1999 HOUSE HUMAN SERVICES

HB 1038

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1038

House Human Services Committee

❑ Conference Committee

Hearing Date 01-11-98

Tape Number	Side A	Side B	Meter #
1	x		49.5
Committee Clerk Signature			

Minutes:

Chairwoman Price opened the hearing on HB 1038 at 11:05

Ms. Jennifer Clark, Legislative Council, is neutral on bill. She gave history on what the insurance committee was planning to do. She explained the background of the bill. Most changes in the bill are housekeeping and that money received must go for training and personnel on ambulance services.

Ms. Senator Karen Krebsbach, Is in favor of the bill. Much study was done in this area. The OEMs system in the state needs to be looked at further. The system is mostly volunteer and they are getting tired. People need to continue training. Ambulance services can impose a mill levy and some areas do very well with fund raising.

Ms. Senator Judy DeMers, Is in favor of the bill. Much has been said on the bill and is very important. Ambulance service funding has been short.

Senator Jerry Kline, Is in favor of the bill. Served on Interim Committee. He is concerned on how the funding will be divided up. Some districts do much to keep their service up and some do very little.

Representative Dale Severson, District 23 Is in favor of the bill. Some areas can't get reimbursed for ambulance service. The industry has changed because technology ha changed also. Some areas have funding problems but need the same services and this bill will help this need.

Howard Snortland, Represents Association of Retired Persons is in favor of this bill. Surveys are taken and then services can be better planned. This service is the number one priority in rural areas.

Mr. Tim Wiedrich, ND Dept. of Health, is neutral on the bill. Much information available is not accurate today.

(see attached written testimony)

Mr. Derek Hanson, is in favor of the bill.

(see attached written testimony)

Roberta Olsen, New Salem Ambulance Service, is in favor of the bill. Their services have had trouble getting reimbursement for services. The have 15 members in service and members have other jobs as well.

Ron Honeyman, ND EMS Association, is in favor of the bill. This is a public safety issue.

Some people think help will always be there and take it for granted. Some one must plan for good services.

Chairwoman Price closed the hearing on HB 1038.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1038 & 1039

House Human Services Subcommittee

❑ Conference Committee

Hearing Date January 19, 1999

Tape Number	Side A	Side B	Meter #
1	X	X	0.0 - End
2	X		0.0 - 7.0
Committee Clerk Signature Susann Lindteigen			

Minutes:

Subcommittee on HB 1038 and 1039 was called to order by Vice-Chairman Robin Weisz.

Present were Rep. ROBIN WEISZ, Rep. RALPH METCALF, and Rep. BLAIR THORESON.

Rep. ROBIN WEISZ stated the funding and the definition for prudent lay person is in the HB 1038 amendment. We combined this amendment with HB 1039 amendment 90179.0201 proposed by Rep. Porter. Sections 2 and 3 of this amendment were made a part of the HB 1038 amendment.

Rep. BLAIR THORESON moved to ADOPT AMENDMENT 90179.0202 to HB 1039

Rep. RALPH METCALF second the motion

VOICE VOTE: 3 yeas, 0 nays.

Motion carried.

In Section 2, the medical reimbursement of 75% was changed to 100%. This amendment would provide $500,000. It is more than the Governor's Budget.

Rep. BLAIR THORESON stated this would have to be re-referred to Appropriations.

Rep. ROBIN WEISZ stated we want this to come back from Appropriations the same way we send it.

Rep. ROBIN WEISZ asked should the language on *service* be changed to *volunteer* to prevent turf war because they hire telephone operators, bookkeepers? Or should we leave it up to the Health Department? Rep. RALPH METCALF said to leave it as is to keep the intent. Rep. BLAIR THORESON agreed.

Further committee discussion.

Rep. ROBIN WEISZ stated the HB 1038 amendment added prudent lay person again. Rep. BLAIR THORESON said to leave it in. Rep. ROBIN WEISZ said that way Chapter 26 and Chapter 50 of the ND Century Code would both have this reference.

Rep. RALPH METCALF said it's a good amendment as it is; except costs need to be defined.

Rep. BLAIR THORESON asked about the intent of the money. Rep. ROBIN WEISZ said the intent is so that the $30,000 can't come out of the $940,000. Rep. RALPH METCALF said the first 50% is in the Human Service Budget.

Rep. RALPH METCALF moved to ADOPT AMENDMENT No. 90180.0102 to HB 1038.

Rep. BLAIR THORESON second the motion

VOICE VOTE: 3 yeas, 0 nays

Motion Carried.

Subcommittee Adjourned.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1038

House Human Services Committee

❑ Conference Committee

Hearing Date January 26, 1999

Tape Number	Side A	Side B	Meter #
3	X		0.3 - End

Committee Clerk Signature Susan Lindtvogen

Minutes:

Rep. ROBIN WEISZ reviewed the subcommittee findings and discussed the proposed amendments. Pages 1 and 2, line 1 - 5 - eliminate reference to financial assistance for equipment.

Rep. CLARA SUE PRICE stated the money would go for training only.

Rep. AMY KLINISKE asked we haven't eliminated the funding; we just dedicated it only to training? Rep. ROBIN WEISZ stated the reference is to equipment to delete that language.

We added Section 2 which is basically the same as Rep. Porter's amendment to HB 1039 which allows medical reimbursement of up to 100% for ambulance service or actual cost whichever is less. This action will benefit all ambulance services.

Rep. TODD PORTER explained the terms which are against federal law and that it must be billed at the same rate. Medicare and Medicaid are paid at different rates.

Rep. TODD PORTER explained the prudent lay person definition.

Rep. TODD PORTER explained Section 3, Health Department Pilot Project for rural ambulance services. The $30,000 will not come from appropriations.

Rep. ROBIN WEISZ commented that the Subcommittee on this bill came out with a unanimous vote for the amendment. The appropriation of $940,000 for training is in HB 1004. $489,800 is Medicaid reimbursement which is in SB 2012. Training funds are to be targeted to volunteer services where needs appear to be the greatest.

Rep. ROBIN WEISZ moved to ADOPT AMENDMENTS.

Rep. RALPH METCALF second the motion

ROLL CALL VOICE VOTE: 15 yeas, 0 nays, 0 absent

Further Committee Discussion

Rep. WILLIAM DEVLIN moved DO PASS As AMENDED and REREFER to APPROPRIATIONS COMMITTEE

Rep. PAT GALVIN second the motion.

ROLL CALL VOTE #5: 15 yeas, 0 nays, 0 absent

CARRIER: Rep. RALPH METCALF

FISCAL NOTE

(Return original and 14 copies)

Bill / Resolution No.: _____ Amendment to: Eng. HB 1038 Conf. Com.

Requested by Legislative Council Date of Request: 04/14/99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative: This bill would require the Department beginning July 1, 1999, and ending June 30, 2001, to spend $276,000 in addition to the $943,068 in the executive budget recommendation for medical assistance reimbursement for ambulance services. The amendment to the bill will have a total fiscal impact of $1,219,068 of which $363,360 is general funds. $1,100,000 of the needed funding is included in Engrossed SB 2012, of which $327,640 is general funds.

2. State fiscal effect in dollar amounts:

	1997-1999 Biennium		1999-2001 Biennium		2001-2003 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:	-0-		363,360	855,708	Unknown	

3. What, if any, is the effect of this measure on the appropriation for your agency or department:

   a. For rest of 1997-99 biennium: -0-
   b. For the 1999-01 biennium: 1,219,068
   c. For the 2001-03 biennium: Unknown

4. County, City, and School District fiscal effect in dollar amounts:

1997-1999 Biennium			1999-2001 Biennium			2001-2003 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
-0-			-0-			-0-		

If additional space is needed, attach a supplemental sheet.

Signed Debra A. McDermott

Typed Name Debra A. McDermott

Date Prepared: April 14, 1999

Department Human Services

Phone No. 328-2397

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: _____ Amendment to: Eng. HB 1038

Requested by Legislative Council Date of Request: 3-15-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   Section one of this bill sets out the criteria for grants to emergency medical services (EMS) to defray training expenses. Included in HB 1004 is $940,000 of general funds appropriated for EMS training.

   Funding for medical assistance coverage is already contained in SB 2012. The amendment in section two will have no fiscal impact.

2. **State** fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:	-0-	-0-	-0-	-0-	-0-	-0-
Expenditures:	-0-	-0-	-0-	-0-	-0-	-0-

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: -0-
   b. For the 1999-2001 biennium: -0-
   c. For the 2001-03 biennium: -0-

4. **County, City, and School District** fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
	-0-			-0-			-0-	

If additional space is needed, attach a supplemental sheet.

Signed _____

Typed Name Robert A. Barnett

Date Prepared: 3-17-99

Department State Department of Health

Phone Number 328-2392

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: _____ Amendment to: HB 1038

Requested by Legislative Council Date of Request: 2-1-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   This bill will provide grants to emergency medical services (EMS) to defray training expenses in the amount of $940,000 appropriated from the general funds in HB 1004. Although not a formal request, the engrossed bill would require an increase of $489,800, of which $146,880 is general funds. The Medicaid portion of this bill is not included in SB 2012.

   This bill requires the Health Department to provide assistance with medical billings to six ambulance services. The Health Department has not included the estimated cost of $30,000 for these services in the Department's 1999-2001 budget request (HB1004).

2. **State** fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:	-0-	-0-	-0-	-0-	-0-	-0-
Expenditures:	-0-	-0-	176,880	342,920	-0-	-0-

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: -0-
   b. For the 1999-2001 biennium: $30,000 Health Department $489,800 Human Services
   c. For the 2001-03 biennium: -0-

4. **County, City, and School District** fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
	-0-			-0-			-0-	

If additional space is needed, attach a supplemental sheet.

Signed _____

Typed Name Robert A. Barnett

Date Prepared: 2-4-99

Department State Department of Health

Phone Number 328-2392

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: HB 1038 Amendment to: _____

Requested by Legislative Council Date of Request: December 23, 1998

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   Narrative:

   Section 2 of this bill would provide $3,800,000 for grants to ambulance services, quick response units and rescue services to defray training and equipment expenses.

2. **State** fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:						
Expenditures:	-0-		3.8 Million		-0-	

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: -0-
   b. For the 1999-2001 biennium: 3.8 Million
   c. For the 2001-03 biennium: -0-

4. **County, City, and School District** fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
	-0-			-0-			-0-	

If additional space is needed, attach a supplemental sheet.

Signed _____

Typed Name Robert A. Barnett

Date Prepared: 12/29/98

Department ND Department of Health

Phone Number 328-2392

Prepared by the Legislative Council staff for
Representative Weisz
January 19, 1999

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1038

Page 1, line 1, after "Act" insert "to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medical assistance coverage of prehospital emergency medical services;"

Page 1, line 2, replace "an" with "legislative intent regarding state department of health assistance for ambulance medical assistance billings and for appropriated funds"

Page 1, line 3, remove "appropriation"

Page 1, line 10, remove "department", overstrike "and", overstrike "shall", and remove "offer financial assistance to"

Page 1, line 11, overstrike "certain prehospital emergency medical services as determined by the", remove "department", and overstrike "in"

Page 1, line 12, overstrike "obtaining equipment" and insert immediately thereafter "department"

Page 1, line 17, remove "and for financial assistance for"

Page 1, line 18, remove "equipment", overstrike "To qualify for financial assistance for equipment", remove "acquisition", and overstrike ", a prehospital"

Page 1, line 19, overstrike "emergency medical service shall certify, in the manner required by the"

Page 1, line 20, remove "department", overstrike ", that the service has fifty percent of the amount of funds necessary for", remove "the", and overstrike "identified"

Page 1, line 21, overstrike "equipment", remove "acquisition", overstrike ". The", remove "department", and overstrike "shall adopt a"

Page 1, line 22, overstrike "schedule", overstrike "for", remove "distribution of", overstrike "financial assistance for equipment. The schedule must"

Page 1, line 23, remove "consider" and overstrike "the number"

Page 1, line 24, overstrike "of responses during the preceding calendar year for the purpose of medical care,"

Page 2, line 1, overstrike "transportation, or both, to individuals who were sick or incapacitated"

Page 2, line 3, remove "; consider the prehospital emergency medical service expenses"

Page 2, line 4, remove "that are not dependent on response volume; and" and overstrike "classify responses and the financial"

Page 2, line 5, overstrike "assistance available for various classifications."

Page 2, after line 12, insert:

"**SECTION 2.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medical assistance - Prehospital emergency medical services. Medical assistance coverage provided by the department of human services must include coverage for prehospital emergency medical services. This coverage must include provider reimbursement at a rate of seventy-five percent of costs for any prehospital emergency medical services assessment commensurate with the level of training of the individual performing the assessment and must include prehospital emergency medical services benefits in the case of a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and which a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part.

SECTION 3. LEGISLATIVE INTENT - DEPARTMENT OF HEALTH - PILOT PROJECT - AMBULANCE MEDICAL ASSISTANCE BILLINGS. The state department of health during the 1999-2001 biennium shall provide assistance with medical assistance billings to six ambulance services on a pilot project basis at a cost of $30,000 from funds, other than emergency medical services funding, appropriated to the department in House Bill No. 1004."

