CASAC Meeting
Minutes – July 31st, 2025

Meeting called to order by Chairman Rosenberg

Will Rosenberg: Welcome to the July CASAC meeting.

Approval of minutes – The minutes from the May meeting were sent out by SOCALR.
Are there any additions or corrections to the minutes? None
Motion to approve: Jonathon Siegel, Seconded by Matt Larrabee.
Any discussion? Anyone opposed?
No objections to the motion – minutes approved.

Will Rosenberg: Hearing no objections the minutes are entered as approved. Dr. Chizmar is on vacation, but I think Mr. Legore has some information on his behalf.

State Medical Director's Report – Scott Legore sharing for Dr. Tim Chizmar

Scott Legore: EDAS

Scott Legore: Dr. Chizmar asked me to pass along three items. So, first as a reminder, it's already gone out but CHATS is retiring effective Monday. It will be replaced with EDAS, the Emergency Department Advisory System. If you're not familiar, it changes the red and yellow alert statues to level 1, 2, 3, and 4. So if you're not familiar with that, there is a website you can view the statuses of the hospitals. That takes effective Monday, August 4th.

Scott Legore: Broselow Recall

Scott Legore: We mentioned this at the last meeting. Broselow tapes have been officially recalled by the FDA a class one recall. So, if you still have the 2025 edition of the Broselow tapes, you should be removing them from your trucks. They have incorrect information on them and they've been officially recalled.

Scott Legore: HHFNC

Scott Legore: The third item is on the high-flow nasal cannula. This went out to the critical care trucks that have the OSP. There was a request to change the language in the OSP. Currently it states that you need the estimated oxygen times two. There's been a request to change that language to times two or 60 minutes. So, Dr. Chizmar is planning to take this to the Protocol Review Committee at their next meeting and the language will now read as a Section Four Procedure A2. Estimate the total duration of transport and ensure there is at least 60 minutes of oxygen reserve or twice the amount of necessary oxygen, whichever is less. So, for the long-distance transports it's 60 minutes reserve, for the shorter duration it'll be twice the amount of oxygen. I think that met everyone's concerns that were sent out in the email. If you have any

more concerns, just send them to me and I'll get them back to Dr. Chizmar before the Protocol Review Committee meeting in September.

Will Rosenberg: Anyone have anything for us to pass along to Dr. Chizmar? All right. We'll let Scott keep rolling right into the SOCALR reports.

SOCALR Report – Scott Legore

Inspection/License/Renewal Update – Marty Johnson

Scott Legore: I think Marty's on, but I talked to Marty this morning and nothing additional on the license update. I do want to throw out there abut scheduling these renewal inspections. We are at July 31st and we have six services to do in August. We only have had one service that has scheduled a date. Please do not wait until the last minute as we need to get you on the calendar. So even if you don't have your paperwork in, at least coordinate with Marty on the inspection dates so we can get you on the calendar and scheduled.

QA Review/Data Import – Scott Legore & Scott Barquin

Scott Barquin: Good afternoon. The only thing I must pass on is that we continue to get emails from University of Maryland Shock Trauma with missing reports. They are trying to locate patients that have been documented as coming into trauma on apparently the reports, but they are unable to locate them in the hospital dashboard. They state that they are probably in University of Maryland somewhere, but they're not coming to shock trauma, so the correct hospital designation of 634 is not being put in. So, if you could check your dispatch and make sure that you are putting in the correct destination, that would be very helpful. And that's all I have.

Equipment Update - Scott Legore

Scott Legore: The equipment update, just a reminder, the new equipment checklist went into effect July 1st. There are a couple of medication changes. On the BLS side, we removed charcoal unless you have a 9-1-1 contract or you're doing special events. And then on the ALS side, reduced the amount of D10 required, added Esmolol, and increased the amount of Dexamethasone required.

Smartsheet Update – Scott Legore

Scott Legore: And then just a reminder to everybody, we continue to use Smartsheet. We still have some services that are not even using it at all for their dashboard. We're going to start using it to send out reminders for expiring items like MSIs and registrations, so you'll be getting some additional Smartsheet notifications. If there's other folks in your service that you want these reminders to go to just let Donna know and she can coordinate that so it goes directly to the right person.

Will Rosenberg: Thank you, Scott. Does Anyone have anything for Scott or anyone else in the SOCALR office? Moving right along.

Clinician Services – Aaron Edwards unavailable. No Report.

Scott Legore: Just a reminder to everybody, the new BLS recertification model went into effect July, starting tomorrow, with the new round of recertifications for the BLS clinicians. So, it changes the recertification requirements. There is information posted on the website and I believe there is information being sent out to all the ones that may be affected by the change. Not the ones that expire today, but anybody that expires past today.

Will Rosenberg: All right. We have Jill. We are missing Jill. Hold on one second.

Zach Risoldi: We continue to experience significant delays waiting for OCS to process reciprocities, new certifications, etc. It has been very frustrating.

Scott Legore: So again, if you have issues, reach out to Scott Barquin. He can sometimes walk these through a little bit faster. I can't make any promises. Some of those processes are quite in-depth, but Scott Barquin should be your first point of contact. He can help navigate the OCS process.

