FIELD HEARING ON ACCESS TO HEALTH CARE IN AMERICA: ENSURING RESILIENT EMERGENCY MEDICAL CARE

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

MARCH 18, 2024

Serial No. 118–FC21

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE
55–785 WASHINGTON : 2024

COMMITTEE ON WAYS AND MEANS

JASON SMITH, Missouri, *Chairman*

VERN BUCHANAN, Florida
ADRIAN SMITH, Nebraska
MIKE KELLY, Pennsylvania
DAVID SCHWEIKERT, Arizona
DARIN LAHOOD, Illinois
BRAD WENSTRUP, Ohio
JODEY ARRINGTON, Texas
DREW FERGUSON, Georgia
RON ESTES, Kansas
LLOYD SMUCKER, Pennsylvania
KEVIN HERN, Oklahoma
CAROL MILLER, West Virginia
GREG MURPHY, North Carolina
DAVID KUSTOFF, Tennessee
BRIAN FITZPATRICK, Pennsylvania
GREG STEUBE, Florida
CLAUDIA TENNEY, New York
MICHELLE FISCHBACH, Minnesota
BLAKE MOORE, Utah
MICHELLE STEEL, California
BETH VAN DUYNE, Texas
RANDY FEENSTRA, Iowa
NICOLE MALLIOTAKIS, New York
MIKE CAREY, Ohio

RICHARD E. NEAL, Massachusetts
LLOYD DOGGETT, Texas
MIKE THOMPSON, California
JOHN B. LARSON, Connecticut
EARL BLUMENAUER, Oregon
BILL PASCRELL, JR., New Jersey
DANNY DAVIS, Illinois
LINDA SÁNCHEZ, California
TERRI SEWELL, Alabama
SUZAN DELBENE, Washington
JUDY CHU, California
GWEN MOORE, Wisconsin
DAN KILDEE, Michigan
DON BEYER, Virginia
DWIGHT EVANS, Pennsylvania
BRAD SCHNEIDER, Illinois
JIMMY PANETTA, California
JIMMY GOMEZ, California

MARK ROMAN, *Staff Director*
BRANDON CASEY, *Minority Chief Counsel*

C O N T E N T S

OPENING STATEMENTS

WITNESSES

LOCAL SUBMISSIONS FOR THE RECORD

PUBLIC SUBMISSIONS FOR THE RECORD

United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

FOR IMMEDIATE RELEASE
March 11, 2024
No. FC-21

CONTACT: 202-225-3625

Chairman Smith Announces Field Hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care

House Committee on Ways and Means Chairman Jason Smith (MO-08) announced today that the Committee will hold a field hearing examining the challenges and opportunities surrounding recent investments in emergency care services and how to strengthen access to emergency care in America. The hearing will take place at **2:00 PM (CST) on Monday, March 18, 2024, at Global Medical Response** in Denton, Texas.

Members of the public may view the hearing via live webcast available at https://waysandmeans.house.gov. The webcast will not be available until the hearing starts.

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Monday, April 1, 2024**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission but reserves the right to format it

according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities accessible to persons with disabilities. If you require accommodations, please call 202-225-3625 or request via email to WMSubmission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the Committee website at http://www.waysandmeans.house.gov/.

###

FIELD HEARING ON ACCESS TO HEALTH CARE IN AMERICA: ENSURING RESILIENT EMERGENCY MEDICAL CARE

MONDAY, MARCH 18, 2024

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to call, at 2:00 p.m. Central time, at Denton Enterprise Airport, 5000 Airport Road, Denton, Texas, Hon. Jason Smith [chairman of the committee] presiding.

Present: Representatives Smith of Missouri, Smith of Nebraska, Kelly, Wenstrup, Arrington, Estes, Smucker, Miller, Murphy, Kustoff, Tenney, Fischbach, Van Duyne, Carey, Sewell, Chu, Moore of Wisconsin, and Beyer.

Also Present: Representative Burgess.

Chairman SMITH. The committee will come to order. Without objection, the gentleman from Texas, Dr. Burgess, is authorized to participate in the hearing and to ask questions.

The Ways and Means Committee is in Denton, Texas, for our seventh hearing outside of Washington. I would like to thank Global Medical Response for hosting us today and giving us the opportunity to see firsthand where you train your pilots, clinicians, and mechanics to respond to emergency situations across the country.

One of our priorities is to help every American access quality health care, when they need it, where they need it. Unfortunately, for too many Americans, especially those living in rural or underserved communities, when they call 911 help may be too far away to reach them in time. That is because there are no ambulances or emergency health care personnel close by to quickly answer the call. Even after help arrives, the trip to the emergency room, if necessary, may be far too long and too expensive.

Today we will hear the stories of Americans who faced challenges accessing emergency care. We will also hear from health care professionals and first responders who rise to meet those challenges and save lives.

Across the country there is a lack of access to emergency care. Eighty-two percent of all U.S. counties contain at least one ambulance desert, where patients live more than 25 minutes from an ambulance post. In Texas it is even worse. Ninety-five percent of the counties in this state have at least one ambulance desert. This problem is amplified in rural areas, where driving distances are longer, and hospitals are further apart. Nearly 4½ million Americans in rural counties do not have ready access to acute care, in-

cluding emergency care. As a result, rural patients can wait up to 30 minutes for EMS after dialing 911, when every second counts.

We also know that access to emergency care can also be a challenge for those living in urban communities, as well. These health facilities frequently must navigate higher volumes of patients with critical emergencies, often stretching hospital staff and resources to the breaking point. Once in the emergency room, patients face another challenge. Wait times have doubled since 2020. Hospitals have had to cut emergency room staff to make ends meet as insurance companies are slashing reimbursements.

It is a nasty consequence from the Biden administration's flawed implementation of a law Congress passed to ban surprise medical bills. Patients in the ER need help quickly. Back in Washington, the Ways and Means Committee has demanded the Biden administration implement the No Surprises Act in accordance with congressional intent and the letter of the law. We will continue our oversight work to shine a light on unfair treatment of patients and ensure Washington bureaucrats follow the laws Congress passes.

A good doctor would stop the bleeding, and we need to stop the financial bleeding of emergency rooms in small towns. One solution is a new designation Congress created under the Trump administration that helps struggling rural hospitals keep their 24/7 emergency rooms open and offer needed primary care. The Rural Emergency Hospital designation has the chance. It has the chance to be a winning scenario. Patients in surrounding areas get the emergency care that they need. Low-volume hospitals no longer have the financial pressure to fill beds, and the local economy gets a shot in the arm.

Texas actually has more rural emergency hospitals than any other state. This designation is off to a promising start, but Congress should continue to bolster this option to make it easier for hospital participation and conversion so that small rural hospitals and similar facilities can better provide needed emergency care.

We need to embrace creative solutions that come from the American people affected by these issues and can positively disrupt a broken status quo. We know the best solutions are ones where we listen first to the American people. That is why we are here today. There will be clipboards passed out in the audience for everyone to share with us your concerns and ideas. We will enter those into the official hearing record and take those back with us to Washington as we consider how to protect rural communities, our farmers and ranchers and small businesses to expand access to quality, timely health care.

I want to thank everyone for taking the time to come today, and particularly to our witnesses for sharing your stories.

I am pleased to recognize the gentlelady from California, Ms. Chu, for her opening statement.

Ms. CHU. Thank you, Mr. Chairman, and thank you to the witnesses for being here today.

Thanks to Democrats in the House, Senate, and White House, more Americans have access to health care than ever before. During the 2024 open enrollment season, a historic 21.3 million people signed up for care through the Affordable Care Act marketplaces. Millions of Medicare recipients are saving money on prescription

drugs, with more to come as Medicare finally negotiates the price of common, costly prescription drugs. We want what is best for America's patients, and that means an affordable, accessible health care system.

Strengthening access to emergency care is certainly a priority, but so should all types of health care be accessible. In many states in the country Republicans are the biggest threat to Americans' health and well-being, doubling down on their threats to the Affordable Care Act and working towards a national abortion ban. Their extreme, out-of-touch agenda would only create a sicker, poorer America.

We have already seen the deadly consequences of Republicans' war on women. Women are being forced to flee their homes to access care, doctors are being threatened with prison terms, and hospitals are being ordered to deny care to women with life-threatening complications. Right here in Texas, Republicans cheered on a near total abortion ban that has put countless lives in danger, like Texas resident Kate Cox, who was denied a medically necessary abortion under draconian state laws and forced to cross state lines to access care. Amanda Zurawski was denied care to address life-threatening pregnancy complications until she went into septic shock. Jennifer Alvarez-Estrada Glick died after being deprived of medical information due to doctors' fears of prosecution. Surely these stories prove that Republicans' extremist, restrictive abortion bans are a barrier to accessing emergency care for countless women.

Not only have Republicans cut women off from accessing abortion care in dozens of states but their repeated attempts to gut the Affordable Care Act and the premium tax credits that millions of Americans count on would devastate access to care. Over 130 million Americans with preexisting conditions count on the ACA's consumer protections that prevent insurers from discriminating against them, and millions of working families are only able to afford health care thanks to Democrats' premium tax credits. Republicans' repeal agenda, cheered on by Donald Trump, would put power back in the hands of powerful health care industry players while leaving working families to foot the bill.

Democrats are ready to go even further toward building the health care systems that Americans deserve. In sharp contrast, Republicans are doubling down on dangerous policies that will harm patients' health and well-being. I urge my Republican colleagues to work with Democrats to invest in the American health care system and abandon these attempts to limit care that will needlessly drive Americans into these emergency care situations.

With that I yield back.

Chairman SMITH. Thank you, Ms. Chu. I am pleased to recognize our generous host, Congresswoman Van Duyne.

Ms. VAN DUYNE. Thank you very much, Mr. Chairman, and to all of my colleagues who traveled here today. This region of the great state of Texas is incredibly dynamic. We have seen a massive growth of employers and families moving to North Texas because of the opportunities offered here that can't be found anywhere else. I am grateful each of you made the time to attend today's field hearing on access to emergency health care, and I would also like

to thank today's host, Global Medical Response, for allowing us to use their phenomenal facilities. And I also want to thank our witnesses for your time and for being here today.

Today's hearing is a continuation of the successful hearings and actions this committee has undertaken to highlight the failed implementation of the No Surprises Act. Last August, I was able to gather with health care leaders across North Texas, and during those meetings I heard repeatedly how unelected bureaucrats are failing to comply with the No Surprises Act. And while this is frustrating for everyone involved, it is the patient who is more often than not stuck in the middle and the most to be hurt.

Looking around this hangar it is clear that citizens have access to lifesaving care. Congress, the private sector, our health care industry, and certainly this Administration must do more to empower patients to make informed decisions.

Congress took an important first step in addressing this through the No Surprises Act. Unfortunately, the Administration is circumventing the intent of the law which was designed to provide lower costs and more transparency. I am looking forward to a productive discussion about this, and again, thank you very much, Chairman Smith, for bringing the Ways and Means Committee to North Texas. And I want to welcome everyone to our great Lone Star State. And let's make health care great again.

I yield back.

Chairman SMITH. Thank you, Ms. Van Duyne. I am pleased to recognize another Texan, Mr. Arrington.

Mr. ARRINGTON. Well, I am not just another Texan, Mr. Chairman. I am from the food, fuel, and fiber capital of the world. We call it God's country. Some call it West Texas. But what we do is put food on the plates of our fellow Americans at a price they can afford, we put clothes on their backs, we turn the cranks in the greatest economy in the world, the life blood of this great American economy, and we provide affordable energy for the best quality of life and standard of living the world has ever known, in the greatest country in human history. Now, that is where I hail from, those are the people I represent, and I have got two colleagues here today on the witness table to bear witness to the fact that without access to critical care in the rural swaths of these great United States, we won't have food security and we won't have energy independence. So, our economy suffers, our security suffers, and we put our future in peril. That is what is at stake, and I am grateful that Mr. Matthews and Mr. Morris, especially, two guys from the God-fearing, freedom-loving state of Texas are here to testify today. Thank you, gentleman.

Chairman, thank you for bringing this field hearing to the great state of Texas.

Chairman SMITH. Thank you, Mr. Arrington. And I am pleased to recognize the gentleman from Texas, that I believe we are in his congressional district, Dr. Burgess.

Mr. BURGESS. Yes, thank you, Mr. Chairman. Thank you for extending the invitation. I am not actually on the Ways and Means Committee but——

Voice. We wish you were.

Mr. BURGESS. I will reserve the right to object to that. No, this is important, and I want to thank our witnesses for being here today. Four and a half million Americans reside in counties without access to an acute care hospital, so the disparity in health care across our nation is significant.

Texas stands out with areas where there are multiple health care options compared to regions where treatment options are extremely limited. Additionally, we are facing a severe shortage of physicians and emergency health care providers throughout our system, which exacerbates this challenge. Representing North Dallas and having served as a practicing physician for nearly three decades prior to my time in Congress, I intimately understand the challenges faced by physicians. From government regulation to inadequate Medicare reimbursements to the issue of burnout, these obstacles underscore the urgent need for bolstering our health care workforce.

Once again, I want to thank you for having me. Thanks to our witnesses for being here. I look forward to the discussion.

I yield back.

Chairman SMITH. Thank you, sir. I will now introduce our witnesses. Chloe Burke is an emergency care patient. We have Dr. Edward Racht, who is Chief Medical Officer at Global Medical Response. GMR is our host for today's hearing. Thank you. We have Matt Zavadsky. How do you say it?

Mr. ZAVADSKY. Matt.

Chairman SMITH. Matt. Matt, it is great to have you with us. He is Chief Transformation Officer at Medstar Mobile Healthcare. We have Ted Matthews, who is CEO of Anson General Hospital. And we have Robert Morris, the CEO of Complete Care. And then Lauren Miller is an emergency care patient.

Thank you all for joining us today. Your written statements will be made part of the hearing record, and you each have 5 minutes to deliver your remarks.

Ms. Burke, you may begin when you are ready.

STATEMENT OF CHLOE BURKE, EMERGENCY CARE PATIENT

Ms. BURKE. Hello. Thank you, Chairman Smith. My name is Chloe Burke. I am here representing myself and the American Heart Association. As the AHA is in its centennial year, the focus is on what we can do now to take a proactive approach to saving future lives. This includes innovation in access to health care and emergency treatment.

I am 25 years old, a Houston native, and I live 3 miles away from one of the biggest medical centers in our country, yet I could not receive the dire surgery I needed to save my life. I was born with an extremely rare congenital heart defect that I went my entire life undiagnosed with. My parents were told they had a happy and healthy child, and never expected the medical emergencies that would arise in my early twenties.

See, no one wakes up and plans to have an emergency. The word "emergency" is fueled by two things: urgency and a need for action. This is why access to emergency medical care is one of the most valuable things we could make the conscious choice to invest in, because nothing is fiscally worth more than being able to respond and save a life, when it is often needed within a matter of minutes.

At age 20, I began experiencing aggressive heart symptoms such as dizziness, chest and left arm pain, passing out multiple times a week, and losing my vision from my body and brain not getting enough oxygen. This is because my heart's major artery was inside of my heart when it is supposed to lay flat on the outside of the heart. At this time, I was a collegiate cheerleader at the University of Houston, and during one of our football games my heart stopped, and I collapsed on the field. I lay there unconscious as thousands of people watched emergency medical professionals rush to my side, taking off my uniform top, filling my chest with patches, and shocking my heart back to a consistent electrical state. I was then taken off the field on a gurney and put in an ambulance to the nearest emergency center where I was able to receive extensive testing needed to save my life. Immediate access to necessary AEDs, blood testing, imaging, and medicines is what saved my life that day, all at age 20, of what appeared at the time to be a healthy athlete.

When someone goes into cardiac arrest or has a heart attack there are only a matter of minutes available to act before it is too late. Three-fourth of cardiac arrests and heart attacks happen outside of the home. Now take a second to think about whether or not you would be able to get your closest loved ones to the nearest ER in time. I was lucky to experience my cardiac event in a situation where there were medical professionals on site, but that rarely happens.

The HEARTS Act, which was recently passed unanimously in the Energy and Commerce Subcommittee on Health, would help develop and distribute educational resources on cardiomyopathy, calls for guidelines regarding the placement of AEDs in schools, and information on CPR training. I say this as a way to show that there are ways for you, as U.S. congressional members that hold influence, to spread the responsibility not only to hospitals, but to us U.S. citizens in a place of civic duty and responsibility, as well.

Emergency services played a crucial role in helping me find my unknown diagnosis quicker. I had to endure months of medical testing beforehand to find the cause of my symptoms. What no one tells you is the months of waiting it takes to even get seen by a cardiologist, let alone the time it takes to schedule different tests, surgeries, imaging, and much more. I went from 9 months of being in and out of hospital testing to getting a diagnosis within 2 months of receiving emergency services that day, all because the ER I went to understand the severity of what I was prioritized my needs as a patient.

When I received a diagnosis, I then had to go to Stanford, California, to receive open-heart surgery, or die within 2 years. Houston is known for its innovative treatment centers, yet I could not get the treatment I needed. Once I got to Stanford, my family was informed my medical bills would exceed $300,000. The cost of being able to save my life and live long enough to graduate college should not be the same cost as buying a house.

That is why it is crucial to have plans in place like the No Surprises Act, which protects patients from receiving surprise medical bills resulting from gaps in coverage for emergency services and certain services provided by out-of-network clinicians at in-network

facilities. I am so lucky that I was able to stay on my dad's insurance, at the age that I received the health care I needed, thanks to the Affordable Care Act, because he is a Federal employee, so we could use the specific things like the Affordable Care Act to be able to save patients like myself, because again, my treatment was over $300,000, and that is not including the other flights to get there, the other treatments, and doctor visits that I had to go through.

You know better than anyone that our country's health care system needs improvement. I am living proof that cardiac events are never planned, so we need to work to create a nation of lifesavers to ensure as many people as possible are equipped with the necessary skills to be able to respond within a matter of seconds when it is needed and save lives. Our emergency care needs to be easily accessible and prioritized as one of the most important issues in our country, because nothing is more valuable than saving a human life. Otherwise, this testimony today would be silent. Thank you.

[The statement of Ms. Burke follows:]

Chloe Burke
March 18, 2024

Written Witness Testimony for Committee on Ways & Means "Access to Healthcare in America: Ensuring Resilient Emergency Medical Care."

My name is Chloe Burke; I am here representing myself and the American Heart Association. As the AHA is in its CENTENNIAL year, the focus is on what we can do NOW to take a proactive approach to saving future lives; this includes innovation in access to healthcare and emergency treatment. I am a 25-year-old Houston native, and I live 3 miles away from one of the biggest medical centers in our country, yet I could not receive the dire surgery I needed to save my life. I was born with an extremely rare congenital heart defect that I went my entire life undiagnosed with. My parents were told they had a happy, healthy child, and never expected the medical emergencies that would arise in my early twenties.

No one wakes up and plans to have an emergency. The word emergency is fueled by two things: Urgency, and a need for action. This is why access to emergency medical care is one of the most valuable things we could make the conscious choice to invest in, because nothing is fiscally worth more than being able to respond and save a life, when it is often needed within a matter of minutes.

At age 20, I began experiencing aggressive heart symptoms such as dizziness, chest and left arm pain, passing out multiple times a week, and losing my vision from my body & brain not getting enough oxygen. This is because my heart's major artery was inside of my heart, when it is supposed to lay flat on the outside of the heart.. At this time, I was a collegiate cheerleader at the University of Houston and during one of our football games my heart stopped and I collapsed on the field. I lay there unconscious as thousands of people watched emergency medical professionals rush to my side, taking off my uniform top, filling my chest with patches and shocking my heart back to a consistent electrical state. I was then taken off the field on a gurney and put in an ambulance to the nearest emergency center where I was able to receive extensive testing needed to save my life. Immediate access to necessary AEDS, blood testing, imaging, and medicines is what saved my life, or I wouldn't be here today…all at age 20, of what appeared to be a healthy athlete.

When someone goes into cardiac arrest or has a heart attack, there is only a matter of minutes available to act before it's too late. ¾ of cardiac arrests and heart attacks happen at home. Now take a second to think about that and whether or not you would be able to get your closest loved ones to an ER in time. I was lucky to experience my

cardiac event in a situation where there were medical professionals there on site, but that rarely happens. The HEARTS Act, which was recently passed unanimously in the Energy and Commerce Subcommittee on Health, would help develop and distribute educational resources on cardiomyopathy, calls for guidelines regarding the placement of AEDs in schools, and information on CPR training. I say this as a way to show that there are ways for you, as US congressional members that hold influence, to spread the responsibility not only to hospitals, but to us U.S. citizens in a place of civic duty and responsibility to help as well.

Emergency services played a crucial role in helping me find my unknown heart diagnosis quicker. I had to endure months of medical testing to find the cause of my symptoms. What no one tells you, is the months of waiting it takes to even get seen by a cardiologist, let alone the time it takes to schedule different tests, surgeries, imaging, and much more. I went from 9-months of being in & out of hospital testing, to getting a diagnosis within 2 months of receiving Emergency services, all because the ER I went to, understood the severity of what I was experiencing, and prioritized my needs as a patient.

When I received a diagnosis, I then had to go to Stanford California to receive open-heart surgery, or die within two years. Houston is known for its innovative treatment centers, yet I could not get the treatment I needed. Once I got to Stanford, my family was informed my medical bills would exceed $300,000. The cost of me being able to live long enough to graduate college should not be the same cost as buying a house. That is why it is crucial to have plans in place like the "No Surprises Act" which Protects patients from receiving surprise medical bills resulting from gaps in coverage for emergency services and certain services provided by out-of-network clinicians at in-network facilities, and the Affordable Care Act,which allowed me to stay on my parent's health insurance plan past the age of 18 and up to 27. I am so lucky that I was able to stay on my dad's insurance, as he is a federal employee, so we could afford the treatment I needed without putting us years into debt. Many Americans are not this lucky.