Page 2, line 13, replace "**APPROPRIATION**" with "**INTENT**" and replace "There is hereby appropriated out of any moneys in" with "The funds appropriated"

Page 2, remove line 14

Page 2, line 15, remove "much of the sum as may be necessary, to the state department of health"

Page 2, line 16, replace "section" with "sections" and after "1" insert "and 2"

Page 2, line 17, after "2001" insert "include $940,000 appropriated from the general fund in 1999 House Bill No. 1004 for training for volunteers and a total of $244,800, of which $171,360 is from the general fund appropriated in the medical assistance grants line item in 1999 Senate Bill No. 2012 for reimbursement of prehospital emergency medical services. The funds provided for training are for volunteer services based on $2,200 for ambulance service training, $500 for rescue squad training, $500 for the initial training of volunteer emergency medical service providers, and $1,500 for training of quick response units, subject to reallocation by the state department of health based on training applications and available funding."

Renumber accordingly

Adopted by the Human Services Committee
January 26, 1999

VK
1/27/99
1 of 2

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1038

Page 1, line 1, after "Act" insert "to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medical assistance coverage of prehospital emergency medical services;"

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SECTION 3. LEGISLATIVE INTENT - DEPARTMENT OF HEALTH - PILOT PROJECT - AMBULANCE MEDICAL ASSISTANCE BILLINGS. The state department of health during the 1999-2001 biennium shall provide assistance with medical assistance billings to six ambulance services on a pilot project basis at a cost of $30,000 from funds, other than emergency medical services funding, appropriated to the department in House Bill No. 1004."

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Renumber accordingly

Date: 1-26-99
Roll Call Vote #: 5

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1038

House Human Services Committee

☐ Subcommittee on

or

☐ Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as Amended Rereferred to Appn

Motion Made By William Devlin Seconded By Pat Galvin

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairwoman	X		Bruce A. Eckre	X	
Robin Weisz - Vice Chairwoman	X		Ralph Metcalf	X	
William R. Devlin	X		Carol A. Niemeier	X	
Pat Galvin	X		Wanda Rose	X	
Dale L. Henegar	X		Sally M. Sandvig	X	
Roxanne Jensen	X				
Amy N. Kliniske	X				
Chet Pollert	X				
Todd Porter	X				
Blair Thoreson	X				

Total (Yes) 15 No 0

Absent 0

Floor Assignment Metcalf

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1038: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (15 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1038 was placed on the Sixth order on the calendar.

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Renumber accordingly

1999 HOUSE APPROPRIATIONS

HB 1038

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. 1038

House Appropriations Committee

❑ Conference Committee

Hearing Date February 4, 1999

Tape Number	Side A	Side B	Meter #
1	x		0-19.9
Committee Clerk Signature	Casey Davis		

Minutes:

HB 1038 - A bill for an act to amend and reenact section 23-27-04.2 of the ND Century Code, relating to state assistance to prehospital emergency medical services; and to provide an appropriation.

CHAIRMAN DALRYMPLE called the hearing for HB 1038 to order.

1A: 0.7 REP. CLARA SUE PRICE introduced the bill and the proposed amendment. (See attached amendment.)

1A: 5.6 REP. CARLSON asked about the issue of people using the ambulance service for transportation rather than real emergencies. Rep. Price said that they are required to pick up anyone who calls the ambulance service with an emergency.

1A: 8.0 REP. DELZER asked for an explanation of the amendment. Rep. Wise, sponsor of the bill, said that $2200 goes directly to the ambulance services for currency training. $500 is for judicial training.

1A: 14.4 REP. CARLSON asked for the number of uncollected bills from ambulance services. Rep. Wise said the number was never received. He did say that $300,000 in Medicaid claims were rejected last year. This number was received from the Dept. of Health.

1A: 17.0 CHAIRMAN DALRYMPLE closed the hearing on HB 1038.

ACTION ON BILL Rep. Carlisle made a motion for a DO PASS as amended. The motion was seconded by Rep. Gulleson. The motion carried with 18 yeas, 0 nays, and 2 absent and not voting. Rep. Metcalf will carry the bill to the floor.

90180.0201
0300

UNAMENDED

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1038

Page 1, line 1, after "Act" insert "to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medical assistance coverage of prehospital emergency medical services;"

Page 1, line 2, replace "an" with "legislative intent regarding state department of health assistance for ambulance medical assistance billings and for appropriated funds"

Page 1, line 3, remove "appropriation"

Page 1, line 10 remove "department", overstrike "and", overstrike "shall", and remove "offer financial assistance to"

Page 1, line 11, overstrike "certain prehospital emergency medical services as determined by the", remove "department", and overstrike "in"

Page 1, line 12, overstrike "obtaining equipment" and insert immediately thereafter "department"

Page 1, line 17, remove "and for financial assistance for"

Page 1, line 18, remove "equipment", overstrike "To qualify for financial assistance for equipment", remove "acquisition", and overstrike ", a prehospital"

Page 1, line 19, overstrike "emergency medical service shall certify, in the manner required by the"

Page 1, line 20, remove "department", overstrike ", that the service as fifty percent of the amount of funds necessary for", remove "the", and overstrike "identified"

Page 1, line 21, overstrike "equipment", remove "acquisition", overstrike ". The", remove "department", and overstrike "shall adopt a"

Page 1, line 22, overstrike "schedule", overstrike "for", remove "distribution of", overstrike "financial assistance for equipment. The schedule must"

Page 1, line 23, remove "consider" and overstrike "the number"

Page 1, line 24, overstrike "of responses during the preceding calendar year for the purpose of medical care,"

Page 2, line 1, overstrike "transportation, or both, to individuals who were sick or incapacitated"

Page 2, line 3, remove "; consider the prehospital emergency medical service expenses"

Page 2, line 4, remove "that are not dependent on response volume; and" and overstrike "classify responses and the financial"

Page 2 line 5, overstrike "assistance available for various classifications."

Rep. Clara Sue Price

Page 2, after line 12 insert:

"**SECTION 2.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medical assistance - Prehospital emergency medical services. Medical assistance coverage provided by the department of human services must include coverage for prehospital emergency medical services. This coverage must include provider reimbursement at a rate of the lesser of one hundred percent of the amount billed or the rate established by the department of human services reimbursement schedule for any prehospital emergency medical services assessment commensurate with the level of training of the individual performing the assessment. This coverage must include prehospital emergency medical services benefits in the case of a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and which a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part.

SECTION 3. LEGISLATIVE INTENT - DEPARTMENT OF HEALTH - PILOT PROJECT - AMBULANCE MEDICAL ASSISTANCE BILLINGS. The state department of health during the 1999-2001 biennium shall provide assistance with medical assistance billings to six ambulance services on a pilot project basis at a cost of $30,000 from funds, other than emergency medical services funding, appropriated to the department in House Bill No. 1004."

Page 2, line 13, replace "**APPROPRIATION**" with "**INTENT**" and replace "There is hereby appropriated out of any moneys in" with "The funds appropriated"

Page 2, remove line 14

Page 2, line 15, remove "much of the sum as may be necessary, to the state department of health"

Page 2, line 16, replace "section" with "sections" and after "1" insert "and 2"

Page 2, line 17, after "2001" insert "include $940,000 appropriated from the general fund in 1999 House Bill No. 1004 for training for volunteers and a total of $489,800, of which $146,880 is from the general fund appropriated in the medical assistance grants line item in 1999 Senate Bill No. 2012 for reimbursement of prehospital emergency medical services. The funds provided for training are for volunteer services based on $2,200 for volunteer ambulance service training, $500 for volunteer rescue squad training, $500 for the initial training of volunteer emergency medical service providers, and $1,500 for training of volunteer quick response units, subject to reallocation by the state department of health based on training applications and available funding."

Renumber accordingly

Date: 2-4-99
Roll Call Vote #: 1

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1038

House **APPROPRIATION** Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number no # ?

Action Taken Do pass as amended

Motion Made By Carlisle Seconded By Gulleson

Representatives	Yes	No	Representatives	Yes	No
Rep. Ole Aarsvold	✓		Rep. Ronald Nichols	✓	
Rep. LeRoy G. Bernstein			Rep. Jim Poolman	✓	
Rep. James Boehm	✓		Rep. Ken Svedjan	✓	
Rep. Rex R. Byerly	✓		Rep. Mike Timm		
Rep. Al Carlson	✓		Rep. Ben Tollefson	✓	
Rep. Ron Carlisle	✓		Rep. Janet Wentz	✓	
~~Rep. Al Carlson~~			Chairman Jack Dalrymple	✓	
Rep. Jeff Delzer	✓				
Rep. Pam Gulleson	✓				
Rep. Serenus Hoffner	✓				
Rep. Robert Huether	✓				
Rep. James Kerzman	✓				
Rep. Ed Lloyd	✓				
Rep. David Monson	✓				

Total (Yes) 18 No —

Absent 2

Floor Assignment Metcalf

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1038, as engrossed: Appropriations Committee (Rep. Dalrymple, Chairman) recommends **DO PASS** (18 YEAS, 0 NAYS, 2 ABSENT AND NOT VOTING). Engrossed HB 1038 was placed on the Eleventh order on the calendar.

1999 SENATE HUMAN SERVICES

HB 1038

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1038

Senate Human Services Committee

❑ Conference Committee

Hearing Date FEBRUARY 24, 1999

Tape Number		Side A	Side B	Meter #
	1		X	1,330
3/9/99	1		X	690
3/9/99	2	X		
Committee Clerk Signature		Carol Kolodziejczak		

Minutes:

The hearing was opened on HB1038.

JENNIFER CLARK, Legislative Council, explained the bill. The original bill initially had two sections. The amendments to this code section were housekeeping and the changes were focused on the formula for distributing grant money to ambulance services. The money was to go for training personnel and any left over for equipment. Section two was the appropriation for $3.8 million dollars to meet the training needs and the equipment needs and met the five year plan to meet the goals of the Emergency Medical Services. There has never been enough money to meet the equipment goals of EMS. Now the engrossed version has 4 sections. In the first section, most of this is housekeeping. The changes on page 1, line 13 and 14, removal of funds for equipment. The funds are for personnel only. Section 2 is reimbursement for pre hospital

services at lesser amount of 100% bills or the rate established by the department that takes into account the level of training of the individual providing medical care. It piggybacks HB1039 talking about insurance coverage's for ambulance services. Medical assistance must provide same coverage as 1039 does. Section 3 is the legislative intention of a pilot program; this program is already implemented regarding billing assistance for the ambulance unit. Section 4 addresses funding for the volunteer training; addresses the appropriation for section 2. REPRESENTATIVE TODD PORTER, Committee member responsible for adding amendments, explained that under section 2, there was testimony received that the Department of Human Services paid less than 50% of the actual cost to provide ambulance service. This causes the cost to be shifted to the private sector. We would like to have the department adhere to the Medicare system. Some of the ambulance services are not billing for entire services they are performing. They need to include all services. This bill would only say the department can do as they have been doing. SENATOR DEMERS: Do they currently reimburse by the training of personnel? MR. PORTER: They reimburse currently by types of procedures performed on a patient. Basically they penalize the advanced services that have the EMT intermediates and the paramedics for not performing advanced procedures. They penalize the ambulance and do not pay for the patient assessment which is the most important in the first place. SENATOR DEMERS is concerned with the fixed costs in the rural area. MR. PORTER answered that it would not affect it. SENATOR DEMERS: None of the fixed costs are figured into this bill. MR. PORTER: This bill will take care of the paid services across the state; large cities with paid staff would not be eligible for any monies of this grant. House felt that only rural receive grants to benefit rural ambulance services. SENATOR DEMERS asked about the equipment being

taken out. That fixed cost is not addressed at all. REP. PORTER: That was removed because the appropriation was cut almost in half. If the dept was going to save anything they would rather save and increase the training and lose the equipment and it was basically on the appropriation. The Health Department is currently setting up a pilot project to help rural ambulance services to deal with the billing problems they currently have. The services did not know how to bill the third party reimbursers and there was a lot of uncaptured money that was available to them. The project is already being done so no provision has to be made for it. Section 4 talks about the equipment was removed and the money put towards training services; the services that had full time paid staff would not be eligible for these funds. The rural area is where the need is and the money was increased.

TIM WIEDRICH, Health Department, supports bill. We have the project underway. This is a special billing service to help rural capture monies that are due them. In section 4, we did want to communicate that the department will be restored the flexibility of levels of funding. There is a high level of explicitly in the intent. We will honor this intent, but in the past we have worked to try to fill the needs in terms of funding and if the training needs are met, the equipment needs may also be addressed. It is a method we can remain more responsive to the needs of communities. We are supportive of the bill; there is $940,000 in our executive budget for the grant program.

DEREK HANSON, ND EMS Assoc., supports bill. (written testimony) Mr. Hanson handed out testimony by MARK HAUGEN.

MIKE HALL, Fargo, supports bill. If it were not for rural departments we would have to expand our territory. We would like to see Medicaid reimbursement. There is a lot of cost shifting and

we have to get that from someplace. We need to figure out how we can cover the cost of survival so there are things to be worked out.

DAVID ZENTNER, Dept of Human Services, has no problem with bill as originally written, but it has changed. (written testimony.) SENATOR LEE: Was the Dept of Human Services involved with this pilot project? MR. ZENTNER: No, we were not. SENATOR DEMERS: Are the reimbursements typical. MR. ZENTNER: There are some that get more dollars; it ranges from nothing up to $4000. You don't find a lot of activity in the rural areas with the Medicaid program. There aren't many that get more than $2000.

The hearing was closed on HB1038.