Scott Barquin: If I could say one thing. We are noticing when people submit applications, they are trying to see how many applications they can submit at one time. Currently I have somebody who submitted four applications in one day, and this does mess up the system. The automated system kind of freezes when that happens. So, if your new hired clinician does not know the Maryland way, it could benefit you to sit down with them and help them fill the affiliation or the BLS reciprocity application so we don't have multiple applications that do hold up the system. Thank you.

Will Rosenberg: Thank you, Scott.

Zach Risoldi: Scott has been trying to help. That's appreciated. More or less a concern about losing new hires, as they cannot work until certified, and after 2-3 weeks, they move on.

Will Rosenberg: I would echo his sentiments about the cumbersome painful process to deal with OCS.

Tyler Stroh: There's also an issue, for anybody who hasn't experienced it, with the people who are drivers, but they are in EMT class when they try to submit or go from driver status to EMT student. That pretty much always requires a direct contact with the licensure office to make that process happen.

Donna Geisel: Barquin can make that happen too.

Scott Legore: Just in the background, there is a non-license side and a license side. And when you go to EMT, you've got to be moved over, and your license side must be made active.

Scott Barquin: I can easily fix that. I just need somebody to contact me and let me know.

Tyler Stroh: Well now that we know what the problem was. The first couple were all in the same class so we got help and got it.

Will Rosenberg: All right. Anything else on OCS before we move to PEMAC?

Committee Reports

PEMAC Report – Jill Dannenfelser

Will Rosenberg: We don't have Jill, but I am sure you have things.

Cyndy Wright Johnson: I have things and I have a couple of quick updates. I sent Donna our July update and she can attach that to the minutes. I won't try to go through the whole thing with you. I think most specifically as we are rewriting the critical patient in the back of the GPC, and that section will now include pediatrics. I think we are on version 3.2. Dr. Levy and Dr. Anders plan to have that ready to finalize soon. This will be a July 26th protocol change and it will all be clinical assessment and treatment with medications and equipment that we already have, but it's to include the fact that children need to be treated where they are until they are stabilized unless there is a critical airway. We are just adding children to that protocol, which I know you all transport a lot of sick kids. So, the other updated we have, there is a conference coming up at Pax River, which will be hosted in Charles County. It will be a two-day conference, Saturday & Sunday, and then Friday night Children's Hospital is offering a one-hour training on pediatric trauma. And as Jill & I talked about at your May meeting, I brought with me and we are happy to mail out, pediatric reference cards and posters which have been updated. We also have a new trauma burn assessment poster. There are also trauma assessment cards but those are geared towards those with prescriptive authority for detailed assessment of child abuse, the PCARN radiology rules, and some major trauma assessment stabilization for our emergency departments before they transfer to a pediatric trauma center. Scott, are you going to talk about Broselow tapes, or should I?

Scott Legore: You already did.

Cyndy Wright Johnson: Okay. All right. Then that's it unless somebody has questions.

Will Rosenberg: Anyone have questions for Cyndy? Hearing nothing, we will move right along.

SEMSAC Report – Danny Platt unavailable. Mike Moretti advised no report.

Will Rosenberg: I don't see Danny on. Mike or Teddy, do you have anything on behalf of Danny?

Teddy Baldwin: No, no report:

Mike Moretti: I do not have a report.

Will Rosenberg: SEMSAC, Scott or Dr. Delbridge, would you like to add anything?

Scott Legore: Was there a July meeting?

Will Rosenberg: There was no meeting.

MIH Report – Deb Ailiff unavailable. No ProCare members available. No report.

Old Business – Will Rosenberg

Will Rosenberg: All right. Moving right along to the old business. We'll kind of jump around here to the non-EMS Driver regulation change.

Non-EMS Driver regulation change – Scott Legore

Scott Legore: So, this is just a reminder. It's already been sent out. So, on July 7th the regulation changes occurred that expend the Non-EMS Driver Program. So that's 30.09.08 that went into effect. That allows the non-EMS Drivers to drive the ALS unit if they meet the staffing requirements within the regulation. There was a couple of minor things in there that cleaned up the regulations. So, that went into effect July 7th.

Will Rosenberg: Want to keep on going with 911 Lift Assists?

911 Lift Assist – Scott Legore

Scott Legore: Sure. So, the 911 Lift Assist, we have talked about this before. I don't remember it if was the last meeting or two meetings ago. We received some additional complaints. This time from Prince George's County and from Baltimore County. Complaints about calls from commercial services to have the 911 companies come out and help them move the patient into the facility or the house. I believe I have addressed them all except for one. The one that is a little concerning out of Baltimore County is apparently the commercial service left the patient on the front step and left, and the patient had to call 911 to get moved into the second floor of the house. They didn't identify the service. The crew just moved them in and didn't think to ask, but that's a little concerning. So again, if you're taking these calls, make sure you have the resources available to move these folks.

Will Rosenberg: I have got no words for that. Hopefully it's nobody on the call. Hopefully it's someone who abstained from the call because I can't even imagine. The only other old business on here was the EMS Compact.

EMS Compact – Will Rosenberg

Will Rosenberg: We talked about this briefly in early May after it came out briefly with no real love in March. I don't know if anyone's reviewed it, has any thoughts, or if it's just I who thinks it's a great idea since it involves our surrounding states and 24 other states. I don't know of Keystone / Lifestar have any thoughts on it since they are in one of the compact states.

Mike Moretti: Yep, I agree. I think we should look into it.