You know better than anyone that our country's healthcare system needs improvement. I am living proof that Cardiac events are never planned, so we need to work to create a nation of lifesavers to ensure as many people as possible are equipped with the necessary skills to be able to respond within a matter of seconds and save lives. Our emergency care needs to be easily accessible and prioritized as one of the most important issues in our country, because nothing is more valuable than saving a human life. Otherwise, this testimony would be silent today. Thank you.

Chairman SMITH. Thank you. Dr. Racht, you are now recognized.

STATEMENT OF EDWARD RACHT, M.D., CHIEF MEDICAL OFFICER, GLOBAL MEDICAL RESPONSE (GMR)

Dr. RACHT. Thank you. Good afternoon, Chairman Smith and members of the Committee. A special thanks to the Congresswoman for allowing us to meet here at our hangar and with our representatives and being in this beautiful space. Having us serve as host for the venue is very much an honor for GMR.

My name is Dr. Ed Racht. I am an emergency physician, and I am the Chief Medical Officer of Global Medical Response and GMR Medicine. I have the privilege of working with 36,000 other folks who are at work right now, out saving lives throughout the country. We respond to about 5 million patients a year in all 50 states. As you can see, one of the components of GMR is being able to be ready to take care of patients, as you've just heard Chloe talk about.

I appreciate being a part of this discussion and the growing challenges in EMS as we face caring for acutely ill and injured patients in urban, rural, and frontier communities. Emergency medicine combines the science of health care with the logistics of getting to that patient's side and getting that patient to the appropriate level of care, in the appropriate community, in a timely fashion.

I want to give you some good news. The good news is over the past two decades emergency medicine—congratulations, as you have heard—has done a very good job of refining the science and the delivery of our care to be able to manage patients. We have made tremendous strides in being able to decrease morbidity and mortality from out-of-hospital acute illness and injury.

It wasn't that long ago that patients who suffered from a stroke were destined for long-term care or permanent disability. It wasn't that long ago that patients who had a myocardial infarction or a heart attack would have permanent disability, and the myocardium, the heart, wouldn't get back to normal function, so they would live a disabled life. It wasn't that long ago that patients who were acutely injured, blunt trauma and penetrating trauma outside the hospital didn't have a chance to survive and live a normal life, as they do today. And it wasn't that long ago that individuals like Chloe, individuals that the world saw in Damar Hamlin, who suffered an out-of-hospital cardiac arrest, the team came together, were able to resuscitate them, and get them back to a normal life.

So, the good news is the EMS professionals, the emergency care professionals have done a very good job of advancing the science and the art of that science to deliver that level of that care.

Our EMS system, thanks to the committed professionals, to research, to technology, and deployment has never been this effective at clinically changing life-and-death situations in the out-of-hospital environment.

But remember, these events occur 24 hours a day, 7 days a week, whether it is rain, a beautiful day like today, and where it is, how remote it may be from a facility, it may not be near the appropriate facility, these events still occur. So, an important part of EMS is

being able to anticipate, prepare for, and predict where those emergencies may occur so that we can be in the right spot.

That cost of readiness is extraordinary. You have a chance to see that today. To be prepared, the men and women that staff these helicopters, these ambulances, have to be up on the science, the skill, and the art of delivering care to their patients.

Our mission in EMS is to manage an acute event, whenever, and wherever it occurs. Our mission statement at GMR is "caring for the world at a moment's notice." I have to tell you; I love that phrase because it says when something happens, we are in there to be able to help the individual get back to normal life.

To fulfill that mission, we need that 24/7 readiness and the ability to respond around the clock. The infrastructure and the teamwork are an important part of making sure we are prepared. You have seen the aircraft. You have seen the ambulances. These are mobile ICUs today, with the technology to be able to stabilize and treat patients in the out-of-hospital setting.

So how we maintain that workforce is an important component during the post-COVID time period. We've struggled with recruiting, we struggle with retention, and many critical access hospitals have closed their doors, so we are trying to maintain that in a difficult time period.

We are the front of the front line in medicine. We struggle with all those challenges and to remain sustainable in the environment. Our ambulances and clinicians are that link to lifesaving care. We struggle for the response in implementing the principles of the No Surprises Act and being able to create sustainable funding for what we do.

One of my colleagues, Flight Nurse Carmen Hicks from Greenville, Texas, is in the room. She responds to these folks. She just completed her 500th flight, out of a community of 700. She has 200 more to go. She and her colleagues have stories of taking extremely difficult, acutely injured and ill patients and giving them a chance.

So, we need your help. We need your help to continue to provide care for these life-and-death circumstances. We need you to help us strengthen the safety net. And all of us in emergency care, all of us in the entire spectrum, thank you for paying attention to this critical issue.

[The statement of Dr. Racht follows:]

TESTIMONY OF EDWARD RACHT, M.D.

CHIEF MEDICAL OFFICER, GLOBAL MEDICAL RESPONSE

Before the U.S. House Committee on Ways & Means

Hearing on "Access to Health Care in America: Ensuring Resilient Emergency Medical Care"

Denton, Texas

March 18, 2024

Good afternoon, Chairman Smith and Members of the Committee. I appreciate this invitation and opportunity to speak with you today. I also want to thank Congresswoman Van Duyne for encouraging the Committee to come to our air operation here in Denton. Having one of our operations serve as the venue for a Congressional hearing is a tremendous honor for all of us at Global Medical Response, and I want to recognize all the work that the Congresswoman's staff and the committee staff have done behind the scenes to make this happen.

My name is Dr. Ed Racht. I am an emergency physician and serve as the Chief Medical Officer of Global Medical Response and GMR Medicine. I have the privilege of working with our 36,000 nurses, paramedics, emergency medical technicians (EMTs), communications professionals. and support team members who help GMR take care of more than 15 million patients every year across all 50 states.

I appreciate being a part of the discussion on the growing challenges EMS professionals face in caring for critically ill and injured patients in urban, rural, and frontier areas. You may have heard of the "golden hour" -- that period after a traumatic injury where prompt treatment is literally a matter of life and death. Over the past two decades, emergency medicine and EMS systems have made tremendous strides in decreasing loss of life and substantial disability in patients suffering an acute event outside of the hospital.

It wasn't that long ago that an individual who suffered a stroke was destined for a lifetime of disability or dependency on care in a long-term care facility. Heart attacks were not treated aggressively or rapidly enough to save critical heart muscle and dramatically worsened a patient's future quality of life. Our coordinated and integrated EMS and healthcare system now gives gravely injured patients, from both penetrating and blunt trauma, the opportunity for rapid surgical intervention and a chance at full recovery. And sudden cardiac arrests, like the one suffered by Buffalo Bills football player Damar Hamlin in January of last year, can be effectively treated with availability of the right resources, at the right time, applied in the right way.

Our EMS system – thanks to committed professionals, research and education, decision support technology, and optimized integration – has never been as effective in the clinical management of these patients. When it all comes together, emergency healthcare professionals pride ourselves on our ability to dramatically decrease morbidity and mortality from unexpected and sudden illness and injury.

But these events happen 24 hours a day, regardless of weather, or proximity to a hospital with a skilled trauma staff, or access to specialized technology or the appropriate medications. These events also do not discriminate between a patient with insurance coverage or a patient without – and neither do EMS professionals.

Our mission at GMR is "providing care to the world at a moment's notice." To fulfill this mission, we need to be ready to respond to an emergency within minutes. This around-the-clock readiness requires the sort of infrastructure and teamwork you see around you today to keep our ground ambulances moving and our aircraft flying. The ambulances of today are "mobile ICUs" and staffed by medical professionals who are smart, compassionate, and strong -- both physically and mentally.

How we maintain the infrastructure and workforce necessary to fulfill our mission is what keeps me and other leaders at GMR up at night. Clinical staff -- nurses, paramedics, EMTs, and physicians -- have been leaving the profession since the beginning of the COVID pandemic. And we in EMS are not alone in facing these challenges – for instance, critical access hospitals and other facilities in rural areas are closing their doors. The costs of recruitment, retention, turnover, and overtime have wounded the healthcare system, both in our hospitals and our ambulances.

The pandemic reinforced that our EMS system is the *front of the front line* in our communities. Our ambulances and our clinicians provide not only immediate life-saving care, but in some communities, we are the only connection to the healthcare system when people are in need.

This Committee can help EMS providers and professionals meet the challenges we face.

Most relevant to your Committee's jurisdiction is Medicare, a vital program for our nation's seniors, but one that is antiquated and outmoded when it comes to covering ambulance services.

Medicare reimbursement rates for both air and ground ambulance services are badly out of date. These rates were established more than 20 years ago and have not been "re-based" since the ambulance fee schedule was implemented in 2002. This means that Medicare reimbursement for ambulances is based on the costs of providing mobile healthcare services from over two decades ago. As a result, a 2017 study by Xcenda found that approximately 59 percent of costs for air ambulance transports were covered by Medicare and beneficiary payments. Fortunately, CMS has been collecting data on cost, revenue, and utilization for ground and air ambulance as directed under the No Surprises Act and the Ground Ambulance Data Collection System.

With this in mind, I have three Medicare-related requests to make to the Committee.

First, Congress should direct CMS to use this data I have mentioned to update Medicare ambulance reimbursement rates through notice-and-comment rulemaking.

Second, Congress should increase the "add-on" reimbursement percentage for ambulance services delivered to Medicare beneficiaries in urban, rural, and "super-rural" communities. This additional reimbursement would help fill more of the gap between Medicare base rates and the added and rising costs of serving seniors in our communities.

And third, Congress should begin considering wholesale reform to Medicare's coverage of and support for emergency medical services and mobile healthcare. For instance, Medicare will not pay for any treatment delivered by an ambulance provider unless the patient is transported to a hospital, yet some state Medicaid programs and commercial health plans have begun covering "treatment in place" and/or treatment with transportation to alternative healthcare sites that

better fit the patient's needs. It is well past time for Medicare's ambulance benefit to catch up to the services that EMS clinicians can provide in the 21st century.

Without these changes, ambulance providers will continue to struggle to keep up with rising workforce, fuel, and technology costs, among other financial headwinds. Many ambulance providers have closed their doors and response times have increased because of the stresses on the system. We are grateful to Members of this Committee, including Representatives Sewell, DelBene, Estes, and Wenstrup, for their leadership in introducing legislation to modernize Medicare reimbursement for emergent air and ground ambulance services.

I would also like to offer some observations and recommendations related to the No Surprises Act (NSA). My fellow clinicians and I at GMR fully support removing patients from the middle of reimbursement disputes between providers and insurance companies. However, the implementation of the NSA has fallen short of what Congress intended in a couple of key areas.

First, the patient protections in the NSA do not apply if the insurer denies a claim for coverage of air ambulance services because the insurer, on their own, retroactively decides the services were not "medically necessary." GMR saw a dramatic increase in commercial insurance companies leveraging this loophole to deny emergency air ambulance claims immediately after the NSA went into effect. To solve this problem, the regulations should be updated to deem an emergency transport as "medically necessary" if dispatched consistent with local EMS protocols, or if a prudent layperson would have made the decision to dispatch under the circumstances.

Second, despite winning more than 90 percent of our disputes heard by an Independent Dispute Resolution (IDR) entity, we have not seen insurance companies pay timely or be willing to enter into reasonable contracts with us. With the number of procedural pitfalls for providers, and no penalties or interest if an insurer does not pay accurately or timely, insurers have little incentive to contract. Since federal regulators have been reluctant to open proceedings against insurers that fail to pay amounts awarded through the IDR process, we have been forced to resort to the courts. We encourage the Committee to urge the regulators to act and ensure that IDR awards are paid on a timely basis, in keeping with the spirit of the NSA.

I am proud to work alongside a dedicated team of EMS professionals, many of whom serve the communities where they grew up and where they currently live. One such person is our very own Carmen Hicks, who is here with us today. Carmen is a flight nurse based out of Greenville, Texas. Carmen has been with Global Medical Response for seven years and has been on more than 500 flight missions. To put that into perspective, Carmen's hometown population is 700 people. She has loved rural communities her whole life, she has learned the value of a strong work ethic and the obligation to speak up for those who could not speak for themselves in rural settings. She is the daughter of a farmer and the granddaughter of a rancher, both of which contributed to the grit it takes to do her job daily.

I want to leave you with one story where Carmen was called into action and helped a patient who was seriously injured. A 5-year-old child was riding a four-wheeler with an older family member on a gravel road. For reasons unknown, the family member lost control of the four-wheeler and both riders were ejected, with the vehicle landing on the child's shoulders, neck, and head.

Upon arrival at the scene, ground EMS professionals placed the child in full spinal immobilization. By this time, the patient's airway had swollen, and the required intubation was

difficult because of the trauma sustained. The local hospital did not have the necessary trauma surgeons, neurovascular surgeons, or a pediatric intensive care unit, so Carmen and her team were quickly called in to transport our patient by air to a level-one trauma center where the child was successfully treated. Without access to clinicians and pilots like Carmen and her team, staffing the specialized aircraft in this hangar today, this patient's outcome would have most certainly been bleak.

EMS providers and systems save lives and dramatically improve outcomes every day. We need your help to strengthen that safety net, which continues to fray, particularly in rural and frontier areas.

All of us in emergency services thank you for taking an interest in and addressing these pressing issues.

Chairman SMITH. Thank you, sir. Mr. Zavadsky——
Mr. ZAVADSKY. Matt is fine.
Chairman SMITH. Matt. You are now recognized.

STATEMENT OF MATT ZAVADSKY, CHIEF TRANSFORMATION OFFICER, MEDSTAR MOBILE HEALTHCARE

Mr. ZAVADSKY. Thank you. Good afternoon. Thank you, Chairman Smith and the House Ways and Means Committee, for inviting me to testify at this field hearing examining the challenges and opportunities surrounding recent investments in emergency care services and how to strengthen access to emergency care in America.

My name is Matt Zavadsky, and I am the Chief Transformation Officer for the Metropolitan Area EMS Authority, which is the public utility model EMS agency for the city of Fort Worth, here in the great state of Texas, and 13 other municipalities that are part of the EMS Authority. We are also known as MedStar Mobile Healthcare. I am also the South-Central Regional Director and past president of the National Association of Emergency Medical Technicians, and still work field shifts on an ambulance at MedStar as an EMT.

I have been an EMS provider for the past 44 years—it was at a time I could begin serving as an EMT at the age of 7, in case you were doing the math—and learned early in my career that a lot of the patients who call 911 for EMS do not need to be treated in an emergency department, but CMS payment policy is such that we are incentivized to force every patient to be transported to the emergency room because that is the only way that we are paid by CMS, is if we transport someone to the hospital.

Having the opportunity to advocate for the improvement of EMS models and payments in Texas is an honor. Ambulance services are a vital component of our local and national health care and emergency response systems and serve as lifelines of care for a wide range of individuals, including seniors who rely on Medicare, especially in urban, rural, and super-rural settings.

Thankfully, innovative EMS agencies such as MedStar, Global Medical Response, Dallas Fire Department, and others have initiated patient-centric programs designed to prevent 911 calls, and even when 911 is called, appropriately navigate patients to the most appropriate care setting.

In 2009, MedStar was one of the nation's first Mobile Integrated Healthcare/Community Paramedic programs in the country. One of our programs is a High Utilizer Group program—most of those patients just need hugs—designed to help frequent 911 callers learn how to better manage their health conditions and connect them to community resources. Since 2013, 22,000 patients have been enrolled in this program, and those patients have reduced their 911 use by 51.2 percent, they have enhanced their perception of care status by 27.1 percent, and reduced their health care expenses related to ambulance, emergency department, and inpatient care use by over $20 million. But yet we have not been paid by Medicare for one of those patients because it is not a covered service.

On the 911 side, we have been working with Congress to sponsor legislation to provide EMS the flexibility to navigate patients to the

right care, at the right time, and in the right setting through Treatment in Place programs. Currently, the EMS economic model incentivizes transport to an ER, since treatment in place is not a covered benefit, and we don't get reimbursed for that service. A recent study by RAND published in *Health Affairs* found that 15 percent of Medicare patients brought by ambulance to the ER could be effectively treated in an alternate setting, and that would save the Medicare program over $550 million annually.

Ambulance services across the nation, especially in rural areas, are facing unprecedented challenges, as you heard Dr. Racht talk about. The pandemic further strained our workforce, placed significant new demands on our services, and has generated enormous competition for health care personnel.

Medicare currently provides temporary 2 percent urban, 3 percent rural and "super rural" add-on payments for ambulance services. These add-on payments are essential to ensuring access for all patients for vital emergency and non-emergency care, but they still do not bring payment rates up to a level that covers the cost of providing many services. Years of below-cost Medicare reimbursement have hampered efforts by ambulance services to hire, update equipment, and continue to provide lifesaving services in their communities. Ambulance services have closed their doors or been forced to lengthen response times because of the stresses on their systems. These add-on payments expire at the end of this year.

Ground ambulance services are currently providing their revenue and cost data to CMS, which will help Congress determine how much to reform the Medicare ambulance fee schedule. However, reform is likely several years away, and ground ambulance service organizations cannot wait that long for additional relief.

Extending the Medicare add-on payments is essential to ensure access for all patients for vital emergency and non-emergency care.

Again, thank you for the opportunity to testify on the challenges and opportunities for EMS to ensure accessibility and quality care to our patients in Texas and the nation. I look forward to continuing to work with you and your committee.

[The statement of Mr. Zavadsky follows:]

Hearing Testimony

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
(817) 632-0522
(817) 632-0530 (Fax)
www.medstar911.org
MZavadsky@medstar911.org

Good afternoon, thank you Chairman Smith and the House Ways and Means Committee for inviting me to testify at this field hearing examining the challenges and opportunities surrounding recent investments in emergency care services and how to strengthen access to emergency care in America.

My name is Matt Zavadsky, and I'm the Chief Transformation Officer for the Metropolitan Area EMS Authority, the public utility model EMS agency for the city of Fort Worth, and 13 other municipalities that are part of the EMS Authority, we are also known as MedStar Mobile Healthcare. I am also the South Central Regional Director, and past president of the National Association of Emergency Medical Technicians.

I have been an EMS provider for the past 44 years and learned early in my career that a lot of the patients who call 911 for EMS do not need to be treated in an ER, but CMS payment policy is such that we are incentivized to transport every 911 patient to the ER because that is the only time we get paid. Having the opportunity to advocate for the improvement of EMS models and payments in Texas and in the nation is an honor. Ambulance services are a vital component of our local and national health care and emergency response systems and serve as lifelines of care for a wide range of individuals, including seniors who rely on Medicare in urban, rural, and super rural settings.
Thankfully, innovative EMS agencies such as MedStar, Global Medical Response, Dallas Fire Department, and others have initiated patient centric programs designed to prevent 911 calls, and even when 911 is called, navigate patients to the most appropriate care setting.

In 2009, MedStar launched one of the nation's first Mobile Integrated Healthcare/Community Paramedic (MIH/CP) programs in the country. One of our programs is a 'High Utilizer Group' program (HUG), designed to help frequent 911 callers learn how to better manage their health conditions, and connect them to community resources. Since 2013, 22,000 patients have been enrolled in this program, and those patients reduced their 911 use by 51.2%, enhancing their perception of their health status by 27.1%, improving their experience of care, and reducing healthcare expenses related to ambulance, ER and inpatient care use by over $20 million.

On the 911 response side, we have been working with Congress to sponsor legislation to provide EMS the flexibility to navigate patients to the right care, at the right time, and in the right setting through Treatment in Place (TIP) and Transport to Alternate Destinations (TAD). Currently, the EMS economic model incentivizes transport to an emergency department since these benefits are not covered by Medicare or Medicaid. A recent study by RAND published in Health Affairs Journal found that about 15% of Medicare patients brought by ambulance to the ER could be safely treated in another setting, saving the Medicare program over $550 million annually in prevented ER payments.
Ambulance services across the nation, especially in rural areas, are facing unprecedented challenges. The pandemic further strained our workforce, placed significant new demands on their services and generated enormous competition for healthcare personnel.

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
(817) 632-0522
(817) 632-0530 (Fax)
www.medstar911.org
MZavadsky@medstar911.org

Medicare currently provides temporary 2% urban, 3% rural and "super rural" add-on payments for ambulance services.

These add-on payments are essential to ensuring access for all patients for vital emergency and non-emergency care, but they still do not bring payment rates up to a level that covers the full cost of providing many services. Years of below-cost Medicare reimbursement have hampered efforts by ambulance services to hire new staff, update equipment, and continue to provide life-saving services in their communities. Ambulance services have closed their doors or been forced to lengthen response times because of the stresses on their system. These payments expire at the end of the year.

Ground ambulance services are currently providing their revenue and cost data to CMS which will help Congress determine how to reform the Medicare ambulance fee schedule. However, reform is likely several years away, and ground ambulance service organizations cannot wait that long for additional relief.

Extending the Medicare add-on payments is essential to ensure access for all patients for vital emergency and non-emergency care.

Again, thank you for the opportunity to testify on the challenges and opportunities for EMS to ensure accessibility and quality care to our patients in Texas and the nation. I look forward to continuing my work with your Committee.

Sincerely,

Matt Zavadsky, MS-HSA, NREMT
Chief Transformation Officer

Chairman SMITH. Thank you, sir. Mr. Matthews.

STATEMENT OF TED MATTHEWS, CEO, ANSON GENERAL HOSPITAL

Mr. MATTHEWS. Thank you. Good afternoon. My name is Ted Matthews. I am the Chief Executive Officer of a small rural hospital in Anson, Texas, located in Jones County. Thank you for the opportunity to testify before the House Ways and Means Committee regarding our recent conversation to a rural emergency hospital. I am truly honored to have this opportunity to come before this distinguished committee to discuss the challenges of maintaining access to care in Texas.

Some background information. On rural health care in our state, geographically 85 percent of Texas, geographically, is considered rural, but we have only 15 percent of the voting bloc. Since 2010, 27 rural hospitals have closed in the state. We lead the country in the number of closed rural hospitals. Fortunately, we have only one rural hospital that has closed in the last 4 years.

