ASSEMBLY COMMITTEE ON HEALTH
INFORMATIONAL HEARING

California's Emergency Services and Trauma Care "System"

Tuesday, February 13, 2001

1:30 p.m. - Room 437

Introduction

The Assembly Health Committee hearing will explore the planning, coordination, oversight and financing of California's emergency and trauma services. A number of reports have been released recently that criticize California for inadequate coordination of and support for emergency services, and in particular trauma care. Panels of experts have been called upon to inform the members of the Assembly Health Committee of the current system structure and the challenges that health care providers face as they attempt to serve the emergency medical care needs of people in California.

I. Planning

The Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act and Local Emergency Medical Services Agencies

In 1980, the Legislature declared its intent in enacting the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act[1] to create a statewide system for emergency medical services by establishing within the Health and Human Services Agency the Emergency Medical Services Authority (the Authority). The Authority is responsible for the coordination and integration of all state activities concerning emergency medical services.[2]

However, each county is not required to develop an emergency medical services program.[3] If a county does develop such a program, the county is required to designate a local emergency medical services (EMS) agency. The local EMS agency is authorized (but not required) to develop and submit a plan to the Authority for an EMS system according to guidelines prescribed by the Authority.[4]

All of California's 58 counties are covered by an EMS plan.[5] California has 32 local EMS agencies serving California's 58 counties,[6] comprised of seven regional EMS agencies covering

33 counties and 25 single county agencies. The Authority is required to develop planning and implementation guidelines for EMS systems that address the following components:

(a) Manpower and training;
(b) Communications;
(c) Transportation;
(d) Assessment of hospitals and critical care centers;
(e) System organization and management;
(f) Data collection and evaluation;
(g) Public information and education; and
(h) Disaster response.[7]

The Authority, utilizing regional and local information, is required to assess each EMS area or the system's service area for the purpose of determining the need for additional EMS, coordination of EMS, and the effectiveness of EMS.[8] The Authority is also required to provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of EMS systems.[9]

The Authority is also required to receive plans for the implementation of EMS and trauma care systems from local EMS agencies. A local EMS agency may implement a local plan, but if it submits a plan, the local EMS agency is required to coordinate and otherwise facilitate arrangements necessary to develop the EMS system.[10] Local EMS agencies are required to annually submit an EMS plan for the EMS area to the Authority, according to EMS systems, standards, and guidelines.[11]

Trauma Care

Trauma is an injury caused by a physical force, most often the consequences of motor vehicle crashes, falls, drowning, gun shots, fires and burns, stabbing, or blunt assault. Trauma kills more people between the ages of 1 and 44 than any other disease or illness. Nearly 100,000 people of all ages in the United States die from trauma each year, roughly half of them in automobile crashes.[12]

A "trauma care system" means an arrangement under which trauma cases are transported to, and treated in, the appropriate trauma facility. A "trauma facility" is a health facility capable of treating one or more types of potentially seriously injured persons and which has been designated as part of the regional trauma care system by the local EMS agency.[13] Trauma centers are hospitals that have been accredited by the Joint Commission on Accreditation of Healthcare Organizations, and have been designated as a Level 1, 2, 3 or 4 trauma center, and/or a Level 1 or 2 pediatric trauma center, by the local EMS agency. Generally, a trauma center is a hospital that maintains a higher level of services than other community emergency departments for victims of car accidents, assaults, falls and other types of critical injuries.[14]

A local EMS agency is not required to implement a trauma care system. However, if a local EMS agency chooses to implement a trauma care system, it can do so only if the system meets

the minimum standards set forth in regulation, and the plan has been approved by the Authority.[15] After the submission of an initial trauma care system plan, a local EMS agency which has implemented a trauma care system is required to annually submit an updated plan to the Authority.[16]

As of July 10, 2000, 18 of the 32 Local EMS Agencies had an approved trauma plan, 2 are pending and 12 are not approved.[17] In the briefing material is a list of the trauma plan status of each of the 32 local EMS agencies, a list of the state's 44 trauma facilities, and a map showing the location of the state's trauma facilities.

TOTAL TRAUMA CENTERS - 2000

Pediatric Only	3
Adult/Pediatric	1
Level 1	12
Level 2	26
Level 3	2
Level 4	0
Total Trauma Centers:	**44**

A recent report by the Sierra-Sacramento Emergency Medical Services Agency identifies two main problems facing California's care for a major trauma victim: California does not have a statewide trauma system, and California lacks dedicated earmarked state trauma funding.[18]

