PARAMEDIC SERVICE • 9-1-1 • EMERGENCY TRANSPORT • NON-EMERGENCY TRANSPORT • BARIATRIC TRANSPORT • SPECIAL EVENTS• CCT
OFFICE OF THE VICE PRESIDENT

November 16, 2018

Ted Selby
EMS Administrator
Solano EMS Cooperative

Dear Ted,

Please accept the below as Medic's key recommendations/comments for the Blueprint report:
(*note the numbers in parenthesis reference the number item on blueprint):

EMS System Revenues, Costs and Oversight: A Background Discussion The Reality of Ambulance Revenues pg 19 -29

We would like to start by stating we appreciate the time the consultant took to explain the realities of ambulance revenues, costs and oversights. This is a detailed assessment of the ambulance world. The overall description of the issues listed is current reality in not only California contracts but nationwide. The over promising that went on in Santa Clara, Alameda and countless other bids by rouge ambulance providers can absolutely cripple an EMS system. The county has the responsibility to ensure a sustainable model for the contractor to prevent any future catastrophic financial events for the contractor. We disagree with the 3-year revenue estimations based on the forecasting provided by the consultant. We understand the attempt and where he is using his payor mix, however that is not the current payor mix reality in Solano County. The consultant estimated a 35% payer mix for commercial insurance and Medic's actual commercial payor mix for the ALS EOA comes in at about 16%. Medicare is 47%, Medical 29%, Private pay 7% and other govt payer at 1%.

(1) implement a tiered ALS-BLS response system with an "Omega" protocol option for low-acuity calls;

Medic would like to go on record that we fully support this type of response model and is consistent with modern EMS practices in California and around the country. Anything that helps to reduce the risk of emergency driving for non-emergency needs should be an immediate action item in our opinion and we agree with the consultant to reform the current response-time performance standards to correspond with standardized EMD response determinants

(2) implement centralized EMD and pre- arrival instructions in a Contractor-based secondary PSAP with a call processing time standard;

Medic ambulance sees this issue as one of the paramount issues to the RFP. The Solano County EMS system must at minimum move forward in this process with the mandating of Emergency Medical Dispatch services to all persons activating the 9-1-1 system. We agree with the consultant that "*To achieve good patient outcomes, which should be the primary goal of EMD, one of the critical requirements is that the dispatchers be trained both as an emergency medical dispatcher and on the specific EMD protocols to be employed."* We agree fully with the contractor's recommendation of robust EMD systems and that any center providing EMD should meet the standards for an Accredited Center of Excellence (ACE) accreditation by the International Academies of Emergency Dispatch (IAED). As Medic stated in the stakeholder's meetings, we have no preference whether the dispatch is a centralized medical or ran by the PSAP. Our main goal is that EMD, priority response, pre-arrival instructions and a robust EMD program are in place in Solano County. Medic will do what is necessary to be compliant with whatever model is in the final draft RFP. Additionally, Medic agrees with the consultant's position to *"substantially reduce red lights and siren usage to benchmarks of less than 50% during response and less than 5% on transport."* This is an attainable metric and seems like a very reasonable requirement.

(5) maintain the PPP unit-hour savings formula for high-acuity calls, implement a response-optional category for low-acuity calls, supplement the PPP payment mechanism with a mandatory per-call fee for utilization of PPP paramedics during transport, and implement an automatic increase in the cost-based payments by the Contractor to the PPP agencies;

Medic Ambulance understands the consultant's ideas for different models for reimbursement within the PPP, and we feel it should be up to the bidding entities to propose a legal model to compensate the PPP cities. This has been the past practice in the last RFP and it should be the same in this RFP. We also disagree with the consultant recommendation that the contractor provide reimbursement to PPP cities when, *"they assist the Contractor on scene or in preparation for patient transport (for example, lift assist),"* due to the PPP cities having a tax-based revenue and charging a current First Responder Fee for response. This cost is already being compensated and to ask it of the contractor is a double dip of revenue. We also feel the PPP portion of the RFP should not have a score and should be a separate submittal under the first responder section of the RFP, as it has been in previous RFP processes. Furthermore, we do not agree with the Fire Departments assessment that all factors of the PPP should be spelled out in the RFP and not negotiated after award. The PPP is a separate agreement to the ambulance RFP and the ambulance contractor and the PPP cities need the ability to negotiate a bi-lateral contract.

