*Executive Offices*
1622 E. Interstate Ave.
Bismarck, ND 58503

(701) 221-0567 Voice
(701) 221-0693 Fax
(877) 221-3672 Toll Free
www.ndemsa.org

June 2, 2010

Testimony – Public Safety Interim Committee
North Dakota EMS Association
Mark Weber, NDEMSA

Good Morning Chairman O'Connell and members of the committee. My name is Mark Weber; I represent the North Dakota Emergency Medical Services (EMS) Association and also the EMS Director at the Heart of America Medical Center in Rugby. Thank you for the opportunity to testify today.

I was asked to present information on; A statewide funding plan for emergency medical services.

In the past I have presented information to the committee regarding the following items.

- Developing EMS primary service funding areas with at least one transporting ambulance service in each area and based on the definition of Reasonable EMS
- A funding formula based on expense vs. revenue for no more than one transporting ambulance and related services to meet the definition of Reasonable EMS for each primary service funding area
- Requiring each primary service funding area provide a local match based on population to access state funding
- Replacing the EMS staffing grants through the Dept. of Health with EMS primary service funding area payments
- Providing $12 million from the Insurance Tax Distribution Fund for EMS primary service funding area payments

Today I would like to provide further detail so we can improve the draft bill and move closer to a long term solution. We believe the proposed funding should be considered "funding assistance" or "permanent funding" rather than a grant program. A grant insinuates that the program is temporary and a

funding source that is temporary is not a long term solution. When the current funding program was developed, ND EMS needed a temporary solution to help ambulance services hold on until a permanent solution could be developed. We believe the development of the 88 primary service areas and the funding formula will be the long term solution we were looking for. We would like the legislature to make funds available to all service areas that can show the need based on their expenses vs. revenue. Every service area that is in need of financial assistance will need to hold to minimum standards and be held to those standards.

The purpose of transitioning to the 88 primary service areas is to assure access to reasonable EMS and for the distribution of financial assistance to ambulance services that cannot generate sufficient local revenue to sustain reasonable EMS within their service area. There may be multiple ambulance services within a primary service area; however minimum financial assistance should be calculated to assure sufficient funding for at least one transporting ambulance within the service area and or reasonable EMS.

Reasonable EMS should be defined as an ambulance service in every community that has a hospital or a population greater than 1000. A community that has a population of 500 to 999 and are greater than 15 miles from the next closest community with a ambulance service should have some form of EMS, (licensed ambulance service, a sub-station or a Quick Response Unit). In urban areas an overall response time of less than 9 minutes 90% of the time. Ambulance service coverage for the highway corridors and rural areas of ND within 20 minutes 90% of the time and all other areas (frontier) covered within a 30 minute overall response time. A 10 minute out the door time should be calculated into the rural, corridor and frontier areas.

In service areas with one transporting ambulance, that ambulance service should be designated as the primary transporting agency. (based on minimum standards). There are approximately 62 primary service areas that will have one ambulance service in the area and approximately 26 areas with multiple services in the area. This would designate 62 ambulance services as the primary ambulance services, allowing them to build a system within the area without worrying about another service coming into the area providing fewer services (first responder system, emergency preparedness), and stabilizing ND EMS services.

The legislation should include a formula to determine the amount of assistance each service area is eligible for. This should be a simple formula based on revenue vs. expense with the revenue including a local match from 10 to 90% of the budget. Revenue needs to include a local match as well as revenue from services (billable revenue). Each service receiving assistance must be maximizing their reimbursement, have policies addressing how rates are set, how the rates are changed and a collections policy. We believe the local match should be based on a flat figure of $10.00 per citizen in each service area. If a service area has 2,000 citizens in its boundaries they would be responsible to generate a local match of $20,000 (maximum). This would be figured in their budget as part of their revenue. If a service area currently generates more than the designated match, they could decrease the amount of mills collected creating a tax relief.