II. Oversight and Regulation

The Emergency Medical Treatment and Active Labor Act (EMTALA) and State Law

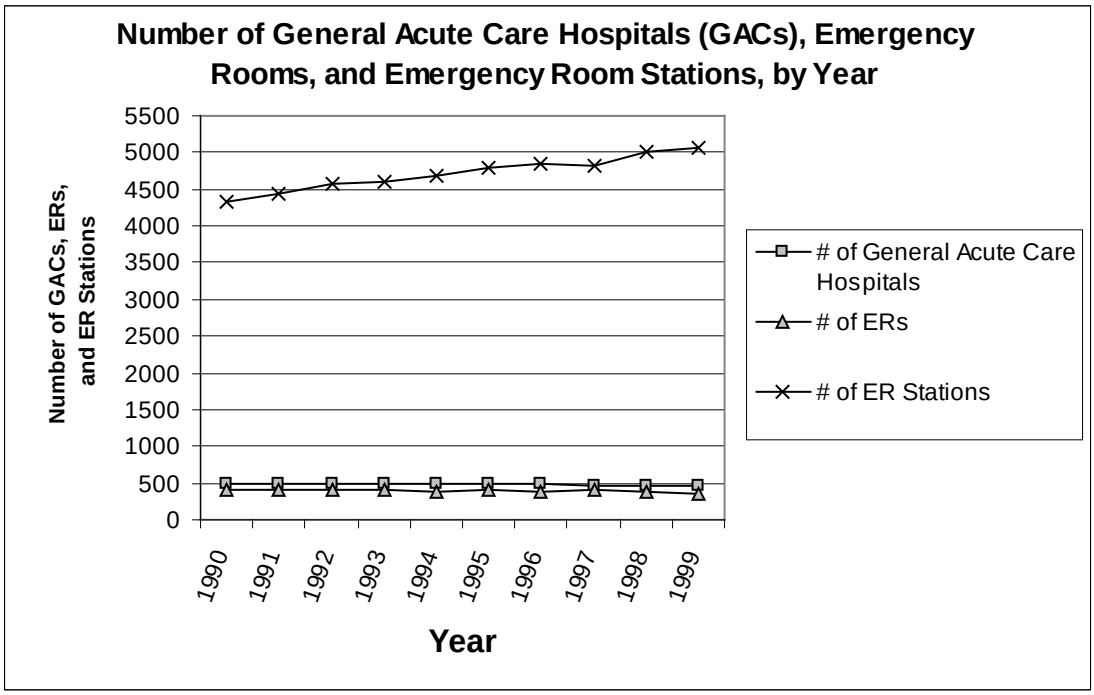
EMTALA, or the federal "anti dumping law," was enacted by Congress in 1985 to ensure that patients who come to hospitals for treatment for potential emergency conditions are not turned away or transferred to another facility. Hospitals that receive Medicare or Medi-Cal funding must provide a medical screening examination to determine the presence or absence of an emergency medical condition to all individuals seeking emergency services prior to inquiring about the method of payment. Hospitals are required to stabilize the medical condition of the individual within the capabilities of the staff and facilities available at the hospital prior to discharge or transfer. EMTALA violations can subject hospitals to civil penalties from $25,000 to $50,000 per violation.[19]

Under California law, emergency services and care[20] are required to be provided to any person requesting services or care for any condition in which the person is in danger of loss of life, or serious injury or illness. This requirement applies to a health facility that maintains and operates an emergency department when the facility has appropriate facilities and qualified personnel available to provide the services or care. Emergency services and care are required to be rendered without first questioning the patient or any other person as to his or her ability to pay.[21]

General Acute Care Hospitals - Emergency Departments

General acute care hospitals are required to be licensed and inspected by the State Department of Health Services (DHS).[22] General acute care hospitals are required to provide 24-hour inpatient care, including the following eight basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.[23] In 1999, there were 465 licensed general acute care hospitals. General acute care hospitals are not required to maintain an emergency department, but they may be approved by DHS to offer special services,[24] which is defined to include an emergency center.[25] DHS is required to adopt standards for special services. In 1999, 365 or 78% of the state's 465 general acute care hospitals had emergency departments.[26]

In 1999, there were fewer hospital emergency departments, more emergency department stations in those hospitals with an emergency department, and more emergency department visits than in

