TESTIMONY BY MICHAEL JORDAN
MINNESOTA HOUSE HEALTH AND FINANCE POLICY COMMITTEE
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Thank you, Chair Liebling and members, for this opportunity to share my perspective on issues relating to the delivery and regulation of Emergency Medical Services (EMS). I am submitting this written summary, in addition to a brief, verbal summary that will be presented, in person, to the Committee during the hearing.

As a part of my testimony, I would like to provide the Committee with a summary of my background. An understanding of the context which forms my perspective, is fundamental to the formulation of the observations, analysis and recommendations that will be presented. It will also substantiate the relevance and validity of my testimony. The summary is as follows:

- Educational Experience – Bachelor of Arts Degree, with a minor in Physics (University of Minnesota, Institute of Technology); Master of Science in Management (Stanford University, Graduate School of Business); Juris Doctor Degree (University of St. Thomas, School of Law);
- Business Experience – Over forty-five years of management experience, in a variety of for-profit, non-profit and governmental enterprises. Most pertinent, relative to this testimony, is my experiences as the (1) Commissioner of the Minnesota Department of Public Safety and (2) Director of a $150 Million Business unit, within a Fortune 100 company, overseeing and coordinating the functional operations of marketing, sales, engineering, product development and manufacturing;
- Emergency Medical Services Regulator Board (EMSRB) Experience – Appointment as the "public member" of the Board in 2009, and continued occupancy of that position, year to date. There is 1 public member in the context of 15 other members who are elected officials, appointed officials and representatives (generally employees or past employees) of various aspects of the "emergency medical services industry". To that point, all of the other members are potentially at greater risk of being susceptible to (1) conflicts of interest and (2) the negative impact of undue and improper

influence generated by affiliation and/or prior relationships. Finally, there have been three Executive Directors, of the Board, during my tenure.

I would now like to focus the remainder of my testimony on three subjects that may be of relevant concern to the Committee, related to the current condition of the EMS in Minnesota and potential issues that may need to be addressed, in order to rectify, mitigate, and/or manage that condition in order to maintain a high standard of health and safety to the public. Those subjects are:

- Factors impacting the current, and future, performance of the EMS industry;
- General comments relative to the role of the EMSRB in the EMS industry;
- Recommendations relative to the modification of the current statute, Minnesota Statutes, Chapter 144E, establishing and governing the operation of the EMSRB.

In regard to the ***current status of the EMS industry***, I freely admit that there are many individuals, including the Executive Director of the EMSRB, other members of the Board, and industry professionals who are actively involved and/or employed in the industry, who have greater knowledge, experience and expertise relative to this subject. Additionally, this discussion is of a qualitative nature, rather than an extensive quantitative analysis (which I would have preferred, but such an analysis was not reasonable given the short time frame available for the preparation of this testimony and the lack of access to information relating to the financial, demographic, and other operational parameters of the participants in the industry). However, as a comparatively 'objective' and 'outside' observer, I would to highlight the following issues, which I believe are of critical concern:

1. The EMS industry segment, composed of ambulance services, is fragmented with the primary market participants being defined as one of the following; (a) directly/indirectly affiliated with a medical institution (eg. hospital), (b) controlled by a municipal fire and/or emergency response department, and (c) Independent/privately-owned by an individual and/or small corporate entity;
2. Each of these service participants has significantly different operational and financial parameters, particularly related to the implications of revenue, expense, and profit. For example, a *large medical institution*, due to its

superior financial structure and market power, can take advantage of the ability to position its ambulance service as a "loss-leader", both from a perspective of operations and negotiating with health insurance entities vis-à-vis cost reimbursement. In regard to *municipal-related services*, certain costs can be absorbed and/or shared as part of the overall operational portfolio (eg. fire fighters can fight fires and they can respond to emergency health-related situations). Additionally, there is an ability to utilize the taxing authority as a means to 'generate additional revenue'. Finally*, independent/privately-owned services* do not have the financial and operational options, and/or the flexibility of their counterparts. They must operate under a much more stringent revenue/cost/profit business model. Their inability to consistently generate necessary profits will expose them to the possibility of the service ceasing to operate;

3. Even though the large services, usually but not necessarily affiliated with medical institutions, have significant financial leverage and operational advantages, they most often make operational decisions, related to what geographic areas to cover, what services to offer and what financial investments to consider, based on a return-on-investment analysis. This is the same for the independently-owned services. Simply put, if they can't make money providing a specific service, they simply won't offer it. Of course, this issue is not as relevant and impactful to municipal services, but they must also be cognizant of the revenue/cost/profit implications of their operational decisions. This also applies to the smaller/independent services;
4. The geographical implications, related to the operation of the varying types of service are significant. Parameters such as; gross population, population density, point to point distances, existing property tax base, age demographics, size, skill, and growth/decline of the labor force and the socio-economic status of the population base all have significant influence on the potential financial and operational viability of an ambulance service. In many rural areas of Minnesota, several of these parameters are trending in a 'negative' direction, with potentially adverse effects;
5. Within the context of geographical considerations, the current EMS model incorporates the concept of Primary Service Areas (PSA). These PSA's are described in statute and rule (MN STAT 144E.06 and 144E.07 and Rule

