TESTIMONY BY MICHAEL JORDAN

PUBLIC MEMBER, EMERGENCY MEDICAL SERVICES REGULATORY BOARD  
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 testimony, in addition to a brief, verbal summary that will be presented, in-person, to the Committee during the hearing (**the in-person presentation did not occur due to time constraints**).

As a part of my testimony, I would like to provide the Committee with a condensed version of my biography. An understanding of the context which informs my perspective is critical to evaluation of the observations, analyses and recommendations that will be presented. It will also help substantiate the relevance and validity of my testimony. The biographical information 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 Degree (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 organizations. Most pertinent, relative to this testimony, are my experiences as the (1) Commissioner of the Minnesota Department of Public Safety and (2) Director of the Honeywell, Inc. Residential Controls Original Equipment Manufacturing Business Unit, supervising and coordinating the functional operations of engineering, factory production, marketing, product development, and sales;
* Emergency Medical Services Regulatory Board (EMSRB) Experience – Appointment as the “public member” of the Board in 2009, and continued occupancy of that position, to date. I am the only “public member” in relation to 16 other members who are either elected officials, appointed officials (or their designees), and representatives (generally employees or past employees) of various aspects of the “emergency medical services industry”. To that point, the public member is the only representative on the Board, who by statute, is specifically charged with singular allegiance to the interest of the “public” rather the interests of an ‘occupational’ entity or responsibility. Finally, there have been three Executive Directors, of the Board, during my tenure.

Before presenting the specifics related to my observations, analyses, and recommendations, I would like to summarize and enumerate my recommendations for legislative attention and action.

1. *Restructure the composition of the EMSRB; increasing the number of “public members”, decreasing the number of “industry-related members”, and decreasing the total membership.*
2. *Emphasize the purpose of the EMSRB as a “regulatory” agency. The focus should be on “enforcement and administrative” functions. “Support-related” functions should be minimized.*
3. *Establish a process whereby local government agencies may contribute to the development of “performance-related” metrics (eg. response time) to ensure EMS provider accountability.*
4. *Reconfigure the structure and amount of licensing fees, to ensure that they are more representative of the financial realities and/or opportunities of the current EMS marketplace.*
5. *Require for-profit EMS providers (ambulance services) to make their pricing structures more transparent to the public. Eliminate the “Revenue Recapture” provision from statute.*
6. *Establish a process to identify and implement strategies to ensure that the availability and sufficiency of rural EMS does not degrade to unacceptable levels, due to financial pressures.*

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;
* Comments relative to the role of the EMSRB in the EMS industry;
* Recommendations relative to the modification of the enabling legislation, Minnesota Statutes, Chapter 144E, which governs 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, whose knowledge, experience and expertise relative to this subject exceeds my own. Additionally, this discussion is of a qualitative nature, rather than an extensive quantitative analysis (which would be preferable, 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 needed to support a thorough evaluation). However, as a comparatively ‘objective’ and ‘outside’ observer, I want 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) operated by a governmental fire and/or emergency response department, and (c) Independent/privately-owned by an individual and/or corporate entity;
2. Each of these market 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 *governmental 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. So, they must operate under a more stringent revenue/expense/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 larger 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 smaller/independently-owned services. Simply put, if they cannot realize a consistent profit by providing a specific service, they probably won’t offer it. Of course, this issue is not as relevant and impactful to governmentally operated services, but they must also be cognizant of the revenue/expense/profit implications of their operational decisions;
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; labor force (size/skill level/growth or decline); and the socio-economic status of the population base all significantly influence 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 & 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 not transparent (not posted or easily 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 significant 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 Recapture” (via the Department of Revenue) to accomplish the 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 impact of financial, population density, and labor force issues, the use of volunteer first-responders has been utilized by many services, most particularly in rural areas. However, several factors, including; **economics** (eg. loss of employment opportunities, reduced wages/salaries, COVID-19), **demography** (aging workforce, out-migration of younger people, net decline in population, reduction in the amount of discretionary time available to individuals), and **training-related activities** (which require a continually increasing amount of dedicated time/effort to acquire and maintain the skills required for qualification as an EMS responder) 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 functions. It is important to recognize that there is a potential that the imposition of additional secondary functional responsibilities, 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 the point of inflection.