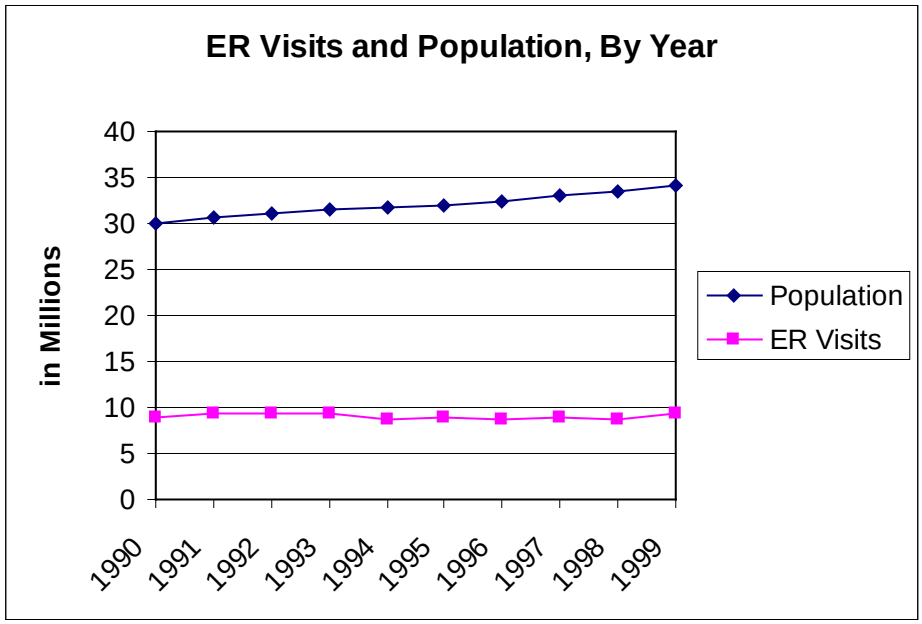


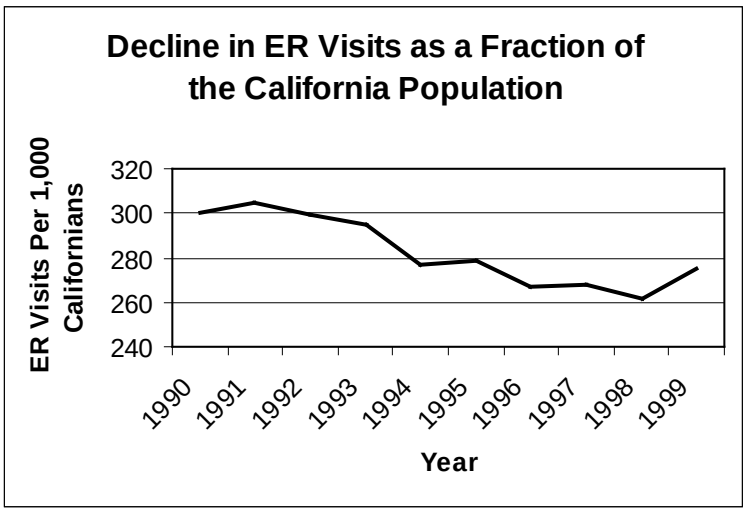
1990. In 1990, there were 415 emergency departments with 4,340 emergency department stations and 8,985,493 emergency department visits. In 1999, there were 365 emergency departments with 5,071 emergency department stations and 9,360,456 emergency department visits.

* An Emergency Department station is a specific place within the emergency medical services department adequate to treat one patient at a time. Holding or observation beds are not included.

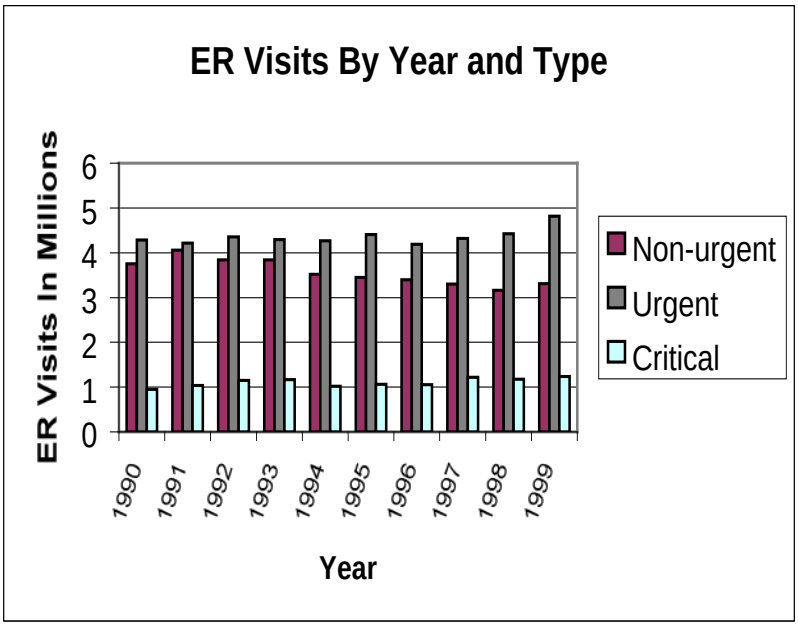
Source: Office of Statewide Health Planning and Development

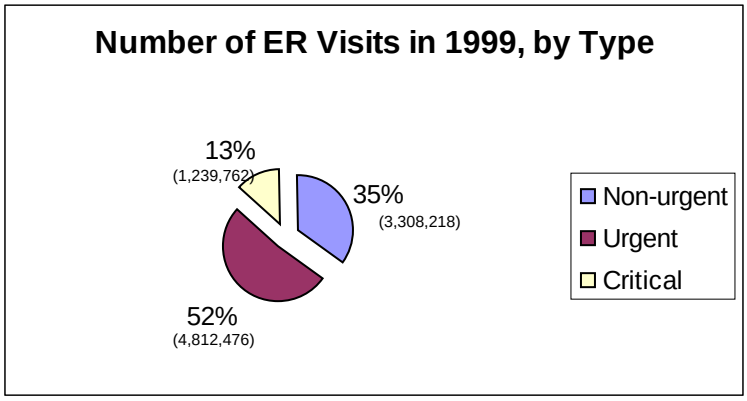
The number of ER visits has grown more slowly than the rate of California's population.