As expected, not only does a hospital closure affect health care availability, the closure of a rural hospital also takes a huge economic toll on the community. According to a recent study, Texas currently leads all states with 45 rural hospitals at risk, which is 28 percent of the 157 rural hospitals in our state. In February of 2023, it was the consensus that Anson General Hospital would become the 28th rural hospital to close.

Why do we need the nation in rural closures, declining census in rural area? The payer in Jones County, 20 percent of the citizens are uninsured. Demographic challenges in rural areas, we are usually older, we are usually poorer, and we have more chronic issues than they have in urban areas. Rural hospitals treat many of the same health conditions, but we do not have the contract negotiations volume to get the good reimbursements that we need.

Socioeconomic issues. Health care recruitment in rural areas, believe me, on the physician side it is next to impossible to recruit a doctor in Anson, Texas. And the infrastructure and the age of our rural hospitals. Most of our hospitals were built in the early '50s.

At one time we had three hospitals in the county. After the closure of two of these hospitals we were now the sole remaining hospital. Our hospital was constructed in 1952, making our infrastructure 72 years old. In our rural clinic, which is adjacent to our hospital, we have two practicing doctors. One has practiced 3 years. Our senior doctor—gray hair like—has practiced 49 years in our community.

At Anson General Hospital I look forward to telling you the story of why we converted to a rural emergency hospital. We had our soft needs assessment. We knew the impact that it would have on our community, but we also knew the financial condition that we were in. And so, the choice was basically do we stay the course, which would have meant our hospital would close, or do we become a rural emergency hospital? We elected to become that rural emergency hospital, and that has made all the difference in the life of our hospital. We now have a future.

And I would like to thank everyone that voted for that bill that put that new Federal designation out there, and again, we were one of the first in the state and the nation to adopt it. Thank you.

[The statement of Mr. Matthews follows:]

Opening Statement of Ted Matthews, Anson General Hospital

Good afternoon, my name is Ted Matthews. I am the Chief Executive Officer of a small rural hospital in Anson, Texas, located in Jones County. Thank you for the opportunity to testify before the House Ways and Means Committee regarding our recent conversion to a Rural Emergency Hospital. I am truly honored to have this opportunity to come before this distinguished committee to discuss the challenges of maintaining access-to-care in rural Texas.

Some background information on rural healthcare in Texas. Geographically, 85% of Texas is considered rural, but we have only 15% of the voting bloc. Since 2010, 27 rural hospitals have closed in the state. Fortunately, we have had only one rural hospital close in the last four years (La Grange, Texas). As expected, not only does a hospital closure affect healthcare availability, the closure of a rural hospital also takes a huge economic toll on a rural community. On average, when a closure occurs, up to180 local jobs are lost with a negative economic impact in the community of $20M. According to a recent study, Texas currently leads all states with 45 rural hospitals at risk of closure (28% of the 157 total rural hospitals in Texas). **In February 2023, it was the consensus that Anson General Hospital would be the 28th rural hospital to close in the state.**

Why do we lead the nation in the closure of rural hospitals?

1. Declining rural census across the state.
2. Payor mix – Texas leads the nation in the number of uninsured/underinsured state residents (17%).
3. Demographic challenges – A rural patient base is disproportionately older (Medicare), poorer (Medicaid), has more chronic care issues than those patients living in Metropolitan areas.
4. Rural hospitals treat many of the same health conditions as urban areas but do so with lower patient volumes and less leverage when it comes to purchasing power and/or contract negotiations (payor source).
5. Socioeconomic issues associated with rural economic industry, for example, in Jones County it is farming and agriculture.
6. Healthcare recruitment difficulties in rural areas (primarily physicians and specialized healthcare workers).
7. Infrastructure, and the age of rural facilities - Plant Property and Equipment. Most rural hospitals were constructed in the 1950s.

At one time, we had three hospitals in the county. After the closure of two of those hospitals, we were now the sole remaining hospital. Our hospital was constructed in 1952, making our infrastructure 72 years old. In our Rural Health Clinic adjacent to the hospital, we have two family practice doctors, one has practiced for 3 years and the other has practiced for 49 years in our rural community.

In early 2023, Anson General Hospital was experiencing many of these issues referenced earlier. We had an outstanding debt of $1.9M, and aging accounts payable of $860K. We had incurred net losses in the prior three years and faced a continuing decline in the population base, leaving us with only 2,200 residents in our community and 17,000 in the county. Basically, a sparsely populated area where, through farming and ranching, we are known for our fiber and food. As one of our board members states often, "we feed and clothe America." In financial hardship, and with a deteriorating infrastructure, we surmised that if we continued along the path we were on, our hospital would close.

So, when the opportunity presented itself to convert to a Rural Emergency Hospital, and based upon our precarious financial position, we elected to move immediately in that direction. After completing community needs assessments, the hospital board voted to initiate the conversion to a Rural Emergency Hospital. In early January 2023, we started the application process by completing Form 855A to change our Federal designation from a Prospective Payment System Hospital to become one of the first Rural Emergency Hospitals in the state and nation. Effective March 27, 2023, we received notice from CMS that our PTAN number (Provider Transaction Access Number – Medicare Identifier) of 72 years had changed to 670781, and that we were now designated as a Rural Emergency Hospital. So, at that time our whole mindset or emphasis shifted away from providing care to our community on an inpatient acute care system and/or swing bed basis to providing Access-to-Care on an **outpatient basis**. Our focus now was to address the healthcare needs of our community through the; 1. Emergency Room, 2. Radiology, 3. Laboratory, 4. Physical Therapy, 5. Observation, 6. Outpatient Surgery (still in discussion), and 7. Behavioral Health (a future consideration).

Over the past year, after initiating additional cost-cutting measures, and increasing our traditional Medicare reimbursement to105%, plus receiving a monthly Facility Payment of $277K, we have seen our financial position improve substantially. In fact, based upon our Rural Emergency Hospital conversion we are confident that our hospital now has a future, and that we will be here for years to come to meet the healthcare needs of our rural community.

Chairman SMITH. Thank you. Mr. Morris

STATEMENT OF ROBERT MORRIS, CEO, COMPLETE CARE

Mr. Morris. Chairman Smith, Ways and Means Committee members, it is a pleasure for me to be here. My name is Rob Morris. I am the President of the National Association of Freestanding Emergency Centers, and I am also CEO of a company named Complete Care. I want to welcome you to Texas. I think you picked a perfect place to talk about access to emergency care.

Over a decade ago, Texas pioneered a model to improve emergency care when it created freestanding emergency centers, also known as FECs. Texas not only pioneered the FEC model, but we have also passed legislation to promote transparency, keep prices down, and make sure patients don't get a surprise medical bill. So, as we discuss the FEC concept and how it improves access to emergency care, and you consider the potential for other states to create their own FEC licensure standards, just know that Texas offers a roadmap on how to better serve ER patients and control costs.

If you are not familiar with an FEC, we have the same capabilities as a hospital ER. We are just freestanding, and we are embedded in the community. We have on-site CT, ultrasound, radiology, pharmacy, lab, we are licensed by the state, we are highly regulated. We comply with EMTALA, so we screen and stabilize anyone who comes through the door, regardless of ability to pay. And we take care of some really sick patients. Heart attack, stroke, fractures, lacerations—you name it, we have taken care of it. We are open 24/7. We are staffed with a nurse, x-ray tech, ER physician on site, and many of our facilities are also physician owned.

Sometimes we are mistakenly compared to an urgent care center, but there really is no comparison when you look at our capabilities and your look at our infrastructure requirements.

My company has 15 FECs, primarily in Texas but also in Colorado. Prior to helping found our company my background was in the hospital, so I have experience in hospital ERs as well as freestanding. In my opinion, FECs increase competition, which leads to better service and quality, and we also improve access to care.

That said, we still have great untapped potential in rural America. For example, FECs can offer the same level of care as a rural emergency hospital. However, we have one major hurdle. Since we are not owned by a hospital we currently don't qualify for Medicare or Medicaid, and that is despite having the exact same capabilities as a hospital ER. And in order for FECs to be viable in rural America we need Medicare and Medicaid reimbursement.

The good news is that we have a bipartisan bill, the Emergency Care Improvement Act, which is authored by Congressman Arrington, which allows state-licensed FECs to qualify for Medicare and Medicaid. For the bill, FECs can only get facility reimbursement for moderate- to high-acuity patients. We also can't build in a rural county that also has a hospital. It is a very well-thought bill.

And as you consider the bill and the potential of FECs to help in these underserved areas, just know that a waiver during the public health emergency was grated to FECs, and we were temporarily allowed to participate in Medicare. So now we have almost

3 years' worth of Medicare's own data that talks about our industry, tells the story about our industry, and it is pretty compelling. For example, severity adjusted, Medicare saved more than 21 cents on the dollar for care provided in FECs compared to hospital ERs. FECs were over twice as likely to discharge patients home than hospital ERs. There was no overall increase in utilization of ER services during our waiver. We just helped decompress hospitals.

Medicare's own data, in my opinion, demonstrates why FECs should be used to improve rural health care, and FECs also encourage competition, promote efficiency, and improve access to care in rural areas, as well.

Finally, speaking of access to care, I wanted to close with a few comments related to the No Surprises Act. Our association, we supported the NSA, FECs were included in the law, but we don't think it has been rolled out appropriately. There has not been transparency on how qualified payment amounts are determined or adequate oversight by HHS. We have seen dramatic reimbursement cuts from commercial insurance, and providers across the country are being squeezed and forced into costly disputes, and, quite frankly, they are going out of business, they are consolidating, and this threatens access to care. And I believe the people who will suffer the most are patients, which is the main group I believe we are trying to protect when the law was created.

So, thank you for your work on the No Surprises Act, thank you for your efforts to improve access to emergency care, and thank you for holding this hearing. I am honored to be a part of it.

[The statement of Mr. Morris follows:]

Testimony before the Ways and Means Committee

Access to Health Care in America: Ensuring Resilient Emergency Medical Care

By Robert Morris, CEO Complete Care

President National Association of Freestanding Emergency Centers

March 18, 2024

Chairman Smith, Ranking Member Neal and Ways & Means Committee Members, thank you for the opportunity to be with you today. My name is Rob Morris, and I live just down the road in the town of Southlake. I am CEO of Complete Care, a company with 15 freestanding emergency centers (FECs) in Texas and Colorado. I am also the president of the National Association of Freestanding Emergency Centers, which represents FECs and specialty emergency hospitals across the country. I would like to start by welcoming you to Texas -- the state that pioneered a new and innovative model to improve access to emergency care.

Recognizing our emergency rooms were overcrowded, patients were at risk because of dangerously long ER wait times, and rural areas were lacking healthcare infrastructure, over a decade ago Texas created a pathway for licensure for FECs that could function independently of a hospital. Before helping found our company in 2012, I spent the majority of my career working with hospitals. I have served in various leadership capacities, including a background managing the emergency department, so I have experience working in both freestanding and hospital-based settings.

Our company, like many other FEC operators, includes physicians, nurses, and other healthcare staff who typically left their hospital-based positions to work in an environment with more flexibility, autonomy, and time to dedicate at the bedside. Through the years, FECs have helped to decongest overcrowded hospital ERs, increase competition, and streamline patient care. Over 200 FECs now operate in several states such Texas, Colorado, Delaware, and Rhode Island. The vast majority are located in Texas.

Background on Freestanding Emergency Centers

FECs are highly regulated state-licensed facilities that provide 24/7 emergency services to patients at the same level of care as hospital-based emergency rooms, with experienced ER doctors, nurses, and radiology technologists always on site. Our facilities provide advanced imaging, laboratory, and pharmacy services. FECs diagnose, treat, and stabilize all major medical emergencies, including heart attacks, strokes, fractures, lacerations, and trauma. We comply with federal and state EMTALA requirements, which require screening and stabilization of all patients regardless of ability to pay. We comply with the No Surprises Act and believe patients should be protected from unexpected medical bills by limiting patient financial responsibility to in-network cost-sharing amounts.

Our facilities have transfer agreements in place and work cooperatively with our hospital partners when a patient requires surgery or an inpatient stay. The transition from the ER to surgical or inpatient care can be timelier when originating from our facilities. FECs have the ability to coordinate transfers to hospitals with available capacity, whereas hospital-based ERs

typically only admit patients to their own institution.

Since the inception of our emergency care delivery model, we have learned the importance of self-policing. Although there will always be a small minority of "bad actors" in various segments of healthcare, the vast majority of FEC operators work in this space for the right reason: To provide exceptional emergency care to patients. We believe if we focus on one thing and one thing only, we can deliver exceptional services. The market has self-corrected and the few FEC operators who were in it for the wrong reason went out of business due to their own self-inflicted wounds. Our state and national associations recognize the importance of holding our Members to a high standard, and we have successfully advocated for additional policies that protect our patients. For example, Texas now has strict rules in place regarding caps on facility charges, disclosure requirements to help minimize confusion regarding ER versus Urgent Care, and guardrails that nearly eliminate the chance of patients receiving surprise medical bills. Patients are better protected because of our collective efforts and the lessons we learned early in the life cycle of our industry. As additional states adopt the FEC model, much of the heavy lifting surrounding patient protections has already been done.

An Answer to Rural Health Care Access Issues

Mr. Chairman, you understand the challenge rural communities confront in accessing health care. Since 2010, 156 rural hospitals have closed, with another 15 rural hospitals closing last year. This is more than double the amount from 2022.[1] These hospital closures contribute to poor patient outcomes and exacerbate access to care issues in rural areas, especially emergency care, forcing patients to drive long distances to receive emergency treatment. Proximity to emergency care can mean the difference between life and death.

The situation could deteriorate further if policy changes to our health care system are not made. A recent report from the Center for Healthcare Quality & Payment Reform found that more than 600 rural hospitals, which represents 30 percent of all rural hospitals, are at risk of closing.[2] More rural hospital closures put 60 million Americans living in rural areas at risk of having limited or no real access to emergency services.[3]

FECs are eager to be a solution for the rural health care crisis. However, a key impediment to FECs expanding to rural areas is the current inability of this relatively new delivery model to qualify for Medicare and Medicaid reimbursement. According to the American Hospital Association, Medicare and Medicaid comprise 56 percent of rural hospitals' net revenue.[4] Because rural areas tend to have higher concentrations of Medicare and Medicaid beneficiaries, building FECs in these areas is unviable.

The lack of Medicare recognition for FECs reflects the unfortunate reality that the Medicare statute lags behind innovative delivery models and must be updated.

---

[1] Rural Hospital Closures, Cecil G. Sheps Center for Health Services Research, The University of North Carolina

[2] Rural Hospitals at Risk of Closing, Center for Healthcare Quality & Payment Reform.

[3] One in Five Americans Live in Rural Areas, United States Census Bureau, April 09, 2017.

[4] American Hospital Association, 2019 Rural Report.

FECs are particularly well-positioned to provide care in rural areas when Medicare and Medicaid reimbursement becomes available. States have the ability to encourage FEC growth in rural areas when developing their licensure requirements. For example, Mississippi has a pilot program that allows freestanding emergency rooms to be built in counties without emergency hospital care. However, success in these underserved areas first requires Medicare and Medicaid recognition.

Unlike a hospital, FECs are efficient sites of care that do not carry the substantial fixed costs of building and staffing numerous, often vacant, operating rooms and inpatient beds. Nor do they need to spend resources on trying to recruit and maintain physician specialists (other than ER physicians) in remote areas where these physicians tend not to reside. Because FECs are efficient and can maintain lower overhead costs, they have a greater ability to serve areas that may be unattractive or unviable for hospitals.

Congress recognized the importance of maintaining access to emergency care in rural areas when it authorized Rural Emergency Hospitals (REHs) several years ago, which allows economically failing critical access hospitals to convert into an REHs. This is essentially an FEC that receives enhanced reimbursement rates. However, the law does not permit an FEC that was not first a hospital to obtain Medicare and Medicaid recognition. With the overhead requirements, staffing issues, and other financial constraints incurred with operating a full-blown hospital in a rural community, it would seem reasonable to allow FECs to be recognized in the first place. The REH designation was created to prevent the loss of essential emergency care. FECs offer the ability to provide that same level of emergency care and also avoid unnecessary hospital closures.

Temporary Medicare Coverage Under Waiver Showed Efficiency of FECs

Thanks to Rep. Jodey Arrington and other congressional leaders, in April 2020 FECs secured a Centers for Medicare and Medicaid Services (CMS) waiver that allowed them to enroll as Medicare-certified hospitals and receive Medicare reimbursement for the duration of the COVID-19 public health emergency (PHE).[5] Over 125 FECs enrolled and were able to provide high-quality emergency services to tens of thousands of beneficiaries for all kinds of emergency conditions at a significant savings to the Medicare program. FECs effectively stepped up to help alleviate nearby hospitals that were overwhelmed with COVID-19 patients and provided care for patients in their local communities closer to home.

An actuarial analysis from Dobson-Davanzo that examined the Medicare claims data from 2019 to 2022 found that on a severity level standardized basis, Medicare saved more than 21 percent for emergency care provided in FECs compared to hospital ERs. Additionally, the analysis found that there was no overall increase in ER services in Texas, where the FECs that participated in Medicare were located, compared to the rest of the country.[6] Texas ER utilization remained statistically consistent with ER utilization across the United States after FECs gained temporary Medicare recognition. There was simply a market share shift of patients from hospitals to FECs.

---

[5] Center for Medicaid & Medicare Services (2020). Guidance for Licensed Independent Freestanding Emergency Departments (EDs) to Participate in Medicare and Medicaid During the COVID-19 Public Health Emergency.

[6] Dobson-Davanzo & Associates. "Effect of the Medicare Waiver for Freestanding Emergency Centers on Emergency Service Utilization." October 12, 2023.

This comprehensive analysis of the claims data demonstrates that competition works to contain costs and outdated narratives of increased patient choice results in overutilization are unfounded when it comes to FECs participation in the Medicare program.

These savings do not capture the substantially reduced inpatient admissions that FECs achieved, thus saving Medicare and our taxpayers even more money. FECs have no incentive to fill empty hospital beds. The study found that FECs were over twice as likely to discharge Medicare beneficiaries home compared to hospital ERs.

When considering patient acuity, FECs treated a wide variety of emergent conditions and traumatic injuries. Distribution of ER encounters by severity showed 86.1% FECs cases were mid-high level of severity, while 90.5% of hospital ER cases were mid-high level of severity.

This empirical analysis of the Medicare claims file demonstrates that FECs increase access to emergency care without increasing Medicare costs AND save the Medicare program significant resources by providing more efficient care. By imbedding FECs in the community, patients are able to receive more timely treatment. We believe this is due to our nimble, patient-centered model, where patients are seen within minutes of arrival and receive focused, individualized care. Due to being seen quicker and earlier in their disease process, patients have better outcomes, require less medical care, and are less likely to be admitted to the hospital for preventable reasons.

Additionally, unlike a hospital ER where medical and ancillary staff are frequently required to support functions in other departments of the hospital, our team is strictly focused on providing services to patients within the confines of the FEC. When a patient arrives at an FEC, all human resources are dedicated to delivering an exceptional experience. Because our physicians have more time to spend at the bedside, they are able to more effectively evaluate the patient's condition and only order diagnostic tests, such as labs and radiology, that are absolutely necessary.

Due to the rushed, overcrowded conditions frequently found in a hospital ER, it is common for diagnostic tests to be ordered before the physician lays eyes on the patient. Tests are ordered based on the patient's presenting condition, so results are frequently available prior to the physician examining the patient. This is an understandable approach due to the hectic nature of a hospital ER, where the lobby and exam rooms are often full and patients who have been waiting hours. This approach expedites care by allowing diagnostic testing results to be in hand when the physician physically evaluates the patient. However, when tests are ordered before the physician has spent time with the patient, a "wide net" is frequently cast and unnecessary tests are performed. In an FEC, however, almost all diagnostic testing and treatment is done AFTER the physician has physically evaluated the patients. Fewer diagnostic tests are performed on patients, with the same level of acuity, when compared to a hospital-based ER. This results in lower costs, as evident in the Medicare claims data.

Simply put: FECs are able to focus on doing one thing exceptionally well. This level of focus leads to better patient satisfaction, improved clinical quality, and lower costs. Unfortunately, the temporary waiver that allowed FECs to be certified Medicare providers expired last year when the PHE ended. Congressional action is now needed to reinstate that coverage.

Emergency Care Improvement Act is a Solution to Health Costs

The Emergency Care Improvement Act (H.R. 1694) modernizes the Medicare statute, improves patient access, and encourages competition by providing statutory Medicare recognition for FECs. The bill has been endorsed by the American College of Emergency Physicians, the thought leader on emergency care. As mentioned, the Dobson Davanzo analysis of more than two years of PHE utilization data shows that FECs can deliver more than 21 percent savings without any increase in ER utilization. CBO should be encouraged to perform an analysis based on data from the real-life Medicare demonstration project that occurred under the waiver and avoid theoretical narratives that imply greater competition increases costs.

The bill includes a notable provision that addresses the issue of low-acuity patients inappropriately utilizing emergency rooms. While the comprehensive Dobson Davanzo analysis found that low acuity patients (i.e., levels 1 and 2) make up a small percentage of FEC encounters, some patients may be more appropriate for an urgent or primary care clinic. In addition to state laws requiring signage and disclosures clearly informing patients of our ER status, the bill also explicitly prohibits facility reimbursement for these low-acuity patients. Since FECs would not bill these patients for anything other than the professional fee, this policy also establishes a useful precedent for reforming hospital payment for low-acuity patients.

Finally, the bill would not permit Medicare recognition of a new FEC located in a rural county already served by any type of hospital, as we have no interest in threatening or competing with struggling rural hospitals.