Expense should be based on actual costs of providing the service. Taking into account all costs associated with an ambulance service. The budget should including revenue and expenses, based on a template budget that outlines allowable funding across multiple line item categories (see budget template). The formulas should be based on a percent average taken from multiple ND ambulance services in 2010. There are many ambulance services that pay providers to cover their 24/7 coverage or a manager to manage their business and sometimes both. Some of these ambulance services have expenses of $120,000 to $150,000annually and they can only generate $ 30,000 to $40,000 in billable revenue. The formula would calculate expense vs. revenue. The shortfall would be the amount the service area is eligible for. (no grant application or outside agency determining which service deserves it more than another)

Use of funds should be defined. Funds should be used to support the ambulance service based on a standard average EMS budget. We need to keep the allowable costs within limits. We can't allow one service to pay their manager thousands of dollars and have poor or no equipment or training. We also can't have services spending all their money on equipment and supplies and not be covering the required 24/7 coverage. (not enough providers). Their budget should be based on a reasonable amount per budget category. For example they could spend 50 to 65% on wages, 15-20% on ALS intercepts, 5-10% on capitol purchase. This would be based on an average budget of multiple ND Ambulance services.

We believe each primary service area should have an oversight committee or board they report to. We cannot develop a funding assistance program without oversight of the funds. We believe it should be the responsibility of the citizens, businesses, local government, EMS agencies within the service area

to help with the process. Most ambulance services already have a board or oversight committee. It is a national standard to have an oversight committee for an ambulance service that is contracted (receiving local, state funds) in a service area. The board or oversight committee would help set standards, and monitor the standards on a regular basis. The ambulance service manager would report to the committee/board. Provide reports on budgets, call volume, performance of patient care.

A simple formula should be utilized to distribute the funds to each service area. Once the allowable amount has been calculated (expense vs. revenue formula) each primary service area would develop a template budget including expense and revenue, a business plan that includes plans to meet the minimum standards required by the oversight committee or board. They would calculate what percent of their service area is in each county, and then divide the allowable amount into each percentage.

Here is an example of how one service area funding distribution formula might look;

1) Primary service areas are not determined by county lines. (reasonable EMS and the closest ambulance service)
2) Each service area will have parts of multiple counties within the service area.
3) Funding should go from the Dept of Health then be distributed to the counties for distribution to each primary service area that provides service into the county.
4) If we base state assistance on revenue vs. expense and if it is determined that a service area is eligible for $50,000 (example of an allowable amount)
5) If service area 1 covers parts of three counties (25% in county A, 25% in county B, and 50% in county C)
6) We would calculate the percentage of service in each county, and then using that percentage determine how much that county would request from the state for that service area.
    a. $50,000 would be the amount this service area could request,
    b. 25% would come from county A $12,500
    c. 25% would come from county B $12,500
    d. 50% would come from county C $25,000
7) The county would request funding for each of the service areas that provide service into that county in the same manner.

8) Each service area would have an independent oversight committee/board that would monitor and report the performance of the ambulance service or services to the county before funding would be distributed. This report would be based on a template performance evaluation.

This distribution process would involve the counties used as a "pass through" sort of entity. There are benefits of including the counties in this process.

a. There will be more than one ambulance service in a county

   i. There is only one county that is entirely covered by one ambulance service, Golden Valley, Beach Ambulance Service.

   ii. All other counties have multiple services covering parts of their county.

b. Counties should have the mill levy information.

c. Instead of dealing with 88 service areas or 130+ services, the DOH would be working with 53 counties

d. Counties are existing political subdivisions and can receive funding directly from the DOH – ambulance services cannot receive direct funding, only grants

e. Counties are "pass-through" entity for other state funding, i.e. townships

f. The responsibility for the budgets and request of funding is with the service area – not the county – the county is the pass-through funding entity