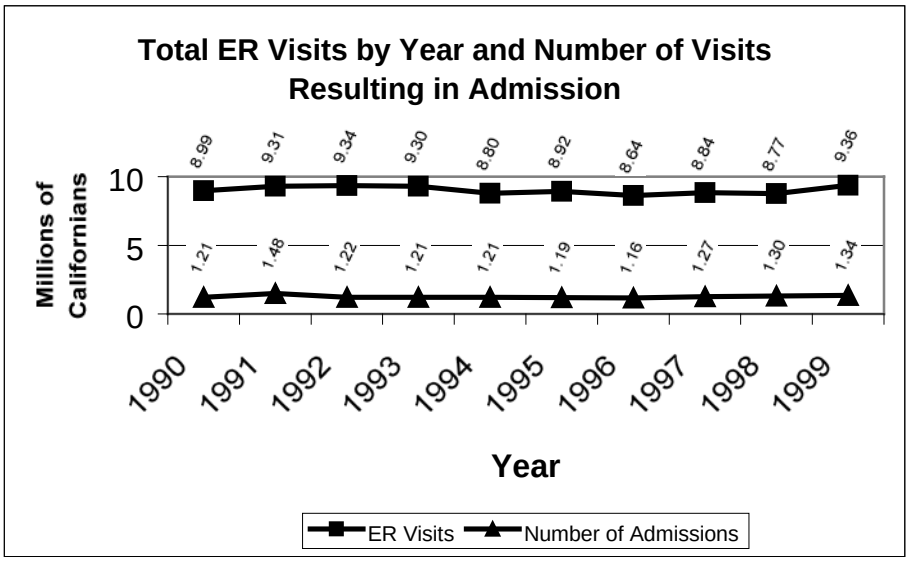


Throughout the 1990s, most visits to the ER were for urgent conditions, followed by non-urgent conditions and critical conditions. An urgent visit is a patient with an acute injury or illness where loss of life or limb is not an immediate threat, or a patient who needs a timely evaluation (fracture or laceration). An non-urgent visit is a patient with a non-emergency injury, illness, or condition (sometimes chronic) that can be treated in a non-emergency setting and not necessarily on the same day seen in the EMS Department (e.g., pregnancy tests, toothache, minor cold, ingrown toenail). A critical visit is a patient with an acute injury or illness that could result in permanent damage, injury or death (head injury, vehicular collision, firearm incident).





Most visits to the emergency room do not result in an admission to the hospital. In 1999, there were 9,360,456 emergency department visits, resulting in 1,342,566 admissions to the hospital.



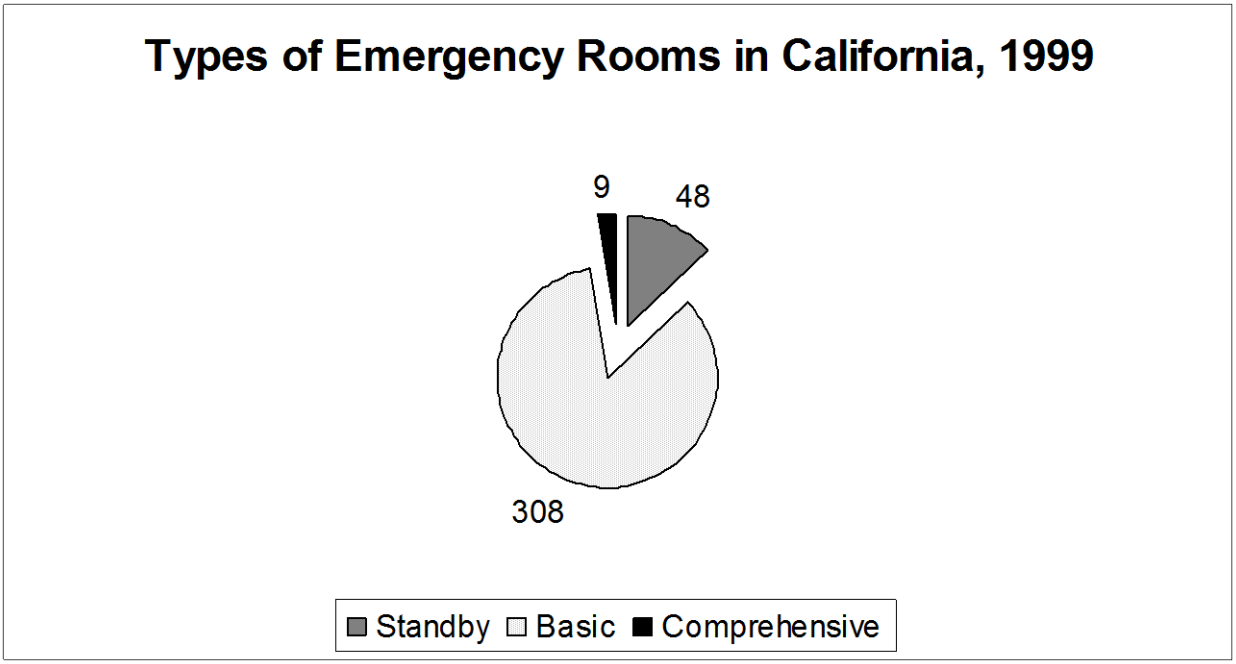
Types of Emergency Service Designations

California regulations establish three levels of emergency room facilities:

- Basic EMS, physician on duty, means the provision of emergency medical care in a specifically designated area of the hospital that is staffed and equipped at all times to provide prompt care for any patient presenting urgent medical problems.[27] In 1999, 308 of the state's emergency departments were licensed as basic.