Discussion was resumed on 3/9/99. JENNIFER CLARK was called from Legislative Council to help write amendments. REPRESENTATIVE TODD PORTER was called to answer some questions on reimbursement. Fee schedule on Medicare by 2000 is the goal. JENNIFER CLARK will draft the amendments. The committee was adjourned until the call of the chair after the Senate session.

The committee was called back to order by Vice-Chair KILZER. The amendments were presented by Jennifer Clark. She walked the committee through the changes that were made. Discussion ensued. SENATOR LEE moved amendments to fix up page 1 and delete lines 16-21. SENATOR KILZER seconded the motion. Discussion. Roll call vote carried 6-0-0. SENATOR LEE moved DO PASS AS AMENDED. SENATOR DEMERS seconded. SENATOR KILZER will carry the bill.

Prepared by the Legislative Council staff for
Senate Human Services
March 9, 1999

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1038

Page 1, line 4, replace "legislative intent" with "for allocation of"

Page 1, remove line 5

Page 1, line 6, remove "for" and after "funds" insert "for the training of prehospital emergency medical services personnel"

Page 2, line 19, replace "department of human services" with "medicare"

Page 2, line 20, remove "assessment commensurate with the level of training of the individual performing the"

Page 2, line 21, remove "assessment"

Page 2, remove lines 27 through 31

Page 3, line 1, replace "**INTENT**" with "**ALLOCATION OF FUNDS**" and remove "The funds appropriated for the purpose of defraying expenses"

Page 3, remove lines 2 through 6

Page 3, line 7, after "provided" insert "during the 1999-2001 biennium" and after "services" insert "and are"

Renumber accordingly

Date: 3/9/99
Roll Call Vote #: 1

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB1038

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number 90180.0202

Action Taken _____

Motion Made By Sen Lee Seconded By Sen Kilzer

Senators	Yes	No	Senators	Yes	No
Senator Thane	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Lee	✓				
Senator DeMers	✓				
Senator Mutzenberger	✓				

Total 6 (yes) 0 (no)

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Prepared by the Legislative Council staff for
Senate Human Services
March 10, 1999

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1038

Page 1, line 4, replace "legislative intent" with "for allocation of"

Page 1, remove line 5

Page 1, line 6, remove "for" and after "funds" insert "for the training of prehospital emergency medical services personnel"

Page 2, line 15, remove "**Medical assistance -**"

Page 2, remove lines 16 through 20

Page 2, line 21, remove "assessment. This"

Page 2, remove lines 27 through 31

Page 3, line 1, replace "**INTENT**" with "**USE OF FUNDS**" and remove "The funds appropriated for the purpose of defraying expenses"

Page 3, remove lines 2 through 6

Page 3, line 7, after "provided" insert "during the 1999-2001 biennium" and replace "based on $2,200 for volunteer" with a period

Page 3, remove lines 8 through 11

Renumber accordingly

Date: 3/9/99
Roll Call Vote #: 2

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1038

Senate HUMAN SERVICES COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do pass as amended

Motion Made By Sen Lee Seconded By Sen DeMers

Senators	Yes	No	Senators	Yes	No
Senator Thane	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Lee	✓				
Senator DeMers	✓				
Senator Mutzenberger	✓				

Total 6 (yes) 0 (no)

Absent 0

Floor Assignment Sen Kilzer

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1038, as engrossed: Human Services Committee (Sen. Thane, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1038 was placed on the Sixth order on the calendar.

Page 1, line 4, replace "legislative intent" with "for allocation of"

Page 1, remove line 5

Page 1, line 6, remove "for" and after "funds" insert "for the training of prehospital emergency medical services personnel"

Page 2, line 15, remove "**Medical assistance -**"

Page 2, remove lines 16 through 20

Page 2, line 21, remove "assessment. This"

Page 2, remove lines 27 through 31

Page 3, line 1, replace "**INTENT**" with "**ALLOCATION OF FUNDS**" and remove "The funds appropriated for the purpose of defraying expenses"

Page 3, remove lines 2 through 6

Page 3, line 7, after "provided" insert "during the 1999-2001 biennium" and replace "based on $2,200 for volunteer" with a period

Page 3, remove lines 8 through 11

Renumber accordingly

1999 SENATE APPROPRIATIONS

HB 1038

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. ENGROSSED HB 1038

Senate Appropriations Committee

❑ Conference Committee

Hearing Date 3/22/99; 3/30/99

Tape Number	Side A	Side B	Meter #
1	3000-end	0-230	
3/30/99 1	2890-3356		
Committee Clerk Signature	Claudia Anderson		

Minutes:

SENATOR NETHING: Opened the hearing on engrossed HB 1038**;** A BILL for an Act to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medical assistance coverage of prehospital emergency medical services; to amend and reenact section 23-27.2 of the North Dakota Century Code, relating to state assistance to prehospital emergency medical services; and to provide legislative intent regarding state department of health assistance for ambulance medical assistance billings and for appropriated funds.

TIM WIEDRICH: Director, Division of Emergency Health Services, ND Department of Health, to testify in support of HB 1038 (testimony attached #1) (tape 1, A, 3000-3395)

SENATOR SOLBERG: Where is the continuing education to be held?

WIEDRICH: The funding will be used at the discretion of the local entities.

SENATOR SOLBERG: Is there any stipulation for education at the different levels?

WIEDRICH: The grant program exists at all 3 levels, so all are eligible.

SENATOR SOLBERG: There is no mandate at what level an EMT or First Response Person has to be at to get a grant?

WIEDRICH: No. The continuing education grants are basically $1,000-$1,200. This has been the variance since the inception of the program. Roughly that would bump up to about $2,000 if in fact the $940,000 is approved for this biennium. But, in the past it has been roughly $1,000-$1,200 that has been given to a local EMT unit to use for continuing education, at their discretion. The individual grants have amounted to about $250/EMT. That's been available at all 3 levels.

SENATOR TALLACKSON: Is this supposed to help retain current staff?

WIEDRICH: Both. The continuing education portion of the grant is to help maintain those actually involved in the service on an ongoing basis. The portion of the grant for new EMT's is to help recruit new people into the service.

ROBIN WEISZ: Representative, District 14, to testify in support of the bill and to urge reinstatement of Medicaid funding that was removed on the Senate Human Services Committee. I chaired the subcommittee on HB 1038 that reached a good compromise with the limited funds that were available. They came in with a request of $3.8M. The Health Dept. had budgeted $940,000. We took that $940,000 and allocated 100% of that to the rural services for initial training and continuing training. That was to help address the problem of retaining staff for the ambulance services. But, at the same time the urban areas gave up any training funds they were already given. One of the things we looked at is that currently we're always reimbursing for ambulance runs at 50% for. We raised that up to 100% which would mean another $489,000 that is going back to our ambulance services. Granted the majority of that money does go to the urban services--probably $300,000-$350,000 would go to the more urban services. Probably about $120,000-$140,000 would go to the rural services. We felt it made sense to go after the federal dollars, because of that $489,000, only $146,000 would be general funds the rest is federal dollars. With the financial problems most of the ambulance services are running into it made sense to fund them at 100% of the reimbursement rate of Medicaid. It was a compromise we felt was a good deal. Everyone in the subcommittee was satisfied when we were done. I would really hope this Committee would look seriously at reinstating that funding up to 100% for Medicaid. This is not the budget we wanted, but considering the budget restraints, we thought we had a good deal put together. (tape 1, A, 3800-4150)

SENATOR NETHING: Did you get a chance to offer testimony on this amendment when it was in the House Human Services Committee?

WEISZ: No, I didn't realize it was going to be a controversial issue until I found out it had been removed.

SENATOR NETHING: Our problem is we're supposed to just deal with the fiscal impact of the bill. People from other committees get upset when we go away from that. Could you tell us once again the fiscal impact of this?

WEISZ: The $940,000 is already in the Governor's budget. We took that $940,000 and allocated 100% of that to the rural ambulance services. From that standpoint, there is no increase in any budget over the Governor's. I realize that is close to about $500,000 from last biennium. I think last biennium was $470,000. That part was in the Governor's budget. The feeling of the House Appropriations and the House Human Services Committees was that if we fund Medicaid at 100% it increases the cost to state general funds of about $146,800. The balance of the $489,000 are federal funds which are available. So, we're not taking those federal funds out of any other program. They would be additional federal funds. It was the feeling of both committees that $146,000 would not have to be an increased appropriation out of the Human Service, but that it could be found in the current budget. I realize the Department would probably have a different

view on that. Our view was not to increase the budget, but to find savings within the Human Services budget. We were not proposing any increase in the overall budget.

SENATOR NETHING: This amendment takes off that part of it?

WEISZ: That is correct. They removed the Medicaid funding from 100% to the current 50%.

SENATOR NETHING: So it affects that $146,000?

WEISZ: That is correct.

SENATOR BOWMAN: Did you consider taking the $146,000 that you were going to match from the federal government out of the $940,000? That way you would maximize the federal dollars and still be $708,000 ahead which is considerably more than last biennium going to the rural ambulances.

WEISZ: We have considered doing approximately half to come out of the $940,000, but it was the feeling of the committee that the greatest need was for training for the rural services and the $940,000 was inadequate. We didn't want to take any away from EMS budget. We discussed doing about $70,000 out of the $940,000 to match federal dollars. But, in the end we decided we would rather see the whole $940,000 to training and additional funds to come out of the Human Services budget for the Medicaid. (tape 1, A, 4630)

SENATOR SOLBERG: Representative Weisz, we're both from rural districts, have you found in your district that one of the biggest problems for volunteers is the demand of over training of the training they must now receive?

WEISZ: I wouldn't disagree. We've had a lot of concerns regarding the amount of training required. We felt it wasn't our place on this bill to address that issue.

SENATOR SOLBERG: If we took, as Senator Bowman said, that $146,000 out of the $940,000 we could cut down on a little of this excess training, could we not?

WEISZ: That won't help this situation at all. This $140,000 is going to training they have to provide. They have no choice. It either comes out of the EMT's pocket or we're going to refund it. That's part of the problem, for some of these its costing hundreds of dollars. They don't want to join the service because it's not only taking time, but it's also costing a lot of pocket money. This barely helps to reimburse this. It's not going to reduce the level of training required by any means if we cut the funding. (tape 1, A, 5030)

DAVE ZETNER: Director, Medical Services, Department of Human Services, to testify that the present bill is acceptable to the Department. The definition of a lay person is something that we're already using. The original bill that came out of the interim committee, did not mention the Medicaid program at all. Those factors, as expressed Rep. Weisz, were all added during the House debate on the bill. We didn't even testify originally on it. The $146,000 doesn't exist in my present budget. I would caution you about thinking those dollars are within my budget.

DEREK HANSON: Pres., ND Emergency Medical Service (EMS) to testify in support of receiving adequate stable funding, and to leave additional funds in the Bill as well as language for equipment in case dollars become available. (testimony attached #2) (tape 5200-5685)

SENATOR SOLBERG: How many hours do you estimate per month on an average rural EMT in service rendered as far as pickups, etc. and as far as training? This pertains to the dollar amount on the training.

HANSON: Those are really 2 different issues because the number of runs the service goes on varies from one to another. We have services that only provide 15-20 ambulance calls per year; and those that might provide 150. The continuing education issue, if the average EMT were to attend no more than 2-3 hours of continuing education per month over their 24 month period to recertify, they would have all of the hours they would need. Most ambulance services meet at least once a month, if not more so to get 2-3 hours of continuing education, is a very simple process. In addition, we offer state conferences, etc. (tape 1, A, 5685-5865)

SENATOR TALLACKSON: Who pays the paramedics in the areas that have them?

HANSON: In those situations like Rugby, Walsch County has paramedics. It is usually the city or the county that picks up if not all, at least part of the fee. Sometimes it is shared between the ambulance service and the hospital because many times they use the hospital internally as an employee part of the time. It is kind of a win-win situation for everyone. That is not paid for out of the state training grants now available.

DALE SEVERSON: Representative, District 23. I've been working with the ambulance service since 1970 as an EMT. I took my first certification training in 1973. The training has not changed since that time. What has changed is that back in those days we could get that training for nothing. Everyone got on the bandwagon and said we'll provide the training, or there would be a very nominal fee. Now, we have actual hospitals that are excellent sources of hospital, marketing EMS training, and are charging $350 to take the EMT course. That's what has changed. Earlier, the federal government through the department of transportation funded all of the test sites. At the test site, they gave me the check and it came through the state government. Now, we have no funding for that testing yet they're required to be It is currently costing me $1200/year out of my pocket. Keep in mind the training has not changed. I would not want the training to lessen, I deal with a life. We asked for $3.8M for the EMT system. The volunteers contribute to this great state about $16M annually in volunteer time to do this work. If we had to fund this, we'd be looking at a lot more money than the $940,000. We were able to convince the Governor this was important. He included that in his budget. The $146,000 put in for Medicaid, and reimbursement is a real problem in ND--Medicaid and Medicare in particular, Blue Cross Blue Shield is not so bad, but they're following in the others' footsteps. Forty-50% is all we get on the cost of what it costs to run an ambulance on an ambulance run. In many of the smaller towns, the Medicaid people don't even call the ambulance because they're afraid that besides what Medicaid pays, we're going to bill them. Unfortunately we don't participate with Medicaid in the rural areas so the patient ends up paying, so they have their neighbor run them in. The Medicaid payment of $146,000 out the Human Service budget was offered as an amendment. When the subcommittee met I went and said we can get by without $3.8 and I offered them a $1.9 amendment. They ended up with the

Medicaid dollar reimbursement of about $1.5. I think that is a reasonable conclusion to come to that does help the EMS profession. It is hard to keep interested in doing what we're doing, but there are ongoing costs. Those are the things that have changed. I would encourage you to put that $146,000 back in the human service budget for the Medicaid reimbursement. (tape 1, A, 5975-end) (tape 1, B, 0-210)

SENATOR NETHING: Referred the bill to the subcommittee chaired by Senator Andrist , Chairman; Senator Grindberg, and Senator Robinson, and closed the hearing on engrossed HB 1038. (tape 230)

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3/30/99 tape 1, A, 2890-3356

SENATOR NETHING: Reopened the hearing on engrossed HB 1038.