Expiration of Waiver and NSA Implementation Put FECs in Financial Duress

As our Medicare revenue dropped to zero, the No Surprises Act implementation has dramatically cut commercial reimbursement and threatened patient access to care. Some FEC companies have successfully achieved network status with major health plans. Many others have been unsuccessful and gone out of business. It appears some insurers may be inappropriately weighting qualified payment amounts (QPAs), which result in artificially low QPAs. These initial QPAs offered by the insurers are often below the Medicare rate, which was explicitly abandoned by Congress in the development of the statute for being too low and unreflective of commercial market rates. This tactic attempts to drive down QPA rates to use them as a "historical" reference benchmark during arbitration while simultaneously forcing more providers out of network. Many FEC companies have struggled to be accepted as in-network providers by certain health plans in the first place, as the plans prefer to rely on the independent dispute resolution (IDR) process, which puts even more financial duress and responsibility on providers.

The $115 administrative fee associated with the IDR process, as well as the inflated fees for the certified independent dispute resolution entities that range between $375 to $1,170, are also financially devastating to providers. It's not unreasonable to consider that claims are significantly underpaid by health plans knowing the only action for providers is the NSA dispute process. Dispute fees have significantly less of an impact on insurers who have the ability to increase premiums or cost share to generate more revenue. It is also well known that insurers have significant IT and programming infrastructure that has allowed them to efficiently prepare

automated dispute response packages whereas providers, with limited resources, rely on the manual preparation of each and every dispute package. Providers are struggling to stay afloat, yet insurers do not appear to be experiencing the same financial demise. As a direct result, we have seen and will continue to see (without change) an increase in providers closing facilities.

As you know, the provider community has prevailed in litigation in all four of the Texas Medical Association cases brought against CMS for the failed implementation process and substantive violations of the statute, which was carefully crafted by Congress. We are grateful the Ways and Means Committee has led Congress in providing needed oversight on the botched implementation of the NSA.

Conclusion

On behalf of the National Association of Freestanding Emergency Centers, thank you for organizing this field hearing and learning about a model that will improve access to emergency care, particularly in rural communities. We look forward to working with the committee and Congress on improving patient access to high quality emergency care by providing permanent Medicare recognition to FECs and properly implementing the No Surprises Act.

Chairman SMITH. Thank you. Mrs. Miller.

STATEMENT OF LAUREN MILLER, EMERGENCY CARE PATIENT

Ms. MILLER. Chairman Smith, Ranking Member Chu, and members of the House Ways and Means Committee, thank you for having me here today. I appreciate the opportunity to address how state-mandated bans on essential medical treatment delayed my access to care, creating an unnecessary medical emergency.

My name is Lauren Miller. I am an eighth-generation Texan and live here in Dallas with my husband Jason and our two young sons. I work with incentives for sustainable agriculture, and Jason is a biochemist.

In July 2022, when our first-born son was a year old, we were thrilled to find out that I was pregnant again. But this pregnancy was different. Just weeks in, I wound up in the emergency room following 36 hours of unrelenting nausea and vomiting.

It was there, while being treated for severe dehydration, that we learned I was carrying twins. I was so sick but so excited. We called the twins "Los Dos," and every night Jason would give my belly two kisses, one for each.

At the routine 12-week ultrasound, everything changed.

The doctor explained that while one of the twins was thriving, the other was not. On the scan, she pointed out two large fluid masses where his brain should have been developing. More testing brought even more horrible fatal diagnoses.

In speaking with our team of doctors, nurses, and genetic counselors, we kept arriving at the same awful conclusion: this twin was going to die. It was just a matter of how soon. And every day that he continued to grow, he put our healthy twin and myself at greater risk.

But because of Texas's insidious new abortion laws, my doctors were terrified to suggest an abortion of one unviable twin even though this would have saved the other twin.

There were no next steps. There were no treatment options. It was a devastating diagnosis, and we had reached the point where health care ends in Texas.

Can you imagine trying to get necessary medical care when your doctor is afraid to explain—or even say—what your possible treatment options are?

In Texas now these cruel, inhumane laws trump, even paralyze, the judgment and training and experience of astute and caring medical professionals and result in a stunning lack of options for patients like me.

If my set of circumstances had occurred just a few months prior, before Texas' abortion bans took effect, the maternal fetal medicine specialist treating me could have performed a single fetal abortion immediately. That is what we wanted and what we needed.

Instead, we were sent home to wait and see whether the prediction of my decline would come true, that I would get sicker and sicker.

Sure enough, just 3 days later, Jason rushed me to the emergency room for a second time. I was vomiting so severely that I thought the placenta would detach and I would bleed out. I was severely dehydrated and shaking uncontrollably as the team in the

emergency room worked to stabilize me. I was at risk of organ damage to the kidneys or brain. There was one solution—the single fetal abortion. But once again I wasn't just denied this care—we couldn't even discuss it.

Abortion bans have eliminated emergency reproductive care in Texas. We can't just be in declining condition. Politicians in Texas force us to linger in physical and psychological pain until we are near death.

Despite years of medical training and practice, my doctor's ability to offer care was reduced to repeating over and over and over "I'm so sorry."

The State of Texas would kill all three of us rather than let my doctor and I determine what was best for me. Where are my human rights to health, bodily autonomy, and life?

So, we tabled our grief and turned our attention to fleeing our home state to protect the health and lives of our viable twin and myself.

What about the people who don't have funds or connections or resources to travel? I understand how very privileged we were. But no one should ever have to rely on privilege to access emergency, lifesaving health care, to make decisions about their own bodies, their own lives, and their own families.

This level of government overreach just can't be the way it is. Why is half of this country undeserving of bodily autonomy?

We need Federal protection for abortion care, no matter who you are, no matter where you live. And we need Federal protection for the doctor-patient relationship to prevent government interference in a patient's decision-making process. Congress has the power and the duty to act and stop this subjugation and dehumanization of women.

Thank you.

[The statement of Ms. Miller follows:]

Testimony of Lauren Miller
Before the United States House Committee on Ways & Means
"Access to Health Care in America: Ensuring Resilient Emergency Medical Care"

March 18, 2024
Dallas, Texas

Chairman Smith, Ranking Member Chu, and Members of the House Ways and Means Committee, thank you for having me here today. I appreciate the opportunity to address how state-mandated bans on essential medical treatment delayed my access to care, creating an unnecessary medical emergency.

My name is Lauren Miller. I'm an 8th generation Texan and live here in Dallas with my husband, Jason, and our two young sons. I work with incentives for sustainable agriculture; Jason is a biochemist.

In July 2022, when our first-born son was a year old, we were thrilled to find out that I was pregnant again. But this pregnancy was different. Just weeks in, I wound up in the Emergency Room following 36 hours of unrelenting nausea and vomiting.

It was there, while being treated for severe dehydration, that we learned I was carrying twins. I was so sick but so excited. I had always wanted three kids close together!

We called the twins "Los Dos" and every night, Jason would give my belly two kisses, one for each.

At the routine 12-week ultrasound, everything changed.

The doctor explained that while one of the twins was thriving, the other was not. On the scan, she pointed out two large fluid masses where his brain should have been developing. More testing brought even more devastating fatal diagnoses.

In speaking with our team of doctors, nurses, and genetic counselors, we kept arriving at the same awful conclusion: This twin was going to die. It was just a matter of how soon. And every day that he continued to grow, he put our healthy twin and myself at greater risk.

Because of Texas's insidious new abortion laws, my doctors were terrified to suggest an abortion of one unviable twin even though this would have saved the other twin.

There were no next steps. There were no treatment options. It was a devastating diagnosis and we had reached the point where healthcare ends in Texas.

Can you imagine trying to get necessary medical care when your doctor is afraid to explain – or even say – what your possible treatment options are?

In Texas now, these cruel, inhumane laws trump, even paralyze, the judgment and training and experience of astute and caring medical professionals and result in a stunning lack of options for patients like me.

If my set of circumstances had occurred just a few months prior, before Texas' abortion bans took effect, the Maternal Fetal Medicine specialist treating me could have performed a single fetal abortion immediately. That is what we wanted and needed.

Instead, we were sent home to wait and see whether the doctor's prediction of my decline would come true – that I would get sicker and sicker.

Sure enough, just three days later, Jason rushed me to the emergency room for a second time. I was vomiting so severely that I thought the placenta would detach and I would bleed out.

Persistent extreme vomiting at this point in pregnancy triples the odds of placental abruption – another emergency situation.

I was severely dehydrated and shaking uncontrollably as the team in the emergency room worked to stabilize me. Lab results showed that I was at risk of kidney failure, coma, heart attack, swelling of the brain, or death. There was one solution - the single fetal abortion. But once again, I wasn't just denied this care – we couldn't even discuss it.

Abortion bans have eliminated emergency reproductive care in Texas. We can't just be in declining condition. Politicians in Texas force us to linger in physical and psychological pain until we're near death.

Despite years of medical training and practice, my doctor's ability to offer care was reduced to repeating over and over and over "I'm so sorry."

The State of Texas would kill all three of us rather than let my doctor and I determine what was best for me. Where are my human rights to health, bodily autonomy, and life?

So, we tabled our grief and turned our attention to fleeing our home state to protect the health and lives of our viable twin and myself.

What about the people who don't have funds or connections or resources to travel? I understand how very privileged we were. But no one should ever have to rely on privilege to access emergency, life-saving health care. To make decisions about their own bodies, their own lives, and their own families.

This level of government overreach just can't be the way it is. Not in Texas. Not in the other 13 states that ban and or criminalize abortion care. Not anywhere.

Why is half of this country undeserving of bodily autonomy?

We need federal protection for abortion care – no matter who you are, no matter where you live. And we need federal protection for the doctor-patient relationship to prevent government interference in a patient's decision-making process. Congress has the power and the duty to act and stop this subjugation and dehumanization of women.

Thank you.

Chairman SMITH. Thank you all for your testimony. We will now proceed to the question-and-answer session. First, I will start out. My question is to Mr. Matthews.

Medicare's rural emergency hospital designation is an innovative way Congress has sought to address the financial sustainability of low-volume facilities that provide emergency care in rural communities. However, I fear that this program is being underutilized.

Mr. Matthews, as someone who has run rural hospitals, including one that converted to the rural emergency hospital designation, can you please share both the benefits your hospital has experienced as a result of becoming a rural emergency hospital, and just as importantly, what additional flexibilities do you think are needed to increase the number of rural hospitals that might help benefit from it?

Mr. MATTHEWS. Yes, sir. Thank you for that question. In early 2023, Anson General Hospital had a bad debt situation of $2.7 million, and $1.9 of that was loans at the bank to help fund operations, and $860,000 was aging AP, and we were on vendor hold and we were on credit hold, and we knew that our facility, again, could not move in that direction. So, in January, really January 2nd, we started the application process of becoming a rural emergency hospital, and the attestation process, et cetera.

So, we completed that, and then on March—so this happened in early January—on March 27th, we received word from CMS, actually Novitas, the intermediary, that we were a rural emergency hospital. It happened that quickly. And so, at that time we went on Medicare hold and Medicaid hold, because we had received a new PTAN, or a new provider number, which identified us as a rural emergency hospital. And within a month, our Medicare dollars had freed up and started flowing to our hospitals. On the Medicaid side it took a couple of more months to get those worked out.

But what was remarkable—so March 27th, we became an REH. On April 20th, we received our first facility payment.

So, I have been involved on a lot of Medicare issues and positions, but I had never been in a program where that happened as smoothly and that quickly. And we also realized, at that time, and we embraced this, that we had a new identity, and that was strictly on the outpatient side, that we were going to focus on the emergency room, that we were going to focus on radiology, on laboratory, on our therapy departments, especially on observation, and start looking a little bit at elective outpatient surgeries. Again, our senior doctor is a surgeon, as well. And with that we no longer had the ability on an inpatient or on a swing bed basis.

But prior to that decision we were averaging 1.5 inpatients a week, so we were 88 inpatients the whole year, and 2 swing bed patients—on a monthly basis. So, what had happened was we did not have the volume, and without the volume you do not have the revenue.

So, this was an easy decision for us. We knew that we had to do this, and we did. Now, there was some feedback from the community, especially on the inpatient side and the swing bed side, but we embraced this new identity, and we have been very successful with it. In 11 months, we have seen 2,600 emergency room, ER,

visits in our ER. We are averaging 25 to 30 observation stays on a 24-hour basis. So, this is definitely working for our community.

And I have had many conversations with other hospitals that are considering this change. They were for it. There were, at one time, five hospitals that actually became REHs in the state of Texas. One of those hospitals in LaGrange is closed, and that left four of us. And I think it is the standpoint that they are just actually sitting back to see how these trailblazers, how it is going to work out for us.

But at the same time, in rural health care, we have seen, at one time we had critical care units. We no longer have critical care units. We had OB services. We no longer have OB services in most of rural Texas. Now we no longer have inpatient, and what really hurt us the most was on the swing bed side. We lost that capability.

Chairman SMITH. So, I want to ask a couple more questions. Thank you, Mr. Matthews.

Mr. Morris, I think it is important that we get to the freestanding emergency departments. They can be a lifeline. But with the exception of the recent public health emergency, they are ineligible, like what you testified, to Medicare reimbursement. This means these facilities are reliant solely on private insurance, private pay, effectively preventing them from spreading into rural and underserved areas, where government payers are more common.

Can you describe the potential impact freestanding emergency departments could bring to rural emergency care access if they are allowed to participate, or continue to participate, in Medicare?

Mr. MORRIS. Well, as I am listening to Mr. Matthews talk about his struggles and thinking about how a freestanding ER could get to the place where he has gotten as a trailblazer, right out of the gate, going in, building a facility with low fixed costs, having emergency care onsite, the ability to stabilize and treat patients, serving as a hub where you could attract primary care doctors to come in, where you could refer patients out. As a foundation of the health care ecosystem, I think it was very wise of Congress to recognize REHs, because you saw the most important aspect of the hospital was access to emergency care.

I think we have so much untapped potential, if we are given the opportunity. But when you look at the demographics in these areas, it is majority Medicare and Medicaid. We cannot make a go of it without the government reimbursements.

Chairman SMITH. Perfect. I now recognize the gentlelady from California, Ms. Chu, for any questions she might have.

Ms. CHU. Mrs. Miller, thank you for your courage and sharing your story. It was very powerful, and I was so moved by what you had to say. And I am so sorry for the horror and the lack of care that you were forced to experience.

Mrs. Miller, can you tell us what treatment options you were left with once your doctors told you there was nothing that they could do for you in Texas, and it was obvious that abortion was one of those. But did you feel you could talk to your doctor about that?

Ms. MILLER. So really there were no treatment options in Texas. I remember talking with genetic counselors. Their role is just to counsel on options, not even to offer abortion care. And they

would get halfway through a sentence and then just freeze, scared to even say the word "abortion" out loud. So, we couldn't even talk freely. And really what I was left with was that if I was going to stay in Texas it would be just to continue to decline until I was close enough to death to be able to get an abortion, or I lost both of my sons. I mean, we weren't just talking in the ER about if I was back; it was when.

And we were making plans and discussing what it would be like for me to be there for the duration of my pregnancy. So that would have been my husband at home alone, and I would have been just trapped in a bed, tied to an IV to keep me stable. And it was either that or go out of state, and I am very lucky to have the time, the money, the connections out of state to be able to have made that trip, as difficult as that was, because I was in really rough shape.

Ms. CHU. How did it feel to know that your choices were so limited?

Ms. MILLER. I didn't feel like I was an entire person, deserving of bodily autonomy. I felt like I had politicians in the room, maybe flipping through my chart and mandating my care rather than just being able to have an open conversation with my doctor and for us to be able to determine what was right for me.

Ms. CHU. My bill, the Women's Health Protection Act, would establish a federal right to access abortion care in every state, no matter where they live. If this bill had been enacted at the time of your abortion, how would it have impacted your experience? Do you think that you would still need emergency care?

Ms. MILLER. I definitely would not have ever had that second trip to the ER. I would have been able to get access to the abortion care I needed about a mile from my house, with a $50 co-pay, rather than travel for days and spend thousands of dollars. And it was apparent how great of a need that was, because once I got that single fetal abortion, I mean, within hours, it wasn't that I just stopped throwing up for the first time in months, I managed to eat dinner that night. I mean, I was so sick that I didn't return to my pre-pregnancy weight or even just top it until I was about 7 1/2 months pregnant.

Ms. CHU. Was there a risk to having to go out of state, and if you didn't have enough time or the funds to travel out of state for your abortion what would have happened?

Ms. MILLER. Yeah, so there were considerable risks just to making that trip. As I said, I ended up in the emergency room twice because of how sick I was. We debated if we would do a 12-hour drive to the hospital in Colorado or if we would fly. And we ultimately made the decision to fly just because there was no way I would have been able to sit in a car that long. I mean, I was vomiting constantly. I was so sick. You know, it was gritty. It was bits of esophagus starting to come up. And there was no way we would have been able to make that drive, so we had to fly. And it would have been so drastically different if I had been able to be home.

Ms. CHU. What would you like this committee to know most about accessing abortion care in this country?

Ms. MILLER. There are a lot of reasons to get an abortion, and every one of them is valid, and that is something that a doctor and patient should be discussing together and making that decision for

that patient in that room, and with the doctor who is treating them. If you are not in that room, you don't know what is happening.

Ms. CHU. Thank you again for sharing your experience. It is the most personal of experiences, and yet you were able to share it with the world. So, I appreciate it and thank you so much.

Chairman SMITH. Thank you. I now recognize Ms. Van Duyne.

Ms. VAN DUYNE. Thank you very much, Mr. Chairman. I am going to get us back on topic here.

Dr. Racht, can you elaborate on the unique impact of serving the North Texas area with mixtures of urban and rural communities?

Dr. RACHT. So, EMS spends a lot of time looking at the configuration of a community—urban, rural, where the health care facilities are, where the specific health care facilities are, so for example, trauma centers, stroke centers, heart attack centers. One of the unique components of emergency services—and I talked earlier about being prepared and planning—is to bring the physicians, the health care systems, the EMS system together to pre-plan how we would approach a system like North Texas.

So, we depend on call volumes. We depend on injury profile, illness profile to then strategize on a deployment plan, and that deployment plan is in concert with a hospital, and it is a dynamic plan. So as weather changes, which I think we are all familiar with, that plan can change to get the patient to the right level of care.

One of the important components of that process is that it requires that we have knowledge of capabilities of the EMS system, we have knowledge of capabilities in openness, bed availability of the hospitals, and we have a way to get patients to specific areas.

Ms. VAN DUYNE. Thank you. When drafting the No Surprises Act, the number one priority was to protect the patient. After that it was to create a balanced dispute resolution process where providers and payers were on equal footing. What has been GMR's experience during independent dispute resolution?

Dr. RACHT. So, we support the No Surprises Act, and we 100 percent agree that the patient needs to come out of the middle of this. I think as we have all heard, these are events that are almost always unexpected, they are quite often significant events, and we manage the patient during that time period.

The intent of the No Surprises Act was to create an environment to take issues where there was disagreement between the payer and the provider, sort through those issues, and reach consensus. Unfortunately, two things cripple us in making that reality come true. One is we can't discuss the medical necessity part of a patient's bill. We can't sit and talk about your question, for example. What was indicated, what was the appropriate level of care, and was this an appropriate decision that was made?

The other is that unfortunately even when we are successful in the IDR process—and again, we support that—even when we are successful, we struggle with collecting from the payers on that particular process, in some cases up to a year. So that creates a significant burden on the EMS system to try and manage, in accordance what we all agreed on was an appropriate way to evaluate those situations.

Ms. VAN DUYNE. Excellent. Thank you very much.

Mr. Morris, Congress wrote the No Surprises Act very intentional and with specific guidance. Yet we have continued to see the Administration ignore congressional intent during the implementation. Secretary Becerra is going to be in front of this committee on Wednesday, in Ways and Means. If you were in my seat, what questions would you ask him?

Mr. MORRIS. Probably at the top of the list would be how are you monitoring, enforcing how qualified payment amounts are determined, because what we are seeing on our end, what are being used by commercial insurance as qualified payment amounts, based on our own actuarial data and fair health data, which is a repository of benchmarks in payments, it appears there is a lot of opportunity there for enforcement on working with payers to make sure that they are honoring the way that statute was intended and the way those QPAs are being calculated is appropriate. That would be at the top of my list.

Ms. VAN DUYNE. Dr. Racht, what about you?

Dr. RACHT. I think at this point I would ask the question about how we address medical necessity. The main reason that our patients activate our health care systems, activate the service, and how do we sit down and resolve those based on discussing that patient encounter, the patient's needs, and the reason they entered the system.

Ms. VAN DUYNE. Mr. Zavadsky, would you ask a question of Secretary Becerra?

Mr. ZAVADSKY. I think I would ask him what is the right thing for the patient, and in this particular case, certainly in regard to the IDR, it is a flawed process. CMS has even sort of hinted, they acknowledge it is a flawed process because it started and stopped and suspended and back on again. So having a closer view of the process, making sure that the provider and the payer are on equal footing, which was the original intent. That is clearly not happening, as we are hearing from all the providers here, many of whom are safety net providers that can't afford to play the games that are currently being played with the IDR process.

Ms. VAN DUYNE. Thank you very much. I yield back.

Chairman SMITH. Thank you. Mr. Arrington.

Mr. ARRINGTON. I want to thank the witnesses for their insights, and I appreciate your very personal story. I am grateful to all of you to help us, guide us to strengthen the safety net as we know it today. We know there are holes in it. We know there are ways to improve upon it.

I was proud to lead rural emergency hospital designation. It was an effort, and a leadership effort, by many Members of Congress. I was fortunate to carry it, but it was also a lot of folks on the outside, mainly rural hospitals, saying, we need something to help us. With the many hospitals that were closing, I think 40 percent of rural hospitals are operating in the red even today. And it is not a panacea, obviously, but for Crosbyton in my district, and for Anson, Mr. Matthews, it has been a lifesaver.

And so, you have implemented it, you and 19 others in the country, but there are 380 some-odd rural hospitals that would qualify for this designation. What do you think we can do to improve upon

it? I mean, we passed it in '20, at the end of '20. Four years later, 19 hospitals. I would like a higher uptake. I would like more stories of turning around a hospital that would have otherwise shuttered and would not be saving the lives that you and I talked about before this hearing. What could we do to improve upon the REH designation, on the implementation side and even broadening the net to catch some other hospitals that might need a lifeline.

