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OPINION	:	No. 11-707
	:	
of	:	December 16, 2014
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THE HONORABLE MARK J. SALADINO, COUNTY COUNSEL FOR THE COUNTY OF LOS ANGELES, has requested an opinion on the following questions:

1. Are cities and fire districts that have been providing prehospital emergency medical services since June 1, 1980, as specified in Health and Safety Code section 1797.201 (local agencies also known as “.201 providers”), required by state regulation to have a written agreement with a Local Emergency Medical Services Agency in order “to participate in the EMS system” as specified in that regulation?

2. Does a contract between a county or Local Emergency Medical Services Agency and a .201 provider for county-supplied emergency medical equipment extinguish the .201 provider’s rights to continue providing prehospital emergency medical services?

3. Does a contract between a county or Local Emergency Medical Services Agency and a .201 provider for medical control and oversight of the .201 provider extinguish the .201 provider’s rights to continue providing prehospital emergency medical services?

CONCLUSIONS

1. Cities and fire districts that have been providing prehospital emergency medical services since June 1, 1980, as specified in Health and Safety Code section 1797.201 (i.e., “.201 providers”), are not required by state regulation to have a written agreement with a Local Emergency Medical Services Agency in order “to participate in the EMS system” as specified in that regulation.

2. A contract between a county or Local Emergency Medical Services Agency and a .201 provider for county-supplied emergency medical equipment does not extinguish the .201 provider’s rights to continue providing prehospital emergency medical services.

3. A contract between a county or Local Emergency Medical Services Agency and a .201 provider for medical control and oversight of the .201 provider does not extinguish the .201 provider’s rights to continue providing prehospital emergency medical services.

ANALYSIS

The Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (“EMS Act” or “Act”) was enacted in 1980 and “created a comprehensive system governing virtually every aspect of prehospital emergency medical services.”¹ This “prodigious” legislative effort reflects a determination that emergency medical services are “at the core of vital civic functions.”² The purpose of the EMS Act is to provide for integrated and effective emergency medical services throughout the state.³

¹ *County of San Bernardino v. City of San Bernardino* (1997) 15 Cal.4th 909, 915 (*San Bernardino*); see Health & Saf. Code, §§ 1797-1799.207.

² *Ma v. City and County of San Francisco* (2002) 95 Cal.App.4th 488, 508, disapproved on other grounds in *Eastburn v. Regional Fire Protection Authority* (2003) 31 Cal.4th 1175, 1184.

³ Health & Saf. Code, §§ 1797.1, 1797.6, subd. (a), 1798; *Valley Medical Transport, Inc. v. Apple Valley Fire Protection Dist.* (1998) 17 Cal.4th 747, 754 (*Valley Medical Transport*); *San Bernardino, supra*, 15 Cal.4th at pp. 928-929; *County of Butte v. California Emergency Medical Services Authority, Inc.* (2010) 187 Cal.App.4th 1175, 1190 (*County of Butte*).

The Act created the Emergency Medical Services Authority, which is the statewide agency responsible for all state activities concerning emergency medical services (widely known as “EMS”), including the promulgation of regulations to implement the Act.⁴ The Act also created a second tier of administrative agencies, known as Local Emergency Medical Services Agencies (or “LEMSAs”), organized by a county or group of counties. The LEMSAs run emergency medical services on a countywide or multicounty basis, and are responsible for the medical control and management of each emergency medical services system.⁵

The questions presented here involve cities and fire districts that historically provided EMS within their territorial jurisdictions before the EMS Act took effect. Health and Safety Code section 1797.201 provides that such pre-existing systems (known as “.201 providers,” taken from the statute number) are to continue providing EMS in the same area and at not less than their former levels of service.⁶ If a .201 provider seeks to change the scope of its services (for example to cease providing EMS; to expand the area in which it provides EMS; or to provide an additional type of EMS), it is entitled upon request to enter into a written agreement with the county or the appropriate regional

⁴ See Health & Saf. Code, §§ 1797.1, 1797.100, 1797.107; Cal. Code Regs., tit. 22, §§ 100000.1-100334; see generally 86 Ops.Cal.Atty.Gen. 153 (2003).

