TESTIMONY BY MICHAEL S. JORDAN

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MINNESOTA HOUSE HEALTH AND FINANCE POLICY COMMMITTEE

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Thank you, Chair Liebling, and Committee members, for this opportunity to share my perspective on issues relating to HF 2736/SF2691. Unfortunately, I am unable to attend today’s hearing in-person, and, therefore, must forgo the opportunity to respond to questions that the Committee members may ask for purposes of obtaining additional information and/or to request clarification of the information presented. Hopefully, such opportunities will present themselves at a later date.

Previously, in my position as the Public Member (my term expired on January 2021, and I attended my final meeting in June 2022) of the Emergency Medical Systems Regulatory Board (EMSRB), I prepared three publicly available documents on various issues confronting the Board. These documents were focused on; (1) the current, contextual environment facing the EMS Industry (25 January 2021), (2) a response to HF34, which proposed potential modifications to the operation of the EMSRB, (23 February 2021), and (3) comments regarding the February 2022 Office of the Legislative Auditor (OLA) Evaluation Report on Emergency Ambulance Services (11 March 2022). For the convenience of the Committee members, these documents are included with this testimony.

In regard to the subject legislation, I am generally in agreement with the specific components that are detailed therein, and the legislative intent that they suggest. As a point of fact, many of the provisions contained in the proposed legislation are very similar to, if not identical to, several of the action steps that I suggested in the documents that were previously referenced. Additionally, many of the components in the proposed legislation are consistent with the findings and recommendations of the OLA Report, as was the case with my document (1).

Before proceeding with my direct testimonial comments, I would like to offer the Committee the following admonition. Please pay particular attention to analyzing, and balancing, the trade-offs between (a) the business-related parameters proffered by the EMS providers and their lobbyists and (b) the unequivocal need to provide adequate and timely EMS to all of Minnesotans, regardless of their financial capability and geographic location (with special consideration for addressing the particularly difficult and complex issues facing many ambulance providers in rural Minnesota). I implore you to evaluate the various testimonial arguments, and other sources of information that you may receive, in such a manner that achieving the highest degree of ‘public safety’ is the primary criterion for all decision-making and operational methodology within the EMSRB.

That said, for the purposes of this testimony, I will focus my supportive, and detailed comments, on the following components of the proposed legislation:

1. Incorporation of direct involvement by municipalities in the development of performance metrics and provision of EMS – described in Sections 7 & 11;
2. Integration of successful execution of performance standards into the Ambulance License Renewal Process – described in Section 14; and
3. Requirement of Ambulance licensees to make “fee schedules” for services provided available to the public – described in Section 14.

In regard to the first component, it is my conclusion that a significant level of input from those who are the ultimate ‘consumer’ of EMS, relative to how those services are delivered, is of great importance. Recently, there has been some conversation relative to the dearth of public input to and/or representation on the EMSRB. This is evidenced by the OLA report, and my comments as the only “public member” on the EMSRB. Additionally, it is instructive to note that the position of “Public Member”, on the Board, has been vacant since June 2022.

Therefore, it seems both prudent and practical that elected and/or appointed municipal governmental officials are an appropriate surrogate for obtaining such input. For example, Fire Chiefs, from several municipalities, have continually requested the opportunity to provide such input, in addition to critical observations on the provision of services, often with little to no success. The time has come to implement a solution to this situation, which could potentially result in sub-optimal delivery of EMS to the ultimate consumer.

Relative to the second component, the development and incorporation of relevant and impactful performance metrics, for example “response time”, for monitoring service levels and providing a means for ensuring accountability is crucial. With this proposed legislation, those performance metrics and/or standards are additionally, and appropriately, utilized to evaluate EMS providers in relation to their renewal process. In the past, the renewal process was often completed without the application and evaluation of objective criteria that would justify a decision to approve or decline the renewal application. This proposed action would provide a significant improvement to the current renewal process.

As an aside, industry participants may raise the argument that technological methodologies, such as ‘dynamic scheduling’ are superior to the reliance on monitoring “response times”. That argument should be challenged! Police and Fire agencies have established and monitored response times for decades, and more importantly, held themselves accountable to consistently adhering to them. For the sake of illustration, in the fire service, if the response to a building fire is not accomplished within a specified time, and sufficient fire suppression action implemented, the structure will be destroyed and life safety will be jeopardized. Similarly, relative to EMS scenarios, in the case of stroke, heart attack, and other life-threatening maladies, if appropriate medical attention is not received within a specified timeframe, the likelihood of patient survival and/or the ability to prevent or mitigate serious injury or other adverse outcomes is significantly decreased.

Finally, regarding the third component, there is a significant history of the high number, and frequency, of anecdotal episodes describing members of the general public being unpleasantly ‘surprised’ when receiving an ambulance bill for a significant amount of money. This level of surprise could possibly be explained by (1) the general assumption (perhaps unjustified) that an ambulance response to a 911 call would be free, just like a response from the police or fire department and (2) the fact that there is little to no transparency regarding the actual costs incurred due to ambulance transport, until after the event has occurred. However, those disclaimers do not provide a justification for such ‘surprises’ to continue to negatively impact the users of EMS.

Therefore, the requirement to make “fee scale” information available to the public appears to be a reasonable and effective means to enhance the level of transparency. There may be negative consequences. Individuals may choose to avoid calling 911, due to their inability and/or unwillingness to incur the cost. However, concern relative to those outcomes should not outweigh the need for transparency. Individuals should be positioned to make informed decisions.

Further, from a tangential perspective, the issue of “revenue recapture” is a relevant topic for inclusion in this general discussion. Again, as a matter related to the enhancement of transparency to the public, and good legislative policy, the application of this governmental power should not be available to private ambulance services. This is not to say that these private enterprises should forego the collection of revenue that is justly due to them. However, it is to say that the government should not be allowed to function as their collection agency.

This concludes my testimony, at this point in time. I look forward to the opportunity to provide additional commentary and engage in further dialogue, with Committee members at their convenience.

Respectively,

Michael Jordan

Former Public Member, EMSRB