Will Rosenberg: DC is pushing forward from what I am told from their new director and adding themselves in the compact as well. I can say it's in two states that we operate in, and it just makes life so much easier. People cross the fake grey lines without a problem. Any other thoughts on EMS Compact? If not, I think I'm going to need a motion to either move forward or not move forward so we can hand that off to Dr. Delbridge and they can do what they want to do with it. But I think, as I've said before, I think commercial services have the most to gain. I don't see how it impacts our 9-1-1 colleagues, right? They're going to go through the academies and get their state certifications. But for those of us that operate in either Virginia, Pennsylvania, West Virginia, Delaware, or soon to be the District of Columbia, literally surround and drown the State of Maryland, all as a compact state. And as we've talked about, OCS and reciprocity is painful and time consuming, especially for EMTs, even more so than paramedics.

Mike Moretti: So that motion.

Will Rosenberg: I'm sorry Mike, you have a question?

Mike Moretti: Nope, I'll make a motion.

Will Rosenberg: Motion by Mike, second on the motion? What is the motion? Mike, you made a motion. It was to support it, or not to support it? I am getting a step ahead of myself.

Mike Moretti: Motion to support moving forward with the EMS Compact.

Will Rosenberg: Got it. A second by Mr. Larrabee. Any discussion on the motion? Anyone from MIEMSS want to weigh in here?

Dr. Delbridge: Sure. In theory, it makes good sense. It's a little bit more complicated than I think it seems on the surface. I've likened the compact to having a driver's license. You have a driver's license in Maryland. You can drive through Virginia and Pennsylvania and you get a ticket that comes back to the driver's license in Maryland. The problem with the Compact has been that it doesn't convey reciprocity. If you have a driver's license and you move to Virginia, eventually you got to get a Virginia driver's license, right? You don't take up residence in a new state and keep the driver's license where you used to live. The challenge with the Compact is that it does just that. You never have to be licensed in the state that you moved to. You can stay with this authority to practice anywhere you go and tied to things in licensure that would make it important that people get licensed in Maryland eventually. So, access to eMeds is tied to somebody's license. Their currency with protocol updates is tied to the license. So, we would have a create a parallel licensure system to keep track of people who were practicing in the state by virtue of the compact, as opposed to being certified licensed. The compact was merely a process to expedite licensure and certification. It would be a lot easier to put them into the process. The fact that it never requires you to be licensed at all is unlike other state compacts or the licensure reciprocity systems that work.

So as a physician, if I want to go to DC, I have got to get a DC licensed and there is a process through which I can do that and that is the way. I can't practice in DC on my own license in that phenomenon without ever getting a DC license. The Compact, when it was born, was to facilitate interstate travel for EMS people. So, like, if somebody working in Pennsylvania has to come to Maryland vocationally, they can practice in Maryland without penalty. We already allow that. The other problem with the Compact is that it requires newly certified people, newly licensed people, to undergo a background check that requires fingerprinting that we priced out at about $50-$60 per person. We must figure out how to do those 2,000 times or so. So, these are just things that we haven't sorted out. Pressure the Compact to change the rules so that the reciprocity part happens in the next way, but it doesn't allow somebody to practice in taking residence in the state. That's something that is a long-term work for that.

Will Rosenberg: So, my thoughts on Dr. Delbridge's comments and having, like I said, Arkansas, Missouri, where we practice, people do cross-line regularly, live in one state, and practice in the other. It allows ambulances to traverse the two states, especially as geographically thin as Maryland is in some areas, size-wise, not provider-wise, right? And we certainly have providers cross back and forth in the district, in Delaware, and across from the Pennsylvania line. Everything, every barrier that MIEMSS has mentioned, both Dr. Delbridge today, short of the licensing system, and in our May meeting is being put forth by our 9-1-1 partners, right? All of our commercial services are doing background checks on a regular basis. They're already paying for them. They're already doing them. They have providers, we have multiple companies here in this, I shouldn't say in this room, on this TV, that cross across mythical boundaries from Delaware, Pennsylvania, the District, and, I would imagine, let Mr. Harsh speak to it, maybe, maybe not out there into Virginia or West Virginia. But I know certainly the District, Delaware, and Pennsylvania, there's a lot of crossover and as I said, they're all compact states. I can't, you know, as the chairman, advocate enough for this. We put, and as Mr. Risoldi pointed out about barriers and losing employees, we've seen that as well. I think Mr. Stroh commented he's seen it in his organization, and I'm going to guess there are other people on this call that have lost employees through the reciprocity process into the State of Maryland. It's a way for use to get providers on the street running ambulance calls a lot quicker. The other barrier that's been thrown up by people I've heard both in and out of MIEMSS is the protocols. But for clarity, the Compact state doesn't allow you to work in your Delaware protocols in the State of Maryland. You have to work in the protocols of the jurisdiction. We are unique in Maryland. I think poorly unique in the sense that we have one state protocol for the entire state as opposed to by system and by medical directors, which is the norm I would say in my experience across the nation as opposed to the way we do it here in Maryland. Wrong, right, or indifferent, just not the norm. So, I know that MIEMSS is going to get a lot of pressure from MSFA and from the 9-1-1 jurisdictions. It's all about cost. Well, it's a shame that they're not actually doing background checks to other providers and we are. I always thought that's a dual standard. We have got to have bolts to secure oxygen. They can let oxygen hit people in the head. We have got to do

background checks. They can kill people. I mean, it's kind of one of those things. It's a little odd in the state and I'm not saying some of our 9-1-1 partners don't do background checks or hire criminals, but legally they can and we can't. It's kind of an interesting perspective. So, just my closing thoughts. Anyone else on the TV have any thoughts or anyone else for MIEMSS want to add in?