⁵ Health & Saf. Code, § 1798, subd. (a); *Valley Medical Transport, supra*, 17 Cal.4th at p. 754; *San Bernardino, supra*, 15 Cal.4th at pp. 915-916, 927.

⁶ An exception to the service-level requirement is available where a particular .201 provider, after conducting a public hearing on the matter, finds that a reduction in the service level is necessary. Health and Safety Code section 1797.201 provides in full:

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, except the level of prehospital EMS may be reduced where the city council, or the governing body of a fire district, pursuant to a public hearing, determines that the reduction is necessary. [¶] Notwithstanding any provision of this section the provisions of Chapter 5 (commencing with Section 1798) shall apply.

LEMSA regarding such new terms or arrangements.⁷ But, until a .201 provider requests a new agreement, it “retains its right to administer prehospital EMS within its borders.”⁸

Although .201 providers are entitled to continue providing EMS within their own jurisdictions, they are subject to significant new constraints under the EMS Act. In particular, the Act places .201 providers under the “medical control” of the medical director of the appropriate LEMSA.⁹ “Medical control” within the meaning of the Act does not necessarily implicate a .201 provider’s internal administrative decisions, such as staffing levels, local dispatch decisions, location of stations, etc.¹⁰ But “medical control” is nonetheless a broad term, and includes such matters as countywide dispatch policies, patient destination policies, patient care guidelines, and quality assurance requirements.¹¹

Striking a proper balance of authority between .201 providers and LEMSAs is not always a simple matter.¹² Under section 1797.201, “a county may not contravene the authority of eligible cities and fire districts to continue the administration of their prehospital EMS without the latter’s consent, either through acquiescence or through formal agreement.”¹³ Numerous .201 providers have expressed a desire to retain their “.201 rights” and not be deemed to have relinquished or waived them—whether by contract or acquiescence—should they take certain actions or, as relevant here, enter into

⁷ *Valley Medical Transport, supra*, 17 Cal.4th at pp. 757, 760; *San Bernardino, supra*, 15 Cal.4th at pp. 913-914, 930; *City of Petaluma v. County of Sonoma* (1993) 12 Cal.App.4th 1239, 1243-1246.

⁸ *San Bernardino, supra*, 15 Cal.4th at p. 925; see also Health & Saf. Code, § 1798; *Valley Medical Transport, supra*, 17 Cal.4th at p. 755; *San Bernardino, supra*, 15 Cal.4th at p. 930 (“In short, section 1797.201 appears to be a preservation of the status quo rather than a broad authorization of municipal autonomy”).

⁹ *San Bernardino, supra*, 15 Cal.4th at p. 925.

¹⁰ See *id.* at pp. 926-927.

¹¹ Health & Saf. Code, § 1797.220; *San Bernardino, supra*, 15 Cal.4th at p. 925; see *id.* at pp. 920, 925-929 (county protocols regarding dispatch of vehicles and patient management were proper exercise of county’s medical control over .201 providers).

¹² See generally Cole, “Grandfathering” of Emergency Medical Services Under “Section 201” of the Emergency Medical Services Act (2014) vol. 37, No. 4, Pub. L.J. 1.

¹³ *San Bernardino, supra*, 15 Cal.4th at p. 924; see, e.g., *Valley Medical Transport, supra*, 17 Cal.4th at pp. 751, 761 (finding acquiescence where .201 provider abandoned a type of service and allowed LEMSA to replace it).

different types of contractual arrangements with the county or regional LEMSA. Against this backdrop, we consider the questions presented.

Question 1

California Code of Regulations, title 22, section 100168 (“regulation 100168”),¹⁴ requires there to be a written agreement between an “approved paramedic service provider” and a LEMSA “to participate in the EMS system”¹⁵ Some counties and LEMSAs take the position that regulation 100168 applies to .201 providers as well as to other providers, such as other local agencies or private ambulance companies. On the other hand, many .201 providers take the position that the regulation does not apply to them, and no written agreement with a LEMSA is required of them. Therefore, the first issue we have to resolve is whether .201 providers are covered by this regulation, and specifically whether such providers are required to have a written agreement with a county or regional LEMSA in order “to participate in the EMS system” as specified in regulation 100168.