Mr. MATTHEWS. Those are good questions, and, honestly, I am surprised also that more rural hospitals in Texas have not converted. We have 19 on a national basis. We have 12 that are in the application process. So shortly we are going to have 31 REHs on a national basis, but again, only 4 in Texas.

And again, I believe that the primary factor is the loss of services, and that has to do with the inpatient and the swing bed program. Now we were a prospective payment system hospital, but many of the critical access hospitals have huge reimbursements on the swing bed side. So, if you have a strong swing bed then you are able to recoup financially and flow those dollars toward operations.

So, a couple of things that I have heard in visiting with my colleagues around the state is the fact that we can operate without the inpatient. We need to keep the swing bed programs in place, and also the 340B.

Mr. ARRINGTON. I was going to ask you about that. You have to abandon the 340B benefit in order to get this monthly payment under the REH?

Mr. MATTHEWS. We do. Now we were not a 340B hospital. We didn't qualify. We were not a DSH hospital.

Mr. ARRINGTON. Okay. So, the calculation wasn't necessarily a tradeoff on that program.

Mr. MATTHEWS. Correct.

Mr. ARRINGTON. But for some hospitals it would be.

Mr. MATTHEWS. Absolutely. Yes, sir, that is true. But on the swing bed part we transferred out 169 high-acuity level patients, and primarily most of those went to Abilene and some to Lubbock. And then after a 3- or 4-day stay in that facility it is time to release them, and those individuals, on a swing bed basis for rehab, they want to come back to our community, and that is not a possibility right now. And the other fact is that the hospital we transferred them to needs to free that bed so that they can come back.

So, if we can get the swing bed program back in some capacity that would make all the difference to our community and rural areas.

Mr. ARRINGTON. Well, we look forward to working with you going forward, and I thank you for being here, and thanks for your commitment to Jones County, America, and the good people in the big country for your willingness to go from Eastland all the way to Anson and make the sacrifice. I know your family lives in Waco, and you are making a difference for our people out there, and on behalf of District 19, thank you.

I have got 35 seconds. Mr. Morris, you said that in the lookback over 3 years with that waiver, where you were on par with conventional hospital ERs you were able to do it at a 20 percent reduction in cost. As Budget chairman I am looking for some dollars and

cents of savings to taxpayers, and for our future taxpayers, namely our children that are going to inherit a big—I won't say the word, but a big Texas debt, a big, Texas-sized debt, that we don't want them to. How did you do that, and I will yield back, Mr. Chairman, if you will let him respond. How did you get that 20 percent reduction?

Mr. MORRIS. It is a matter of more individualized care. It is not having empty inpatient beds available to fill. We don't have the luxury of pulling a lever and referring to a hospitalist. We take care of patients in our facility and do everything possible to discharge them home, including lining up outpatient testing and treatment, and taking steps, really, to avoid admissions.

And quickly, I was reading an interesting article. There is disagreement among emergency physicians—let me rephrase it—only 52 percent of the time physicians consistently agree on admissions. There is a huge swing on it from an ER physician, on whether a patient should be admitted or not admitted. There is a sea of gray in there. So things that you can do to keep patients out of the hospital is what is going to save taxpayers money, and I think, by nature, that we don't have any inpatient beds available to fill, that in itself, from a process standpoint, helps keep patients out of the hospital.

Chairman SMITH. Thank you. Ms. Sewell.

Ms. SEWELL. Thank you, Mr. Chairman, and I want to thank our witnesses for being here today.

I am excited about the opportunity to really talk about the need for better infrastructure when it comes to emergency care, but also primary care in rural America. I have the great honor of representing my hometown of Selma, Alabama, and the historic cities of Birmingham and Montgomery, but I also grew up in the Black Belt, a very rural part of my district. And in Alabama, where we have not expanded Medicaid and where we have the lowest reimbursement rate because of the wage index, we have seen that most of our rural hospitals operate in the red. In fact, according to the Alabama Hospital Association, 88 percent of the rural hospitals in Alabama operate in the red, with 75 percent of Alabama's rural hospitals also operating in the red. And I have lost rural hospitals in my district because of the inability to sustain a profitable emergency room.

So, one of the ones that I lost, literally a month before COVID hit, was a hospital in Aliceville, and frankly, the four that were teetering on the brink of being lost was aided greatly by the money that Congress provided for the CARES Act and the American Rescue Plan. But Aliceville closed, and because of that we have seen deaths that have occurred in and around that area simply because they haven't had emergency services.

So, I want to talk a little bit about the ground ambulance services because those have been strained, as well, in Pickens County and other places where closures of hospitals have occurred. Most days there is only one ambulance covering the entire county of Pickens. That is true of a lot of the counties that I represent. And when that ambulance is tied up, transporting a patient 45 minutes to an hour away, other citizens must wait for a response. Condi-

tions are worse when there is rain and medevac services are not able to transport patients in the air.

Pickens County is the only rural area within my district struggling. That is why I am proud to have co-sponsored, with our colleague, Brad Wenstrup, the Protecting Access to Ground Ambulance Medical Services Act, that would address inadequate Medicaid payments that would have stabilized a lot of those areas. I think that this would be one way of helping to level the playing field when it comes to providing emergency services. The super-rural add-on payment of 22.6 percent within our bill would help support ground ambulance services in communities like Pickens and all across.

I actually wanted to ask my question of you, Dr. Racht. First of all, thank you for allowing us to be right here in your facility. Can you speak to the dangers of not expanding the add-on payments for ground ambulance, especially for super-rural providers?

Dr. RACHT. One of the scariest things in emergency health care and one of the scariest things that any patient or potential patient has is what would happen if I had a potentially life-threatening event here, or at home, or on the way home, and there wasn't a way to get me to the right level of care, and there wasn't a way to immediately stabilize that abnormal physiology when that occurred.

Your efforts—and thank you, by the way, for those efforts—your efforts to build the infrastructure to help pay for that cost of readiness—and again, the rural, the frontier areas, the good news is there aren't a lot of emergency calls. The bad news is because there aren't a lot of emergency calls, similar to our hospital colleagues, trying to maintain an infrastructure becomes very difficult.

Ms. SEWELL. Yeah. You know, I actually have a personal story, Mr. Chairman. My dad suffered from a stroke in Selma, Alabama, and as you know, strokes are a matter of seconds. Time is of the essence. And the fact of the matter is that our hospital had just gotten a medevac helicopter, which saved my father's life.

So, I really think that we, as a committee, Mr. Chairman, should work on trying to figure out an add-on payment for ambulance emergency services so that cases like mine are more the norm and not the reverse. I have had patients that have lost their loved ones simply because there wasn't an ambulance service available.

Thank you all. I yield back the balance of my time.

Chairman SMITH. Thank you. We are going to pause very briefly to adjust the doors. I want to take care of our members on the end.

Mr. ARRINGTON. Mr. Chairman, some of our colleagues from the Northeast said the weather is too cold here in Texas, and I said, "No, no, no. Your skin is too thin in the Northeast." So, thank you for doing that.

Chairman SMITH. Perfect. Let's stand in recess until the doors are down.

[Recess.]

Chairman SMITH. All right. Can members take their seats.

Dr. Burgess, you are recognized for questions.

Mr. BURGESS. Thank you, Mr. Chairman. Mr. Morris, just a point of clarification. In your testimony I think you said some of your facilities are, in fact, physician owned. Is that correct?

Mr. MORRIS. Yes, sir, yes.

Mr. BURGESS. Well, through the pandemic you had the waiver to be able to participate in Medicare and Medicaid. Is that correct?

Mr. MORRIS. We did, yes.

Mr. BURGESS. That has now gone with the expiration of the public health emergency.

Mr. MORRIS. This past May, yes sir. When it expired that went away.

Mr. BURGESS. So for several years I have worked on trying to undo the effects of the Affordable Care Act that prohibited physician ownership of hospitals, and it just strikes me that your type of facility, regardless of whether it is physician owned or not, should be able to participate in the rural emergency center program that Mr. Matthews has. Can you speak to that at all, why it would be important, why physician ownership would make a difference?

Mr. MORRIS. The physicians in the ER are the quarterback for the team, and they have a great amount of insight. They set the tone. They influence the culture. I contribute a lot of our success, and I know a lot of other freestanding operators contribute to being able to partner with physicians. I think that a lot of them are looking for some flexibility and autonomy that perhaps they haven't always been able to get in a hospital setting. So when you talk about a rural environment, being able to give a physician the opportunity to continue to be an owner, to manage not only clinically but help to manage operations, I think that would be a good step, and I think it would encourage more docs to move out into rural communities and be a part of that solution.

Mr. BURGESS. Well, that was going to be exactly my point because Mr. Matthews alluded to the fact that there are not many docs working in Anson right now. If this were a way to encourage more doctors to look at a facility like yours in Anson ultimately that would be a plus, wouldn't it?

Mr. MORRIS. Oh, absolutely. Physician recruitment is a huge area in rural areas. In fact, all health care, even administrators, we just have trouble getting those individuals into rural areas.

Mr. BURGESS. So Ms. Burke, let me ask you a question, if I could. In the early days of automatic external defibrillators, AEDs, that everybody is so familiar with now, but in the early days the data was collected that a witnessed cardiac arrest and the immediate availability of an AED could, in fact, positively affect the outcome. I just have to say, you had the ultimate in a witnessed event in a football stadium full of people on national television.

Ms. BURKE. Yeah, absolutely. It is obviously medically proven that whenever cardiac arrest happens specifically, you only have a matter of minutes to respond to get that heart back to its natural state. Otherwise, the person can be left permanently disabled or die. That could have been me if I would have had that cardiac arrest happen anywhere else or in any other event. That is why it is so crucial for us to continue to try to put funding and put resources towards getting CPR and AED training.

Like one thing I talked about briefly in my statement that I think is so important to highlight is the HEARTS Act. I mean, I'm sure you know, as politicians, it is not common to get unanimously agreed upon bills to pass. But the fact that that HEARTS Act was unanimously agreed upon by the Energy and Commerce Subcommittee on Health proved how important it is to have access to CPR and AED resources.

Mr. BURGESS. Yeah, the Energy and Commerce Committee, we frequently work together. Thank you for mentioning that because that was an important bill.

Mr. Smith just reminded me I was an invited guest.

Matt, your comments about the ambulance service with being able to have the ability to interact with the population prior to actually transporting to a hospital, enormous cost-saving potential there. Unfortunately, Mr. Arrington is no longer here, from the Budget Committee. That is one of the things I want us to look at is the enormous cost-saving potential that we have.

Mr. ZAVADSKY. It absolutely is, and it is a pretty easy calculation, because we have been able to track how many times Dr. Racht called 911 for some of his issues, and then when he gets enrolled into a community paramedic program from an agency who is familiar with him, because they have responded on 911 calls, he is a trusted partner because that EMS responder really can address the data that we see in those patients and their decrease in 911 use and decrease in emergency room use is a very simple math calculation and very compelling.

Mr. BURGESS. Very compelling. What is the average cost of the ER visit if they get to the hospital without the community participation.

Mr. ZAVADSKY. Exactly right, and for Medicare it is $700, $800 for a treat-and-street ER visit. For a commercial payer it is usually much higher than that. So, the savings across the spectrum of the health care system is very dramatic.

Mr. BURGESS. Thank you. Thank you, Mr. Chairman. Thanks for letting me be here. I yield back.

Chairman SMITH. Thank you, Dr. Burgess. I would just like to point out for the record that two committees, Energy and Commerce and Ways and Means, just recently passed very large bipartisan bills. Energy and Commerce passed the TikTok ban. Ways and Means passed the tax cuts bill, and we actually got way more votes than they did on the TikTok ban. So, it was a much more aggressive bipartisan accomplishment.

Mr. Smith, you are recognized.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman. Certainly, thank you to our witnesses, as well. Looking at this infrastructure here I can't help but think that lives have been saved by innovation, new ways of doing things, new thinking in accomplishing the objectives that are out there of health care and access for everyone across America.

America is a big country. We know that needs are very diverse. I mean, I represent a very rural district. I say rural. Parts of it I would say are remote. My district has over 60 hospitals, most of which are critical access hospitals, and yet I still have a lot of constituents who reside more than an hour from a facility.

So, because of the alarming rate of rural hospital closures, I was glad to support, as mentioned before, the creation of the rural emergency hospital program, which was, as mentioned, enacted as part of the 2021 Consolidated Appropriations Act. The program threw a lifeline to struggling critical access hospitals and rural Indian Health Service hospitals by allowing them to downsize and receive a restructured reimbursement rate for emergency and outpatient services instead of closing their doors entirely.

I am pleased to see the successful conversion to REH status for the first Nebraska hospital, a community by the name of Friend, with their community health care system. They are in my district. While they were able to complete the conversion process, a new program like this often has problems or issues that need to be worked out, and Friend's experience illuminated just a few of those.

First, when planning a change in operating status of this magnitude a hospital needs clear, two-way communication with CMS regarding where they are in the process and what is expected to happen next. The final stages of the approval process appear to take place in a back room, basically, with little information from CHS, as day after day went by with no updates. It took this community hospital several weeks between when they shut down their inpatient beds and when they were fully approved as an REH, depriving an already struggling hospital of a significant amount of revenue, not to mention access to health care for the patients. They planned ahead and were able to secure emergency local government financing to bridge the gap, but if the approval process stretched any longer, they were at serious risk of closure, despite everything done to gain the REH status.

So, Mr. Matthews, if you would, most hospitals that elect to convert to REH status are already facing huge financial challenges which threaten their ongoing operations from day to day. Based on your hospital's experience, how much in operating reserves would you recommend a critical access hospital have when they initiate the process to ensure that they can survive days in approval with no inpatient revenue—I am sorry, when they can ensure they survive delays in approval with no inpatient revenue.

Mr. MATTHEWS. So, as I mentioned at one time, we had five rural emergency hospitals. Since that time, one has closed, and that was a timing issue. They should have moved forward with this conversion much earlier than they did. They just waited to the point that once they started this application process, they just didn't have the funds coming in to continue.

So, with us, again, by early February we had all of our applications in. By the end of March, so within, I would say, operating funds of at least a couple of months. But what happened was we were one of the first, so there wasn't a queue or a line waiting, so Medicare moved us through pretty quickly. But for us it wasn't a long delay at all. We continue to see inpatients up to the point that we became an REH, and then at that point we did the split bill. We billed under our old number and our new number, because we continued to operate as a PPS hospital until the day we got the notification. Then at that point we converted over on the observation side. We had to keep some of those inpatients a couple of days. We

were responsible for that cost. But we did a split billing there and it worked very well for us.

Mr. SMITH of Nebraska. Thank you. And then in terms of transparency, are there points of transparency that you would recommend that could be offered by CMS so that the process could move more smoothly or more efficiently?

Mr. MATTHEWS. Well, always transparency is critical, and you have those situations. You just try to find out where you were in the line or the queue. We did not know when we were going to become—it was a surprise, that day, that we got the letter, the emails, in, telling us that we were an REH. We did not know. In fact, we thought it was going to be later than that.

Mr. SMITH of Nebraska. Thank you. Mr. Chairman, I do want to take just a point of personal privilege here today. You can hear us joking about the Energy and Commerce Committee versus the Ways and Means Committee. This is actually the Ways and Means Committee hearing but we are grateful to have a valuable member of the Energy and Commerce Committee, as well. There is a great, healthy rivalry between the two committees. We share jurisdiction of health care, hence Dr. Burgess' presence here today.

Now, the sad part of this is both Dr. Burgess and Dr. Wenstrup are leaving us. They will be missed, as physicians working in the trenches of health care. I want to take just a moment to salute their service and thank them.

[Applause.]

Mr. SMITH of Nebraska. I yield back. Thank you.

Chairman SMITH. I about said Dr. Moore, but Ms. Moore is recognized.

Ms. MOORE of Wisconsin. Well, I tell you, good thing no one is clapping for me today because when they start celebrating you, you know you are on your way out. [Laughter.]

Ms. MOORE of Wisconsin. Let me just thank you all for the tremendous opportunity to come here. I have learned so much today. I just want to thank you, Ms. Burke, for reminding us how important the Affordable Care Act has been. Not only could you have stayed on your parents' insurance until you were 26 but you had a preexisting condition that people would not have—you would have had a $300,000 bill. And so, the Affordable Care Act has faced 50 times of folks trying to end it, but you are walking, living testimony, sermon in shoes about the importance of it.

And you, Mrs. Miller, I am going to have something to say before my time expires.

Dr. Racht, thank you for hosting us. Dr. Racht, thank you for closing the door here. I was curious about your testimony, as well as Mr. Zavadsky—notice I was not laughing when you said your name. I am from Wisconsin. I am used to names like that. You talked about the treatment in place and the inability to get reimbursed. So, someone is on a picnic, they get a bee sting, you come along, give them an epinephrine shot, or they have an asthma attack, and you give them a breathing treatment. It's all good and you leave, and you can't get paid, unless you just insist, hold them by gun point, say, "You better go to the hospital so we can get paid."

I really do get it, that that is unfair in terms of not treating you. I am asking you, Dr. Racht, what is the argument against that? Is there a fear that, say for example, this 911 navigator type situation you talked about, Mr. Zavadsky, that people who don't have the proper training might insert their own lack of expertise into a situation and not take someone to the hospital. Is there a liability issue? What is the billing issue that we ought to know about?

Dr. RACHT. So, I think one of the things that everyone in EMS would agree on is that we are able to collectively solve issues relating to patient care amongst ourselves. We support, and EMS has supported, Matt has done a tremendous amount of work in looking at mobile integrated health care, treat and release, the ability of the EMTs, paramedics, nurses in the field to manage a patient that doesn't necessarily need hospitalization. Unfortunately, because the benefit is a transportation benefit there is the disincentive to move that patient to a hospital as opposed to solve their problem up front.

And the other thing that I would mention—and by the way, putting the doors down is the prevention side of emergency medicine. We have a few ambulances and helicopters but not enough hospitals to take everyone to. But being able to manage patients up front and prevent their need with chronic illness, from having to use the emergency services side is also a very strong argument.

Ms. MOORE of Wisconsin. Thank you so much. And I just want to say to you, Mrs. Miller, I just want to ask you, how old is your son, and the name of your son, your twin son who survived?

Ms. MILLER. His name is Henry, and he turns one in 2 days.

Ms. MOORE of Wisconsin. Yes. The dawn of spring. He is turning one and he is healthy, doing well. And, you know, I am so sorry. That must have been so frightening what you went through, and your testimony, your empathy, for the doctors who couldn't do anything because they had to preserve themselves too. It is very frightening for people to insert themselves into health care at a point at which you almost died.

And you, Ms. Burke, you almost died, and thank God that you were covered so that there would be no disincentive to take care of you.

I just want to ask you a quick question while I am just sitting here. I may as well, Mr. Matthews. I mean, Mr. Morris. Your health care centers, without the waiver that Mr. Arrington was the champion during COVID, you would not have been able to take care of Medicare or Medicaid patients. And, Ms. Burke, had she not had these wonderful parents, might have been an uninsured person. So, under what chapter, verse, law can you get reimbursed for stabilizing people that you won't be paid for? Because you are required. Is that correct?

Mr. MORRIS. We are required, correct.

Ms. MOORE of Wisconsin. So, if someone comes in—except for an abortion—but if someone comes in with a heart attack and they don't have any insurance or don't have commercial insurance, what fallback do you have in terms of getting some reimbursement, were it not for this waiver?

Mr. MORRIS. We provide millions of dollars in uncompensated care. If we have medically screened someone and ruled out a life-

threatening emergency, we will, for example, a Medicare beneficiary, we will then talk to them about the fact that we are not a Medicare provider—we want to be and we will explain that—and then we will talk to them and give them the option to pay cash. So, we do, but plenty of times you can't have those conversations in an emergency situation because they are not capable of having those conversations. You have just got to take care of the patient.

So, it is very difficult. So, then you rely on people with commercial insurance, right, to help close that gap so that you can stay afloat, until we can get permanent Medicare and Medicaid recognition.

Ms. MOORE of Wisconsin. Thank you so much, and thank you, Mr. Chairman, for your indulgence.

Chairman SMITH. Thank you. Mr. Kelly.

Mr. KELLY. Thank you, Mr. Chairman. First of all, the ability for us to travel from wherever it is that we live to come to Texas to talk to you all today about rural health care and what it is that we are trying to get done, there is no other nation in the world that spends more attention to taking care of its citizens than the United States of America. And I think that is the thing we need to champion. I hear too often the back-and-forth about a political decision as opposed to a really solid policy position. Ms. Burke, you are certainly a testament to that. When we were meeting in the room I said, "You are a cheerleader. You are on this field cheering and you have a heart attack."

And all my fellow members of Ways and Means, we always think the same thing. I will just tell you this. I am from the private sector, which I really do believe before you can serve in public service you should have gone to the private sector, been paid on commission only, and lost your job at least once. You are given a much better perspective of what these business models look like, because this is a business model.

I don't know how you do what you do. I am from a rural area of Pennsylvania, and there are a lot of areas where we just don't have the coverage that we need. We not only don't have the facility, but we also don't have the talent, and in some of the places there is not enough need for certain specialists to have them actually on the team. That just doesn't work out as a business proposition. I know somebody will say, "Oh, he is just talking about dollars and cents and business," and the answer is, you are right. You are right.

But for all of you to be here today—and I had a chance to talk to our helicopter pilots in the back. My brother is a retired Army helicopter pilot, and they gave me a set of wings to give to my brother when I get back home.

What we are able to do, nobody else in the world can do. And the old saying is, you know what, you can't fix something with nothing, but you can keep complaining about it, I guess, and keep going on and on and on and on, and the answer to this is more money, and the question is, that is fine but where does more money come from? And then all of a sudden you have got to take a look and say, you know what, maybe I ought to take a look at how I am spending my money and see if I am spending too much in the wrong place, for the wrong reasons, and not getting good results.