Scott Legore: I think you had a motion and a second.

Will Rosenberg: We had a motion and we were in discussion. We haven't had a vote. I was letting people finish their discussion, but thank you for keeping me on track. I often get sidetracked. So, just like anyone else, since we're mostly virtual now, I'll take any oppositions to the motion and if I don't have any oppositions, we will pass in our unanimous consent. So, anyone opposed to the motion as presented by Mr. Moretti for CASAC to support moving forward the EMS Compact to the MIEMSS leadership or EMS Board? Last call. Any objections? Okay, so the motion passed. Any other old business?

New Business – Will Rosenberg

Will Rosenberg: All right. Now onto the topic everybody wants to talk about. The State of Maryland raising more fees, but don't worry. They're not taxes folks. I'll let Scott Legore tell you.

Fee Increase – Scott Legore

Scott Legore: So, at the end of last month, we put out a notice that we were going to institute a fee increase effective January 1st, 2026 tied to the consumer price index. So, I put a little presentation together to explain the reason that we feel we need to do this and kind of give an update on where we stand. Just to start off the presentation, there are two ways established in the regulation that MIEMSS can raise the rates. The first is tied to the consumer price index, can be done yearly. It's, in essence, consumer price index is based on the previous year. You can raise your rates based on that to the closest $5 increment. And that is what we're proposing for January 2026.

Will Rosenberg: What thing of CPI, transportation, healthcare, what are you tying it to?

Scott Legore: I think it's overall. Correct?

Kelly Hammond: It's the national one.

Scott Legore: National.

Will Rosenberg: It's that national one, not even the state one. That's interesting.

Scott Legore: Right. So, the one for national was 2.9% for the previous calendar year, 2024.

Will Rosenberg: So, Pixton has a question. Go ahead Jim.

Jim Pixton: Yeah. That's incorrect. When you go to Maryland for a raise on the cost price index, you have to use the CPI for that area. Like Will said, there's transportation, there's healthcare, blah, blah, blah. You can't use a national one. Maryland doesn't even allow us to use the national one. I just wanted to make that comment.

Scott Legore: Okay. We will have to look at it, but I'm pretty sure that's the way the regulations are spelled out. So anyway, the second way is a complete regulatory change where we must go through the regulatory process to change the rates. So, those are the two that are tied to it. So, to explain where we're at, the current fees, and this is just for BLS and ALS renewals. We can break down the whole one, but these are the two major fees that are going to be impacted. So, the current fees: BLS unit is $880, ALS is $930. These fees have been in place since 2007 without any changes and then prior to that there was a consumer price index every year on back to 1998. That's as far back as I could go. And you can see the rate changed a little bit each year based on the consumer price index. Since 2007 there has not been a fee increase for the BLS renewals and the ALS renewals. There's been some modifications based on regulatory changes, like the neonatal unit dropped off when we went to a service license. We removed triage tags from it and those things, but there's been no fee increase overall since 2007.

Will Rosenberg: Mr. Pixton has a question. Yes Jimmy.

Jimmy Pixton: You know why there wasn't an increase after 2007?

Scott Legore: That is well beyond since I was here.

Jimmy Pixton: Right. Nobody there at MIEMSS remembers why or what happened or the reason?

Scott Legore: Not that I'm aware of.

Will Rosenberg: Do you know the reason, Jimmy?

Jimmy Pixton: Absolutely. So, let's just keep going. I will get to that.

Scott Legore: Okay. So, where we are at. This not only shows the SOCALR budget, but also show the reserve fund or the fund balance. Fund balance is the top line. You can see it went up in 2018, 2019, 2020, and then kind of leveled out. Then started dropping off after 2022.

Will Rosenberg: What the heck did you spend your money on in 25?

Scott Legore: We will get to that.

Jimmy Pixton: Yeah.

Scott Legore: So that's where the fund balances have gone as you can see the revenue decreased significantly and the expenditures increased. We'll talk about each one individually just so you understand where we're at and the reason we needed a fund increase. We projected this out for the physical year 26. We would be okay with the reserve fund, but for the physical year 27 we would be in the red, so that was the reason for the fee increase. On the revenue side we saw a decrease in the number of units from a high of 485 in 2021 and 22, down to a 440 in 23. We kind of tried to trace that down. Several mergers and purchases were made that resulted in an overall decrease in the number of units. One medium-sized service ended their Maryland operations and eliminated a whole bunch of ambulances. Ten services closed over the last five years which resulted in a loss of 24 units with only five new services coming in with 9 units added. We're seeing it track in the right direction. We're currently at 464 units, but again we're nowhere near where we were. We're still down 20 units from where we were in 2021 when we were at our high. And then on the expenditure side, just so you understand, salaries make up 87% of our expenditures. It covers two full-time positions, seven contractual employees, and then we pay a percentage of the MIEMSS employee salaries that support the SOCALR operations. It includes legal, executive management, finance, and IT. And then the operational costs. They make up the remaining 13% of the expenditures, including IT licenses and equipment, communications, vehicle maintenance, training, education, office supplies, and that kind of stuff. So, through 19, 20, 21, we did not have a full staff of full-time folks. So, in 19, the ambulance manager position was vacant. I came in 2020 and Lisa left in 2020. I then moved up to Lisa's position as the director, leaving the ambulance manager position vacant for more than half a year before Marty was hired back into that position. And then on the contractual side, you see the drop there in fiscal year 22. We were without a secretary for a good portion of that year, nine months before Donna was brought onboard. And then we also hired our full staff of contractual folks. We delved out some of the job duties to them and increased the number of hours that the contractual folks had. So that was some of the additional contractual hours. Operational cost.