SENATOR ANDRIST: Moved do pass engrossed HB 1038.
SENATOR ROBINSON; Seconded the motion.
ROLL CALL: 13 yeas; 0 nays; 1 absent & not voting.
MOTION CARRIED TO DO PASS ENGROSSED HB 1038.
Yeas: Nething, Naaden, Solberg, Lindaas, Tomac, Robinson, Krauter, St. Aubyn, Grindberg, Holmberg, Kringstad, Bowman, Andrist
Absent & not voting; Tallackson

CARRIER: Senator Kilzer

SENATOR NETHING: Closed the hearing on HB 1038.

Date: 3/30/99
Roll Call Vote #: 1

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. Engrossed HB 1038

Senate APPROPRIATIONS Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS

Motion Made By Senator Andrist Seconded By Senator ~~[illegible]~~ Robinson

Senators	Yes	No	Senators	Yes	No
Senator Nething, Chairman	✓				
Senator Naaden, Vice Chairman	✓				
Senator Solberg	✓				
Senator Lindaas	✓				
Senator Tallackson					
Senator Tomac	✓				
Senator Robinson	✓				
Senator Krauter	✓				
Senator St. Aubyn	✓				
Senator Grindberg	✓				
Senator Holmberg	✓				
Senator Kringstad	✓				
Senator Bowman	✓				
Senator Andrist	✓				

Total (Yes) 13 No 0

Absent 1

Floor Assignment Senator Kilzer

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1038, as engrossed and amended: Appropriations Committee (Sen. Nething, Chairman) recommends **DO PASS** (13 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1038, as amended, was placed on the Fourteenth order on the calendar.

1999 HOUSE HUMAN SERVICES

HB 1038

CONFERENCE COMMITTEE

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1038

House Human Services Committee

☒ Conference Committee

Hearing Date April 6, 1999

Tape Number	Side A	Side B	Meter #
2	x		0.0-end
Committee Clerk Signature			

Minutes:

Then conference committee was called to order by Rep. ROBIN WEISZ. Also present were Rep. JACK DALRYMPLE, Rep. RALPH METCALF, Sen. RALPH KILZER, Sen. RUSSELL THANE, and Sen. JUDY DEMERS.

Rep. WEISZ asked the Senate members to discuss the reason for the Senate changes about where the funds were to go. Sen. KILZER explained that the bill had started out with a price tag or $3.8 million. Everything was removed from the bill except the appropriation for training volunteer ambulance crews.

Continued discussion highlighted the following positions. It turned out that the entire amount set aside for training volunteer crews would go to the rural EMS groups because the urban ambulance services are paid, not volunteer. Because of that, the urban services felt they were being discriminated against. They thought they should have as much help in training costs as the

volunteer groups. They were willing to back away from that position, however, in return for an increase in Medicaid reimbursement. The house felt that the funding for this could be worked out in appropriations. The Senate position was that all medical providers have to cost shift for Medicaid reimbursement schedules and didn't like to see an exception made for one group. The House thought that ambulance services were currently reimbursed at 50% of Medicaid and this could be increased to 100%. The Senate thought that current reimbursement was already at 100%.

It was decided that additional information needed and another meeting held. The conference committee meeting was adjourned.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1038

House Human Services Committee

☒ Conference Committee

Hearing Date April 7, 1999

Tape Number	Side A	Side B	Meter #
1	x		0.0-end
Committee Clerk Signature	Wayne G Mountain		

Minutes:

Then conference committee was called to order by Rep. ROBIN WEISZ. Also present were Rep. JACK DALRYMPLE, Rep. RALPH METCALF, Sen. RALPH KILZER, Sen. RUSSELL THANE, and Sen. JUDY DEMERS.

DAVID ZENTNER, Department of Human Services, was asked by the committee to discuss the current fee structure for ambulance services. In response to questions he explained that the rates were paid at 100% up to the full amount of the bill. It was noted that the 100% refers to the reimbursement schedule which translates to about 50% of the average ambulance charge. The house bill, as it currently stands, has no bearing on the current pay procedures unless additional funding is made available. The fiscal note was prepared by the Health Department based on the House's desire to increase the reimbursement rate by 50%. If there is no increase in funding, there can be no increase in the reimbursement schedule.

Rep. METCALF asked about the removal of pre-hospital emergency assessment. Mr. ZENTNER explained that when an ambulance call is answered and it is found that life support ambulance transportation was not medically required there is no reimbursement for the emergency assessment. Discussion followed. Ambulance services don't know if it is an emergency when the call is answered. If they find there was no medical emergency, the cost of the run doesn't change. Now they will not be reimbursed for the call. On the other hand, tax dollars shouldn't be used to fund unnecessary ambulance calls.

Rep. DALRYMPLE indicated that the chairman of the house human services appropriations committee was aware of the house intentions by the passage of HD1038 and are prepare to address the fiscal note expenditure.

There was addition discussion about the "prudent lay person" definition in the bill and its purpose. There was agreement as to the definition, its purpose and its use.

The committee was divided concerning special appropriations to improve ambulance reimbursement rate. One question was the source of the money for this program which has to be clearly identified before the decision is made. It was agreed that Medicaid payments were low for ambulances but they are low for all services. It didn't seem right to show favoritism to one area by increases its reimbursement. On the other hand, if a reimbursement increase is not possible then the urban ambulance services will be concerned about the rural services being given all of the training funding and the urban services getting nothing. The question also was raised as to the appropriateness of the legislature stepping in and overriding the work of the Department of Human Services rate committee.

It was decided that another meeting would be required and the conference committee was adjourned.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1038

House Human Services Committee

☒ Conference Committee

Hearing Date April 8, 1999

Tape Number	Side A	Side B	Meter #
1	x		0.0-end
Committee Clerk Signature			

Minutes:

Then conference committee was called to order by Rep. ROBIN WEISZ. Also present were Rep. JACK DALRYMPLE, Rep. RALPH METCALF, Sen. RALPH KILZER, Sen. RUSSELL THANE, and Sen. JUDY DEMERS.

Rep. WEISZ discussed proposed amendments (attached) that had been provided to the committee members prior to the meeting. The purpose of the amendments on the first page is to return the language to current original law. Section 2 returns the bill to Senate language and removes the Medicaid 100% reimbursement language. In section 3 the $30,000 for the pilot program was left out because it is already in place. The House language on the appropriation of the funds and language relative to the intent of the legislative assembly that the Department of Human Services use the Medicare reimbursement rates for ambulance services was left.

It was explained that the additional funding was already covered by the appropriations committee base on the House amendments.

Sen. KILZER expressed his displeasure at the legislative assembly mandating rate structure for services. He feels it sets a precedent for other under reimbursed providers who will also want action taken by the legislature on their behalf. A point of discussion was the ability of other medical services to shift cost to cover the low Medicaid reimbursement. Ambulance services don't have that option. Legislative action has already been taken in favor of dentists. The point was also made that ambulance services cost shift through insurance billings and county mill levies.

Sen. DEMERS moved that the committee recommend the Senate recede from its amendments and the committee adopt proposed amendment 90180.0205 and amend by inserting a period after the word "volunteers" on page 3, line 4, delete the rest of the sentence and delete page 3, lines 5 and 6. Rep. METCALF seconded the motion. After discussion concerning the appropriateness of the action, the motion PASSED on a roll call vote: Senate: 2 YES, 1 NO, 0 ABSENT. REPRESENTATIVES: 3 YES, 0 NO, 0 ABSENT.

The conference committee meeting was adjourned.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1038

House Human Services Committee

☒ Conference Committee

Hearing Date April 13, 1999

Tape Number	Side A	Side B	Meter #
1	x		0.0-end
Committee Clerk Signature	Wayne B Hamilton		

Minutes:

Then conference committee was called to order by Rep. ROBIN WEISZ. Other members present were Rep. JACK DALRYMPLE, Rep. RALPH METCALF, Sen. RALPH KILZER, Sen. RUSSELL THANE, and Sen. JUDY DEMERS.

The conference committee met again because the Senate rejected the April 8th conference committee recommendation.

New proposed amendments were discussed. Rep. DALRYMPLE told the committee that the appropriations committee would provide the general funds if the proposed amendment was accepted by the legislature. This additional $35,000, with the federal monies, will provide sufficient funding to raise ambulance reimbursement rates to Medicare rates.

Rep. METCALF moved that the committee recommend the Senate recede from its amendments and adopt proposed amendment 90180.0207. The motion was seconded by Sen. KILZER. After

discussion that clarified the funding the motion PASSED on a roll call vote: 6 YES, 0 NO, 0

ABSENT.

The conference committee adjourned.

Prepared by the Legislative Council staff for
Representative Weisz
April 8, 1999

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1038

That the Senate recede from its amendments as printed on page 1120 of the House Journal and pages 699 and 700 of the Senate Journal and that Engrossed House Bill No. 1038 be amended as follows:

Page 1, line 5, replace "ambulance" with "prehospital emergency" and replace "assistance billings" with "services"

Page 1, line 6, replace "for appropriated funds" with "department of human services medical assistance reimbursement rates"

Page 1, line 11, remove the overstrike over "~~assist~~" and remove "offer services and financial"

Page 1, line 12, remove "assistance"

Page 1, line 13, after "~~branch~~" insert "department" and remove the overstrike over "~~and financially shall assist certain prehospital emergency medical~~"

Page 1, line 14, remove the overstrike over "~~services as determined by the~~", after "~~branch~~" insert "department", remove the overstrike over "~~in obtaining equipment~~", remove "department", remove the overstrike over "~~Assistance~~", and remove "No more"

Page 1, remove lines 15 and 16

Page 1, line 17, remove "and financial assistance"

Page 1, line 19, remove "services and financial"

Page 1, line 20, remove the overstrike over "~~To qualify for financial assistance for equipment, a prehospital~~"

Page 1, line 21, remove the overstrike over "~~emergency medical service shall certify, in the manner required by the~~", after "~~branch~~" insert "department", and remove the overstrike over the second overstruck comma

Page 1, remove the overstrike over line 22

Page 1, line 23, remove the overstrike over "~~acquisitions. The~~", after "~~branch~~" insert "department", and remove the overstrike over "~~shall adopt a schedule of eligibility for financial~~"

Page 1, remove the overstrike over line 24

Page 2, remove the overstrike over lines 1 through 4

Page 2, line 5, remove the overstrike over "~~financial assistance available for various classifications.~~"

Page 2, line 10, remove the overstrike over "~~No more than one-half of the funds~~"

Page 2, remove the overstrike over lines 11 and 12

Page 2, line 15, remove "**Medical assistance -**"

Page 2, remove lines 16 through 20

Page 2, line 21, remove "assessment. This"

Page 2, remove lines 27 through 31

Page 3, line 11, after the period insert "The state department of health may accept funds from other sources and may distribute these funds to prehospital emergency medical services providers for the purpose of obtaining equipment. It is the intent of the fifty-sixth legislative assembly that the department of human services adopt the medicare reimbursement schedule for medical assistance reimbursement for basic rate prehospital emergency medical services."

Renumber accordingly

Adopted by the Conference Committee
April 8, 1999

VR
4/8/99
1 of 2

CONFERENCE COMMITTEE AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1038 **HUMSER 4/8/99**

That the Senate recede from its amendments as printed on page 1120 of the House Journal and pages 699 and 700 of the Senate Journal and that Engrossed House Bill No. 1038 be amended as follows:

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Page 2, remove lines 27 through 31

CONFERENCE COMMITTEE AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1038 HUMSER 4/8/99

Page 3, line 4, remove "and a total of $489,800, of"

Page 3, remove line 5

Page 3, line 6, remove "in 1999 Senate Bill No. 2012 for reimbursement of prehospital emergency medical services"

Page 3, line 11, after the period insert "The state department of health may accept funds from other sources and may distribute these funds to prehospital emergency medical services providers for the purpose of obtaining equipment. It is the intent of the fifty-sixth legislative assembly that the department of human services adopt the medicare reimbursement schedule for medical assistance reimbursement for basic rate prehospital emergency medical services."

Renumber accordingly

REPORT OF CONFERENCE COMMITTEE

HB 1038, as engrossed: Your conference committee (Sens. Kilzer, Thane, DeMers and Reps. Weisz, Dalrymple, Metcalf) recommends that the **SENATE RECEDE** from the Senate amendments on HJ page 1120, adopt amendments as follows, and place HB 1038 on the Seventh order:

That the Senate recede from its amendments as printed on page 1120 of the House Journal and pages 699 and 700 of the Senate Journal and that Engrossed House Bill No. 1038 be amended as follows:

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Renumber accordingly

Engrossed HB 1038 was placed on the Seventh order of business on the calendar.