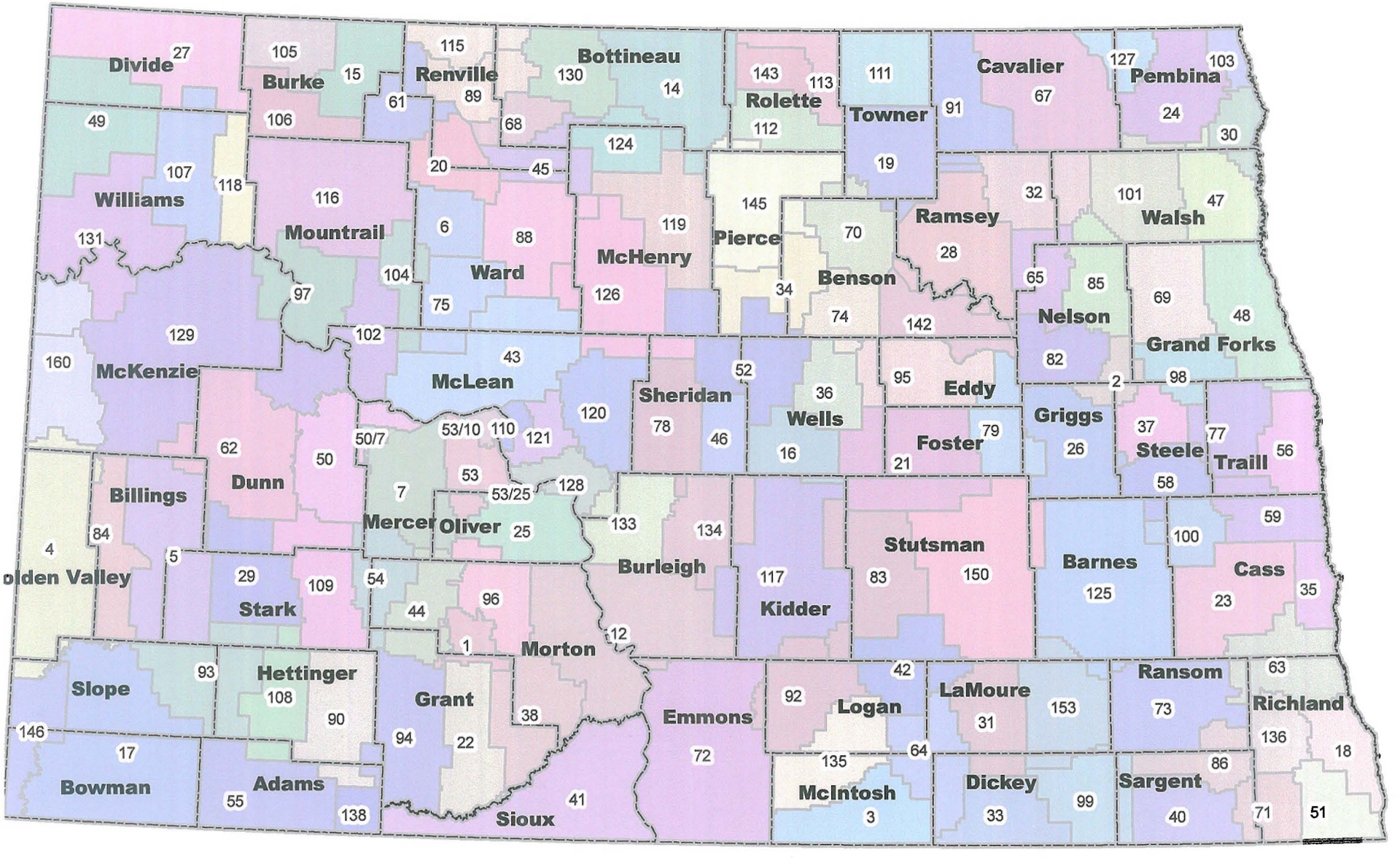
The ND EMS Association would like the committee to consider making the following amendments to the draft bill.

- Replacing the current grant program with a funding assistance program available to all primary service areas.
- Develop minimum funding based on one transporting ambulance service in each primary service area.
- Using the current definition of reasonable EMS to determine the primary service areas.
- Designate the primary ambulance service in the 62 service areas that only have one current provider.
- Include a funding formula based on expense vs. revenue utilizing a budget template with allowable budget line items to determine allowable funding assistance. (10 to 90% of budget)
- Providing for a local match based on $10.00 per citizen in the service area.