Will Rosenberg: Go back a second. How many hours does SOCALR allocate a week? In other words, if you assume both two FTEs or the two times are 40 hours a piece that's 80, how many other hours are we paying for week on average, I understand it's obviously a variable.

Scott Legore: Yeah. So, Donna is 40 hours a week, Barquin is 20 hours a week on average, Sarah is 10 hours I think, and all the others are 10 hours or so across the board.

Will Rosenberg: What that, 200?

Scott Legore: Yeah, probably. Then a follow-up question?

Will Rosenberg: I'll hold it.

Scott Legore: Okay. Operational costs. And I don't know exactly what year these fell in, but it built into the operational cost or some one-time expenditures that were made in there. So, we delved out the airway grant to support the pediatric extraglottic airways. That was about $26,000 give or take that went out to the services. We also purchased some iPads or replaced our iPads so that we could go out and do the infield inspections. We also replaced the suction and oxygen testing equipment with the digital equipment that we now have. We were using stuff that was more than 20 years old. Then you see the one-time purchases of the vehicles. The 22 and 23 are the actual vehicle purchases and then in 24 is the charges for radio and light removal from both vehicles and the installation of the lights and radios in the vehicles. The radio cache… SOCALR purchased a 12 portable radio cache. That came out of not only the Larkin Chase incident after action report, but also some comments made during COVID, that we needed a radio cache that could be deployed for an incident. We went out and bought 12 portable radios, batteries, chargers, and all are built into a case that can be deployed rapidly if we need to do that. That's the radio cache. Questions?

Will Rosenberg: How many radios does MIEMSS have in a cache that we need 12 at SOCALR? I know that Jeff, and maybe not Jeff anymore, I guess, I don't even know who's in charge of it anymore. Special programs.

Jeff Huggins: A similar number.

Scott Legore: I think we doubled it, but we were concerned that the ones with MIEMSS wouldn't be available to SOCALR. So that was our concern with purchasing our own stand-alone. What we have done internally already is we reviewed and adjusted some of the percents of the MIEMSS staff that we cover on the budget. We reduced that by about $23,000. I did not renew four of the employee contracts for the physical year 26, so that estimated savings was $50,000 of reduction. And then we reviewed some operational expenses and have been able to identify about $10,000 in reduction that we can do for that. And with the CPI rate increase for 26, which will take place January 1st, 2026, it'll bring in about an extra $6,000 because it's only half of the physical year. So where does that put us? Where we were previously in the red for the fiscal year 27, we will now come out with a small surplus in the fund balance for 27. We have reduced it so that we carry through 27. That was the reason for the increase. That's where we're at right now. With that being said, we are talking internally. We will probably need to, as you can see here, we're still a significant upside down in our budget with expenditures compared to revenue. We will probably need to increase rates again for the fiscal year 27. We're trying to determine the extent of that and that will probably be a regulatory change. We'll probably bring something back at the September meeting.

Will Rosenberg: Regulatory change indicates you want to raise it higher than CPI.

Scott Legore: Right. If you look at that, it's$180,000 difference there. CPI, you know, is probably only going to be 3% so it ties our hands to what

percentage we could raise if we just went with CPI. We don't believe that's going to be enough to close the gap. We're looking internally on ways to reduce some additional expenditures. But the revenue side is where we are.

Will Rosenberg: How many cars are allocated to SOCALR? Vehicles, not cars, is the right word.

Scott Legore: Two, Marty has one and I have one. So, that is all that I have got. That is the explanation. I'm happy to answer any questions and I'll scroll back if need be.

Will Rosenberg: Questions from the team online?

Justin Kram: Is there no other mechanism? Maybe this is a dumb question. Is there no other mechanism to raise funds besides increased fees?

Scott Legore: I'd be happy to listen to any thoughts, but the bulk of our income comes from renewal fees. We only get one or two new individual new services a year so increasing the amount that we charge them would only bring in a minimal amount. I don't know any other option that would bring in a significant amount of money.

Will Rosenberg: Mr. Pixton has his hand up and Mr. Rosoldi would like to hear Mr. Pixton's history lesson.

Jim Pixton: Well, first off, if we were to increase the new service fee substantial, like 10 grand like other states, it stops anybody from coming in that's fraudulent, and they would take it more seriously. And you just said that the rate increases you're doing is only $6,000, even if you double that number is $12,000. If we had two new services, that'd be an additional $20,000. So, that would definitely be a revenue source if we were to raise the new service fees substantial because most companies that want to do business could afford that. Just like any of us that went to DC. We spent, in some cases, much higher than that. That's a good point. Let's fine services $10,000 for leaving patients on the doorstep. That's actually interesting because we can't fine in this state. As far as the history lesson goes, I'm not going to get into the weeds on it, but basically there was money that had been moved around and shifted. What I would say "misallocated" and they got their hand caught in the cookie jar. We ended up having a huge surplus and this was all based on what I would say "a whistle blower". I was more concerned with where all that money went over the years, but you have done a good job explaining it. But, yes, we overpaid for many, many years is the point. That's why they didn't raise the rates. They didn't want that egg on their face. But, I guess, everybody's gone now, so it is what it is. But that's what happened.