- Comprehensive EMS means the provision of diagnostic and therapeutic services for unforeseen physical and mental disorders which, if not promptly treated, would lead to marked suffering, disability or death. The scope of services is comprehensive with in-house capabilities for managing all medical situations on a definitive and continuing basis.[28] In 1999, 9 of the state's emergency departments were licensed as comprehensive.

- Standby EMS, physician on call, means the provision of emergency medical care in a specifically designated area of the hospital which is equipped and maintained at all times to receive patients with urgent medical problems and capable of providing physician service within a reasonable time.[29] In 1999, 48 of the state's emergency departments were licensed as standby.



Emergency Department Closures or Downgrades

Any hospital that provides emergency medical services is required to provide notice of a planned reduction or elimination of the level of EMS to the following entities as soon as possible, or within 90 days:

- the State Department of Health Services;
- the local government entity in charge of the provision of health services; and
- All health care service plans or other entities under contract with the hospital to provide services to enrollees of the plan or other entity.

In addition, the hospital is required to provide public notice of the intended change in a manner that is likely to reach a significant number of residents of the community serviced by that facility.[30]

In addition to the above requirements, a health facility implementing a downgrade or change is required to make reasonable efforts to ensure that the community served by its facility is informed of the downgrade or closure (this applies to all downgrades or changes and not just emergency services). Reasonable efforts can include, but not be limited to, advertising the change, soliciting media coverage regarding the change, informing patients of the facility of the impending change, and notifying contracting health care service plans.[31]

Hospitals are exempt from the above requirements if DHS does either of the following: (1) determines that the use of resources to keep the emergency center open substantially threatens the

stability of the hospital as a whole or (2) cites the emergency center for unsafe staffing practices.[32]

Health plans, within 30 days of receiving the notice, are required to notify enrollees who have selected a medical group or independent practice association that uses a hospital that the hospital will reduce or eliminate its emergency services. The plan can require that its contracting medical groups and independent practice associations that use the hospital provide this notice. The notice is required to include a list of alternate hospitals that can be used for emergency services.[33]

III. Financing

Health Care Service Plans

Health care service plans (health plans) licensed under the Knox-Keene Act (generally HMOs) must provide "basic health care services," which includes emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.[34] Health insurers licensed under the Insurance Code are not required to provide emergency health care services, but if they do provide the service, they are also required to provide coverage for emergency medical transportation (ambulance) services.[35]

Health plans (or its contracting medical providers) are also required to provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care in situations where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician is required to be available for consultation and for resolving disputed requests for authorizations. Health plans are required to reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee.[36]

Health plans are prohibited from requiring prior authorization or from refusing to pay for any ambulance or ambulance transport services provided to an enrollee as a result of a "911" emergency response system request for assistance if either of the following conditions apply:

- The request was made for an emergency medical condition and ambulance transport services were required.

- An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

After a health plan authorizes a specific type of treatment by a provider, the plan is prohibited from rescinding or modifying this authorization after the provider renders the health care service in good faith and under the authorization.[37]

Medi-Cal Managed Care

Medi-Cal Managed Care regulations require health plans to make payment for emergency services at the lesser of: (1) the usual charges made to the general public by the emergency services physician; (2) the maximum Medi-Cal Fee for Services rate; or (3) the rate negotiated between the plan and the physician.

Health plans often subcontract the risk for emergency room services and payment responsibilities to a variety of independent practice associations (IPAs) and medical groups that have contracted for primary care risk. Health plans usually do not contract directly with emergency room physicians. IPAs and medical groups may also sub-subcontract the risk to other groups. With few exceptions (county hospitals and teaching hospitals), hospitals do not employ physicians, so billing and collection responsibilities are left to the emergency room physician groups. Medi-Cal health plans are required to pay for medical screening examinations (an examination to determine the presence or absence of an emergency medical condition), even if the enrollee's primary care physician has not authorized the exam.

A payment dispute between the provider and health plan must first be processed through the health plan's provider claims appeal process. The provider has an additional avenue for appeal through the Office of Administrative Hearings and Appeals (OAHA) at DHS, if the dispute is not resolved. A health plan must reimburse the provider in full within 30 days of the effective date of the decision, if the OAHA rules in favor of the provider.