90180.0207
Title.0500

Prepared by the Legislative Council staff for
Representative Weisz
April 12, 1999

VR 4/13/99 1082

CONFERENCE COMMITTEE AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1038 **HUMSER 4/13/99**

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SECTION 4. MEDICAL ASSISTANCE - REIMBURSEMENT FOR AMBULANCE SERVICES. During the biennium beginning July 1, 1999, and ending June 30, 2001, the department of human services shall spend $276,000 in addition to the $943,068 in the executive budget recommendation for medical assistance reimbursement for ambulance services. If the amount of ambulance services billing is less than the amount required to be spent under this section, the department of human services shall reimburse ambulance services at one hundred percent of billing for ambulance services and the department shall use the remainder for medical assistance reimbursement for other medical services."

Renumber accordingly

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE) - 420

07398

(Bill Number) HB1038 (, as (re)engrossed):

Your Conference Committee
Attending 4/13/99

For the Senate:	Attend	Vote	For the House:	Attend	Vote
Kilzer	Y	Y	Weisz	Y	Y
Thane	Y	Y	Dalrymple	Y	Y
DeMers	Y	Y	Metcalf	Y	Y

X ☐ recommends that the (SENATE/~~HOUSE~~) (~~ACCEDE to~~) (RECEDE from)
723/724 725/726 S724/H726 S723/H725
the (Senate/~~House~~) amendments on (~~SJ~~/HJ) page(s) 1120 - _____

☐ and place _____ on the Seventh order.
727

☐ , adopt (further) amendments as follows, and place _____ on the Seventh order:

☐ having been unable to agree, recommends that the committee be discharged and a new committee be appointed.
690/515

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: ____/____/____

CARRIER: _____

LC NO. _____ . _____ of amendment

LC NO. _____ . _____ of engrossment

Emergency clause added or deleted _____

Statement of purpose of amendment _____

(1) LC (2) LC (3) DESK (4) COMM.

REPORT OF CONFERENCE COMMITTEE

HB 1038, as engrossed: Your conference committee (Sens. Kilzer, Thane, DeMers and Reps. Weisz, Dalrymple, Metcalf) recommends that the **SENATE RECEDE** from the Senate amendments on HJ page 1120, adopt amendments as follows, and place HB 1038 on the Seventh order:

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Renumber accordingly

Engrossed HB 1038 was placed on the Seventh order of business on the calendar.

1999 TESTIMONY

HB 1038

WISHEK ALS AMBULANCE SERVICE

TO: Members of the Human Services Committee.

From: Wishek ALS Ambulance Service.

We the members of the Wishek ALS ambulance service along with our associates the Lehr and Zeeland First Responders support bill number 1038.

This funding is vital to our survival in prehospital care.

Please consider the consequences of emergency care in North Dakota when voting on this bill.

We thank you for your support to the dedicated EMS workers in North Dakota.

Jo Vilhauer squad leader, Wishek ALS ambulance Service.

Jo Vilhauer

NAPOLEON AMBULANCE SERVICE
NAPOLEON, NORTH DAKOTA.

Human Services Committee:

Clara Sue Price Chr.

This letter is in support of bill number 1038.

The past funding has been a key to our survival as a pre hospital provider.

Funding for our service is a critical issue, we urge you to support the dedicated EMS workers in our state.

Without the division of emergency health services our state EMS would be in a sorry state as well.

Please consider North Dakota EMS a priority in your voting.

Thank you for your support.

Napoleon Ambulance Service.

Napoleon, North Dakota.

Deb Sperle, Squad Leader, EMT P

Madam Chairman
Members of the Human Services Committee,

I have been involved in E.M.S. for 25 years in this state. I have been a E.M.S. Board member for 15 years. I work for a small rural ambulance in N.E. North Dakota.

Over the years we have seen a steady decline in any help that we get. When you figure an ambulance cost anywhere from 60, to $100,000 it is very hard to keep up with the technology.

The only thing I see wrong with this scenario is when an ambulance breaks down, it is very hard to repla[illegible] have over 100,000

miles on them et are stating to nickel and dime us to death.

When are the people in the state going to matter to the legislature people?

You are sitting on a proposed money allotment of 52 million dollars to give Grand Forks a big dirt wall. ~~Do~~ Are the people not more important than some dirt wall? Then again maybe you would rather save a lot of property, than care about the people of the state.

In Emrs, we are available 24-7, we go out in all kinds of weather at times even risking our lives,

we have equipment that is getting older and no way to replace it, we have done every conceivable fund raisers there are. When do we count in trying to save the people rather then property of North Dakota?

You will have to excuse my writing, as I am not an English major, I kind of write from the hip.

Thank you for your time
Robert Crawford
Cavalier Ambulance
N.E. Director E.M.S.

Rolette Ambulance Service

attn: Mark

Concerning House Bill # 1038

Our service would like the Human Services committee to support this bill for the ambulance services

Thanks

Rolette Amb. Service

Paul

Members of Human Services Comm.

Please support HB 1038

$3.8 millon is much needed by EMS of North Dakota

Dean Bluek
Rolette Ambulance Sepvice

Delbert A. Bertsch
Mayor

James D. Eberle
Auditor

City of Ellendale

Box 267
Ellendale, ND 58436

Phone (701) 349-3252
TDD (701) 349-3215
FAX (701) 349-4646

To: Human Services Comm. Fax 701-224-7076

From: Richard D. Young Sr.
Ellendale Ambulance Service
Ellendale, ND 58436

Subject: HB 1038 - Please be informed that we support HB 1038 and ask that you do the same.

Thank you, Richard D. Young Sr.

Richard D. Young Sr

Drayton Ambulance Service
Drayton, ND 58225
Phone 454-6505

ND House Human Services Committee

Honorable Chairperson,

I write to urge your support of House Bill 1038 which will appropriate $3.8 million for North Dakota's emergency medical services.

A dedicated funding source is crucial to the survival of North Dakota's rural emergency medical services. Without it, our services usually fund themselves with donations and fundraisers—very unreliable sources of money. How can we continue to allow the quality of emergency health care for North Dakota's citizens and visitors to depend on bake sales and funeral memorials?

No matter the volume of calls, an emergency service needs to purchase and maintain a certain amount of equipment and needs to keep its personnel well-trained. In a remote area, an ambulance service needs to have the same expensive ambulance vehicle, cardiac equipment, trauma equipment, garage and training hall as a service in a more populated area. County funding and patient billing are not enough to cover those expenses, but people there deserve the same access to emergency care as people in the city.

An appropriation of $3.8 million will ensure quality emergency medical care throughout our state.

Thank you.

Cordially,

Rob Boll

Rob Boll, Squad Leader
Drayton Volunteer Ambulance Service

Post-It™ brand fax transmittal memo 7671 | # of pages ▸ 1

To Mark Haugen	From Rob Boll
Co.	Co. DVAS
Dept.	Phone # 701-454-3317
Fax # 701-224-7076	Fax # 454-3817

Nancy Theurer
14 Benteen Drive
Lincoln, ND 58504

To Whom It May Concern:

I'm writing this letter asking for your support of House Bill 1038. This bill is of utmost importance to all rural as well as urban ambulance services. The testimony, the letter, the people are asking for these monies to help keep our ambulance services and their people well trained. Many of the EMS providers are volunteers, and have many out of pocket expenses for required classes to keep themselves current with all the changes in EMS. This takes money, & when you volunteer your time and yet are charged for education to keep them selves current, it becomes a very large burden on the volunteer. We need out volunteer services and need the funding to insure that these services do not disappear, and that out volunteers are trained to the highest standard.

Again I ask for your support on bill 1038.

Thank you for taking this matter seriously and supporting EMS.

In EMS
Nancy Theurer
ND Board of EMS Directors

Phone: 701-223-3751 ctems@btigate.com

North Dakota EMS Association

HUMAN RESOURCES COMMITTEE
Testimony in Support of HB 1038

Monday, January 11, 1999
Fort Union Room

By; Derek Hanson, President
ND EMS Association

SYSTEM OVERVIEW:
Emergency Medical Services (EMS) in North Dakota is in serious trouble. Approximately 95% of the prehospital emergency care is rendered by volunteer EMS providers. Where the average size ambulance squad back in the late 70's consisted of usually 25 - 30 volunteers, currently, volunteer ambulance services are operating routinely with 5 - 7 volunteer members attempting to provide twenty four hour EMS coverage in their community. With usually both parents in the family working, this makes it difficult to find the time to take call for their local EMS unit. And an even harder experience finding the time to conduct fund raisers and complete the necessary training.

The EMS system in North Dakota handles approximately 30,000 ambulance calls each year. This does not reflect the number of calls that Quick Response Units (QRU's), or Rescue Services respond on. An average ambulance call in rural North Dakota usually takes four to six hours to complete because of geographic locations and the locations of medical facilities. How many volunteers can afford to leave their job to go on ambulance calls with these time factors in mind? How many providers can afford to continually take food off of their families table to go on an ambulance call? And how long can we expect them to continue this before there are no rural ambulance services available?

EMS CONCERNS:
Listed below are the top six concerns and problems that EMS in North Dakota faces;

1. Funding is at the top.
2. Recruitment and retention of volunteers.
3. Time Commitment from family, job, etc.
4. Training time, including the financial burden on the individual.
5. Insurance issues - with reimbursement low the volunteer is forced to help conduct more fund raisers.
6. No benefit package. There are no health, life or retirement benefits for these volunteers.

HOW ARE WE COPING?

The first fact that we must all face is that ambulance services in rural area's cannot survive from "fee's for service". With fewer people insured, and less reimbursement paid out than ever before it is not feasible to expect an ambulance service who only generates one hundred calls each year to survive on it's fee's collected. This is why it becomes necessary to solicit additional funding. Additional funding sources include; community donations, city or county subsidy, or mill levy dollars.

Not all communities take advantage of the five mills available to them for a variety of reason's. In some instances, a full five mills would only generate a few thousand dollars in the county. Currently the ambulance might be receiving more dollars in donations than the mill levy would generate so they have opted not to pursue it. In most instances, if the typical taxpayer is already paying taxes to support EMS then the donations stop.

Many services are hiring companies to handle their billing since it is a complicated system and many claims are initially rejected. By doing so, a slight increase in revenue has been noted. Most ambulance services could not replace their vehicle if they were forced to because they don't have the money available to them. The oldest ambulance vehicle in the state is a 1970 ambulance. Actually, about 27% of the state's ambulance vehicles fall between the years of 1970 and 1984.

In the past, our association has offered many possible funding sources for legislative committee's to research such as alcohol tax, cigarette tax, license increase, telephone tax, general funds and others.

TYPES OF SERVICE PROVIDED:

There are several different levels of emergency services provided to citizens in the state.

Ambulance Service - there are 141 licensed ground ambulance services in the state. Ambulance services license at two levels; BLS (basic life support) which is primarily the volunteer EMT's in rural communities. An ALS(advanced life support) ambulance provides EMT-Paramedics to provide a higher level of care for the patient. Some rural communities offer ALS services such as; Linton, Hazen, Cavalier, Wishek, and Garrison just to name a few.

Air Ambulance - currently there are four rotor wing (helicopter) air ambulance services and approximately eight fixed wing (airplane) air ambulance services in the state. Most air ambulance service is provided by advanced level personnel such as EMT-Paramedics, Nurses or physicians.

Rescue Services - these departments provide the heavy duty extrication skills that would be required at a moter vehicle accident or an agricultural accident to extricate a patient. There are approximately 113 rescue services in the state. Rescue service is usually provided by the local fire departments.

Quick Response Unit (QRU) - a QRU can be found in communities who might be too small to support an ambulance service or in a community that does not have adequate numbers of

personnel who can leave their jobs for hours at a time on an ambulance call. Most of the QRU staffing is done by volunteers who respond to the emergency and assist the patient in providing life support skills until a nearby ambulance service arrives to transport the patient.

911 Dispatchers - are trained to provide life saving instructions over the telephone to callers who might need assistance in such emergencies as bleeding, childbirth or cardiac arrest. 911 dispatchers are trained to the standards of the EMD (emergency medical dispatch) program which has been implemented statewide. These skills are proven to be particularly important in rural area's where response times are long.

Training Levels - There are four main training levels involved in EMS. They include; First Responder (40 hours), EMT-Basic (110 hours), EMT-Intermediate (123 hours) and EMT-Paramedic (1200 hours).

SUMMARY:
With hospitals closing their doors, patients living longer, and more medical patients than ever before the EMS system will be a vital part of this state's future. Our association does not look at funding as a local issue, but rather a statewide concern. As you travel from Fargo to Beach you travel through 22 separate EMS systems, most of which are volunteer. And since none of us can predict when our medical emergency or accident might occur, I would think we would all be interested in assuring there will be an ambulance service to care for us.

During this past year, at Republican and Democratic-NPL district and state conventions, resolutions were adopted that said "During the fifty-sixth legislative assembly the Republican and Democratic-NPL parties will work to find a solution to the crisis in emergency medical services." We have confidence in you as law makers to find a solution.

Without adequate funding from the state we are guaranteed to see fewer ambulance services to provide this care when needed. We would like the legislative body to consider a dedicated funding source for the retention, recruitment, and equipment challenges we face.

Please help us secure the much needed $3.8 million to help fund this vital component for life in North Dakota.

Thank you.