As I started off telling you, it is really a pleasure to be with you all today and to listen to what you do here in Texas. Mr. Arrington, we feel the same way about western Pennsylvania. We all come from very unique areas and places that we are very proud of. But to be with my colleagues today to talk about issues that affect everyday Americans' lives, and especially those times when you just don't have the talent or the ability to take care of what you want to take care of at that time.

We will continue to work that way. We will do everything we can to possibly make sure that every single person who invests in this incredible experiment feels, at the end of the day, their money was spent wisely and they got the return on that investment that they deserve, and in this case it is just really good health and responding as quick as we can.

I am really glad to hear about your twin and what you went through. That has to be a horrible thing. My wife and I are blessed. We have four children, but between one and two we had an ectopic. And so, you know when you go through that loss you know what happens and the decision you have to make at that time. And sometimes it is just between you and the Lord to figure out what is in the best interest of everybody.

Chairman, thank you so much. It is good to be here. I don't think we have had this many colleagues at one of these hearings for a long, long time. So again, thank you to all of you for hosting us. We are glad to be here, and we are glad to hear from you. And please, don't give up. It may not be exactly what you want today but just don't ever walk away from it. If you refuse to lose, we will keep getting better.

Thanks so much. I yield back.

Chairman SMITH. Thank you. Dr. Wenstrup.

Mr. WENSTRUP. Thank you, Mr. Chairman. Thank you all for being here today. I really am grateful that we have the opportunity to discuss this topic. I served as a surgeon in Iraq. This is the very system that we are talking about, where you have to go from one phase to the next, and you have to do it quickly. Ms. Burke, thank you for sharing your story and your unique diagnosis, by the way. We are all pretty intrigued by it. But now the question is how we detect it sooner for people when it is a rare entity like that. But thank you for sharing that.

You know, we see some stories that get a lot of attention. You mentioned Damar Hamlin with commotio cordis. You know, that was a situation that was a witnessed event, and you had a complete medical team there with AED, and everybody knew exactly what to do right then and there. Fortunately, he was lucky that that was the situation, with the medical center right there, as well, in Cincinnati. I am from Cincinnati. It was a proud moment in Cincinnati for us to have that happen and save his life.

Steve Scalise, another example. When he was shot, I mean, a lot of things had to happen right that day for him, but one of the things was the fact that there was a park police helicopter already in the air when the call went out, and he could fly anywhere over the Capital unrestricted, and he landed on the baseball field and was able to take Steve to the hospital. I believe he flew in the war. I met the pilot one time. He said, "I flew that bird like I stole it."

But see, every minute counts. Every minute counts. And so, we want to be able to provide that to as many people across America as we can. Not every event is witnessed and fully supplied with everything it needs, so how do we make it better. And it is always going to be tough.

One of the things I wanted to talk about was Protecting Access to Ground Ambulance Medical Services Act. My colleagues, Ms. Sewell, covered that down very well and answered it, so we are going to continue to push for that, and we understand the great need.

So a lot of things to look into. I have always felt like, you know, I came from a large orthopedic group, and there was a time when Congress wasn't paying us for Medicare because they were figuring out the payment scheme. Well, guess what? We had to go to the bank and get a line of credit to keep our doors open because we weren't getting paid. When you don't get paid you can't keep your doors open. You can't provide the service. And I think for communities, especially where they are taking on a large amount of Medicare and Medicaid, you can't just run a practice on just Medicare and Medicaid. It doesn't pay for itself.

I think the reimbursements should be based more on what your previous year's payer mix looked like, because if you have a lot of private pay you are going to do better. Something I have been throwing out here, and maybe we still need to consider that because we really have to take care of the areas that are taking care of people where the reimbursement is less and more difficult.

But I want to go to the No Surprises Act. What has happened with HHS is extreme frustration for me. I know you were asked if you could ask the Secretary a question what would it be. Well, my question has been why is a lawyer the Secretary of Health and Human Services, and maybe somebody that took care of patients might be better to lead that particular agency.

But, you know, we got together. We worked very hard, in a bipartisan fashion, many doctors, both sides of the aisle, trying to bring forward what this does to patients. And you are in an emergency situation, your insurance isn't in network, you don't have a choice. You know, when you have the anxiety of who is going to pay that bill, that doesn't make you get better any faster. So, we tried to take the patients out of it, put in a fair process, and I believe we did. And we made it very clear that what we wanted is a situation where doctors wanted to be in network and insurance companies wanted to get you in network, so you could avoid arbitration altogether.

And we wrote a bill that would accomplish that, and do it fairly, and the agency changed it with their rule. And they actually implemented what we rejected in Congress. And now everyone is suffering from that. And I would just say that we need you to be as loud as you possibly can about what this process has done providing care.

And I will just, because I am about out of time, but Dr. Racht, maybe you can talk about how this flawed implementation of the No Surprises Act impacted patient access to air ambulance services in rural and underserved areas.

Dr. RACHT. Substantially, and the potential is greater moving forward. If we can't sustain those resources, that cost of readiness

because of the struggles with payment in a post-IDR environment, we are not going to be able to sustain everything that we have been talking about today.

One thing that I think is critically important in that process is everybody was excited—that doesn't happen very often—that we finally got an approach to managing the unexpected, the high severity in a way that was fair to the patient, that allowed them to heal. And unfortunately, because of the challenge in collection, we have not seen that come to fruition.

An important thing to remember from all of us is, on the emergency care side, we don't know if you can pay or not. We don't know if you have insurance or not. We may not even be able to talk to you. But we do the same thing to stabilize your anatomy and physiology and get you to the point where you maximize your chance of survival.

Mr. WENSTRUP. Excellent. Thank you. I yield back.

Chairman SMITH. Thank you. Mr. Beyer.

Mr. BEYER. Thank you, Mr. Chairman. First, Chairman, thank you very much for giving us a reason to come to Texas. And Dr. Burgess, thank you for hosting us, and I thank all of you for being here. It is very interesting, and I have learned a lot.

Dr. Racht, my sister went to Medical College of Virginia, and you probably taught her, a great career as a pediatrician, so thank you.

Ms. Burke, I am very impressed to find out—I didn't discover you were 25 years old until after you spoke and realized, my goodness, so self-possessed. You know, I am terrified speaking before this committee, so it is really terrific, and good luck with your health.

You know, I do want to get back on topic too, because the topic was insuring resilient emergency medical care. And Ms. Miller, it was very difficult to listen to your testimony, especially the quote, "The State of Texas would kill all three of us rather than let my doctor and me determine what was best for me." I hope Jason, Henry, and everyone is doing well now.

But talk to me about the mental health part of it. What was it like for you to be denied health care, in terms of the mental and emotional aspects of that?

Ms. MILLER. I felt like I was a walking coffin. It felt like I had no say, and it was so depressing to know that if I was to stay in Texas it would be just to watch my son suffer. And also, Henry wouldn't be here. I would not be baking a cake tomorrow for his birthday. I wouldn't know that his favorite toy is a ball, or that he likes things that open and shut, like every door and every book in the house. And none of that would have been the reality.

And the tragedy, too, is that I am not that unique. My own OB had to leave the state for her abortion just shortly before I did because her pregnancy had anencephaly, so no skull. And to know she had gone through that, and then to go through it myself, it just haunted me through the rest of my pregnancy. I felt hunted.

And when Henry was born my first words to him were not, "Welcome, little one. I'm so glad you're here." It was just this feeling of relief, and I just breathed out and said, "You made it."

Mr. BEYER. Thank you very much. To stay on that topic of mental health, Mr. Matthews, with your decision to move from full thing to the rural emergency hospital, what difference have you

seen in terms of the care for those that come in with mental health, psychiatric conditions, recognizing that with the new 989 number that the emergency room is usually the first point of access for somebody with suicide ideation.

Mr. MATTHEWS. Yes, sir. And so, in our conversion that was an option, and behavioral health is something that we are looking at. But at this point, when, of the 2,600 visits that we have in our emergency room, when those are behavioral health, we will evaluate the patient and then we will call for the services out of Abilene.

Mr. BEYER. Okay, great. So, you actually move it on.

Mr. MATTHEWS. Yes, sir.

Mr. BEYER. Let me move it over to Mr. Morris. I was really fascinated to read all about the freestanding emergency things. I think my wife accessed one in Maryland just on Saturday. And I love the model, especially if the legislation doesn't compete with a rural hospital that is already in trouble.

What is your approach to those with mental health issues, specifically psychiatric breaks, suicide ideation, and the like?

Mr. MORRIS. We also have, in the markets we serve, relationships where we can refer to outside of our confines. But we absolutely do our best to treat and stabilize those patients while they are in the facility. We work with telehealth, as well, as another option that a lot of freestanding operators utilize to help with those types of patients. But it is a challenge. What you are talking about is a challenge for all emergency care providers or finding good resources for mental health.

Mr. BEYER. Yeah, and because you are not a hospital you are not going to keep them. But one of the things you had in your testimony you talked about the rush to overcrowded conditions frequently found in hospital ERs. I am not rural. I am inside the Beltway outside D.C. But 8 hours, 10 hours, sometimes days in an emergency room. I would love to think that the combination of solutions we have talked about with you today can make those conditions get a lot better.

And Mr. Chairman, with that I yield back.

Chairman SMITH. Mr. Estes.

Mr. ESTES. Thank you, Mr. Chairman, and thank you to all our witnesses for being here today and welcoming us to your community.

When I go home to Kansas nearly every week to contact with constituents it is always nice to have the opportunity to take our work outside the D.C. bubble and to hear directly from folks impacted by our policy decisions and how they impact them in their daily lives, in their own home communities.

And what brings us here to the Lone Star State today is a critical issue. It affects Kansans, it affects Texans, it affects Americans all over. And we would all like to think that we will escape emergency medicals. They happen to other people. But when the unimaginable happens, knowing we can count on responsive and reliable emergency medical care brings us some comfort.

The key means of delivering this care, as we talked about earlier, especially in rural communities, is through air ambulance services. The Fourth District of Kansas, that I represent, includes many rural communities which rely on these emergency air services. A

study released last spring found that 77 percent of urban counties and 84 percent of rural counties have ambulance deserts, locations that could take more than 25 minutes to be reached by ambulance. And in rural areas, after dialing 911, patients can still wait up to 30 minutes for an ambulance to arrive, or even longer.

Given the state of air ambulance services can be the difference between life and death. A 2019 study found that injured patients transported by air ambulance were less likely to die than those taken by ground ambulance.

That is why last spring I worked with my Ways and Means colleague, Ms. DelBene, along with Senators Michael Bennet and Marsha Blackburn to introduce legislation to improve access to the emergency air medical services that are critical for saving lives, particularly those of Americans that live in rural communities. The Protecting Air Ambulance Services for Americans Act would use data collected from the No Surprises Act to update Medicaid reimbursement rates for emergency air services. This common-sense bipartisan bill will ensure all Americans have efficient access to hospitals and specialty providers, regardless of their location. When seconds matter, air ambulances are proven to be the best way to care for patients in need, as those of you that work here at Global Medical Response know.

Dr. Racht, in 2002, CMS established the first air ambulance fee schedule. Can you share what improvements and equipment changes you have had since 2002?

Dr. RACHT. Thanks. I didn't realize the hearing was going to last until tomorrow. Substantial, and I think what you have seen hopefully today in terms of the technology, in terms of the skill level of our providers, being able to resuscitate, intervene, decision support tools that identify patients that may be at risk for a myocardial infarction, and blood-carrying capabilities, the ability to stabilize patients in ways that we never ever would have imagined before.

And I think it raises an important point, which is there are two sides to the air ambulance that are critical for patients' morbidity and mortality. The first is we have to get to them, wherever they are, with the tools and the expertise of our providers to stabilize that illness or injury immediately. Because one of the things, as I talked about in the beginning, we have a logistics problem. Nowhere else in medicine do we have this strange problem of saying you have this injury or this illness, but look how far you are, or look where you are in relation to definitive care.

So, the technology has evolved that allows us to stabilize. We can communicate a lot of that technology to health care facilities and professionals and maximize our ability to make a difference. It is huge.

Mr. ESTES. And what risks do you have of the bases being in danger of closing, just from not having reliable reimbursement and fee changes, reimbursement rates that have not changed?

Dr. RACHT. It is very worrisome, and it is worrisome in exactly the environment that you are in and described, which is if we can't sustain the technology, the education, the equipment, if we are unable to do that we essentially have an aircraft that is not moving

patients that frequently, which can no longer support the ability to stay in that community.

So, if you were to ask, I think, our colleagues, whether it is hospital, air ambulance, we are fearful that without the support of that cost of readiness we will have to move bases, we will have to close bases, and as we have already heard, unfortunately close hospitals.

Mr. ESTES. Thank you. And 5 minutes just isn't enough time to go through all these questions that I have, and the services that you all provide for our citizens of our country are so important. So, I yield back, Mr. Chairman.

Chairman SMITH. Thank you. Mr. Smucker is recognized.

Mr. SMUCKER. Thank you, Mr. Chairman. I appreciate the opportunity to be with you here in Denton to see the facilities here. Unfortunately, I didn't get to hear your testimonies. My plane was delayed from Pennsylvania, so I didn't have the benefit of hearing that, and I didn't get some of my initial questions, so I apologize if my questions may duplicate some of those.

I have no background in health care. I have been in Congress now for 8 years and in the State Senate prior to that. I am fascinated by the advances that we are seeing in the ability to treat patients for various diseases and the ability to keep Americans healthier.

But one of the most frustrating things as I have learned a lot more about health care was seeing the impact of may be reimbursement systems or regulations that we have in place that I think, and the doctors here know a lot better, but I think not only affect how doctors and hospitals are treating patients but I think disincentivize advancements and sometimes prevents ways of providing better care. So that frustrates me. I know we have those regulations in place for a reason, but it is one of the things that I have noticed in the years that I have been here.

I am particularly interested, Mr.—let me see if I got this—is it Zavadsky?

Mr. ZAVADSKY. Very good. Well done.

Mr. SMUCKER. I am particularly interested in paramedicine, because here again, by doing preventative care, by doing care prior to getting to an emergency room, outcomes are better, and I think costs are better, as well. I represent Lancaster and York Counties in Pennsylvania, and really fortunate, in our area we have access to a number of health care systems, have access, so we don't have the problems with access that some of the other rural areas of Pennsylvania do.

But we had a paramedicine program that was established in 2016. It started with 99 patients treated in the first year. And now they serve around 1,000 patients per month. The program has innovated, over time, to meet the needs of the community, now even works with patients that are discharged from behavioral health facilities, with new patients to learn about infant CPR, first aid, lots of different things that they are doing.

So, I don't know. I probably have some questions, but have you seen the paramedicine program hindered by reimbursement models? Can you talk a little bit more about how that's worked for you

and what we could do to ensure that these programs could continue to start and grow in communities.

Mr. ZAVADSKY. The economy model for a community paramedic program is fundamentally flawed in that Medicare does not recognize it as a covered benefit. Therefore, Medicaid typically does not, as well. Commercial insurers typically do not, as well. So many community paramedic programs who started with grants—Medicare did healthcare innovation award grants, and there were six of them that were community paramedicine programs, and then as soon as the grant program ran out, they closed, because there was no sustainable funding mechanism for it.

So those communities that have been able to determine and to prove to innovative payers—in our programs we have got managed Medicare, managed Medicaid, we have got commercial insurers who are paying for our community paramedic program because they have done the back-of-the-napkin math and said, oh my gosh, the outcome, and really the financial outcomes, yes, they care about the clinical outcomes and the patient experience, but their number one metric is how much money is it saving them.

We need a federal reimbursement program that can be as nimble as Aetna and Cigna and Molina and as some states, who their Medicaid program is now paying to prevent the 911 call because it makes financial sense.

Mr. SMUCKER. Thank you. I have a lot more questions about it. I look forward to continuing the discussion. But thank you so much for the work you do and thank you all for hosting us here.

I yield back, Mr. Chairman. Give you a few seconds.

Chairman SMITH. Thank you so much, Mr. Smucker. We are glad you made it. Mrs. Miller.

Mrs. MILLER of West Virginia. Thank you, Chairman Smith, and I thank all of you for being here today. And I also want to give a very special personal thanks to Lauren Billman. And I don't even know if she is still in the audience or not, but she works with Baylor Scott & White Health, and she taught me how to be a congresswoman. Thank you, Lauren. I think she stayed with me for over 4 years, and I was very wet behind the ears when I came from my house of delegates over to Congress.

I represent rural West Virginia, and when we were flying in here, I am looking out the window going, "Wow. I've never seen so much flat land, and so many houses and businesses." But I would say a third of our committee represents rural areas, rural states. I know Terri and I; Alabama doesn't resemble West Virginia at all, but our people do, and our needs do.

So, we care a lot about access to care, and one of the major barriers patients face in accessing health care, particularly where I am, is transportation. It takes some people 5 hours to get to the hospital. That is crazy. Have any of you been to West Virginia and seen those roads, and those of you who have flown over understand how they go round and round and round those beautiful mountains. So, it is important that we get to our providers. And this is what makes medical emergency services crucial to patients in my home.

Dr. Racht, you have been around rural emergency medical response for over 30 years. Can you speak to some of the unique

challenges that your team faces in triaging medical responses in remote areas of the country?

Dr. RACHT. I think my colleagues would agree with me, and we talk about it often, that that is often the longest journey you will ever have, with a critically ill or injured patient without additional help, where you are maintaining them to definitive care. The challenge of access—you know, land here, turn left at the big rock, go to the pond—the patient's physiology and anatomy is still going through the same processes. We need to find them and get to them. The ability to have other responders assist us in those environments and help with that, and then the patient destination piece. So based on where you are, what is the most appropriate facility to take that patient to, which often is not the closest facility. It sounds counterintuitive, but those critically ill and injured patients often need to go a little bit further to get the specialized care that will give them outcome that is most important.

Mrs. MILLER of West Virginia. On the other hand, I have even heard from my constituents, the EMTs, if somebody falls out of bed they call 911, and they have to go and help put Granny back in bed, or somebody that weighs 300 or 400 pounds, because the people who are taking care of them can't do it. So, it is unique, but we all understand those things.

One model that I really think can help in some of these rural EMS's challenges is the Treat in Place model. The Treat in Place model allows EMS providers to triage and treat patients when an ambulance does arrive on the scene, or to bring them to the lower-acuity facilities outside of hospitals and emergency rooms for treatment.

Mr. ZAVA [continuing]. I am going to say it—Zavadsky——

Mr. ZAVADSKY. I am going to keep say it, Matt is fine.

Mrs. MILLER of West Virginia. I am married to a Matt. I know. I understand from your testimony that you are a long-time advocate for Treat in Place. Can you explain why this model of care for the EMS services is so impactful in rural communities?

Mr. ZAVADSKY. What Dr. Racht has said was very important, is that in many cases when a rural hospital is not available, when a critical access hospital is not available in the community, like West Virginia, EMS becomes the default health care provider, and they are doing everything. In patients that have to be transported 3, 4, 5 hours away to the next most appropriate clinical care facility, that takes the ambulance out of service, and it is very inconvenient for the patient.

Oftentimes that patient can be very effectively treated in place with perhaps a telemedicine connection that gets a prescription or has some other type of follow-up care. Therefore, the ambulance doesn't have to take the patient 3 or 4 hours away. It becomes more available for that community because now the ambulance can go back in service and the patient gets to stay at home. Maybe that crew comes back and check on the patient in a couple of hours to make sure they are doing okay. But it increases resources in the community because the EMS stays there, it is more convenient for the patient, and it saves a ton of money in getting that patient, not having to go to that high-expensive medical care facility.

And West Virginia did this. West Virginia state legislature passed a law that allows EMS to be reimbursed for Treatment in Place services, and that has revolutionized the protocols and the procedures that can be put in place with those providers in West Virginia, like Jan-Care and others, to really improve not only the medical care but the availability of resources in those communities.

Mrs. MILLER of West Virginia. I know I am way out of time, but could you talk about the mountainous terrain exception? Have you heard of that?

Mr. ZAVADSKY. Because of the geography.

Mrs. MILLER of West Virginia. Mm-hmm.

Mr. ZAVADSKY. Yes. So, everything has to be taken into account, even weather. We have talked about a weather exception because in Lake Tahoe, during the summer, not as big an issue as it is in the winter. So, we need to make sure that legislation and reimbursement policy takes into account those nuances that you have heard all of us talk about, because health care, and specifically emergency services, very unpredictable and very fragile right now.

Mrs. MILLER of West Virginia. I know. Thank you. I yield back.

Chairman SMITH. Thank you. Dr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman, and thank you all, all members of the committee. You know, I am sitting here thinking, I have got like 15 pages of notes and stuff like that, but I think a common theme here is CMS doesn't know what the hell it is doing. And truth be told, it has grown into this massive, burgeoning bureaucracy that grows year after year after year that is just so out of touch with payment reform, with regulation reform, it is killing medicine. And then throw the middlemen in it, which has exploded in the last decade, where all the money is going, it is killing the people who deliver the care, and it is killing access to the patients who need the care.

Mr. Matthews, I just had one question for you. Has a hospital ever approached you as being part of their system?

Mr. MATTHEWS. Another hospital approach us about being part of their system?

Mr. MURPHY. Right.

Mr. MATTHEWS. No.

Mr. MURPHY. So, I come from eastern North Carolina, and we have an 11-bed system, very rural area, extremely rural. In fact, when I saw patients, and I still do, they were coming from a 29-, 30-county referral area, 2 hours north, 2 hours south, and 5 hours out on the coast on the islands. So, it is a long way.

But we bought a small hospital that was being flooded every time, and we had to close it. Its census was 1½. The numbers didn't work. But we built a real emergency facility right there, to facilitate quick movement with thing.

The sad fact is, as census are dropping, as you pointed out, in towns, not only is the emergency care needed, but it is also the economic engine of the town, in so many instances. So, the fact that, you know, I do believe 100 percent, Mr. Zavadsky—that is close; I just kind of missed a Z—I absolutely believe, and this comes from a surgeon. This comes from folks who I am in the emergency room department all the time with other guys that absolutely a lot of

things can be carried out in the field with a telehealth visit, that it is as easy as a phone in some of these things. But again, this is where regulation just supersedes common sense. And we could save an infinite amount of money, and somebody doesn't have to come and clog up an overloaded emergency room, and some of these different regards. So, I agree with you 100 percent.