Source: Department of Health Services, Medi-Cal Managed Care Division

DHS Report on Emergency Room Professional Services Claims Processing

In a December 2000 report by the Medi-Cal Managed Care Division of DHS in response to concerns that health plans were not in compliance with contractual requirements regarding payment of emergency services, DHS concluded that the "apparent tenuous financial status and the widespread late payment practices of IPAs and medical groups contracting with health plans, are problems present throughout managed care, and not unique to Medi-Cal." DHS suggested that a backlog of disputed claims on file with OAHA may have provided a general disincentive for health plans to take a pro-active approach to enforcing contracted IPAs and medical groups to pay claims on a timely basis.

The report sampled health plans participating in the Two Plan Model.[38] Under DHS contracts, health plans are ultimately responsible for the timely payment of claims. DHS also examined the practice of health plans "down coding" emergency services billed by providers. Down coding refers to when health plans or medical groups change the billing code designation, resulting in a lower reimbursement paid to the provider. The report determined that the incidence of down coding is low. Further, DHS indicated that down coding is allowable under DHS regulations and concluded that it is an appropriate practice under managed care when applied in accordance with sound policies and procedures.

On Call

When California operated in a fee-for-service environment, doctors would build their medical practices by taking emergency calls. Call coverage was also considered part of a doctor's ethical responsibility. Increasingly however, physicians are refusing to take call. The on call problem has been the subject of a task force and two separate reports, one issued by physicians and emergency room physicians, and the other by hospitals.[39] Reasons cited in a report by the California Medical Association (CMA) and California Chapter of the American College of Emergency Physicians (Cal-ACEP) for physicians' unwillingness to take call are as follows:

- Lack of payment by managed care plans and public payors;
- Lack of medical staff membership;
- The aging of some medical staffs;
- Culture change;
- Not necessary to build practice;
- Liability considerations;
- Increasing physician specialization;
- Depletion and/or maldistribution of specialists;
- Managed care promotes accountability only for contracted patients.

Acute care hospitals providing basic emergency services are required to have a physician trained and experienced in emergency medical services. The physician or his/her designee is responsible for providing physician staffing for emergency services 24 hours a day, and the development of a roster of specialty physicians available for consultation at all times.[40]

As a condition of licensure, hospitals are also required to ensure that physicians who serve on an on call basis to the hospital's emergency room cannot refuse to respond to a call on the basis of the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. However, this anti-discrimination provision is prohibited from being construed as requiring that any physician serve on an "on call" basis.[41]

According to the CMA and Cal-ACEP report, hospitals and their medical staffs have tried to address the call coverage problem in various ways, including:

- Voluntary on call coverage;
- Mandatory on call coverage;
- Contracting for on call services;
- Paying stipends to physicians for "standby" services;
- Change in payment mechanism by some Medical Groups;
- Closure of the Emergency Department.

Proposition 99

The Tobacco Tax and Health Protection Act of 1988 (Proposition 99) raised the tax on a pack of cigarettes by 25 cents and earmarked the resulting revenue for health education and research, indigent health care services and resources programs. Proposition 99 initially provided revenues

of about $570 million for health care related programs, but as smoking prevalence and consumption has declined, the Proposition 99 revenues available for health care have declined to an estimated $401 million. As Proposition 99 revenues have declined, the Legislature and the Governor have funded certain health screening and health insurance programs, while funding for the California Healthcare for Indigents Program (CHIP), which funds uncompensated physician and hospital services including emergency services, has declined even more dramatically than overall Proposition 99 revenues. In 1991-92, CHIP funding was $336.4 million. By 1999-2000, it had declined to $74.6 million or 22% of the original allocation.

Disproportionate Share Hospital Funding

Although not specifically earmarked for emergency medical services or trauma care, many public and private hospitals receive supplemental Medi-Cal payments through the Disproportionate Share Hospital (DSH) Program to offset uncompensated care costs. In total, DSH payments to eligible hospitals are not quite $2 billion, annually. However, in general, half of the total distribution is funded through intergovernmental transfers (IGTs) by counties with public hospitals, UC hospitals, and hospital districts. The IGTs are matched by the federal government and after the state withdraws $29.8 million for "administrative expenses," the remainder of funds are distributed to qualifying hospitals (hospitals in which Medi-Cal inpatient days are at least one standard deviation above the mean or revenues from low-income utilization account for 25% or more of total revenues).

Maddy Emergency Medical Services Fund

The Maddy Emergency Medical Services Fund (Maddy EMS Fund) is utilized to reimburse physicians and hospitals for patients who do not make payment for emergency medical services and for other EMS purposes as determined by each county. Each county may establish a Maddy EMS Fund upon adoption of a resolution by the county's Board of Supervisors. To date, 45 counties have established a Maddy EMS Fund. The costs of administering the fund are reimbursed by the fund, up to 10% of the amount of the fund. After the costs of administration are deducted, the money is available as follows:

- 58% to physicians for emergency services provided by all physicians in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized. Physicians employed by a county hospital are excluded from the fund.

- 25% to hospitals providing disproportionate trauma and emergency medical care services.

- 17% for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers.[42]

The source of funding in the Maddy EMS Fund are additional penalties (penalty assessments) on fines and bail forfeitures for certain criminal offenses and motor vehicle violations.