- Budgetd costs should be based on actual costs or costs as determined by the SafeTech Solutions study of ND EMS completed in 2008.
- Each service area needs to have an oversight committee/board (could be county commissioners or city council) that sets and monitors performance standards within the service area.
- The distribution of financial assistance utilizing a simple formula that takes into account the percent of service area in each county. And use the counties as a pass through entity for funding.

Chairman O'Connell, thank you for this opportunity to testify and I would be happy to answer questions the committee may have.

# ND Ambulance Response Areas




ated 3/15/2010
er Request
LRN

NORTH DAKOTA
DEPARTMENT of HEALTH
Emergency Medical Services and Trauma

**Ambualnce Budget for a part time paid, part time volunteer service that pais a fulltime Manager**

| | | |
|---|---|---|
| Calls | $ 106,000.00 | 200 calls at $530 |
| Mill Levy | $ 24,000.00 | |
| Training Grant | $ 2,000.00 | |

| | |
|---|---|
| Total Income | $ 132,000.00 |

Expenses:

| | | | |
|---|---|---|---|
| 0.74% | Accounting fees | $ 1,200.00 | Tax prep/Audits/Misc |
| 11.05% | ALS | $ 18,000.00 | 90 calls at $200 per intercept (should budget $450/intercept) |
| 1.99% | Billing/Data Entry | $ 3,250.00 | |
| 1.23% | Building Maintenance | $ 2,000.00 | Heat, repairs, electricity, etc. |
| 0.00% | Building Rent | $ - | Use hospital garage |
| 0.00% | Office/Classroom space | $ - | Use hospital office and classroom |
| 23.01% | Call Time Wages $2.50 | $ 37,500.00 | 6200 hrs nights-wkends 2 staff + 2600 hrs day call 1 staff |
| 4.60% | Captital Purchase Exp | $ 7,500.00 | Save for ambulance purchase |
| 0.40% | Cell Phone | $ 650.00 | |
| 4.60% | Employee Benefits | $ 7,500.00 | Health Insurance, PTO |
| 0.23% | EMT Expense | $ 375.00 | 10 person roster |
| 3.84% | EMT Training | $ 6,250.00 | 1 EMT class and conferences |
| 3.84% | Equipment | $ 3,500.00 | |
| 1.72% | Fuel | $ 2,800.00 | |
| 3.53% | Insurance | $ 5,750.00 | Auto, liability, workers comp, life/disability |
| 0.03% | License | $ 50.00 | State, CLIA, INC. |
| 25.77% | Manager Salary | $ 42,000.00 | 40 hrs per week-$3500 per month |
| 0.61% | Misc. | $ 1,000.00 | |
| 0.74% | Office Supplies | $ 1,200.00 | |
| 0.61% | Pagers | $ 1,000.00 | |
| 6.14% | Part Time Employee | $ 10,000.00 | 15 hrs per week- $12 hr |
| 2.76% | Payroll Expense | $ 4,500.00 | FICA, Medicare, Unemployment |
| 0.28% | Phone/Internet | $ 450.00 | |
| 0.03% | Postage | $ 42.00 | |
| 0.21% | Promo/Ads | $ 350.00 | |
| 0.33% | Refreshments | $ 540.00 | Meals at squad meetings |
| 0.61% | Repairs/Main.-Amb | $ 1,000.00 | Oil changes/tires/Repairs/Misc. |
| 0.15% | Repairs-Equip | $ 250.00 | |
| 1.10% | Suppplies-Amb | $ 1,800.00 | |
| 1.53% | Uniforms | $ 2,500.00 | Shirts, Pants, Boots for squad |
| 101.69% | | | |
| | Total Expenses | $ 162,957.00 | |

| | |
|---|---|
| Income/shortfall | $ (30,957.00) |