HB 1038

Madame Chair and Members of the Committee:

My name is Vicki Berreth, I am a paramedic and have been involved with EMS for 10 years. I started my career in EMS as a volunteer driver for the Kidder County Ambulance in Steele ND. I continued to move up the training ladder to my current level and have become very involved in all aspects of EMS across the state. I am in a unique position, I make my living in EMS and am also a volunteer. I currently put in 60-80 hours per week, not including my volunteer hours, in The EMS field. I work as a paid paramedic 40 hours per week for The Standing Rock Ambulance Service in Fort Yates, I am an EMS Instructor for St. Alexius Medical Center and provide EMS Education to all levels of EMS for students in North Dakota as well as other states 20-40 hours per week. I was the EMS Coordinator for Kidder County for 4 years, served on the Kidder County Ambulance Board of Directors for 3 terms, served as the 911 Coordinator for 2 years and am currently serving a 2 year term on the North Dakota EMS Association. I am here today representing The ambulance services in Fort Yates and Steele which have approximately 40 paid and volunteer personnel, and Quick Response Units that include the cities of Steele, Robinson, Tuttle, Tappen and Dawson, that have approximately 30 volunteers. As a SW Regional Director for the ND EMS Association I represent the cities of Steele, Dawson, Tappen, Robinson, Tuttle, Wing, Driscoll, Sterling, Wilton, Goodrich and Fort Yates.

We have a serious problem in our North Dakota EMS system. We are in trouble and we are not being heard. We consist of thousands of volunteers that donate tens of thousands of hours. We give up family time, holidays, birthdays, and paid time at work, not to mention all of the hours of sleep. What do we do it for? For your child who fell off his swing, for your father who is having chest pain, your mother who broke her hip, your wife who is having a baby and you who rolled your car at 5:00 am. We have been your friend, your rescuer, your nurse, your physician, your councilor, your minister and your sounding board. We have been there for your emergencies from runny noses to death. We have stood beside you and prayed with you in the emergency room when we could have been working for pay. We have laid in the ditch with you and yours trying to keep you alive and warm while you are being cut out of your car. We have injured our backs, broke our hearts and bruised our feelings. We have been spit on, thrown up on, punched, kicked and cussed out. We go home and to work tired, defeated, depressed but also elated, happy and at peace.

Imagine that you had a job that included all of this? What would this position be worth to you? Have you ever read a job description such as this? Would you work for an employer who demanded all of this and more, yet expected that we not ask for pay, raise our own money for supplies and equipment in whatever way we could. And arrange our own job training and continuing education.

Yet we still continue to go to work, some of us for 20 or 30 years. We have asked for your help

repeatedly in the past. We are getting tired. Tired of being told our needs are not as great as others. We are tired of not being a priority. Tired of being told our jobs are not as important as some. When we ask for funding it is not because we want to be paid. We are asking for our 10 year old ambulance and equipment be replaced. We are asking for training dollars so we can continue to care for you and yours. We are asking for assistance to train new people to cover our burnout. And we are asking this not for ourselves, we are asking this for your life.

The expenses we have to absorb are rising rapidly, our collections are down, we have done this on our own for as long as we could. We need your help, When I go home and go back to the squads I represent I want to be able to tell them that help is on the way. I want to tell them that our State is behind us. Please hear us this time and send bill # 1038 out of this committee with a do pass recommendation.

Thank You for your time.

Testimony for House Bill 1038
before the
Human Services Committee
by
Timothy Wiedrich, Director
Division of Emergency Health Services
North Dakota Department of Health

January 11, 1999

The statutory responsibilities of the Department of Health concerning emergency medical services (EMS) are generally described in N.D.C.C. Chapter 23-27. This chapter governs the licensing of ambulance services by the health council, places limitations on the liability of EMS volunteers, requires the health council to establish training requirements for providers and provides financial assistance by the Department to local providers.

We are aware that members of the North Dakota EMS Association will be providing testimony for you today regarding the need for additional financial support , so we will not be redundant by addressing that issue. I would like to give you an overview of the Emergency Medical Services Grant Program and define for you what is contained in the Department's Executive budget request.

The Emergency Medical Services Grant Program was created by the Legislative Assembly in 1989 following completion of a legislative study. The grant program allows the Department to establish policies for the distribution of grant funds. Eligible entities for receipt of funds include ambulance services, quick response units (which provide care while an ambulance is enroute) and rescue services (which remove patients from situations of entrapment).

The statute allows the provision of grants for two purposes. The first is to defray training expenses for EMS personnel. The second is to assist with the purchase of equipment.

The equipment grants require a 50% local contribution. Legislative intent created in 1989 established that the equipment grant be provided only if training needs were adequately met. No equipment grant has been provided since the inception of this program.

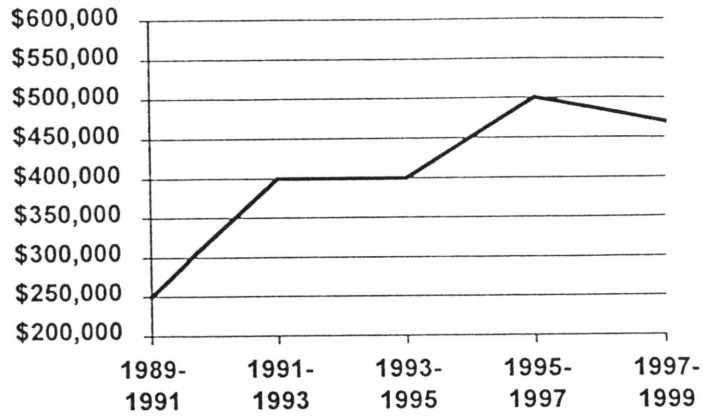
Training grants are provided to eligible services for newly trained Emergency Medical Technicians (EMT) at the Basic, Intermediate and Paramedic levels. Historically, these training grants have been approximately $250 for each new EMT. Approximately 300 EMT grants are provided each year to eligible services.

Continuing education grants are also provided annually to each eligible service. These funds are used to defray continuing education costs associated with maintaining existing personnel. The annual grant amounts have ranged between $1,000 and $1,200 for each eligible service. There are currently 213 eligible services.

There has been variance in the level of appropriations provided to the EMS Grant Program since it's inception. The appropriation provided has not met the level requested by the North Dakota EMS Association or the recommendations of the 1988 Interim Legislative Committee which developed the bill creating the grant program.

Emergency Medical Services Training Grant Program

Biennial Budgets



All funds are from the State General fund with the exception of the 1995-97 biennium which contained $200,000 of Federal Highway Safety funds and $300,000 of State General funds. The ND Legislature appropriated $500,000 at the grant program's inception. The fund was eliminated in the first biennium as a result of a tax referral. It was later re-established at the level of $250,000 by the Governor midway through the biennium.

Section One of HB 1038 has several housekeeping revisions including removal of the phrase health services branch which is no longer used in statute when referring to the Department. The only revision of substance would be the removal of the provision to develop a schedule requiring greater local contribution for services with higher run volumes and adds a requirement to establish a schedule which takes fixed costs of the service into consideration.

Section Two adds an appropriation. The Department's appropriation for the current biennium contains $470,000 for the grant program. The Executive budget for next biennium doubles that amount to $940,000. We believe that North Dakota's EMS System is facing significant financial challenges and that it is appropriate and necessary for us to increase this fund to the $940,000 level. All of the funds contained in the Department's budget request for next biennium would be used to fund training grants. No equipment grants would be provided.

We believe the EMS Grant Program has been effective in helping stabilize North Dakota's EMS System. The Department will continue to work closely with the EMS community to distribute these funds in an equitable and effective manner.

TESTIMONY BEFORE THE SENATE HUMAN SERVICES COMMITTEE

REGARDING HOUSE BILL 1038

FEBRUARY 24, 1999

Chairman Thane, members of the committee, I am David Zentner, Director of Medical Services for the Department of Human Services. I appear before you today to provide information and to recommend changes in this bill.

This bill as originally introduced did not contain reference to the Medicaid Program. For that reason, the department did not offer any testimony during the committee hearing before the House Human Services Committee.

Subsequently, the bill was amended to provide a definition for emergency services, define how Medicaid must pay for ambulance services and includes $146,880 in general funds to provide additional payments to ambulance providers during the next biennium. The additional funds were not included in Governor Schafer's budget nor were they included in the budget approved by the Senate.

It is my understanding that the original purpose for this bill was to provide training funds for Emergency Medical Technicians (EMT's) in rural areas of the state. Most of these individuals are dedicated volunteers who receive little or no pay for their services and often have to pay for their own training.

The Medicaid funds were apparently added to augment the $940,000 of the original $3,800,000 that was included in this bill for training costs. The additional funds that would total about $489,800 will likely provide little or no funding for this training effort for small rural community ambulance services.

The additional Medicaid funds would permit the department to raise fees to

providers by about 50% over the two years of the next biennium. These funds would go directly to the ambulance services with no strings on how the money would be spent. There is no guarantee the funds will be used to provide training for EMT's. Most of the funds will go to urban ambulance or out of state providers. Most of our recipients who utilize ambulance services reside in the eight largest cities in North Dakota. Many rural ambulance services do very little business with Medicaid because most of their runs are for elderly patients who have Medicare coverage. Our records indicate that 64% or about $313,730 would be paid in these cities. The major ambulance companies in Bismarck/Mandan and Fargo would receive about $76,100 and $74,500 respectively.

In addition about 8.5% of ambulance payments are made to out of state providers. The amount of funds that would go directly to out of state providers for this fee increase would be about $41,600.

The amount of dollars from this fee increase that would be paid to the urban and out of state providers totals $355,330 or about 72.5% of the dollars. As noted previously these funds can be used for any purpose and will not be used to provide training to rural ambulance services in North Dakota.

By way of contrast, many small struggling rural services will receive very few additional dollars. For example, four small ambulance services in each area of the state were reviewed, Regent in the southwest, Westhope in the northwest, Lakota in the northeast and Lidgerwood in the southeast. For the year ended September 30, 1998, those providers received payments of $73.80, $93.27, $111.14 and $97.98 respectively from the Medicaid Program. Assuming similar utilization patterns these ambulance services would receive about $36, $47, $56 and $49 more per year in Medicaid payments during the next biennium. Also, these funds are not designated for training purposes and; therefore, can be used for anything the provider determines appropriate. There is no expectation or requirement from the Medicaid Program that the funds will be spent for training EMT's.

If the purpose of the portion of this legislation relating to payments for Medicaid services in Section 4 is intended to increase the amount of training dollars available to rural ambulance services, it appears it will not accomplish that goal. If it is designed to provide additional funds to ambulance providers operating in the largest cities in North Dakota to use as they see fit, that goal will be accomplished.

Section 2 of this bill sets forth the method the Department must use to pay ambulance providers and defines what constitutes a medical condition for payment under the program. The payment method described in the legislation is the current procedure used to pay ambulance providers. Also Medicaid Programs are required to ensure that recipients have medical transportation to and from necessary medical care.

The Medicaid Program must operate within the confines of the appropriation provided to it for each biennium. For that reason it is important that the Department have flexibility to manage the payment aspects of the program in order to react to changes in numbers of eligible recipients, utilization and other factors. Prescribing specific payment methods in state law restricts our ability to make those necessary management decisions. While this bill only relates to prescribed payments for ambulance services it can serve as the model for other provider groups to ensure a specific payment level for the Medicaid Program.

We would recommend removal of the language that specifies the type of payment process we must follow for payment of services contained on lines 15 through 21 of the bill in Section 2 of this bill.

The Department is also opposed to the additional appropriation for the Medicaid Program as it was not included in governor Schafer's budget request and will do little to improve available dollars to provide training to the rural EMT's of our state.

I would be happy to answer any questions you may have.

The Role of Rural Primary Care Providers in the Provision of Mental Health Services: Voices from the Plains

Letter to the Field No. 10

by Jack M. Geller, Ph.D., Marshfield Medical Research Foundation

Introduction

It has been twenty years since Regier, Goldberg, and Taube (1978) coined the phrase the "de facto mental health system," referring to the provision of mental health services by the general medical sector. At that time, using epidemiological methods, they estimated that approximately 60 percent of the total persons affected by mental disorders sought treatment in a primary care setting. Subsequent studies have continued to affirm the presence and importance of this de facto system (U.S. Department of Health and Human Services, 1984; National Rural Health Association [NRHA], 1992; Regier, Boyd, & Burke, 1988; U.S. Congress, 1990).

Physicians that practice in rural and frontier areas tend to play an even larger role in mental health care provision than their urban counterparts. This is in part due to the relative scarcity of mental health and other health care professionals in these outlying areas of the country. Other factors include the apparent preference rural residents have for primary care physicians (Johnson, 1995) and the stigma often associated with seeing a mental health professional. Unfortunately, sparsely populated areas without established mental health services (i.e., counseling) or providers (i.e., psychologists, social workers) also tend to have relatively few primary care physicians to act as substitutes. Nonmetro and frontier areas possess far less physician coverage than more urbanized areas even after controlling for population size. For example, Frenzen (1991) found that in 1988, the ratio of primary care physicians per 100,000 persons for remote rural areas was 38.2; for the more inclusive nonmetro areas it was 51.3. In comparison, metro areas had a ratio of 95.9.