In response to statements made in the blueprint from the closed Fire Chiefs and City Manager's meeting, Medic offers the following statement and response:

"Revenues to the PPP Cities from the current EOA provider do not fully cover the Cities' costs in providing ALS first response services "

It has never been the intent of the PPP nor should it be the intent of the ambulance franchise to cover the full cost of Paramedics services for member PPP cities. As everyone is aware this is an ambulance contract, not a fire services contract. There must be a cost savings to the contractor to share dollars with cities. It would be illegal to just say we have to cover the cost of the fire departments ALS first response service, let alone the cost and benefit package would cripple any ambulance franchise revenue model. It is the member cities prerogative to negotiate their labor agreements and in no way could those benefit packages ever allow for a sustainable ambulance financial model.

"Any increase in money going into the system should be used to help the PPP fire departments. The PPP Cities should receive all or at least a percentage of the Contractor's additional revenues due to its rate increases."

The PPP fire departments are not the entire EMS system and should not be the benefactors of increased money going into the system. Medic Ambulance has a union workforce with labor agreements that we must maintain competitive wages to retain employees. Those cost increases will be going to contractor related expenses as well as system improvements through technology, infrastructure, maintenance and other related operating expenses. We completely disagree that any increase in money into the system should be used to help PPP fire departments, or that the cities should receive all of the contractor's additional revenue from a rate increase.

"There should an increase in PPP City response time to 8 minutes due to the need of their personnel to put on protective equipment"

We do not feel there should be any additional time added on the PPP cities response time. The PPP Cities already receive additional time for response as their response clock begins when the engine is notified to arrival on scene; while the ambulance contractor is monitored from the time the is call taken to on scene. We believe there is already an inherit "head start" given to the member cities that the ambulance contractor does not receive.

The Contractor should provide funding for each PPP City to have a cardiac monitor

As we have stated above, contract or ambulance services who have offered these types of kickbacks routinely fail as the EMS system revenue is not set up to fund the entirety of the Fire Service ALS program. Many of the local fire jurisdictions can use state and federal grant funding for these items, and many have done so in their purchases. We feel any inclusion of this into the

RFP would not be in the good faith of wanting to continue as sustainable EMS model and sends the wrong message to the possible contractor.

(6) incorporate CCTs into the EOA as a necessary response to the erosion of market-based CCT capacity in the County, maintain the ALS+RN program, and implement a re-triage transport (RTT) program for rapid interfacility transports;

Medic is opposed to the inclusion of CCT into the EOA and disagrees with the consultant's assessment of the current market. While we do agree that CCT volume has decreased due to the ALS RN program and providers finally are complying with our EOA, we provide a couple points as it relates to the reduction of market capacity. In 2017, Kaiser and Sutter both had recent procurements for BLS and CCT services which they in turn awarded 5-year contacts. Prior to this, multiple providers were providing service in Solano and to those hospitals. Currently, we have three contracted providers for CCT servicing the 5 local hospitals, and another providing back up services. These contracts are in place with the providers until at least 2022 and have allowed those CCT providers to cost shift possibly with CCT volume of the hospital. In review of the hospital stakeholder meetings, it is apparent the hospitals too would rather not include CCT Services. The county has done a very good job over the last 8 years of enforcing the ALS EOA, and we believe with ALS RN and the county continually reviewing the use of CCT the ALS EOA does not need to include CCT to properly protect it. Solano County has many primary contracted CCT providers and we feel the market is very stable.

Additionally, Medic opposes the implementation of a re-triage transport (RTT) program and new response level (Priority 9), allowing hospitals to utilize incoming ambulance for ALS interfacility transports that require service under certain conditions, until more data is reviewed. All the was presented was random sampling of the issue. Not only is a 15-minute interfacility response time criteria unheard of in our industry, we feel this has the most likelihood for abuse of the EOA. The point of fact that was continually brought up at the stakeholders' meetings, were transfers out of Kaiser Vacaville. Most of these transports are STEMI patients, whom are being transported to Kaiser Vallejo, past the closer STEMI Center in Fairfield. It's puzzling that instead of reviewing outcome and facts related to the cases mentioned at the stakeholder meetings, Priority 9 was hastily offered. A full assessment into destination decisions, on scene time of the transport team, paperwork readiness, and many other factors should be looked at before a 15-minute response time and RTT are created. We can easily see a situation where a Priority 9 transport is called, and the in-network destination hospital passes a closer appropriate hospital for this immediate transport, and this should not be allowed to happen, nor does it support the necessity for RTT. We urge a proper assessment be done into the facts and outcomes before the county offers such a program and changes response and priority codes.