Ordinary rules of statutory construction generally apply to the interpretation of an administrative regulation.¹⁶ That is, we seek to determine the purpose of the regulation, looking first to the usual and ordinary meaning of the words used.¹⁷ We give significance, if possible, to every word, phrase and sentence,¹⁸ avoiding a construction “that would render related provisions unnecessary or redundant.”¹⁹

¹⁴ In 2013, former California Code of Regulations, title 22, section 100167, was renumbered as section 100168. (Cal. Code Regs., tit. 22, § 100168, Register 2013, No. 7 (Feb. 11, 2013).)

¹⁵ Regulation 100168, subdivision (b)(4) states:

(b) An approved paramedic service provider shall:

...

(4) Have a written agreement with the LEMSA to participate in the EMS system and to comply with all applicable State regulations and local policies and procedures, including participation in the LEMSA’s EMS-QIP [EMS Quality Improvement Program] as specified in Chapter 12 of this Division.

¹⁶ *California Drive-in Restaurant Assn. v. Clark* (1943) 22 Cal.2d 287, 292; *Guerrero v. Superior Court* (2013) 213 Cal.App.4th 912, 955.

¹⁷ *See Hunt v. Superior Court* (1999) 21 Cal.4th 984, 1000; 89 Ops.Cal.Atty.Gen. 63, 64 (2006).

¹⁸ *Dyna-Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1386-

Regulation 100168 states, “(b) An *approved* paramedic service provider shall . . . (4) [h]ave a written agreement with the LEMSA to participate in the EMS system” (Emphasis added.) Thus we see that the regulation applies to providers that the LEMSA has “approved” for EMS.²⁰ Critically however, unlike other providers, a .201 provider does not require the LEMSA’s *approval* to provide EMS. Instead, it is authorized to do so directly by statute (i.e., section 1797.201)—in its existing territory and at least to existing levels, until a *different* agreement is reached with the LEMSA. As the California Supreme Court has observed, “Under section 1797.201, the cities’ and fire districts’ authorization to provide EMS comes directly from statute, rather than from the local EMS agency.”²¹

Moreover, the state Emergency Medical Services Authority itself has interpreted regulation 100168 this way in its published reports and memoranda, and in advice letters to LEMSAs and fire departments.²² While the Authority has encouraged agreements between .201 providers and LEMSAs, it has declined to pronounce that such agreements are mandatory in order for .201 providers to participate in the EMS system.²³ The

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¹⁹ *Kleffman v. Vonage Holdings Corp.* (2010) 49 Cal.4th 334, 345.

²⁰ Cal. Code Regs., tit. 22, § 100168, subd. (b)(4); see generally Cal. Code Regs., tit. 22, § 100145, subds. (a), (b).

²¹ *San Bernardino*, *supra*, 15 Cal.4th at p. 924; see *id.* at p. 923 (rejecting “illogical” interpretation of Health and Code section 1797.201 that would require “an agreement to do something—continue to provide EMS—that these cities and fire districts would then have the right to do without an agreement under section 1797.201”).

²² See, e.g., Emergency Medical Services Authority, *EMS System Coordination and HS 1797.201 in 2010* (Apr. 2010) at p. 13, available at <http://www.emsa.ca.gov/media/default/pdf/201emssystemcoordfinal-ds-4-21.pdf> (as of Dec. 16, 2014) (“provided an eligible ‘.201’ agency complies with the medical control requirement, there is no reason that a formal written agreement be required in order to provide this patient-oriented care. [¶] In the event there is no formal written agreement, in order to achieve the medical control requirement, mechanisms for accountability and quality control must still be in place to ensure that EMS provider agencies adhere to all of the policies, procedures, medical controls and protocols of the Local EMS system”).

²³ We have been told that that until 2008, the Authority had found some LEMSA plans deficient for lacking agreements with .201 providers. If so, the Authority was free to change its policy and interpretation. (See *County of Butte*, *supra*, 187 Cal.App.4th at p. 1196, fn. 7 [“In any event, we see no reason why a position taken years ago with respect

Authority's interpretation of its own regulation is entitled to great weight.²⁴

We therefore conclude in response to the first question that regulation 100168 does not require .201 providers to have a written agreement with the LEMSA in order "to participate in the EMS system" as specified in that regulation.