Mr. Morris, I had a question for you. When you said you, guys comply with EMTALA, is that a personal choice, or it is a requirement.

Mr. MORRIS. That is a requirement since the inception of our state licensure. It has been a requirement and with the No Surprises Act we also advocated to have that same Federal requirement. So, it is absolutely a requirement.

Mr. MURPHY. Correct. Correct. Someone else said earlier—I think we had a little discussion offline here—that you did not have to comply. You absolutely have to comply.

Mr. MORRIS. We absolutely have to comply. Yes, sir.

Mr. MURPHY. And so how do you see yourself different than a rural emergency hospital, other than seeing somebody overnight?

Mr. MORRIS. Other than, well, and respectfully, we don't have to build a critical access hospital first and then convert to get to the same point, so that is a big step. Our fixed costs are a lot lower, I think, arguably, because of not having that history of building a hospital first. But as far as capabilities, from an emergency standpoint there is no difference.

Mr. MURPHY. Right. Right. And so that providing the care, it is providing a resource for communities that, without a doubt, there is—well, there is a certain lobby. There are several lobbies in Washington, D.C., that are very, very strong. But you should absolutely be able to bill Medicare and Medicaid.

Mr. MORRIS. Yes, sir. And by the way, the existence of more freestanding, just ER access in these communities can free up EMS—a lot of the discussion has been around EMS—to do other things. You have an access point that people can go to. That frees up these other resources, so they can do their jobs more appropriately.

Mr. MURPHY. Correct. I just want to highlight one thing, that a lot of folks say this is a target-rich environment and great discussions. You know, we talk about a doctor shortage. You can't hire doctors. The pipeline is not looking good. Two-thirds of people now in medical school say they are not going to practice clinical medicine, two-thirds, and the doctors who are coming out now, the Gen Z's, up to 40 percent saying they are getting burned out in the first 5 to 10 years.

So, I will say this. I don't think our medical schools are doing a very good job of picking the correct students that will actually practice medicine and then do it for a long time. It is really going to be a massive burden on rural areas, and urban areas, eventually.

Mr. MORRIS. Yes, sir. We have four nurse practitioners that work in our ER, and through telemedicine virtually connect with the doctors.

Mr. MURPHY. And while that, I think, is good care, I don't believe it is excellent care. Because there is a difference between a person that follows a protocol and person who is a diagnostician.

Mr. MORRIS. That is true. It is the only option we have.

Mr. MURPHY. Yeah, absolutely. I absolutely understand it.

Thank you, Mr. Chairman. I yield back.

Chairman SMITH. Thank you. Mr. Kustoff.

Mr. KUSTOFF. Thank you, Mr. Chairman, and thank you to the witnesses for appearing today. Thank you to all the personnel, everybody who flies and drives. We appreciate all the care that you give.

Mr. Matthews, if I can go back to you for just a moment. I know that you have talked about your experience now converting to rural emergency hospital. In Jones County, where you are, the population is roughly 19, 20, 21,000 people.

Mr. MATTHEWS. Yes, sir. Closer to 17,000.

Mr. KUSTOFF. And I imagine you probably serve some people outside of Jones County and the surrounding areas.

Mr. MATTHEWS. Correct.

Mr. KUSTOFF. Can you talk about, just your experience, the conversion from what you went from to an REH, and I guess you have talked about the benefits. Is this something that you would encourage other hospitals in rural counties to look at? Talk about the model.

Mr. MORRIS. Yes, sir. Absolutely I would encourage them. We now have a future because of that option to convert, and that was available to us. And what we do, when we converted, we lost our inpatient stays, but we have been very aggressive on the observation side of it. So, we will admit those patients on observation, anywhere from 24 to 36 hours. And where we lose is our transferring those patients that need a 3- or 4-day stay, we transfer them when they come in out of the emergency room versus trying to transfer them out of the floor.

But basically, of the 2,600 ER encounters that we have had in our emergency room, 94 percent we were able to take care of. The 6 percent we actually had to transfer to a higher level of care.

So, we are still meeting the needs of 94 percent of our patients. And what would have happened if we had not had this option, we would have had to close, and then we wouldn't have met the needs of any of our patients.

Mr. KUSTOFF. Right. Can you talk about, and I think you did in your opening statement, but the services that you offer in terms of diagnostic, for example, what do you offer now that you offered when you were a hospital?

Mr. MATTHEWS. When we were a hospital, at one time we had outpatient surgery, and we no longer offer that, even though that is available to us right now. That is a factor of the physician is just no longer doing surgery, and we just have one surgeon.

We have a rural health clinic across the street from us that is part of our hospital, and on average we have about 1,100 visits a month through that rural health clinic. And in the hospital setting we have, of course, the labs, the radiology, and all of those types of services.

And really, it hasn't been as difficult for us to make that change as people thought. There are instances when you would have those family members that had pneumonia or COPD or needed a 3- or

4-day stay. That is the situation that we no longer can keep them there. But again, that is only about 6 percent of the time.

Mr. KUSTOFF. And I think you answered this when Dr. Murphy asked you, but staff-wise, can you talk about the staff now that you are an REH, in terms of physicians? And I think you mentioned four nurse practitioners.

Mr. MATTHEWS. Well, in our emergency room, yes, sir. They rotate out of our emergency room.

When we became a rural emergency hospital, yes, we had staff reduction of about 9 percent in our hospital. We had to get that cost down.

Mr. KUSTOFF. Mr. Morris, if I can with you. You operate a different model but certainly an essential model for the communities that you are in. There has been talk about recruitment and retention of personnel, certainly the physicians, the licensed nurses. Can you talk about the experiences that you have now recruiting and retaining personnel?

Mr. MORRIS. In our model we have challenges, just like probably everybody in health care, recruiting and retaining talent. But there something, I think, about the freestanding model of doing one thing and focusing on doing one thing really well, and our nursing staff and our physician staff being able to spend more time at the bedside. I think we have it easier than most. We have staff that we have held onto [audio interruption] attract and retain talent in our ER easier, typically, than a hospital-based ER.

Mr. KUSTOFF. Good. Thank you very much. I yield back.

Chairman SMITH. Ms. Tenney.

Ms. TENNEY. Thank you, Mr. Chairman, and thank you to the witnesses. This is tremendous to have your expertise. I feel like, as I think, my colleague from West Virginia mentioned, most of us do serve rural areas.

I just first want to say thank you to Kevin Johnson, who took me on the simulator in the helicopter, and the good news is I am not going to be driving one of the helicopters, because I think I almost crashed it until he took over. And who knew who you are going to meet in Texas, a guy who went to high school with me, same high school, Stephen Northrup over here, who is your government affairs person.

So, I have served on hospitals, nursing home boards, school of nursing boards throughout my tenure in life, and I just want to talk to Mr. Matthews first. Everything you have got in here is exactly what we have in Upstate New York—the rural problems, the disproportionate Medicare and Medicaid, socioeconomic issues, we have a terrible time trying to recruit doctors, trying to get nurses, and also deal with nurses to even get them to go to nursing school and also to graduate from nursing school has been a challenge.

But one of the things that has been, while we have this crisis everywhere, and I agree with Dr. Murphy's sentiment about CMS. The more bureaucratic it gets, the more difficult it is for doctors and patients to really come together. But how are you handling—and I don't know if this is something that his required in Texas, but it is something that has been proposed on the Federal level that could happen soon, but it has happened in New York and it is making a major crisis with our rural hospitals—is the safe staff-

ing requirement for nurses, and how is that affecting your hospital? And maybe anyone else. Is this a problem that you are facing yet, or how would you handle this if it comes to the forefront in Texas rural areas? Or is it already an issue?

Mr. MATTHEWS. So currently no, ma'am, we do not have that problem at our hospital. Most of our staff lives within our small community, so we have been fortunate from that standpoint. But obviously if you come in with those ratios and you have to bring in more staff, that creates more pressure on the bottom line. And so, we have to balance between patient care and the cost to do so. But fortunately, we haven't had to encounter that, but we have heard about it out there, yes, ma'am.

Ms. TENNEY. Yeah. Obviously, we have other issues and impediments that you don't have, such as very high taxes, low property values with high property taxes, and also New York still has I think one of the most expensive medical malpractice rates still in the country, which is a deterrent. So, we are always trying to find any way that we can get doctors and professionals to come to our state.

I just thought maybe I could ask Mr. Morris a question. I know Mr. Smith touched on this, but how can we get so we can have more freestanding emergency centers? This is a huge problem. My district is about 6 hours long. It is basically the length of the New York shoreline, of Lake Ontario, one of the Great Lakes, and we have a real problem getting someone to an emergency situation, although there is a Medtrans currently in my district, in Auburn, New York, which I am probably going to be losing next year.

So, what can we do on that issue? I know Adrian Smith touched on this, but what can we do, and what can we do as legislators to help this problem?

Mr. MORRIS. The first step is the Medicare and Medicaid recognition. Then at the state level, states have the ability, when they are crafting—so the Emergency Care Improvement Act allows state-licensed freestandings to qualify, if that bill passes. So, a state could pass their own freestanding licensure designation, and Mississippi has a pilot program right now like this, where it narrows the focus. It only allows the freestanding operator to build a certain mile radius away from the closest hospital, and it narrows that focus into these underserved communities.

And I think with our model, with the low fixed cost that we have, I think that the math would work if you are going in, and you have an incentive from a state, if you wanted to focus in a rural area, and you could probably provide some tax incentives, I would think, as well, that would help. States also have creative programs with nurses and doctors, where you can give some tuition relief if they agree to go and work in these underserved areas.

So, I think there are a lot of different options, but again, the model doesn't work unless we can get Medicare and Medicaid. But there are a lot of us in this space that would love to go out into those underserved areas.

Ms. TENNEY. Yeah, well thank you very much. I think I am about to run out of time. But I appreciate all of your expertise, and thank you so much, and thank you also to Beth Van Duyne and

Jodey Arrington and our hosts. It is an amazing setting here. Thanks so much.

Chairman SMITH. Thank you. Mrs. Fischbach.

Mrs. FISCHBACH. Thank you, Mr. Chair, and Dr. Racht, thank you for hosting us today and for all of the personnel that were here to give us tours and explain equipment to us. We really appreciate it.

And as you know I am from Minnesota, and I was the one that was really cold, so thank you for closing the door. I think they put me here on the end thinking, oh, the Minnesotan can handle it, but not so much. So, I appreciate that.

And I also want to thank Congresswoman Van Duyne and Dr. Burgess and Congressman Arrington for having us here. And I will tell you, all of them hold a very special place in my heart, for various reasons. I serve with all of them on various committees. And I just want to tell you that the Texans are very well represented by them. They are treasures, so keep sending them to D.C., because we love working with them.

Just so you know, I represent a very rural district. Most of the members have mentioned those things, and the same kinds of things that Congresswoman Tenney had mentioned about not being able to get health care providers. And I was so glad when telemedicine was finally mentioned because it is something we are focusing on. And just so you understand, if you look at Minnesota, I am the western half, from Canada—I border Canada—and I am one county short of Iowa. So I have got all of that. My largest city is 50,000. So, when we are talking rural, it is a serious issue.

Emergency response is huge, and even just getting basic care. My folks have to travel quite a way just to get the basic care, so telemedicine is so important. And my hospitals survive as critical access hospitals—that is how they survive—because they are very concerned about the 340B and the beds. So, from what I have talked to them about, that is why they haven't switched over.

But I am very interested in the community paramedic program, and I know that Mrs. Miller mentioned it, and I believe Mr. Smucker mentioned it. Because I believe in Minnesota, at one point, we did have some pilot programs that the state was covering. Because I was in the state legislature before I came to Congress, and so I am just kind of, you know, I know that it improves potential outcomes, and I would love for you to talk a little bit more about that. Because in one of your statements you said sometimes, they just need a hug. And I think those folks are the repeat kind that will call 911.

So, I'm not even going to try—Matt, would you address that for me?

Mr. ZAVADSKY. Sure, and congratulations. Minnesota was one of the first states to authorize and pay for community paramedicine services through Medicaid, because of the rural areas in Minnesota. And in many of those communities the only providers that were able to go see those patients were the specially trained local EMS agencies who had the foresight to—Dr. Wilcox and others who were big drivers in that program—to be able to deliver essentially basic primary care for patients in the rural areas to prevent them from

having to call 911, to keep them healthy, educate them about their health care programs.

But the same model, or the same principle, applies from a rural area to a very urban area like ours. You know, we have 20, 30, 40 patients at a time in our high utilizer group of patients, our HUG program, and they run the gamut from behavioral health issues to uncontrolled diabetics to uncontrolled asthmatics, pediatric patients. We just did a program, or are starting a program with our children's hospital because they are part of the CHIP program, and they said, you know, even though the state won't reimburse us, meaning the CHIP program, because it is not a covered service, the CHIP program is willing to pay for it because it reduces their cost, and they actually will make out better financially by having fewer patients go to their own hospital and having to pay their hospital for those ER visits.

So, when we look at those patients, the fixes, if you will, and it is typically a 90-day enrollment. We don't want to adopt those patients. We don't want to make them codependent on us. We want to teach them how to better manage their health care so that, like the patient that would have come here to testify, instead of calling 911 20 times in 30 days, we get her connected to the resources, a new primary care physician who happens to be on the bus line, because she doesn't have transportation. So, by the community paramedic recognizing that, asking the payer—Medicare—to change the patient's primary care physician to one who is on the bus line so she can actually go see the doctor where she couldn't before, those things are what leads to her not calling 911 in the last 6 months. But it is the EMS agency that can recognize that because the crew says, "Well, gosh, this is the seventh time in a month that we have come to your house for a low-acuity medical complaint. Let's get you into this program to try and get you to stop calling," but we don't get reimbursed for any of that.

Mrs. FISCHBACH. But I also see, and I think we saw so much during COVID with the telemedicine. And one of the things as we talk about broadband, we are looking at making sure that we have that, in like a rural area, available. And I see that that community paramedic could be such a partner with telemedicine.

And I am out of time, and I appreciate the Chairman's indulgence, but thank you all for being here because it has been a wonderful conversation. So, thank you, Mr. Chair. I yield back.

Chairman SMITH. Thank you. Mr. Carey.

Mr. CAREY. I want to thank the Chairman. I also want to thank the witnesses. I have heard directly from our first responders and Matt was one of them—including the firefighters, the emergency medical service personnel, of the lack of reimbursement by Medicare to treatment provided to seniors in place, and the fact that it is harming our seniors' access to emergency care.

Our country's emergency medical services are struggling, whether it was due from the pandemic, whether it has been related to just simply finding other jobs. So, there are workforce challenges in this arena.

Currently, Medicare treats the EMS as a transportation service, which fails to recognize the valuable role EMS providers play in de-

livering essential health care, while also failing to reimburse them properly for the care that they provide.

So today I am releasing a discussion draft of legislation that I have been working on with several EMS stakeholders that would require the Center for Medicare and Medicaid Innovation to create a model for test Treatment in Place policies for seniors on Medicare. The model will also qualify providers to be reimbursed for providing care onsite or transporting patients to appropriate destinations instead of solely reimbursing for emergency department visits. So, I would like to work with my colleagues to further that in a bipartisan way.

So, Mr. Zavadsky, or Matt, as we will call it——

Mr. ZAVADSKY. That is fine.

Mr. CAREY [continuing]. Can you explain the potential Medicare savings for Treatment in Place?

Mr. ZAVADSKY. Yeah. During the pandemic, Medicare issued a waiver that allowed EMS to get reimbursed for non-transport, which was very appropriate, and we encouraged that, and you guys helped us with that. Fifty-five thousand patients were not transported to the emergency room under that model. At an average cost to the Medicare program of $700 per ER visit, that means that 55,000 patients did not have that Medicare spend for the ER visit, and then whatever happens downstream.

So based on the Healthcare Utilization Report data, based on 42 million 911 calls that we respond to, of which 40 percent are Medicare patients, if we could reduce the transportation of those patients by appropriately treating them in place, using telemedicine, doing other things, and reduce the transport by 15, 20 percent, which is what studies have shown really don't need to be there, we are talking close to $1.5 billion a year—a year—savings to the Medicare program if they would stop reimbursing us for the mile and reimburse us for the treatment we provide.

Mr. CAREY. So, to that end, can you give some examples of what exactly Treatment in Place is like in the field?

Mr. ZAVADSKY. Sure. Real quick. So, the last one that I did—because I did a lot of the Treatment in Place when I was working on the ambulance during the ET3 model—a pediatric patient, abdominal pain. Went to the ER. The ER took 6 hours. The mother got frustrated, drove her home, called 911, falsely thinking that going by ambulance to the ER would get them a higher priority. That is not how that works. Twenty-seven percent of the patients we bring to the ER go to the waiting room, directly.

Instead of bringing her to the emergency room, we arranged, through a telemedicine visit, to have her mom take her to the Children's Center, to the Urgent Care Center, because the patient told us that she was having abdominal pain for 3 days, and she hasn't had a bowel movement for a week and a half. Okay, it doesn't take a rocket scientist to probably figure out what is going on there.

Mom texted me an hour and a half later. They were in and out of the urgent care. She was treated for her constipation, felt much better, and she was bringing her back to school.

Those are the types of patients we are talking about.

Mr. CAREY. And I think those are the good examples. Those are the examples that you shared with me when we met.

So really quick, because we only have about 53 seconds, how would the Treatment in Place be handled under balanced billing?

Mr. ZAVADSKY. We follow the same rules. So, whatever the GAPB Committee recommends, and Congress approves, we would do the exact same thing under the Treatment in Place program, so that the patients, again, aren't in the middle. We work with the payers, and quite frankly, a lot of the commercial payers, as mentioned earlier, are starting to pay us for that service anyway, because they are more willing to pay for that than they are willing to pay for the ER visit.

Mr. CAREY. And with that, Mr. Chairman, I yield back.

Chairman SMITH. Thank you. I would like to thank our witnesses for appearing before us today. I want to thank my colleagues for making the effort to travel to hear from folks across the country outside of Washington, D.C. And I want to thank Ms. Beth van Duyne and Dr. Burgess and Mr. Arrington for hosting us in your great state of Texas. And I want to thank Global Medical Response once again for allowing us to have this field hearing here. We are very grateful.

Please be advised that members have 2 weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record. And with that the committee stands adjourned.

[Whereupon, at 4:41 p.m., the hearing was adjourned.]

LOCAL SUBMISSIONS FOR THE RECORD

Date	March 18, 2024
Name (Print)	**Kristine Bray**
Company	**Walkable Denton**

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care

We want to hear your story. Below please provide any personal experiences or general comments about access to health care in America that you wish to be included in the official hearing record.

The CBO, as well as a private study funded by the Koch brothers found Medicare for All would decrease America's spending on healthcare, while increasing patient outcomes. Let's join the rest of the world and pass Medicare for All.

The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/

Date	March 18, 2024
Name (Print)	**Lyle Butler**
Company	**Global Medical Response – MedTrans**

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care

We want to hear your story. Below please provide any personal experiences or general comments about access to health care in America that you wish to be included in the official hearing record.

As the Director of Clinical for our company, we have found it increasingly difficult to recruit and retain qualified clinicians as we compete against hospitals and HCFs. Wages have dramatically increased as we try to compete. At some point it's unattainable. Staff wages rise, pilot wages rise, costs increase for fuel, medical supplies, drugs, and equipment. We try to balance, but the NSA has dramatically [hurt] our ability to get paid, also paid a fair amount for the service we provide, and finally the length of time, when we do get paid.

Thank you!

The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/

Date	March 18, 2024
Name (Print)	**Michael Lawyer, RNCP**
Company	**UT Health East Texas AIR 1**

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care

We want to hear your story. Below please provide any personal experiences or general comments about access to health care in America that you wish to be included in the official hearing record.

At this time, the NSA is broken. Currently, it is taking us 280-300 days to receive payment from our commercial insurance payors. This has increased from 70-80 days outstanding. This didn't happen until the NSA was put in place. The insurance companies have used the NSA to hold payments as long as possible. EMS companies across the nation are having the same problems. This needs to be resolved before we start losing EMS companies due to delayed revenue and the inability to pay their bills and their employees.

Thank you for your time.

The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/

Date	March 18, 2024
Name (Print)	**Joanna Martin**
Company	**Global Medical Response**

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care

We want to hear your story. Below please provide any personal experiences or general comments about access to health care in America that you wish to be included in the official hearing record.

Insurance is healthcare to Americans. Without insurance, many people don't pursue healthcare services at all – and only rely on EDs for severe incidents. Expanding coverage, whether by Medicare, Medicaid, or something else, is the only way to help lift millions out of healthcare poverty and simultaneously support our medical system, including EMS.

SMS – quality SMS – should be a basic American right. Without funding, it won't achieve its potential.

The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/

Date	March 18, 2024
Name (Print)	**William Seroggins**
Company	**MedTrans (GMR)**

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care

We want to hear your story. Below please provide any personal experiences or general comments about access to health care in America that you wish to be included in the official hearing record.

Coming from a very rural hometown, Wayside, Texas, Armstrong co [sic.]; we have an aging community. Our small community, up until six years ago, had a volunteer EMS. Six years ago, the EMS closed due to funding, leaving our rural community waiting for EMS services 20-30 minutes from neighboring communities by ground or 35-40 minutes from air medical services.

Very sad and unfortunate for family and friends who may suffer from trauma and/or medical issues.

More funding for emergency medical training. The better trained the clinicians are, the better care we can provide.

The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/

Date	March 18, 2024
Name (Print)	**Mike Sykes**
Company	**US Aviation Group**

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care

We want to hear your story. Below please provide any personal experiences or general comments about access to health care in America that you wish to be included in the official hearing record.