Physicians seeking reimbursement from the Maddy EMS Fund are required to submit their losses incurred due to patients who do not make any payment for services and for whom no responsible third party makes any payment. The amount a physician is required to be reimbursed can be no greater than 50% of those losses. Reimbursement for losses incurred by physicians is limited to services provided to a patient who cannot afford to pay for those services, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, and after a physician has billed for payment of services and waives collection efforts after receipt of funds from the fund.[43]

Each county establishing a Maddy EMS fund is required to annually report to the Legislature on the implementation and status of the EMS Fund.[44] There are thirteen counties that have not established a Maddy EMS fund. Those counties are: Calaveras, Imperial, Kings, Lassen, Modoc, Mono, Santa Barbara, Shasta, Sierra, Tehama, Trinity, Tulare and Tuolumne.

For the 1999-2000 reporting period, over $42 million in total assessments were collected; over $59 million in interest and funds were carried over from prior years; over $41 million in total funds were disbursed; and over $56 million in total funds were remaining in county EMS fund accounts.[45]

A number of counties have significant balances remaining in either their physician or hospital funds. Only Butte, Monterey, Nevada, Plumas, Sacramento, San Bernardino, San Diego, San Mateo, and Santa Clara disbursed all or nearly all (over 85%) of their available physician and hospital funds.

Seventeen counties reported paying 100% of the number of physician's claims received and 24 counties reported paying over 90% of the number of hospital claims received. Five counties reported paying 100% of the amount of physician's claims received, while 24 counties reported paying less than 50% of the amount of physician's claims received. Eleven counties reported paying 100% of the amount of hospital claims received, while 17 counties reported paying less than 36% of the amount of hospital claims received.

Attached is a spreadsheet aggregating the data as reported by the individual counties.

Realignment

In 1991, the state enacted a major change in the state and local relationship -- known as realignment. In the areas of mental health, social services, and health -- realignment shifted program responsibilities from the state to counties, adjusted cost-sharing ratios, and provided counties a dedicated revenue stream to pay for these changes. Each county created three program accounts, one each for mental health, social services, and health. Through a complicated series of accounts and sub-accounts at the state level, counties receive deposits into their three accounts for spending on programs in the respective policy areas. Realignment transferred more than $1.7 billion in state program costs to counties, accompanied by an equivalent amount of realignment revenues. The realigned health programs received $833 million of the original realignment allocations, which had grown to $1.3 billion in 1999-00.

Unlike some programs within the social services and mental health areas, the realignment of health programs was largely not intended to alter fiscal incentives, establish performance measures, or shift program administration to the counties. According to state and local government officials, the main purpose was to relieve the state General Fund of fiscal pressure. Essentially then, realignment substituted fund sources--replacing state General Fund appropriations with realignment's tax increases.

Realignment was intended to reduce county reporting requirements. Prior to realignment, counties were required to submit to the state a specified plan and budget and an actual financial data report, which showed how certain funds were being allocated among public health, inpatient care, and outpatient care within an individual county.

Under realignment, counties are no longer required to submit those plans and budgets to the state. The Legislative Analyst's Office notes in its analysis of realignment's impact on health programs that there are data gaps in the realigned health programs. Specifically, the Analyst notes there is no state system to collect data regarding each county's (1) total expenditures for indigent care by fund source, or (2) total expenditures by fund source for each major spending category--public health, indigent inpatient care, and indigent outpatient care. The lack of this data leaves the state unable to answer fundamental questions regarding the provision of health services in each county and hampers the state's ability to devise effective health financing policies and budgets.[46]

Legislative Actions - 1990-2000 Session

In the 1999-2000 legislative session, the Legislature considered bills and budget proposals addressing emergency services, including funding for uncompensated emergency room physician and hospital services, increasing Medi-Cal rates for emergency physician services, prohibiting the downgrade or closures of hospital emergency departments in urban counties, and making it a violation of the Medical Practice Act for a physician who is scheduled to be on call to refuse to care for a patient in the emergency department. The following is a list of relevant legislation and budget proposals:

Medi-Cal Rate Increase for Emergency Room Services - The Budget Act of 2000, increased Medi-Cal rates for emergency room services by 40%.

SB 2132 (Dunn, Chapter 826, Statutes of 2000) - Appropriated $24.8 million in Proposition 99 funds (the Cigarette and Tobacco Products Surtax Fund) for allocation in the 2000-01 fiscal year for emergency services.

AB 2611 (Gallegos, Chapter 828, Statutes of 2000) - Requires the Senate Office of Research to conduct a comprehensive study of the hospital emergency room department on call coverage issue in California. The study is required to include, but not be limited to,

- the magnitude of the challenges facing California hospital emergency room departments, including those in underserved and rural areas;
- the scope of the challenges facing other states relative to these issues; and
- how other states have addressed these complex and challenging issues.

The Senate Office of Research is required to report to the Legislature by January 1, 2002, and the report is required to include recommendations to address California hospital emergency room on call issues.