Will Rosenberg: So, my question is, since SOCALR is the only MIEMSS department that I'm aware of that's essentially self-funded, right? We provide it, right? Is it fair to say they're the only self-funded department? Who's approving, like I'm not going to get into the validity of whether you should have had 12 new radios or not, it's not what I want to fight over right now, but

my question is that's a hundred- and twenty-three-thousand-dollar capital expenditure that's really coming out of our, the 28 services' pocket. Don't you think we should have been included in that conversation?

Scott Legore: I don't know the answer.

Will Rosenberg: I didn't think so. That's why I didn't bring it there.

Scott Legore: Although, we ran it through everybody internally with MIEMSS to approve it before we went through with it.

Will Rosenberg: But essentially, Tyler and me, and everybody else on the phones, we just wrote a check for $120,000. MIEMSS isn't paying for it. We're paying for it.

Jimmy Pixton: Based on one event that the county should have handled. So, you know I'm going to agree because when this was originally set up, the State Office of Commercial Ambulance Licensing and Regulation was supposed to be between the commercial services and MIEMSS. That's what all this is about. It was never to be about a moneymaker and that's why it was self-funded. I have to agree it was never intended for anybody to spend our money like that. It's just how many times have we supported other things for MIEMSS through you guys? Like staffing from the commercial side has does for other MIEMSS groups. Like who pays for that? Do you get refunded for that?

Scott Legore: I'm not sure what specifically you're referring to.

Jimmy Pixton: Like doing clinics and giving people shots and things like take during COVID and going out & doing volunteer inspections. Things like that. Has all that changed?

Will Rosenberg: In other words, when commercial service inspectors do VAIP inspections, are we getting reimbursed from the state?

Scott Legore; The short answer to that is no, but we have not done a VAIP inspection in more than a year.

Jimmy Pixton: Right. I get that, but it's still been done for many, many, many, many, many years. It's just unfortunate I have the 35 years of experience and knowledge of all this. I understand most of you guys don't have the knowledge of any of this. Just asking. I'm not trying to argue, just asking. That's the kind of stuff that's been going on for years and we've not been reimbursed. Things were fine. Now all of a sudden everybody wants a raise.

Will Rosenberg: Right. My next question is how much overhead is MIEMSS allocating to the commercial services? You did a good job describing it but no one told us what the amount is like, what is that allocation? And what is the dollars and cents for which percentage of the 50,000, or is of 500,000. I know there's no real number, but you know, what is the real number is the question

that I am asking. For what, the percentage that we pay for the, I just want to clarify, the percentage that we pay of the MIEMSS salaries? I was really looking for the dollar sign, you can give the percentage. Well, percent or dollars.

Dr. Delbridge: Percentage comes out in real dollars.

Will Rosenberg: Yeah, that's what I'm asking.

Kelly Hammond: So, for instance, for our legal support, because she is so involved in promulgation of regulations and such, SOCALR pays 25% of her salary, which winds up around 50 grand. And then for the other support: IT Finance, Dr. C, Dr. D…

Scott Legore: I think Lisa is in there.

Kelly Hammond: Lisa Chervon for doing investigations… that is about another 50 grand. So, about 100 grand is what is outside of the SOCALR unit per year.

Will Rosenberg: So MIEMSS allocates 100 grand of cost to SOCALR. I know I'm dumbing it down, right? From MIEMSS infrastructure, overhead, whatever the right word you want to use is.

Kelly Hammond: Generally, if you want to talk about percentage wise, that amount to one to two percent for most employees who support SOCALR, IT, finance, and so forth. Then Lisa's a little more because she's more involved.

Will Rosenberg: So interestingly enough, how much does SOCALR allocate back to MIEMSS for Mr. Barquin's time? None, right? So, the allocation's only going one way.

Kelly Hammond: What is he doing for MIEMSS?

Will Rosenberg: Oh my god, if he isn't involved in fixing IT or OCS, it's never getting fixed. Mr. Barquin is a great resource to dealing with all the IT issues related to NEMESIS. He is helping with OCS. We've talked about VAIP, you know, and I hear you, Scott. No one you know has done VAIP inspections for the past year. But every VAIP inspection had a commercial inspector for the past 15 years. Would that be fair to say, Jimmy?

Jimmy Pixton: Longer than that.

Scott Legore: I'm not that old, but I don't think that's correct. But we have assisted with previous ones.

Jeff Huggins: Yes, I think specifically, at least to my team of regional programs to 09 there was basically a one-for-one exchange. We would support commercial services and from their services, would support regionals. That's how, at least for many years, I think a lot of that was basically done.

There was an assessment done and was determined to basically end up being in Washington to avoid just moving stuff back and forth it was left that way.