Question 2

We are informed that some counties or regional LEMSAs have contributed medical equipment and supplies—such as automatic external defibrillators, disaster caches, and narcotics for patients—to fire departments, including those performing EMS as .201 providers. These supplies are generally accompanied by agreements between the agencies concerning the roles and responsibilities of each for the maintenance of the items provided, as well as training, reimbursement, and information sharing. The question here is what effect such an agreement has on a .201 provider's ".201 rights."

Here again, we refer to the principle that, under Health and Safety Code section 1797.201, "a county may not contravene the authority of eligible cities and fire districts to continue the administration of their prehospital EMS without the latter's consent, either through acquiescence or through formal agreement."²⁵ The issue, therefore, is whether an agreement to use county-supplied medical equipment (with associated terms about maintenance, training, reimbursement, or data collection), amounts to a concession of authority by a .201 provider to the county or LEMSA. We find that such agreements do not constitute a concession of authority. Their purpose is to enhance the quality or efficiency of prehospital EMS services by making specialized equipment more available to providers. If anything, agreements such as these demonstrate an understanding that the .201 provider will *continue* providing these services.

Accordingly, we conclude in response to the second question that a contract between a county or LEMSA and a .201 provider for county-supplied emergency medical equipment does not extinguish the .201 provider's rights to continue providing prehospital emergency medical services.

to Sonoma County would operate to preclude the Authority from changing its position with respect to Butte County"].)

²⁴ *Industrial Indemnity Co. v. City and County of San Francisco* (1990) 218 Cal.App.3d 999, 1009; 80 Ops.Cal.Atty.Gen. 283, 289 (1997).

²⁵ *San Bernardino, supra*, 15 Cal.4th at p. 924.

Question 3

To reiterate, a .201 provider loses its rights to continue providing the same services in the same area only by express written consent or acquiescence.²⁶ The same statute that permits a .201 provider to continue providing these services also subjects .201 providers to the “medical control” of LEMSAs. Again, “medical control” in this context is a broad term that includes coordinated dispatch, patient destination policies, patient care guidelines, and quality assurance requirements.²⁷ Where an EMS protocol relates to “the provision of emergency medical care,” and not to “purely internal administrative matters,” it is a valid subject of medical control.²⁸

The question here is whether an agreement for a LEMSA to “oversee” a .201 provider would forfeit the .201 provider’s right to continue providing EMS. To the extent that such oversight concerned only medical control of a .201 provider, it would govern matters that are materially and legally distinct from the .201 provider’s ongoing administration of EMS within its boundaries. By simply agreeing to such oversight, therefore, a .201 provider does not consent, either explicitly or by acquiescence, to relinquish its right to provide EMS.²⁹

For this reason, we conclude in response to the third question that a contract between a county or LEMSA and a .201 provider for medical control and oversight of the

²⁶ *Ibid.*

²⁷ Health & Saf. Code, § 1797.220; *San Bernardino, supra*, 15 Cal.4th at p. 925; see *id.* at pp. 920, 925-929 (county protocols regarding dispatch of vehicles and patient management were proper exercise of county’s medical control over .201 providers).

²⁸ *San Bernardino, supra*, 15 Cal.4th at pp. 926-927.

²⁹ Some .201 providers have expressly reserved their .201 rights in written agreements with counties. One county has taken the position that an express reservation of rights is required for .201 providers to retain their .201 rights in agreements for medical control or for equipment or supplies because these agreements involve EMS.

.201 provider does not extinguish the .201 provider's rights to continue providing prehospital emergency medical services.³⁰

³⁰ We have also been asked whether, in the event that either or both types of contracts described in questions two and three would result in the loss of a qualifying city or district's .201 rights, such rights would or could be resurrected upon the termination of the contract. Based on our conclusions that neither such contract would result in the loss of a city or district's .201 rights, we foresee no occasion for this question to arise. Nonetheless, we note that, in the words of the California Supreme Court, "section 1797.201 does not provide for a right of resumption." (*Valley Medical Transport, supra*, 17 Cal.4th at p. 760; see also *id.* at p. 761 ["When a [.201 provider] ceases to be involved in the administration of some distinct part of EMS, and allows the local EMS agency to assume that authority, then it no longer has the prerogative to unilaterally resume control of that part of the EMS operation"].)