Unfortunately, much has also been written about the deficiencies of primary care physicians in their treatment patterns (Anderson & Harthorn, 1989; Rost, Humphrey, & Kelleher 1994; Rost, Williams, Wherry, & Smith, 1995), referral patterns (Anderson & Harthorn, 1989; Farmer & Griffiths, 1992; Ozbayrak & Coskun, 1993), and training to treat people with mental disorders (U.S. Congress, 1990; Zimmerman & Wienckowski, 1991; NRHA, 1992). However, there is a growing realization that, regardless of shortcomings, primary care providers will continue to be sought out by patients for care of mental disorders, due to preference or lack of alternatives. Thus, a more recent focus has been on improving the link between primary care providers and mental health specialists. This may include integrated clinics, telecommunication links, or simply improving the competency of primary care providers through clinical practice guidelines, utilization of screening instruments, or greater contact with mental health professionals.

Conspicuously absent from most of these studies, commissioned reports, and policy papers, is the voice of the rural primary care provider. Perhaps due to their intense practice schedules, little has been written from their perspective. Accordingly, this paper presents the findings from a focus group held in early 1998, of a group of rural primary care providers who practice on the Western plains. While it would be far too presumptuous to suggest that this group of rural providers

represent the thousands of physician, nurse practitioners, and physician assistants who treat rural and frontier residents every day, it does provide some insight into their perspective.

Methodology

As part of the Frontier Mental Health Services Resource Network, focus groups of providers and consumers were held in many rural locations throughout 1997 and 1998. The were held to better understand how people receive mental health services in the most remote areas of the country. This particular focus group was held during the winter of 1998 and consisted of six providers: three physicians, two nurse practitioners, and one physician assistant. All the providers practice in rural communities within a 30-40 mile range from each other.

All can be characterized as generalist providers who actively see and manage patients, many with serious mental disorders. Most of their patients have few or no other local choices, except for a visit from a mental health outreach worker from the nearest urban area (population 65,000, approximately 50 miles away). Three of the group members were male and three were female. The only unusual feature of this group of providers was their age. With the oldest group member being 49 years of age and the youngest being less than one year out of his internal medicine residency program, these providers are clearly younger than your average rural provider. On the other hand, these group members may represent "the new rural provider". Again, no claim is being made that this group represents anything beyond the views of the six members themselves.

The group was convened at a central location away from their clinics to discuss the extent to which mental health services are a part of their practice. The participants discussed their treatment and referral patterns, their training and competencies, and their relationship with the formal mental health system. The entire focus group discussion was audio taped, with the permission of the group members, and subsequently transcribed. Below I have attempted to juxtapose the contemporary literature on the role of primary care providers with the comments from focus group members. As one will see, in some areas the comments of the focus group members mirror previous findings in the literature. However, in other areas, new data emerged.

A note about confidentiality; all members of the focus group were assured that their identities would be kept strictly confidential. As this group of providers would be easily identified if their practice locations were revealed, the fictitious town of "Plainville" was created to represent their practice location. Two additional communities are referenced in their comments. The first is the closest urban community, a college town of approximately 65,000, which I have named Collegeville. The second is the largest metropolitan city in the state (population over 1 million), where large tertiary centers are located. I refer to this city as "Metropolis".

The Role of Primary Care Providers

As mentioned above, it is clear from previous literature that primary care physicians provide a large percentage of the mental health services to patients with mental disorders. This was clearly true among our focus group participants. All viewed mental health as a significant part of their practice. When asked to estimate what percentage of their patient load is primarily mental health, most estimated 10 percent. When further asked what types of common disorders their patients'

experience, the most common disorders were depression, anxiety/panic attacks, attention deficit disorder, and dementia among the elderly.

It is also important to recognize that, since these providers are virtually the only ones in Plainville, their patient load comes from a variety of sources. These providers not only have their private clinic and hospital practice, but they must provide care at nearby nursing homes and at the county jail. This diversity leads to providers always feeling inadequate with some of their patients. As one physician noted, **"I have a pretty clear idea of how far I can go with a depressed patient ... but the place where I really get stuck all the time is with geriatrics. Particularly dementia, they're real tricky and they mask a lot of things. ...they tell you what you want to hear. They want to please you and then you find out from their family that, oh yeah, they're running around in their underwear out at 6:00 in the morning. You know, yeah, that kind of thing."**

Another provider noted, **"...what's been interesting since we've been covering the jail, that's another whole segment there, that population has a lot of significant mental health problems. ...they all fall between the cracks....they've been on medication, they come in, and it's been stopped. Then it's really a difficult thing ... you know, being confined and not having their medication, not having someone to send them to or try to find out what they were on. It really is an area that needs to be dealt with somehow."**

As suggested, these providers take their role as mental health providers seriously. Unfortunately, they have few local specialized services to access for their patients and describe what can be best called a fragmented system. When asked to describe the mental health resources, one provider noted that, **"maybe one psychiatrist comes out periodically."** Another provider quickly noted that the psychiatrist covers three counties. Further discussions about another area psychiatrist quickly displayed the fragmentation. When asked if this second psychiatrist came from Collegeville, he noted, **"I'm not sure where he comes from. I guess that's the whole idea is that we do not know!"** Another focus group participant noted, **"And another particular entity that I think we're missing are care planners, or what's that term, 'care coordinators'. We are desperately in need of those folks to just let everyone know what's going on with this patient."**

When asked how they cope with such fragmentation, these providers displayed the same resourceful ingenuity found in all sectors of rural life. **"But Plainville is a small enough town,"** one participant noted, **"so we regularly ... discuss patients who are really difficult who – most of whom turn out to be people with a mental health diagnosis or substance abuse diagnosis. But what we have really done is we've developed kind of a, not just practice-wide, but community-wide approach to them, so that when my patient X shows up in the ER, everybody kind of knows what to tell her. And that's one of the advantages of this real small system."**

General Competencies

A number of articles have concluded that non-psychiatrist or primary care physicians are, by and large, inadequately prepared to recognize, refer, or treat mental disorders (Feldman, 1978; Pincus,

Strain, Houpt & Gise, 1983; Jones, Badger, Ficken, Leeper & Anderson, 1988; Zimmerman & Wienckowski, 1991; Barrett, 1991; NRHA, 1992). Other possible reasons for this drawback, besides inadequate training in psychiatry/psychology, include:

- heavy patient load and time constraints on patient visits
- expectations of authority and peers
- medical school selection processes
- students' experiences in medical school.
- patients' lack of complaints concerning mental disorder
- lack of familiarity with the patient
- uneasiness about confronting the patient with the diagnosis
- apprehension about submitting the patient to possible side-effects of drug treatment
- mistaking symptoms of mental disturbance for situational adjustment reaction
- a lack of interest in psychiatry (Feldman, 1978; Orleans, George, Houpt, & Brodie, 1985; Fogel, 1993; Zung, Magill, Moore & George, 1983; National Institute of Mental Health, 1986; Kelleher, Holmes & Williams, 1994)

Somewhat contrary to previous findings, Andersen and Harthorn (1989) found that primary care physicians recognized the presence of mental disorder essentially as well as mental health professionals (e.g., psychiatrists, psychologists). However, these physicians were less accurate in their diagnoses of affective, anxiety, somatic, and personality disorders. Generalist physicians were most accurate (81%) in recognizing organic disorders and least accurate (14%) in identifying personality disorders. Only about one-half of the physicians correctly identified anxiety (49%), somatic (49%), and affective (47%) disorders (Andersen & Harthorn, 1989).

There was significant consensus among the focus group participants that they do the best they can, but clearly were not adequately trained to provide a full range of mental health services. As one physician succinctly put it, "**And I think that, just speaking freely, I don't think I'm adequately trained to do a lot of what I do. So I make a lot of phone calls to psychiatrists I know in Metropolis, and just ask– what would you do given the situation? ... Well, I just don't feel adequate doing a lot of what I do. A lot of hand holding.**" While another participant philosophically noted, "**Well, I think – I've used this line many times, I hope I haven't seen more than I have. Because you don't know how much you miss. You always know that there is more out there that you don't know, and you're not recognizing. You just say, I'll take care of what I can identify. And that's why the relationship with the patient is so important.**"

Consequently, all the participants noted the need for better training in medical school and residency programs. As one of the older physicians noted, "**I had to learn how to put in a chest tube, and that's true, you do have to know how to put in a chest tube. But how many times a year do you put in a chest tube when you are practicing in a small town? Once, maybe. How many people are you going to see with depression?**"

At the same time, all the providers noted that while identifying depression, or other mental illness is sometimes illusive, there are more times when patients reveal mental health problems within the course of a routine office visit. As one of the nurse practitioners noted, "**But you never know**

what you are going to get. They tell the front office that they only have this. Then they get in and they tell you they only have this. And then [at the end of the visit] your hand reaches for the door handle and they say, 'I've been using drugs for this period of time, and I'm thinking of killing myself.' And then you go, oh." While another physician noted, "...**it's like they have been wanting to talk to you so they come in under the guise of insomnia or whatever, and then the mental health stuff starts surfacing.**"

It's reasonably clear that all of the participants were aware of their apparent deficits in recognizing mental disorders among their patients. At the same time they are quite honest and straightforward about it. As one physician mentioned, "...**I think that sort of uncertainty is just one of the things you live with being a generalist.**"

The Relationship between Rural Physicians and Mental Health Professionals

When one reads the literature, one gets a clear impression that there is a strain between these two professional communities. Much of the literature is written by mental health professionals (primarily psychiatrists and psychologists) and suggests that generalist physicians do a poor job of recognizing mental illness in their patients, over-prescribe medication, under-dose, and do not refer patients frequently enough to mental health professionals.

This professional strain was quite apparent amongst the focus group participants. Interestingly however, these participants told a much different story than the literature suggests. For example, when first asked about the percentage of patients they refer to mental health professionals, instead of the relatively low percentages (10-30%) cited in the literature (Shapiro & Fink, 1963; Locke, Krantz, & Kramer, 1966; Fink, Goldensohn, Shapiro, & Daily, 1967; Orleans, George, Houpt, & Brodie, 1985), these providers responded with figures that ranged from 40 percent to 80 percent. Confused over this disparity, we discussed the definition of a referral.

Through this discussion several things became clear. All the providers in the group recognized the need for adjunctive therapy (primarily counseling) in addition to the medical management of their patients' medications. They were also acutely aware of the time constraints that exist in a primary care medical practice. Thus, they routinely seek out mental health counselors for their patients, which they define as a "referral". These counselors may be masters prepared counselors, or social workers, but rarely psychiatrists or psychologists. These rural providers speak highly of these counselors and rely on them to assist in the management of their patients with mental illness. However, when asked about referring their patient to a psychiatrist, they admit that this percentage is very small.

When asked what criteria they use to decide when it is time to refer their patient's care to a psychiatrist, each provider had his or her own criteria. However, some of the more common criteria included: if the patient is acute (i.e., needing to be hospitalized); if they come into the emergency room with a mental disorder; if, after several attempts, their medication regimen fails; or if they routinely find that they cannot meet a patient's needs within the time constraints of a medical practice.

Another important factor influencing referral patterns was the expectation of the rural patient. Many of these physicians believe that their patients fully expect them to meet all their health needs regardless of origin. Consequently, some of these rural providers feel pressure to treat patients, even through all their uncertainty, due to this patient expectation. As one provider stated, referring to other rural physicians, "... **these good old boys were there to deliver the babies, to fix the hernia, to take out the appendix, and they pulled them through all of these things. And now mental health is another thing he can fix because he fixed all these other things**."

Overall, it is fair to say that referral to a psychiatrist is closer to a last resort that a first resort. Most of the focus group participants noted that because of past experiences they are uncomfortable referring any but the most acute patients to psychiatrists. One noted that by not referring patients she was "protecting them from the [mental health] system." Others recognized that this aversion to referring patients to psychiatrists further strains the relationship. As one physician noted, "**And I think that creates a bad rapport between the folks (psychiatrists) that we do use because we send them our 'bombs'. And they think, 'here's someone else from Plainville!**"

Another problem voiced by the group was the lack of communication between rural primary care providers and urban psychiatrists. This is often reflected in the amount of patient information received by the rural provider from the psychiatrist after a referred patient returns to the rural community. These providers feel that, unlike other medical specialists (e.g., cardiologists or oncologists) who provide feedback to the primary care provider regarding the diagnosis and treatment regimen of their patient, psychiatrists use the veil of confidentiality to keep information from them. This creates a great deal of frustration for the primary care provider who must now deal with the patient using incomplete information in their ongoing treatment after their return. In fact, as one provider related to the group his frustration about not getting even a discharge summary from a psychiatrist after one of his patient's inpatient episodes, none of the other providers seemed even remotely surprised. As one physician reflected, "... **the mental health profession is now so scared of sharing information, much more than in any realm of medicine. So like this day-of-discharge summary thing you were talking about, they had to do a whole extra song and dance about sending any information back to you about the patient who you referred in with an acute problem. Because they are so worried about confidentiality, although you are the referring physician. ...But they're in a kind of legalistic mode rather than a serve-the-patient mode**."

Further, some rural providers appear to be quite skeptical of the quality of service psychiatrists provide. One physician noted, "... **but anymore, the psychiatrist is someone who calls himself or herself a psychopharmacologist, and they spend 15 minutes with a patient anyway and have a less clear idea than I do about what's going on and spend their time adjusting their medication, and that's all they do. ... and so the services are just really stinky**."