Jimmy Pixton: And I want to explain our hesitation. Unfortunately, we get paid a fixed rate from the insurance companies and some of those have been the same for a very long time. We can't raise our rates. Why can't you work within what you have? We do that every single day. We work within what we get and that sets how we operate. I don't think anybody in this industry would argue with me about that. Why aren't you doing the same thing? You work with what you got.

Scott Legore: I think the thought process is that we've kind of done that over the last two or three years, operating in the red without a fee increase to bring down the reserve fund, and it's now time since there hasn't been a rate increase for 18 years.

Jimmy Pixton: Well, that's because MIEMSS got caught with their hand in the cookie jar. That's what I'm telling you. So that's the issue, we had a massive surplus. What happened to that massive surplus or did we not get refunded that money and they just buried it by… oh, we just won't raise fees for 18 years? I mean, do we need to dig all that stuff back up or???

Scott Legore: This is the first time I'm hearing about any of this and I have no idea what happened in 2007.

Jimmy Pixton: Well, I'm sure MIEMSS keeps records. I maybe the only person that was here during that time.

Will Rosenberg: Ask a different question. While we still need the answer to Jimmy's question, I'm not putting that aside, so if I watched your chart, staff costs have gone up a high percentage and ambulances have gone down, so inspections have obviously gone down, so why is staff going up and revenue doing down? If revenue is driven by the number of ambulances, we should need the same or less staff. That is a pretty fair parallel, I think. The big heartache I have overall, Scott, is not the three percent. I don't know anything about what happened ten-twelve years ago, but what I do know is we all have to, and Jimmy said it best, and I would encourage some of my colleagues to chime in here, because it seems like there's four or five people talking, but we all have to operate within the revenue we get from Medicare and the it's not going up. It's CPI. That sounds great, but it isn't going up at that pace. So, if you keep trying to raise CPI every year, you're outpacing our revenue. So, we would encourage cost cuts, you know, et cetera. We don't get that. We aren't the governor. We can't wave a magic wand and just raise everybody's fees. Matter of fact, but now that I mentioned that, so thankfully, commercial services are most impacted. Now registrations 6.5%. Now we have to pay $10 on every tire we put on our commercial service. So, you're hitting us left and right. Mr. Kram had a question before I, you know.

Justin Kram: No, please continue.

Will Rosenberg: Right, and you know, like Mr. Moretti said, I don't care so much about the 3%. I'm concerned about what you're to try to come back with in September. I feel like, you know, $126,000 capital, or $122,000, I don't want to misquote it, $122,000 capital expenditure of our money absolutely should have been approved by this body. Like, I don't see any which way, I mean, you know, I mean, I own the place, so I can go spend $122,000. But most people on this call can't walk in and go buy $122,000 in radios without their funding source agreeing to it. And at the end of the day, we are the funding source, not the EMS Board, not Dr. Delbridge, not Governor Moore, not the state legislature. The funding source is right here in this room or on the TV.

Scott Legore: Okay.

Will Rosenberg: Go ahead, Mr. Kram.

Justin Kram: Obviously we have to work within the margins that we have without, you know, an increase in return for a similar length of time in many cases. And I think the other concern is that the burden is coming to us and the return on investment, it seems like, we're seeing a decrease in the number of units, decrease in the number of staffing, and we're getting less and less. I mean, perhaps, that's beyond the purview of this. I know recruiting isn't necessarily. But it seems like one this goes to legislative action; I'm concerned what the rate is going to be at that point and what are we going to get in return because there doesn't seem to be initiative to help support our efforts that can bring the revenue and that can in turn pay for these increases. That was all. Thank you.

Will Rosenberg: Any other thoughts from the group? Now's your chance ladies and gentlemen, if you have anything else to say. So, last call for thoughts on this. Do you think the body deserves a response to Mr. Pixton's question and probably not on the floor? Because, I think, well he said it, I don't know the history of it, right? So, I guess there was supposed to be a large surplus that's now missing and unaccounted for 2007? I don't know. That predates me.

Scott Legore: Kelly, do you have anything before 2018?

Kelly Hammond: I wasn't here.

Scott Legore: I know you weren't here, but what you sent me was 2018 and moving forward with the fund balance. Do you know if the records go back?

Kelly Hammond: I don't know.

Scott Legore: We can look and see what we have.

Will Rosenberg: I wasn't expecting an answer from the floor.

Kelly Hammond: In looking through historic records, prior to that, it's not as clear to me. We'll say that. We can try to put something together for prior to 2018, but those are the numbers based on state historical records that I was able to put together, that I know are completely accurate and factual.

Scott Legore: We can. We'll have to look to see, because again, I'm not familiar with whatever happened in 2007. And the numbers we tracked down were from 2018 on.

Will Rosenberg: All right, so we have some comments in the chat box. County Medical, opposes any increase in fees. Thank you, Mr. Harsh. He's got a lot of friends who are going to "thumbs up" that. And then Mr. Rosoldi said "We recently eliminated the fees for EMS personnel only affiliated with commercial services. Where did this money previously go?

Scott Legore: It went to OCS and MIEMSS. Those were the ones processing those requests.

Tyler Stroh: I just want to add one the Medicare reimbursement thing. The other problem with that, what did it go up this year? One and half percent. 1.4, I think. Yeah, and we didn't find that out until two weeks before January 1st. So, we don't know what next year's increase is going to be. We all hope that one year we're going to get a 5% increase or more. But like Will said, you go up 3% now, 3% next year, or try to do more. We're all operating on very tight margins and we don't have many 3%s to give. And then your number of units you're going to push, you know, some smaller company, you might just push their few units out because it's just not feasible. It's not sustainable.