Additionally, the risk of ‘mission creep’, in such a situation, becomes substantial. The assignment and execution of duties, other than those related firstly to, “regulation” and secondarily to, “support”, can become conflicting, counter-productive, and may result in the diffusion of limited resources. Therefore, it is imperative that any such tertiary diversions of focus and effort be avoided, whenever possible. This will require stringent efforts, relative to prioritization of the allocation of funds and human resource, related to administrative and enforcement actions by EMSRB staff, policy decisions by the membership of the Board, and the structure of the enabling legislation and administrative rules.

A major point of consideration, in regard to the EMS industry and the role of the EMSRB in regulating 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 and intermediary, albeit significant, life-saving measure. Therefore, in relationship to the safety services provided to the public, my observations and analyses suggest that there are three major operational tenants, related to ambulance service, that must be administered and regulated by the EMSRB. Those tenants are as follows:

1. The **competence** of the first responders – primarily addressed by MN STAT 144E.27 [registration and discipline] & 144E.28 [certification and training];
2. The **effectiveness and efficiency** of the transport equipment (ambulance) – primarily addressed by MN STAT 144E.10 [licensing and equipment], 144E.18 [inspections] & 144E.19 [discipline];
3. The **timeliness** of the arrival of the first responders 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 arrival of intermediary medical treatment is critically important. 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 point-to-point distances, population density, and availability and allocation of equipment & human resources, are major contributing considerations in ensuring the appropriate level of public safety, in regard to the timeliness of EMS arrival. Therefore, it follows that some system of metrics must be imposed that will specify and measure the tenant of timeliness. Additionally, those metrics must provide a means to establish and enforce system accountability.

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, modification of the current statute is required. However, discussions related to cosmetic issues, such as ‘in which agency’, if any, should EMSRB be hosted are unnecessary and present inappropriate distractions at this point in time. Given that perspective, there are several operational conditions that require further analysis and evaluation, and that may result in legislative action. They are as follows:

1. Restructuring the membership of the Board – MN STAT 144E.01, Subd.1 specifies the membership. There are 17 members (public membership = 6%). From my perspective, this is an unwieldy and inefficient number, and composition of membership is ‘skewed’ in favor of industry participants (for the sake of comparison, consider the following similarly positioned regulatory/licensing boards: *Board of Cosmetology ,* 7 members, public membership = 14%; *Board of Dentistry*, 9 members, public membership = 22%; *Board of Medical Practice*, 16 members, public membership = 31%); *Board of* *Pharmacy*, 9 members, public membership = 33%; *Board of Psychology*, 11 members, public membership = 27%). The requirement and/or desire for industry ‘input’ and ‘expertise’ to be available on pertinent matters is understandable. However, that requirement can be achieved by methods other than simple, numeric representation. Additionally, the applicant pool for board membership often consists of employees (or past employees) of the very ambulance services and/or medical-related institutions that are to be regulated. Further, due to its insular nature, many of the industry participants have long-standing business affiliations and/or personal relationships with one another. Finally, industry associations, and their hired lobbying entities, could potentially exert undue and inappropriate influence on Board members and staff. These factors create an unacceptable risk of opportunities for the; (a) reduction of regulatory effectiveness, (b) need of Board members to recuse themselves from significant policy discussions and decisions, (c) existence of conflicts of interest, and (d) potential for self-dealing. **The mitigation of the potential for ‘regulatory capture’ and the elimination of** **any appearance of impropriety must be an imperative**. When considering a modification of the EMSRB structure and membership composition, to achieve that imperative, other state-sanctioned, free-standing, regulatory agencies, such as those previously stipulated, could be evaluated as potential models. Further, the Public Utilities Commission (PUC) represents an additional model for comparison. In that case, there are 5 Commissioners who evaluate proposals from, and provide oversite of, the entities that are regulated. In this situation, none of the Commissioners are closely connected to the industries (telecommunications, electricity and natural gas) that are regulated. Finally, there are other potential models, located within a state-sanctioned agency (eg. Liquor and Gambling Control in the Department of Public Safety), that regulate industries without having participants, who are working in or affiliated with those industries, in policy making and/or administrative roles related to the agency’s regulatory activities;
2. Managing changes in the EMS industry composition and operational 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, appropriate, and actionable 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. Additionally, the entity charged with researching and developing the recommendations should have significant experience of successful completion of research projects of a similar nature, demonstrating a high degree of objectivity and thoroughness. However, implementation of such a research endeavor does not necessarily require the appropriation and expenditure of additional, and substantial, state funding. Such an endeavor would be an ideal candidate for the “Loaned Executive Program” concept, first introduced in 1972. Another scenario for implementation action would be that Minnesota corporate entities could ‘donate’ the funds and/or human resources required to accomplish the task. A third scenario could be that 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, and provide relevant recommendations. Regardless of the methodology that is selected, such a research project is necessary, given the age of the current statute and the need to prepare for adaptation to the changing conditions in the EMS industry environment, that are confronting us now, and will continue to escalate in the future;
3. Reexamining the fee structure for issuing ambulance licenses - MN STAT 144E.29 defines the current 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” (for the sake of comparison, consider the following similarly positioned regulatory/licensing boards: *Board of Cosmetology*, **Practitioner** - $195.00 initial fee, $145.00 renewal fee on 3-year cycle, **Salon** - $250.00 initial fee & $225.00 renewal on a 3-year cycle; *Board of Dentistry*, initial application fee = $140.00 + license fee = $168.00, total fee = $308.00, license is renewed annually; *Board of Medical Practice*, initial fee = $200.00 & annual renewal fee = $192.00; *Board of Pharmacy*, **pharmacist** = $175.00/**pharmacy** = $260.00/**wholesaler** = $5,260.00 [fees for each category are for the same for initial licensing and annual renewal]; *Board of Psychology*, initial fee = $250.00 & annual renewal = $250.00). 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, rationality, and equity of the existing licensing methodology and fee structure. Additionally, a ‘revised’ licensing model, incorporating a methodology whereby large [often urban] ambulance services would assist in the financial underwriting of small [often rural] ambulance services (a potential modification of the general concept of “local government aid”), should be examined. Finally, instead of the current circumstance, where the ambulance license fees are “…deposited as nondedicated receipts in the general fund”, a scenario should be examined in which those funds would be allocated as operating revenue to support the “administrative and enforcement” activities of the EMSRB;
4. Ensuring receipt of relevant input and/or feedback from all stakeholders, including industry participants, local governmental entities, and consumers of the service (eg. people who utilize ambulance services) - MN STAT 144E.16, Subd.5 stipulates that “local governments may…establish standards for ambulance services which would impose additional requirements upon such services”. It is logical to assume that such standards and/or requirements would include metrics related to the performance of ambulance services related to such parameters as ‘total response time’ (eg. elapsed time from *receipt of 911 call* + elapsed time from dispatch of the ambulance to the *arrival of the ambulance at the scene of the incident* + elapsed time from ambulance departure from the incident scene to *arrival at the hospital or final treatment destination*). However, to date, no process or methodology has been initiated to implement this portion of the statute. This section of the statute should be modified to specify the development and implementation of a methodology to simultaneously obtain input from local governments, end-users of ambulance services, and industry participants to ensure that all of the necessary input would be obtained, and that the concerns/interests of all stakeholders are acknowledged and represented.

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

Michael Jordan

EMSRB Public Member

Michael.S.Jordan@state.mn.us

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