However, the greatest display of animosity toward psychiatrists came from the most senior member of the focus group. A physician who has practiced in both urban and rural environments and has also taught in one of the state's residency program, he boldly stated, " **I think psychiatrists are really; I hate to over-psychologize about psychiatrists, but I think they are**

at this time, they're a miserable bunch! You know, they feel their avenue, their professional venue being shrunk (you should excuse the expression). But what can they do, what can they make, what their view is, and I think they are just pretty miserable people. And that makes them hard to deal with as colleagues too. Because it is very hard to get them to do what you want, or what the patient needs, or to see you as a customer. Because it's like any other, it's like your unhappy waiter that throws food at you. That's how I feel. I practiced in Collegeville for nine years and I knew everybody. And I still know all the shrinks in Collegeville, but when you ask me who did I like to refer to there, it's still zero. I use them some, but there's nobody I really like."

While this remark was the boldest of all, none of the other focus group participants came to the defense of the psychiatric community. Clearly there is a significant gulf between these provider groups that needs to be addressed.

Summation and Limitations

As noted earlier, no attempt has been made to suggest that this group of rural providers is representative of any larger group or constituency. However, their attitudes and opinions can provide us with some insight into the perspective of the rural primary care provider. With that said, I have attempted to juxtapose salient findings in the literature regarding this "de facto" mental health system with the knowledge, attitudes, and opinions of this small group of providers.

In general, one could conclude that many of the findings in the literature have been confirmed. Generalist providers do seem to provide a large percentage of the mental health services in rural areas. Additionally, while, as the literature suggests and the focus group confirms, these providers do the best they can, they often feel uncertain and less than fully prepared to serve the mental health needs of their patients. Yet as one provider noted, uncertainty is a phenomenon all too familiar to the generalist provider.

What was surprising was the extent to which these providers recognize this deficit and seek out "mid-level" mental health workers to provide adjunctive therapy for their patients experiencing mental illness. Focus group participants noted that somewhere between 40-80% of their patients with mental disorders are referred to these mental health workers. This number far exceeds the literature that suggests as few as 10-30% of eligible patients are ever referred to a mental health professional.

Of course, the difference appears to be in the definition of a referral. The literature usually defines referral as a change in the provider who supervises the medical and psychological management of the patient experiencing a mental disorder. These providers defined a referral as the act of seeking adjunctive counseling in addition to their medical and supervisory management of the patient. If this differential definition is common, then it may be quite fallacious to assume that primary care providers who choose to manage patients with mental disorders are inadequately providing or ignoring the counseling needs of these patients.

Another problem highlighted by the focus group was rural providers apparent inability to get patient information back from the urban psychiatrist after they refer patients to them. The

frustrations expressed by these rural providers appear to be a function of two differing standards of patient confidentiality. Where in other sectors of medicine the routine sharing of patient information between the primary care provider and medical specialist is the norm, psychiatrists appear to use a different standard. Consequently, rural providers often have to treat patients returning home from psychiatric treatment with incomplete information on what occurred during hospital stays and without other vital information. This not only frustrates primary care providers, but it further compounds the referral problem by decreasing the probability that the rural provider would ever refer future patients, except for the most acute. One would think that a reasonable compromise could be achieved to ensure that patient confidentiality is upheld and necessary information is shared amongst all appropriate providers.

Finally, it was surprising to find the extent to which these rural providers felt animosity toward the psychiatric community. Throughout the focus group, few if any kind words were spoken about psychiatrists. These rural providers were wary of the way they have been treated by the psychiatrists they refer to and were equally concerned about the quality of care their patients receive. This feeling is apparently so common among these providers that their tendency is to try everything they can to avoid referring the patient. As one provider noted, "...**to protect them from the [mental health] system.**" It is unclear whether it is fully realized at this time how great the gulf is between these professional communities. However, until this gulf is truly recognized, it is hard to imagine how one might initiate a process that will begin to close it.

Lastly, it is important to note again that the data for this paper comes from a very small sample of rural providers in one location. Therefore, it would be extremely risky to suggest that these views are truly representative of all rural providers. However, they do provide some interesting insights and raise some long standing issues. Further, there is little doubt that the voice of the rural primary care provider in this discussion is long overdue. Consequently, further data collection from other primary care providers in other rural locations is sorely needed to help us better understand the dynamic relationship between these two important provider groups.

Reader inquiries are welcome!

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TESTIMONY IN SUPPORT OF HOUSE BILL 1038

Senate Human Services Committee
Senator Russell Thane, Chair
Wednesday, February 24, 1999
Red River Room

Mr. Chairman, my name is Mark Haugen. I am a Past President and a Director of the North Dakota EMS Association. I am presenting written testimony in support of HB 1038.

95% of the EMS systems in North Dakota are considered **"Volunteer."** These systems are made up of people who have a passion and love for this type of work. Without these dedicated volunteers, many rural communities would be without basic emergency medical care. House Bill 1038 helps to assist the volunteer with the cost of education with through direct grants for initial and continuing education. The cost of education for a volunteer EMT can be $1000-$2000 per year. Because of the expense, many young families cannot afford to volunteer for their local EMS system.

House Bill 1038 **as amended,** will give grants to volunteer EMS systems only. We are in support of this amendment, which shifts the funds to only rural EMS systems. However, there was a considerable appropriation reduction in the engrossed bill compared to its original version. The bill originally called for $3.8 million in training grants. Currently, there are only $940,000 in training grants, as amended. We hope this committee will consider an additional appropriation beyond the $940,000. The current appropriation will help, but it will not solve our financial problems we are facing in rural North Dakota.

In Section Two, Medical Assistance-Prehospital Emergency Medical Services, additional funding has been appropriated through the Medicaid program that is administered by Human Services. Once again, we are in support of this amendment. The additional funding will be welcomed by many of our urban EMS systems that handle a large volume of Medicaid clients. However, we are very concern about the statement that reads "The coverage must include provider reimbursement at a rate of the lesser of one hundred percent of the amount billed **or the rate established by the department of human services reimbursement schedule."** What is the Department of Human Services reimbursement schedule? Will it be 100% of the provider reimbursement or something less? If that figure turns out to be something less than 100%, we would like to offer the attached amendment.

This proposed amendment would give the EMS Association the responsibility to survey the providers on the current basic and advanced life support rates. The goal behind the survey would be to give us an accurate assessment of the average rate of reimbursement across North Dakota.

NORTH DAKOTA EMS ASSOCIATION PROPOSED AMENDMENT TO ENGROSSED HOUSE BILL 1038

Section 2, Medical Assistance-Prehospital emergency medical services

Remove the words, "by the department of human services reimbursement schedule."

Add the words, "by the north dakota ems association's annual reimbursement survey."

North Dakota EMS Association

TESTIMONY IN SUPPORT OF HB 1038

Senate Human Services Committee
Wednesday, February 24, 1999
Red River Room

By; Derek Hanson, President
ND EMS Association

Emergency Medical Services (EMS) in North Dakota is in serious trouble. Approximately 95% of the prehospital emergency care is rendered by volunteer EMS providers. In the late 70's, the average size ambulance service consisted of about 25 - 30 volunteers. Today, there are many rural services attempting to provide twenty four hour EMS coverage in their community with only 5 - 7 volunteers. With usually both parents in the workforce, it makes it difficult to find the time to take the training and to take ambulance call within their community. This is primarily due to expenses. And this same group is finding it more difficult to find the time to conduct fund raisers.

We find that many of those in the current baby boomer generation are extremely busy, and look to be paid for their services. Younger folks don't seem to be as willing to donate their time as groups in the past. Plus, when they find out that it will cost them out of pocket expenses to take the training and continue with taking call, it usually scares them away. A person interested in taking Basic Life Support training might need to pay anywhere from $1000 to $2600 out of their own pocket. While some ambulance services do have funds to reimburse these individuals, many do not.

The EMS system in North Dakota handles approximately 30,000 ambulance calls each year. This does not reflect the number of calls that Quick Response Units (QRU's), or Rescue Services respond on. An average ambulance call in North Dakota can take anywhere from four to six hours to complete because of our vast geographic locations and the locations of the medical facilities. How many volunteers can afford to leave their job to go on an ambulance call? By leaving their job they are taking food off of their own families table because their employer does not pay them and many of the ambulance services cannot afford to pay their volunteers. How much longer do we really think these rural ambulance services can hold on? As you travel from Fargo to Beach you cross twenty two EMS jurisdictions, mostly volunteer, that you are at the mercy of should an accident or illness occur. That is, if they are still there when your medical emergency occurs.

Listed below are the top six concerns and problems that EMS in North Dakota faces;

1. Funding is at the top!
2. Recruitment and retention of volunteers.
3. Time commitment from family, job, etc.
4. Training, including the financial burden on the individual.
5. Insurance issues - with reimbursement low the volunteer is forced to help conduct more fund Raisers.
6. No benefit package. There are no health, life or retirement benefits for these volunteers.

Most all of these problems could be addressed if we had adequate funding at a state level.

With hospitals closing their doors, patients living longer, and more people growing older with medical problems, it is obvious that the EMS system in North Dakota will be relied upon and more of a vital part of this state's future than ever before. But will it be there for you and the citizens of this great state?

During this past year, at Republican and Democratic-NPL district and state conventions, resolutions were adopted that said "During the fifty-sixth legislative assembly the Republican and Democratic-NPL parties will work to find a solution to the crisis in emergency medical services." We have confidence in you as law makers to find a solution.

Without adequate funding from the state we are guaranteed to see fewer ambulance services to provide this care when needed. We would like the Senate to consider the bill as it was passed from the House, and to consider an additional appropriation, to help with the recruitment, retention and equipment challenges we face.

Please help us secure the much needed dollars to help fund this vital component for the future of North Dakota.

Thank you.

3/22/99 Derek Hanson

North Dakota EMS Association

SENATE APPROPRIATIONS COMMITTEE
David Nething, Chair

Testimony in favor of
HB 1038
March 22, 1999

By; Derek Hanson, President
ND EMS Association

The North Dakota EMS (Emergency Medical Service) Association has been in existence for twenty-four years. Our mission is to provide educational opportunities and to help secure adequate funding for the EMS system in this state. Approximately 95% of the licensed ambulance services in this state are rural volunteer. Many of these volunteer services are in serious trouble if a stable funding source is not found.

A few ambulance services have needed to close their doors until they were able to retrain adequate personnel and/or find additional funding sources. Luckily, they have been able to reopen and provide emergency services within their region. But the big question is, for how much longer? This is a statewide concern, and not just a local issue! If a person were to travel from Fargo to Beach you would travel through twenty two EMS jurisdictions on that route. At any given time you could be at the mercy of one of those local EMS Systems should you have a heart attack or motor vehicle crash - that is, if they are still there.

Here are the facts; 1. Insurance companies are not reimbursing ambulance services at what we consider to be an acceptable level. Meaning that the expenses for an average ambulance run are typically not covered in full or at a break even rate. Therefore, rural ambulance services just slip further and further into financial distress. It is a myth to believe that rural ambulance services can operate from the "fee's for service". A new ambulance vehicle can cost between $60,000 to $80,000.

2. Not all ambulance services take advantage of the mill levy cap that is available to them. And there's a good reason for that. In some communities the mill levy would only generate a few thousand to maybe four to six thousand dollars. Currently many of them receive more in donations from persons in the community than the mill levy would produce. And if the local citizens are already paying for a tax, then the donations would stop. Which means the ambulance service would take a step backwards.

3. Training is not free. Whether the rural services take advantage of a training agency or a local certified EMS instructor, training is not offered at no cost. And I think we would all agree on the necessity of having people adequately trained. The time involved in training is really not the issue for the rural EMS providers. It all comes down to dollars again. Would you pay for an EMT-Basic course out of your own pocket and then receive nothing back but the gratification of helping people? Then why do we keep expecting these folks to pay for their own training? The average person pays approximately $2000 - $2600 to take an EMT-Basic course. This includes the $300 tuition fee, books, travel, uniforms, etc. Currently, when a person agrees to take an EMT-Basic course they are reimbursed $250 from the state training grants available. The remainder comes out of their own pocket. This means they take food off the table from their own family to have the privilege to volunteer. I wonder why it is so difficult to recruit volunteer EMS providers?

4. Having an Ambulance Service available is a "Public Safety Issue". Fire Services and Law Enforcement agencies are assisted by the state with training dollars, equipment dollars and more. Since Ambulance Service really is a "Public Safety Issue", why shouldn't the state assist EMS so they too can be "ready to respond"?

5. In the present economy it has become necessary for both spouses to work. How many of them can afford to leave their "paying job" to volunteer on an ambulance call? Add this financial burden to the fact that the younger generation doesn't seem to give of themselves like many of us have done over the years, explains why we are having such a problem with recruiting and retaining volunteer ambulance personnel.

The $3.8 million we are asking for does not entirely fund the state system, however, it would give the rural services the financial boost for training & equipment that is much needed. The population in this state is growing older, we are seeing more medical problems such as diabetes than ever before, and people are living longer. Add this to the problem of rural hospitals closing and the EMS System will be relied upon in the future more than ever before. The state AARP group found our dilemma so important that we became one of their top two priorities this legislative session.

We fear for the future of Emergency Care Services if an adequate, and stable funding source is not secured. We ask for your support on HB 1038. We ask you to consider an enhancement to the current bill and to reconsider leaving the additional Medicaid dollars offered in the amendment.

Should you have any further questions please don't hesitate to contact me anytime. Thank you in advance for your consideration.