Jimmy Pixton: Insurance is crushing everybody too. So, you got to add that in.

Tyler Stroh: We can break down our budgets, but we're all limited by the same thing. The revenue is what it is.

Will Rosenberg: Mr. Risoldi pointed out the obvious for those of us who already knew this. Provider salaries have gone up nearly double. He could probably put that into the high doubles since COVID is probably a better way of putting it, but definitely doubles. I mean, I would challenge MIEMSS to come up with some better fees rather than raising them on us. If it's going to be on new applicants, Jimmy's right, DC is like a $25,000 entry fee, you know, by the time you're all in, right?

Tyler Stroh: You guys got that under control.

Will Rosenberg: I don't necessarily disagree with Mr. Risoldi on his, although it was a joke, right? I mean, DC hands out fines if you spit on the sidewalk practically. You leave some on the front porch of a residence, you really deserve to have your company license revoked, if you ask me.

Scott Legore: That is one thing that we are pursuing. I've talked with Claire several times and we recently had the discussion with leadership as to having some type of civil penalty, not specifically for the existing commercial services, but like the ones that are operating without a license and that we issue a cease and desist for and issuing some type of civil penalty to go with those. Again, you know, depending on what we do. We did 17 of those over the last 3 years. If there was a penalty associated with those, that would bring in a little additional funds.

Will Rosenberg: The District of Columbia, and Jimmy's familiar with this and I don't know who's on from AMR … they may or may not be familiar with this, but about 4 or 5 years ago the District of Columbia handed out a quarter million dollars of fines to all the providers out there and it had to do with provider cards, licensing, and some other things. Some people got caught. There are options out there. Just raising the fee per ambulance is a good way, you know… we hear from our executive leadership and MIEMSS that commercial services help out. One meeting we hear there's not enough commercial services out there and the next meeting we want to raise the price to add another ambulance. That's counterintuitive, right? All of our 9-1-1 partners can put in an ambulance and they don't pay a fee for any of them. There's no fee to get a VAIP, or what is it, $40, what's the VAIP fee? Anybody? Oh, there is no fee. No VAIP fee. Mr. Pixton has another comment.

Jimmy Pixton: Yeah, Will, because I want to bring it up, because the same thing happened in Delaware with their BS. We rolled out, so that wiped out 10 ambulances in Delaware. I reduced out DC fleet. I'm sure we all did. So, at the end of the day, we're going to have to find a place to cut it. So, I'm going to reduce my reserve fleet. You see what I mean? So, it can cause a chain reaction that actually affect the citizens of the state because at the end of the day, we get no support. We get nothing. You know, we get nothing from nobody, and we can't keep operating that way. It's like most people's insurance. I'm hearing nightmares that people's insurances have gone up 15, 20 percent. That's a big deal. But if you have to eliminate an extra truck, then that gets eliminated when you run out of trucks. You just tell everybody, I can't come. You know what I mean? Just so they're aware, everybody's going to eliminate something somewhere to pay for everything. You know what I mean? It's no different with TraumaSoft raising their fees. We all found a way to pay for it. And it was probably eliminating something else. I just want them to know that.

Will Rosenberg: And the question is, MIEMSS has to look at itself, the more you raise the price of the ambulances, if you lose ambulance, are you not counteracting what may happen?

Zach Risoldi: It's Zach here. I just want to make one last comment. I disagree fundamentally with MIEMSS requiring MIEMSS or SOCALR to fund itself. It's much like the post office. People complain the post office loses money. It's an essential public service. It's a business. And if a disaster hits, we may not be the 9-1-1 responders, but these hospitals are going to fail without our

support. So, for MIEMSS to take the stance that commercial services are somehow not part of a safety net for the state and our neighboring states if frankly ridiculous.

Will Rosenberg: Look at the cost of stamps, but I do agree with you Zach. Any other comments, thoughts, or concerns? I guess I have one question for you Scott, and it's not a comment. So, this 3% is a done deal? We don't' have a say in the matter?

Scott Legore: Right.

Will Rosenberg: So, you guys have raised our rates without even an input and spent $120,000 of our money without any input.

Scott Legore: Right.

Will Rosenberg: Wow! That's all I have got to say is "wow". Any other new business?

Matt Larrabee: I second the "wow".

Will Rosenberg: I do like that.

For the Good of the Committee – Will Rosenberg

Will Rosenberg: Anything for the good of the committee?

Adjournment – Will Rosenberg

Will Rosenberg: Motion to adjourn. Have a great day guys.

Attendance:

In Person: Will Rosenberg, Scott Legore, Donna Geisel, Tyler Stroh, Jeff Huggins, Dr. Delbridge, Barbara Goff, Cyndy Wright Johnson, Kelly Hammond, and Christian Miele.

Virtual: Jim Pixton, Kate Passow, Bobby Harsh, Jimmy Harsh, Matt Larrabee, Mary Bell, Mike Moretti, John Pierce, Teddy Baldwin, Jonathan Siegel, Steve Rawheiser, Justine Kram, Zach Risoldi, Jeff Kreimer, Todd Abramovitz, Scott Barquin, Jodi Canapp, and April Morgan.

Caller #1: Leigha McGuin.