4690.3400). While the use of specifically assigned areas of service coverage has certain advantages, there are also potential disadvantages that should be examined. These include: (a) The PSA provides a given ambulance service, in point of fact, with a 'monopoly' on the provision of EMS to the residents of that PSA; (b) the fees for ambulance service, within the PSA, are non-transparent (not posted, accessible for review) to the public and are not subject to any competitive and/or market forces; (c) the non-competitive environment of the PSA model allows ambulance services to institute a fee structure, to the end-user, that is decoupled from the actual expenses that the service may incur (eg. licensing fees from the EMSRB) which may allow for the potential to extract excessive levels of profitability, for an entity that is offering a public safety service; and (d) For-profit ambulance services are allowed, by statute (MN STAT 270A.03, Subd.2), to utilize "Revenue Re-Capture (via the Department of Revenue) to implement collection of unpaid ambulance billings;

6. The implications of these factors are particularly relevant when considering the operation, and financial viability, of ambulance services in urban versus rural geographies. The financial strain on services serving rural areas has been evident for a sustained period of time, with service closures (and the resulting negative impact on public safety) occurring with some regularity;
7. As a method to offset the financial, density, and labor force factors, the use of volunteer first-responders has been utilized by many services, most particularly in rural areas. However, several economic factors (eg. loss of employment opportunities, reduced wages/salaries, COVID-19) and demographic factors (aging workforce, out-migration of younger people, net decline in population, reduction in the amount of discretionary time available to individuals) are making reliance on volunteer resources less reliable and sustainable as an operational strategy;
8. The combined affects of negative economic indicators, changing demographics, and the increasing difficulty in the implementation of volunteer staffing options, at the sufficient scale, suggest that the efficacy and sustainability of EMS in rural Minnesota will be under increasing levels of financial stress, in comparison to their urban counterparts. A significant level of consideration, analysis, and action should be focused on this issue.

Those considerations should include the development of non-traditional funding streams and consolidation of existing services, at minimum.

The next section of my testimony relates to the ***role of the EMSRB, relative to the EMS industry***. The mission statement of the EMSRB, *"…to protect the public's health and safety through regulation and support of the EMS system"*, provides a description of the role. Additionally, the duties of the EMSRB are stipulated in statute, MN STAT, 144E.01, Subd.6. In summary the primary responsibility of the EMSRB is to "administer and enforce" the provisions of the statute. There are other duties and responsibilities that are defined and/or suggested as "support". However, these duties should be considered as secondary to the administration and enforcement function. It is important to recognize that there is a potential that the imposition of secondary functions, without a corresponding increase in financial and human resources, will dilute the agency's ability to execute its primary function. Currently, the EMSRB may be approaching that point of inflection.

Additionally, the risk of 'mission creep', in such a situation, is substantial. The assignment and execution of duties, other than those related to firstly, "regulation" and secondarily, "support", can become conflicting, counter-productive, and may result in the diffusion of limited resources. "Those who would defend everything defends nothing". Therefore, it is imperative that any such diversions of effort be avoided, whenever possible;

A major point of consideration, in regard to the EMS industry and the role of the EMSRB in that industry, is the manner in which ambulance services function. Simply put, their primary function is to transport a person, who has suffered an injury and/or who is experiencing a medical emergency, from where they are to a place where they can obtain necessary and sufficient medical care, eg. a hospital. The ambulance is a temporary, albeit significant, life-saving, intermediary measure. Therefore, in relationship to the safety services provided to the public, my observation and analysis suggests that there are three basic important, operational tenants, related to ambulance service that must be administered and regulated by the EMSRB. Those tenants are as follows:

1. The <u>competence</u> of the first responders – primarily addressed by MN STAT 144E.27 [registration and discipline] & 144E.28 [certification and training];

2. The <u>effectiveness and efficiency</u> of the transport equipment (ambulance) – primarily addressed by MN STAT 144E.10 [licensing and equipment], 144E.18 [inspections] & 144E.19 [discipline];
3. The <u>timeliness</u> of the arrival of the first responder and treatment – this tenant is not specifically addressed by statute. Rule 4690.3400 offers general guidance, but no specific requirements.

