporting the system, even if it is provided by a private provider.

## **CONCLUSIONS AND RECOMMENDATIONS**

Cities and political jurisdictions such as fire protection districts have historically provided necessary levels of service such as fire protection, emergency dispatch, rescue and emergency ambulance transportation services to their communities under the concept of "local control." Local government is tasked with risk mitigation while being fiscally accountable to the community they serve. The responsibility to determine the level and manner in which services are provided lie exclusively with the city or political jurisdiction which is responsible to fund and manage those services.

The California Fire Service remains committed to providing these essential public safety services and understands its roles and responsibilities as providers of prehospital emergency medical services within the State of California. Regrettably, several city fire agencies are experiencing repeated attempts by some LEMSAs to inexorably and systematically remove them from the provision of prehospital emergency medical

services. In order to avoid a legislative remedy, the CFCA, CPF, and League Chiefs believe that educating California Fire Service members, LEMSAs, the California State Emergency Medical Services Authority, local public officials, and State of California elected officials about this important public safety issue can prevent misunderstandings and legal challenges in the future.

The CFCA, CPF, and League Chiefs are asking that all prehospital emergency providers and LEMSAs collaborate as the EMS Act intended. This is accomplished by cities and fire districts taking proactive steps to:

- Inform public officials of the EMS Act and eligibility for rights and obligations under 1797.201;
- Meet with the LEMSA to discuss and come to agreement on the EMS Act and 1797.201 rights and obligations; and,
- Not enter into any written agreement with a LEMSA without a clear articulation that the document has no affect on 1797.201 rights and obligations, unless waiver of rights is specifically requested by and acknowledged by the city or fire district entering into the agreement; and,

The CFCA, CPF, and League Chiefs are requesting the EMS Authority to convene a Task Force of EMS stakeholders to develop guidelines standardizing statewide, the following:

- Review and develop ambulance transportation contract provisions and exclusive operating areas (EOA) terms and conditions. This can be accomplished either by a single contract term or through the aggregate of automatic renewal provisions.
- Develop regulation requiring evidence of an EOA's financial viability prior to a Request for Proposal (RFP) and contract award. Regulations should include general guidance on how indigent care and rural areas are to be subsidized.
- Establish a LEMSA/Provider dispute resolution and appeal process. This process which will address irresolvable system issues can be incorporated into the LEMSA EMS Guidelines (as required by H&SC 1797.103). In the event that the LEMSA and Provider cannot reach an agreement under the process established within the LEMSA EMS Guidelines, then the EMS Commission would serve as arbiter in an alternative dispute resolution process. The alternate process can be modeled after the Office of Administrative Hearing utilizing the APA process.



### **A NOTE TO THE READER:**

This position paper is the result of many differing viewpoints solicited statewide from multiple EMS system stakeholders. These viewpoints have been consolidated into a solidified Fire Service Position Paper.

The information and recommendations expressed within this position paper are supported by numerous references and citations which are provided at the end of this document. The reader is encouraged to review these sources.

If you have any additional questions, you may contact Michael Antonucci, Fire Chief and EMS Section President at: [mantonucci@ci.upland.ca.us](mailto:mantonucci@ci.upland.ca.us).