(8) restructure the liquidated damages provisions to incentivize evidence- based practices that are shown to optimize patient outcomes while eliminating built-in incentives for non-compliance, and increase the flat franchise fee to cover estimated Contract oversight costs;

Medic would like to be on record stating that we support the concept of point number 8.

(9) implement a weighted and scored formula for patient charges in the RFP process, and require the Contractor to adopt certain consumer protections such as hardship waiver criteria;

Medic does take issue to language related to the CPI language shown in the document. The blueprint states, *"In the event this annual average CPI figure is zero or negative, we recommend the Contractor not be entitled to an automatic increase in charges."* Medic requests language that even if the annual average CPI figure were to be zero or negative on a given year, the contractor should still be entitled to some portion of a rate increase by showing an increase in employee and operating expenses. Employer is expected to keep competitive wages, retain employees, and maintain high level equipment standards. Contractor needs the ability to build in these inflating costs to increase revenue stream and prevent financial issues. Currently Medic has labor agreement until April 2021 with avg annual Step and COLA Raises. Without this ability to request a rate increase based solely on operational cost increases the contractor could be negatively harmed based on zero or negative CPI year.

(10) implement workforce protections including a hiring preference for the incumbent provider's field personnel in the event of a change in Contractor, implement turnover disincentives, promote workforce diversity and assure training on infrequently-used critical skills;

Medic takes issue with the Turnover Disincentives, not that it shouldn't be tracked but how question how data would be used to come with an acceptable metric. There would need to a clear definition of what is included and/or excluded in the disincentive number. Many of Medic's employees, and private employees throughout the state of California, turn to public employment for public safety. This is a cycle of employment that has gone on for over 30 years, where employees start out as EMTs, Paramedics and dispatchers then move on to Public Firefighter/Paramedics, Dispatchers, police officers, county officials, fire chiefs, doctors, nurses, etc. Many of the current fire department workforce started their careers at Medic or with a private ambulance service. We don't feel it would be fair to penalize the contractor for losing employees to public agencies. More discussion and understanding are needed for this section.

(13) implement a requirement that the Contractor have current and 5 years' prior experience as an EOA provider of a population of at least 300,000.

Medic Ambulance vehemently supports this clause as a matter of system structure to ensure the safety of our citizens. In addition, we ask the county to consider adding ALS EOA to the experience description. We agree with the consultant's assessment *"that there is a substantial difference in the experience it requires for one entity to deploy EMS system resources for a 300,000 population of an EOA versus multiple entities deploying to serve smaller subpopulations of that area."* This is a real concept that many if not all counties have mandated in their RFP processes. The following recent procurements have mandated this language, Alameda, Napa, San Joaquin, Yolo, Fresno, Merced and San Mateo all recently required experience. Contra Costa did not, even though its previous RFP did. This process is also currently under investigation by the State Attorney General's office for possible anti-trust violation. Also, California EMSA has already ruled against this process and deemed Contra Costa an open market and non-exclusive due to how their RFP process was conducted. We do not support waiving this requirement to allow the fire departments and districts to use an alliance model to jointly bid on the EOA contract as a partnership.

In closing, Medic would like the SEMSC to ensure the process is fair and transparent. We know there are seats on the board of SEMSC that have inherent financial conflicts. In the previous contract, the PPP cities were not represented on the SEMSC board, yet in this contract process there are two seats held by PPP member cities. At the stakeholder meeting, there was a comment stated by one of the deputy fire chiefs who openly stated, during a heated exchange with the consultant regarding dispatch, that they had two seats on the board. As past members of the board with conflicts have done, we would expect those parties to recuse themselves from any vote, input related to issues that can impact their ability to bid, increase revenue, etc. This is a very serious matter and could impact the entire RFP process and will cause major issues with the drafting, and awarding of any ambulance RFP.

Sincerely,

James Pierson,

Vice President / COO