AB 421 (Aroner) - Would have prohibited the Department of Health Services (DHS) from approving the downgrade or closure of an urban hospital emergency department, if a county or its designated emergency services agency (LEMSA) concludes that it would not be in the best interest of the community.

AB 1455 (Scott, Chapter 827, Statutes of 2000) - Increases the interest rate on an uncontested health care provider claim that is not paid by a health plan within a prescribed time period to 15% per annum, and imposes a $10 charge on a plan that fails to automatically include this interest amount in its payment to a provider. Requires a health plan to ensure its dispute resolution mechanism is available to noncontracting providers.

Discussion Questions:

1. Should the state require every local EMS agency to have a trauma plan?

2. What is the role of local EMS agencies, state and local governments when a hospital ER closes? Should those roles be changed?

3. Is DHS the appropriate regulator for emergency room oversight?

4. Does DHS have adequate resources to regulate emergency rooms?

5. Does the State EMS Authority have any regulatory power over emergency rooms or trauma centers? If not, why not? Should it?

6. To what extent do counties use realignment funds for trauma care?

7. Should the state earmark funding specifically for trauma care? If so, how much and on what basis?

8. Why are hospitals having trouble finding physicians willing to take call?

9. How are hospitals and their medical staffs addressing on call?

10. Why are there fund balances in the Maddy EMS Fund?

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[1] SB 125, (Garamendi), Chapter 1260, Statutes of 1980.

[2] Health and Safety Code Section 1797.1.

[3] Health and Safety Code Section 1797.200.

[4] Health and Safety Code Section 1797.250.

[5] Letter from the Emergency Medical Services Authority dated February 7, 2001.

[6] Emergency Medical Services Authority Department Description.

[7] Health and Safety Code Section 1797.103.

[8] Health and Safety Code Section 1797.101.

[9] Health and Safety Code Section 1797.104.

[10] Health and Safety Code Section 1797.252.

[11] Health and Safety Code Section 1797.254.

[12] American Trauma Society, What is Trauma? at http://208.58.30.127/ATSnews/page4.html.

[13] Health and Safety Code Section 1798.160.

[14] Los Angeles County Department of Health Services Public Hearing on Funding and Stabilization of the Los Angeles County Trauma Hospital System, September 11, 2000. The

Trauma Care System regulations are located in the California Code of Regulations, Title 22, Division 9, Chapter 7, Sections 100236-100266.

[15] Health and Safety Code Section 1798.162.

[16] Health and Safety Code Section 1797.258.

[17] Trauma Plan Status: EMS Agency - Approval Order, updated 7/10/00.

[18] "California's Trauma Care*: in Crisis*," January 2001, p. 8.

[19] Report of the Organized Medical Staff Section Governing Council, "EMTALA Quick Reference Guide."

[20] Health and Safety Code Section 1317.1 defines "emergency services and care" as a medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

[21] Health and Safety Code Section 1317.

[22] Health and Safety Code Section 1254.

[23] Health and Safety Code Section 1250.

[24] Health and Safety Code Section 1252.

[25] Health and Safety Code Section 1255.

[26] Data from the Office of Statewide Health Planning and Development (OSHPD).

[27] California Code of Regulations Title 22, Section 70411.

[28] California Code of Regulations Title 22, Section 70451.

[29] California Code of Regulations Title 22, Section 70649.

[30] Health and Safety Code Section 1255.1.

[31] Health and Safety Code Section 1255.2.

[32] Health and Safety Code Section 1255.2.

[33] Health and Safety Code Section 1364.1.

[34] Health and Safety Code Section 1345.

[35] Insurance Code Section 10126.6.

[36] Health and Safety Code Section 1371.4.

[37] Health and Safety Code Section 1371.8.

[38] In 12 counties--Los Angeles and most of the other more populous counties--most families who are Medi-Cal beneficiaries choose either a designated commercial HMO or the "local initiative" plan, which is established by the county and includes "safety-net" providers.

[39] "Potential Solutions to the Lack of Physician Backup in Hospital Emergency Departments." Report of the CMA/Cal-ACEP Emergency On-Call Task Force.

"Physician Backup in Hospital Emergency Departments," California Healthcare Association Report.

[40] California Code of Regulations Title 22, Section 70415.

[41] Health and Safety Code Section 1317.3.

[42] Health and Safety Code Section 1797.98a.

[43] Health and Safety Code Section 1797.98c.

[44] Health and Safety Code Section 1979.98b.

[45] Data is based on a compilation of the 1999-2000 EMS reports submitted by counties with EMS funds. The reports were due January 1. Marin County's report has not yet been submitted. The 1999-2000 reports from Alameda, Alpine, Amador, Butte, Los Angeles and San Joaquin are incomplete. It should be acknowledged that some limitations exist with the data based on the reports. For example, some claims reported during this reporting period may be paid during the 2000-01 reporting period. Additionally, all counties do not report interest income consistently, and reporting periods may not be reported consistently (i.e., some counties use the fiscal year as the reporting period while other counties use the calendar year).

[46] "Realignment Revisited: An Evaluation of the 1991 Experiment In State-County Relations," Legislative Analyst's Office, February 6, 2001.