## REFERENCES

- <sup>1</sup> J.S. Pantridge, J.S. Geddes. A mobile intensive care unit in the management of myocardial infarction, *Lancet*, 2:271-273, (1967).
- <sup>2</sup> National Committee of Trauma and Shock. Accidental death and disability: the neglected disease of modern society, p. 12, Washington D.C., National Academy of Sciences/National Research Council, September, 1966.
- <sup>3</sup> “Statutes of 1967,” p. 3641, “August 25, 1967” (CH 1530).
- <sup>4</sup> Principles of EMS Systems at p. 11; Prehospital-cardiac care in a paramedical mobile intensive care unit, *Calif. Med.* 117:1-8, 1, October, 1972.
- <sup>5</sup> “Statutes of 1970,” pp. 832-34, “July 15, 1970” (CH 421).
- <sup>6</sup> “California Statutes of 1974,” pp. 2558-62, at “§ 14,” “September 23, 1974” (CH 1188); “California Statutes of 1976,” pp. 237-38, at “§ 3,” “May 11, 1976” (CH 148); “California Statutes of 1977,” p. 3492, at “§ 2,” “September 27, 1977” (CH 1085); “California Statutes of 1978,” pp. 667-68, at “§ 3,” “June 30, 1978” (CH 324, 1978); “California Statutes of 1979,” p. 1764, at “§ 3,” “September 10, 1979” (CH 555, 1979); and “California Statutes of 1980,” p. 4605-06, at “§§ 1, 1.5,” “September 10, 1979” (CH 555, 1979).
- <sup>7</sup> “Statutes of 1980,” pp. 4261-77, “September 27, 1980” (CH 1260).
- <sup>8</sup> “Statutes of 1980,” pp. 4269-70, “September 27, 1980” (CH 1260).
- <sup>9</sup> “West’s Ann.Cal.Health & Safety Code §§ 1797.6, 1797.85, 1797.224,” “Statutes of 1984,” pp. 4778-79, “September 26, 1984” (CH 1349); and “West’s Ann.Cal.Health & Safety Code § 1797.226,” “Statutes of 1984,” p. 3344, “September 22, 1986” (CH 965).
- <sup>10</sup> 62 FR 32715, 32718 (Medicare funded ALS level as a separate reimbursement scheme – prior, ambulance transportation services were paid at the BLS rate irrespective of the *level* of services the ambulance provided).
- <sup>11</sup> City of Lomita v. County of Los Angeles, 196 Cal. Rptr. 221 (Cal. App. 2<sup>nd</sup> Dist., 1983) (Lomita I); and City of Lomita v. Superior Court, 230 Cal. Rptr. 790 (Cal. App. 2<sup>nd</sup> Dist., 1986) (Lomita II).
- <sup>12</sup> County of San Bernardino v. City of San Bernardino, 15 Cal. 4<sup>th</sup> 909, 922 (Cal. 1997).
- <sup>13</sup> County of San Bernardino v. City of San Bernardino, 15 Cal. 4<sup>th</sup> 909, 925 (Cal. 1997); See Also Valley Medical Transport, Inc. v. Apple Valley Fire Prot. Dist., 17 Cal. 4<sup>th</sup> 747, 755 (Cal. 1998).
- <sup>14</sup> County of San Bernardino v. City of San Bernardino, 15 Cal. 4<sup>th</sup> 909, 914, 924, 925, 934 (Cal. 1997); See Also Valley Medical Transport, Inc. v. Apple Valley Fire Prot. Dist., 17 Cal. 4<sup>th</sup> 747, 761-62 (Cal. 1998).
- <sup>15</sup> Valley Medical Transport, Inc. v. Apple Valley Fire Prot. Dist., 17 Cal. 4<sup>th</sup> 747, 761-62 (Cal. 1998).
- <sup>16</sup> County of San Bernardino v. City of San Bernardino, 15 Cal. 4<sup>th</sup> 909, 925 (Cal. 1997).
- <sup>17</sup> County of San Bernardino v. City of San Bernardino, 15 Cal. 4<sup>th</sup> 909, 914, 932, 933, 934 (Cal. 1997); See Also Valley Medical Transport, Inc. v. Apple Valley Fire Prot. Dist., 17 Cal. 4<sup>th</sup> 747, 755 (Cal. 1998).
- <sup>18</sup> “West’s Ann.Cal.Health & Safety Code § 1797.201.”
- <sup>19</sup> County of San Bernardino v. City of San Bernardino, 15 Cal. 4<sup>th</sup> 909, 924. (Cal. 1997).
- <sup>20</sup> Valley Medical Transport, Inc. v. Apple Valley Fire Prot. Dist., 17 Cal. 4<sup>th</sup> 747, 757 (Cal. 1998).
- <sup>21</sup> “West’s Ann.Cal.Government Code §§ 54980, 39794.”
- <sup>22</sup> County of San Bernardino v. City of San Bernardino, 15 Cal. 4<sup>th</sup> 909, 930 (Cal. 1997); See Also Valley Medical Transport, Inc. v. Apple Valley Fire Prot. Dist., 17 Cal. 4<sup>th</sup> 747, 757 (Cal. 1998).
- <sup>23</sup> County of San Joaquin v. City of Stockton, CV No. 379455, “Notice of Entry of Statement of Decision,” filed May 5, 2009 (CA Sup. Ct, 2009) (Findings 15 - 23 addressing the issue of “acquiescence”).
- <sup>24</sup> National Association of EMS Physicians (U.S.). Prehospital Systems and Medical Oversight, 2002
- <sup>25</sup> “Statutes of 1988,” p. 4271, “September 27, 1988” (CH 1390, 1988).
- <sup>26</sup> “West’s Ann.Cal.Health and Safety Code § 1798.”
- <sup>27</sup> Note: On “July 1, 2010,” the “EMT-II” *level* of prehospital EMS will be reclassified as Advanced EMT or AEMT.
- <sup>28</sup> Emergency Medical Services Dispatch Program Guidelines, EMSA #132, at 1.
- <sup>29</sup> County of San Diego v. Vilorio, 80 Cal. Rptr. 869 (Cal. App. 4<sup>th</sup> Dist., 1969).
- <sup>30</sup> City of Lomita v. County of Los Angeles, 196 Cal. Rptr. 221, 223 (Cal. App. 2<sup>nd</sup> Dist., 1983).
- <sup>31</sup> City of Lomita v. Superior Court, 230 Cal. Rptr. 790, 791-792 (Cal. App. 2<sup>nd</sup> Dist., 1986).
- <sup>32</sup> City of Lomita v. Superior Court, 230 Cal. Rptr. 790, 791 (Cal. App. 2<sup>nd</sup> Dist., 1986).
- <sup>33</sup> **Editor Note:** the first appellate court case concerning EOA’s, City of Petaluma, occurred as a result of a county EOA award in 1989, the same year that medical control authority was “unconstrained” by the Legislature. City of Petaluma v. County of Sonoma, 15 Cal. Rptr. 2d 617, 618 (Cal. App. 5<sup>th</sup> Dist., 1993).
- <sup>34</sup> Cole Schafer’s Ambulance Service v. County of San Bernardino, 80 Cal. Rptr. 2d 385 (Cal. App. 4<sup>th</sup> Dist., 1998); “West’s Ann.Cal.Health and Safety Code §§ 1797.6, 1797.85, 1797.224;” effective “January 1, 1985;” A.E. Kuehl.