The issue of the timeliness of the availability of necessary medical treatment is of critical importance. The obvious example of a person suffering a stroke or heart attack illustrates the importance of ensuring the most immediate arrival, and application, of medical assistance that is practicable. Equally obvious is that factors, such as of point-to-point distance, population density, and availability and allocation of equipment and human resources, are major contributing considerations in ensuring the appropriate level of public safety.

This brings me to the final section of my testimony, regarding the ***modification of Chapter 144E,*** in order to enhance the already effective performance of the EMSRB. Let me be clear, major changes in the statute are not required. Additionally, discussions related to "what agency", if any, should EMSRB be hosted are also unnecessary and present inappropriate distractions at this point in time. However, there are several operational conditions that require further analysis and evaluation, and perhaps legislative action. Those considerations are as follows:

1. <u>Re-structuring the membership of the Board</u> – MN STAT 144E.01, Subd.1 specifies the membership. There are 16 members in total. From my perspective, this is an unwieldy, and inefficient, number. The desire for 'industry input' is understandable, but that can be achieved via other methods. Additionally, the applicant pool for membership are often employees (or past employees) of the very ambulance services that are to be regulated. Further, due to its insular nature, many of the industry participants have long-standing affiliations and/or relationships with one another. Finally, industry associations and their hired lobbying entities exert, what could be, undue and inappropriate influence on Board members and staff. These factors create opportunities for conflict of interest, self-dealing, and application of undue influence that should be

avoided. In considering a change in the EMSRB structure, and membership composition, other state-sanctioned regulatory agencies could be evaluated as potential models. The Public Utilities Commission is one example. There are 5 Commissioners who evaluate proposals from the entities that are regulated. There are no Commissioners who are closely connected to the industries (telecommunications, electricity and natural gas) that are being regulated. Additionally, there are other models, such as Liquor and Gambling Control (Department of Public Safety) that regulate industries, without having participants of those industries in policy making and/or administrative roles relative to the regulatory activities;

2. Managing changes in the EMS industry composition and requirements - MN STAT 144E.01, Subd.6 provides for the Board to "make recommendations to the legislature on improving the access, delivery and effectiveness of the state's emergency medical services delivery system". However, the resources and expertise required to thoroughly develop a relevant and appropriate set of recommendations is beyond the current capabilities and resources of the EMSRB staff and board membership. Such an undertaking would require substantial, additional financial and human resources. However, implementation of such a research endeavor does not necessarily mean the appropriation and expenditure of additional state funds. Such an endeavor would be an ideal candidate for the "Loaned Executive Program" concept introduced in 1972. Another scenario for implementation action would be that Minnesota corporate entities could provide the funds and/or human resources for the task. Or, one of the many business consulting firms, operating in Minnesota, could take this on as a public service project. Or, finally, the State Legislative Auditor would also be a reasonable entity to conduct such a research analysis. Regardless, such an undertaking is necessary, given the age of the current statute and the need to prepare to adapt to changing conditions, in the EMS industry environment, that are confronting us now, and will continue to escalate in the future;
3. Re-examing the fee structure for issuing ambulance licenses - MN STAT 144E.29 stipulates the fee structure for ambulance licensing. The "initial application for, or renewal of, an ambulance service license is $150.00". Additionally, "each ambulance operated by a licensee, $96.00". "…All fees are for a two-year period". Given the extreme variability between the

levels of revenue and profits that an ambulance service can generate, based on such factors as; geography served, number of ambulances in service, affiliation with a major medical institution, profit vs. non profit status, and urban vs. rural location, it would seem prudent to analyze the relevance and rationality of the existing licensing methodology. Additionally, should a 'revised' licensing model incorporate a methodology whereby large (often urban) ambulance services would assist in the financial underwriting of small (often rural) ambulance services (a variation of "local government aid")? Finally, instead of the current circumstance, where the ambulance license fees are "deposited as nondedicated receipts in the general fund", one could examine a scenario where those funds could be allocated as operating revenue to support the "administrative and enforcement" actions of the EMSRB;

4. Ensuring receipt of relevant input and/or feedback from all stakeholders, including industry participants, municipal governmental entities and consumers of the service (eg. people who utilize ambulance services) - MN STAT 144E.16, Subd.5 stipulates a process whereby "local governments may…establish standards for ambulance services which would impose additional requirements upon such services". This aspect of the statute could be modified to simultaneously obtain input from municipalities and users of ambulance services, and still incorporate a mechanism for industry participants to provide the necessary input that would ensure that their concerns are acknowledged and their interests are represented.

This concludes my testimony. Thank you, again, for this opportunity to present by observations and recommendations. I look forward to the opportunity to respond to your comments and questions.

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