---

Prehospital Systems and Medical Oversight, 3<sup>rd</sup> Edition, p. 76, *National Association of EMS Physicians*, Kendall/Hunt Publishing Company, Dubuque, Iowa (2002); See Also Health care law and policy at pp. 62-66 (For discussion on “uncompensated care and internal cross-subsidization”); and “West’s Ann.Cal.Health and Safety Code §§ 1797.201, 1797.178.”

<sup>35</sup> R.P. Kusserow. Medicare part b ambulance services, OAI-03-86-00012, p. 1, 12, *Office of the Inspector General, Department of Health and Human Service*, Washington DC (March, 1987); B.B. Mitchell. Review of medical necessity for ambulance services, A-01-91-00513, pp. 1, 8, *Office of the Inspector General, Department of Health and Human Services*, Washington D.C. (October, 1992) (OIG noting that the average base rate in 1989 paid by Medicare was \$284 for ALS versus \$140 for BLS).

<sup>36</sup> “West’s Ann.Cal.Health and Safety Code § 1797.222;” Review of medical necessity for ambulance services at 13 (OIG officially reviewing California “ALS Only Transportation Ordinances”).

<sup>37</sup> “West’s Ann.Cal.Health and Safety Code §§ 1797.103, 1797.204, 1797.195, 1797.254.”

<sup>38</sup> Review of medical necessity for ambulance services at p. i.

<sup>39</sup> R.P. Kusserow. Medicare part b ambulance services, OAI-03-86-00012, p. i, *Office of the Inspector General, Department of Health and Human Services*, Washington D.C. (March, 1987).

<sup>40</sup> Medicare part b ambulance services at 1.

<sup>41</sup> The six states selected represented over 50% of Medicare’s ambulance costs; Medicare part b ambulance services at pp. 1-2.

<sup>42</sup> Medicare part b ambulance services at 5-6.

<sup>43</sup> Medicare part b ambulance services at 12; the OIG also noted that the majority of private providers were supplying BLS level ambulance services exclusively.

<sup>44</sup> “Statutes of 1980,” pp. 4605-09, “September 30, 1982 (CH 1322, 1980).

<sup>45</sup> R.P. Kusserow. Medicare part b ambulance services, OAI-03-86-00012, *Office of the Inspector General, Department of Health and Human Services*, Washington D.C. (March, 1987); B.B. Mitchell. Review of medical necessity for ambulance services, A-01-91-00513, pp. 1, 8, *Office of the Inspector General, Department of Health and Human Services*, Washington D.C. (October, 1992); J.G. Brown. Ambulance services for medicare end-stage renal disease beneficiaries: payment practices, OEI-03-90-02130, *Office of the Inspector General, Department of Health and Human Services*, Washington D.C. (March, 1994); J.G. Brown. Ambulance services for medicare end-stage renal disease beneficiaries: medical necessity, OEI-03-90-02130, *Office of the Inspector General, Department of Health and Human Services*, Washington D.C. (August, 1994); J.G. Brown. Follow-up to review of medical necessity for ambulance services, A-01-94-00528, *Office of the Inspector General, Department of Health and Human Services*, Washington D.C. (June, 1995); and J.G. Brown. Medicare ambulance payments, OEI-05-95-02130, *Office of the Inspector General, Department of Health and Human Services*, Washington D.C. (November, 1997); See Also 62 F.R. 32715 (1997).

<sup>46</sup> “Balanced Budget Act of 1997,” Public Law 105-33; 64 F.R. 3637, 3638.

<sup>47</sup> 64 F.R. 3637, 3638.

<sup>48</sup> 67 F.R. 9100, 9128 Medicare program; fee schedule for payment of ambulance services and revision to the physician certification requirements for Coverage of nonemergency ambulance services; final rule, Centers for Medicare and Medicaid Services (February 27, 2002); effective “April 1, 2002.”

<sup>49</sup> 67 F.R. 9100, 9131.

<sup>50</sup> 67 F.R. 9100, 9131.

<sup>51</sup> “Cal Admin. Code tit. 22, § 100167(b)(4).”

<sup>52</sup> County of San Joaquin v. City of Stockton, CV No. 379455, “County of San Joaquin’s Verified Complaint for Declaratory and Injunctive Relief and Petition for a Writ of Mandate,” filed “August 21, 2008.”

<sup>53</sup> County of San Joaquin v. City of Stockton, CV No. 379455, “County of San Joaquin’s Verified Complaint for Declaratory and Injunctive Relief and Petition for a Writ of Mandate,” filed “August 21, 2008.”

<sup>54</sup> County of San Joaquin v. City of Stockton, CV No. 379455, “County of San Joaquin’s Verified Complaint for Declaratory and Injunctive Relief and Petition for a Writ of Mandate,” filed “August 21, 2008.”