As a business owner, I encourage Congress take action to decouple health insurance from employment. It does not make sense to put the employer between our valued staff and their healthcare. It restricts individuals' ability to consider other job opportunities because that would possibly change their healthcare, since their healthcare is tied to their employee.

Additionally, as the employer, we are having to choose the healthcare provider for all of our employees, knowing that the choice we make may not be the best option for all.

Thank you.

The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/

Date	March 18, 2024
Name (Print)	**Brian Tibrney**
Company	**Global Medical Response**

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care

We want to hear your story. Below please provide any personal experiences or general comments about access to health care in America that you wish to be included in the official hearing record.

Congress, and the Committee on Ways & Means in particular, needs to help healthcare providers by:

1) Closing loopholes in the No Surprises Act that allow insurance payers, who lose under the independent dispute resolution process in the NSA, to fail to or delay payments to providers, and
2) Forcing CMS to rebase Medicare for emergent reimbursement using data already collected under the NSA.

The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/

Date	March 18, 2024
Name (Print)	**Donnie Woodyard, Jr.**
Company	**U.S. Interstate Commission for EMS Personnel Practice**

WRITTEN SUBMISSION TO BE INCLUDED IN OFFICIAL HEARING RECORD

Committee on Ways and Means
Field Hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care

We want to hear your story. Below please provide any personal experiences or general comments about access to health care in America that you wish to be included in the official hearing record.

The United States Emergency Medical Services Interstate Compact is the governmental body responsible for reducing bureaucracy, increasing access to EMS personnel, and for the interstate movement and recognition of licensure across state borders. Today, 24 states have enacted the legislation, representing 400,000 EMS personnel. However, the national EMS system continues to struggle with resiliency, reliability, recruitment, retention, and sustainability.

We urge the Committee to identify resources to ensure the Commission's national work is funded, so that EMS personnel can work across state borders, the workforce can remain mobile to respond to patients, and public protection can be enhanced via data sharing.

The official hearing record will be made public as part of the transcript. This will be posted on the Committee on Ways and Means website at: https://waysandmeans.house.gov/

PUBLIC SUBMISSIONS FOR THE RECORD

Statement for the Record
American Ambulance Association

U.S. House Committee on Ways and Means
"Access to Health Care in America: Ensuring Resilient Emergency Medical Care"
Monday, March 18, 2024

The American Ambulance Association (AAA) appreciates the opportunity to provide this Statement for the Record in connection with the U.S. House Committee on Ways and Means hearing entitled, "Access to Health Care in America: Ensuring Resilient Emergency Medical Care". The AAA is the primary association for ground ambulance service suppliers and providers, including private for-profit, private not-for-profit, governmental entities, volunteer services, and hospital-based ambulance services. Our members provide emergency and interfacility medical transportation services to more than 75 percent of the U.S. population. AAA members serve patients in all 50 states and provide services in urban, rural and super-rural areas.

Ground ambulance service providers and suppliers serve as an essential component of our nation's medical infrastructure, functioning at the forefront of emergency healthcare delivery. Often serving as patients' first point of contact with the healthcare system during emergencies, our members ensure prompt access to high-quality care irrespective of geographical location. Particularly in small communities and rural areas where other healthcare providers have scaled back or withdrawn, ambulance services serve as critical healthcare safety nets, providing essential services and responding to national emergencies and crises. However, ground ambulance services across the nation, especially in rural areas, confront unprecedented challenges. Inadequate reimbursement and funding severely strain our workforce and perpetuate demands on emergency medical services (EMS) systems, regardless of the geographic area served or the service provider's nature.

Medicare's temporary urban, rural, and "super rural" add-on payments for ambulance services, while essential, fall short of covering the full costs of providing many services. Prolonged under-reimbursement hinders the service providers' ability to recruit staff, upgrade equipment, and maintain life-saving services. In the FY2023 Omnibus Appropriations Bill, Congress extended the add-on payments for two years until the end of 2024, but another three years is necessary to analyze ongoing data collection and reform the ambulance fee schedule.

It is vital that the Congress not only extend the add-on payments for another three years but also increase the percentages of the add-on payments. We greatly appreciate the leadership of Representatives Wenstrup and Sewell on the *Protecting Access to Ground Ambulance Medical Services Act of 2023* (H.R. 1666) to extend the add-on payments for three years and ask for the support of the Committee to help assure that we can continue to provide the critical services that our communities need.

Additionally, our nation's EMS system faces severe staffing shortages exacerbated by the COVID-19 pandemic. The shortage is resulting in longer 9-1-1 response times for ambulances to reach patients in need of emergency ambulance services as well as an urgent interfacility ambulance transport to receive a higher level of care. Negative Medicare and Medicaid margins further impede service providers' ability to retain talent, with hospitals increasingly recruiting emergency medical technicians (EMTs) and paramedics to address their own staffing shortages. The *Preserve Access to Rapid Ambulance Emergency Medical Treatment Act* (H.R. 67433) proposed by Representatives Gluesenkamp-Perez and Finstad aims to alleviate this crisis by providing funding for paramedic and EMT recruitment and training, employee education, and support programs.

Unlike other Medicare providers or suppliers, ambulance services are not reimbursed when they provide care. However, many times, paramedics and EMTs provide health care services without reimbursement because transport to a hospital is not required, or the patient denies transport. It is important to recognize the significant role that ground ambulance services play in providing healthcare services without transport, particularly in rural communities lacking round-the-clock emergency departments. AAA advocates for innovative payment models tailored to address rural challenges, including treatment in place such as the draft legislation, Improving Access to Emergency Medical Services Act, by Representative Carey. These models not only ensure patients receive necessary care on-site but also alleviate financial burdens associated with unnecessary transportation. Additionally, removing barriers to technology adoption can enhance the effectiveness of treatment in place initiatives.

EMS services are the backbone of their communities. Ground ambulances service organizations provide unique services, and the Ground Ambulance Patient Billing Advisory Committee (GAPBAC) has recognized that the one-size-fits-all approach of the *No Surprises Act* will not work to address surprise billing in this field. The Congress established GAPB Advisory Committee to address the uniqueness of ground ambulance EMS services in the health care continuum and to ensure that communities across America have uninterrupted access to essential ground ambulance medical services.

Thank you for your leadership in promoting greater use of emergency medical services in our healthcare system. AAA is committed to working with the Committee to reach this goal.

INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE

5010 E. Trindle Road, Suite 202
Mechanicsburg, PA 17050
Phone (202) 888-4142
info@emscompact.gov
www.emscompact.gov

March 28, 2024

Chairman Jason Smith
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Subject: Testimony on "Access to Health Care in America: Ensuring Resilient Emergency Medical Care"

Dear Chairman Smith and Esteemed Members of the House Committee on Ways and Means,

In the context of the recent hearing on "Access to Health Care in America: Ensuring Resilient Emergency Medical Care," I am presenting this written testimony on behalf of the United States Emergency Medical Services (EMS) Compact. This testimony seeks to inform the Committee on how the EMS Compact serves as a pivotal instrument in resolving critical challenges faced in emergency medical care, especially those highlighted in the hearing, such as the necessity for effective EMS system development, billing reforms, and the assurance of resilient health care access in rural and underserved areas.

Introduction to the EMS Compact
The EMS Compact is a successful example of innovation and cooperation in the realm of health care policy. Enacted through state legislation, it represents a collective response to the emergent needs for efficient and borderless EMS. With 24 states currently participating, this initiative equips nearly 400,000 EMS practitioners with multi-state practice privileges, directly addressing some of the most pressing challenges in emergency medical care, as discussed in your hearing.

The EMS Compact is a living example of how cooperative federalism can work to reduce bureaucracy while seamlessly to improve access to EMS. The Compact enables states to address shared challenges while respecting their individual sovereignty, thus fostering unity and shared purpose among states in protecting public health.

Purpose and Legislative Mandate
The EMS Compact's legislative mandate is deeply rooted in a commitment to public health and safety. This mandate is multifaceted, encompassing several key objectives that collectively enhance the EMS system's efficacy and reach. These objectives are not only critical in their individual capacities but also synergistically work together to create a robust and responsive EMS framework.

1. **Increasing Public Access to Qualified EMS Personnel**: A primary goal of the EMS Compact is to ensure that qualified EMS practitioners are readily available to the public, regardless of state boundaries. This access is particularly crucial in rural or underserved areas where EMS resources are limited. By allowing practitioners to operate across state lines under the provisions of the EMS Compact, it significantly reduces response times and improves access to emergency medical care for a broader segment of the population.

2. **Enhancing State Capacities in Ensuring Patient Safety and Health Protection**: The Compact strengthens each member state's ability to safeguard public health. This is achieved through shared standards and practices, ensuring that every EMS professional adhering to the Compact's guidelines maintains a high level of care, thus enhancing overall patient safety and health protection in every participating state.

3. **Facilitating Interstate Cooperation in EMS Personnel Licensure and Regulation**: One of the critical aspects of the EMS Compact is its role in promoting cooperation among states regarding EMS personnel licensure and regulation. This cooperation ensures uniformity in qualifications and regulatory standards, making it easier for EMS practitioners to provide services in different states while maintaining a consistent standard of care.

4. **Assisting Military Members Transitioning to Civilian Life and Their Spouses in Obtaining Licensure:** The Compact acknowledges the unique challenges faced by military personnel and their spouses, especially when transitioning to civilian life. By facilitating easier licensure for these individuals, the Compact not only aids in their professional transition but also enriches the EMS workforce with experienced and skilled practitioners.

5. **Streamlining the Exchange of Licensure and Regulatory Information Between States**: Efficient communication and data sharing between states regarding licensure and regulatory matters are vital for a seamless EMS operation. The Compact facilitates this exchange, ensuring that each state has up-to-date information on EMS practitioners' licensure status, thus enhancing mobility and response capabilities.

6. **Ensuring Compliance with EMS Personnel Practice Laws**: Compliance with practice laws is essential for maintaining the integrity and professionalism of EMS services. The Compact provides a framework for ensuring that EMS practitioners across member states adhere to a set of agreed-upon laws and regulations, thus maintaining a high standard of practice.

7. **Empowering States to Effectively Hold EMS Personnel Accountable**: Finally, the Compact gives states the authority and means to hold EMS personnel accountable for their actions. This accountability is crucial for maintaining trust in EMS services and ensuring that the practitioners adhere to the highest standards of professional conduct and patient care.

The EMS Compact's legislative mandate is comprehensive, addressing various aspects of EMS practice and regulation. By achieving these objectives, the Compact significantly contributes to an efficient, reliable, and high-quality EMS system across the United States.

EMS Compact and Health Care Access

The EMS Compact significantly enhances health care access across the United States, particularly addressing critical needs in emergency medical care. Its role in bridging gaps in service delivery is multifaceted and profound, especially in underserved and rural communities.

1. **Swift and Seamless Cross-State Service Delivery**: The EMS Compact allows for a rapid response to emergencies across state borders. This agility is crucial during critical incidents where the nearest appropriate care might be in a neighboring state. The Compact eliminates the usual red tape associated with cross-state practice, ensuring that patients receive timely and effective care, which can be life-saving in many scenarios.

2. **Addressing Rural and Underserved Areas**: Rural and underserved areas often face a scarcity of medical resources, including limited access to EMS. The Compact allows EMS practitioners from other states to provide care in these areas, effectively reducing the impact of geographical disparities in health care access. This is particularly valuable during large-scale special events and other situations where local resources might be overwhelmed or insufficient.

3. **Improving Response Times and Quality of Care**: By enabling EMS practitioners to operate across state lines, the Compact directly improves response times in emergencies. This cross-state mobility ensures that the nearest available and qualified EMS professional can respond, irrespective of state boundaries, leading to quicker interventions and potentially better patient outcomes.

4. **Facilitating Specialized Care**: In certain medical emergencies, specialized care may be required that is not available locally. The EMS Compact facilitates the movement of specialized EMS practitioners, ensuring that patients have access to the best possible care, regardless of where they are located. This is particularly important for patients with conditions that require immediate specialized intervention, such as trauma, cardiac emergencies, or stroke.

5. **Strengthening Response and Preparedness**: The Compact enhances the capacity of states to respond to mass casualty incidents. It provides a framework for the mobilization and deployment of EMS resources across state lines during widespread emergencies. This coordinated response is vital for ensuring that help is available where and when it's most needed.

6. **Enhancing Public Health Surveillance and Response**: The EMS Compact contributes to public health surveillance by facilitating the movement of EMS personnel across regions. This movement enables a broader collection of health data and insights, which can be crucial in identifying and responding to public health emergencies, such as epidemics or bioterrorism events.

The EMS Compact is a cornerstone in the national effort to improve health care access and quality, particularly in EMS. Its impact extends beyond simplifying administrative procedures – it is a critical tool in ensuring that every individual, irrespective of their location, has access to timely and high-quality emergency care. This is essential not only for individual patient outcomes but also for the broader public health and emergency preparedness of the nation.

Interstate Commission for EMS Personnel Practice Funding

The EMS Compact, while a critical initiative for enhancing EMS across the nation, is impacted by the historically flawed EMS funding mechanisms, and specifically the financial challenges impacting State EMS Office across the nation. State EMS offices are integral components of the national EMS ecosystem. However, they are currently contending with severe resource and budget constraints, combined with extremely high leadership attrition rates. These constraints not only impact the State's ability to support the Compact but also affect their broader capacity to manage and improve state-level EMS services. This situation is further compounded by the impacts of the COVID-19 pandemic, increasing demands for EMS services and the need for continuous education and upgradation of skills and equipment.

While the Commission has the legislative authority to impose fees on member states to support its operations, the Commission recognizes that many State EMS Offices are facing significant financial burdens. Therefore, the Commission has refrained from exercising this authority. This decision, while empathetic to the states' EMS Office financial struggles, limits the speed and impact of the Commission's impact, making it heavily dependent on alternative funding and grants.

Federal funding support for the EMS Compact would provide a more stable and suitable solution. Such funding is common for interstate compact initiatives with national impact and could significantly aid the EMS Compact in its mission to coordinate data, streamline processes, and improve access to emergency medical care.

National EMS Coordinated Database (NEMSCD)

In accordance with the EMS Compact legislation, the Commission is mandated to establish and maintain a National EMS Coordinated Database. This system is a landmark achievement in the history of modern EMS in the United States and represents a significant technological and administrative advancement, addressing several longstanding challenges in EMS workforce management and coordination. This national system provides new mechanisms for increasing access to health care while improving public health and safety, including:

1. **Synchronization of State EMS Licensure Data**: The NEMSCD effectively synchronizes licensure data from multiple states, creating a unified, national database. This synchronization is crucial, as it ensures that EMS practitioners' licensure information is consistent, up-to-date, and readily accessible across state lines. It is a critical tool for state EMS authorities and agencies to verify the credentials and licensure status of EMS personnel quickly and accurately.

2. **Deduplication of Practitioner Information**: A major feature of the NEMSCD is its ability to deduplicate EMS practitioner data. This process removes redundancies and errors, leading to a more accurate and reliable repository of EMS personnel information. The deduplication of data is particularly important for practitioners who are licensed in multiple states, ensuring their information is correctly represented and managed.

3. **Strategic Workforce Planning and Distribution**: The NEMSCD provides invaluable insights into the distribution and availability of EMS practitioners across the nation. This information is critical for strategic planning, especially in allocating resources to areas most in need, such as underserved rural or urban communities. It enables policymakers and EMS leaders to make informed decisions on workforce development, education needs, and deployment strategies.

4. **Ensuring Resilient EMS Services**: The NEMSCD plays a vital role in ensuring resilient EMS services across the United States. By having a comprehensive view of the EMS workforce, emergency response can be more adaptive and responsive to changing needs, such as during natural disasters, pandemics, or other mass casualty events. This adaptability is crucial for maintaining uninterrupted and efficient EMS services under varying circumstances.

5. **Facilitating Interstate Communication and Cooperation**: The database enhances interstate communication and cooperation among EMS agencies and professionals. By providing a platform for sharing licensure and certification information, it fosters a more collaborative environment, encouraging states to work together more effectively in managing and deploying EMS resources.

6. **Supporting Regulatory Compliance and Enforcement**: The NEMSCD aids in regulatory compliance and enforcement. By maintaining accurate and current licensure data, it helps ensure that EMS practitioners are practicing within the bounds of their licensure and qualifications, thereby upholding the standards and safety of emergency medical care.

7. **Data-Driven Policy Making and Research**: The availability of comprehensive EMS data opens avenues for data-driven policymaking and research. It provides a rich source of information for studying workforce trends, service delivery models, and other aspects of EMS that are crucial for continuous enhancements and innovation in the field.

The National EMS Coordinated Database is a dynamic tool that empowers decision-makers, enhances interstate collaboration, and plays a pivotal role in ensuring high-quality, resilient EMS services nationwide. Its creation marks a significant step forward in the modernization and standardization of EMS systems across the country.

Reducing Bureaucracy and Barriers

The EMS Compact's role in reducing bureaucracy and barriers in the field of EMS is a major advancement in streamlining EMS operations across the United States. The Compact's approach to standardization and harmonization of EMS education, certification, and state licensure has significant implications for the efficiency and effectiveness of EMS practitioners.

1. **Standardization of EMS Education and Certification**: By establishing uniform standards for EMS education and certification, the EMS Compact ensures that all EMS practitioners, irrespective of their state of origin, meet a consistent level of training and competency. This standardization is crucial for maintaining high-quality care and for the mutual recognition of EMS qualifications across member states. It eliminates the need for practitioners to undergo additional education or testing to work in different states, thereby reducing redundancy and expediting the process of cross-state practice.

2. **Harmonization of State Licensure**: The Compact harmonizes state licensure requirements, creating a more streamlined and efficient process for EMS practitioners seeking to practice in multiple states. This harmonization not only simplifies the licensure process but also reduces the administrative burden on both the practitioners and the state licensing authority. It allows for quicker mobilization of EMS personnel in response to emergencies, particularly in border areas or in states participating in the Compact.

3. **Facilitating Cross-State Mobility**: One of the most significant barriers in the EMS field has been the difficulty of cross-state practice due to varying state requirements. The EMS Compact addresses this by allowing licensed EMS practitioners to work in other Compact member states without the need for additional licensure. This mobility is a game-changer, especially in situations where rapid deployment of EMS resources is necessary.

4. **Reducing Administrative Overheads**: The streamlining of standards and processes significantly reduces the administrative overheads for EMS practitioners and state agencies. Practitioners spend less time navigating bureaucratic procedures and more time focusing on their critical role in patient care. For state agencies, it eases the burden of managing licensure applications and renewals, allowing them to allocate resources more efficiently.

5. **Enhancing Preparedness and Response**: By reducing bureaucratic barriers, the EMS Compact enhances overall preparedness and response. In events like natural disasters, pandemics, or large-scale accidents, the ability to quickly and seamlessly deploy qualified EMS practitioners across state lines is crucial. The Compact facilitates this rapid deployment, ensuring that responses are not hindered by procedural delays.

6. **Promoting a More Unified EMS System**: The Compact contributes to a more unified national EMS system. It fosters a sense of cohesion and standardization across state lines, which is vital for the integrated functioning of emergency medical services throughout the country. This unity is especially important in ensuring that wherever patients are in the Compact member states, they can expect a consistent level of EMS care.

Through reducing bureaucracy and barriers, the EMS Compact has significantly streamlined the process of EMS education, certification, and licensure. This has allowed EMS practitioners to serve more efficiently and effectively, improving the overall responsiveness and quality of emergency medical services across the nation.

Conclusion and Requests

As demonstrated, the EMS Compact is an integral part of the solution in enhancing the national EMS system. However, for it to realize its full potential, specific national policy reforms are urgently needed:

1. **Billing and Payment Reform**: It is essential that EMS services be recognized and billed as medical providers, not merely as a transportation benefit. This recognition will enable EMS services to receive appropriate compensation for the comprehensive care they provide, which is crucial for the sustainability and development of a robust EMS system.

2. **Strong Financial Foundation**: A strong financial foundation is critical for the continued development and effectiveness of the national EMS system. Support for diverse funding sources, including federal grants and private partnerships, is necessary to ensure the sustainability of initiatives like the EMS Compact.

3. **Support for the EMS Compact**: Continued support and expansion of the EMS Compact are vital. We urge the Committee to consider policies that facilitate the Compact's objectives, particularly in areas of cross-state practice and workforce mobilization.

Our office remains a committed resource and is ready to provide further information and support as the Committee deliberates on these policy options. The advancement of the EMS Compact is not only a testament to our collective ability to innovate in healthcare but also a crucial step towards ensuring accessible, resilient, and high-quality emergency medical care for all Americans.

Thank you for considering this testimony. We look forward to continued collaboration and meaningful dialogue on these critical issues.

Sincerely,

Donnie Woodyard, Jr.
Executive Director
Interstate Commission for EMS Personnel Practice

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement

of the

American Hospital Association

for the

Committee on Ways and Means

of the

U.S. House of Representatives

"Access to Health Care in America: Ensuring Resilient Emergency Medical Care"

March 18, 2024

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers; and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) welcomes the opportunity to comment on ways to ensure patients can receive timely emergency medical care, particularly in rural and underserved areas. We share the committee's interest in ensuring that Americans have high-quality, affordable health care in the face of life-threatening crises.

Hospitals and health systems are the lifeblood of their communities and committed to ensuring local access to health care. At the same time, many hospitals, including those in rural and underserved areas, continue to experience unprecedented challenges that jeopardize access and services. These include workforce shortages, high costs of prescription drugs, and continued severe underpayment by Medicare and Medicaid.

Rural hospitals make up about 35% of all hospitals in the U.S. Nearly half of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds. Given that rural hospitals tend to be much smaller, patients with higher acuity often travel or are referred to larger hospitals nearby. As a result, in rural hospitals, the acute care occupancy rate (37%) is less than two thirds of their urban counterparts (62%).

Below are a series of proposals and suggestions for the Ways and Means Committee to consider as it seeks to strengthen emergency medical care for patients across the country.

Creating Financial Stability for Emergency Care Services

One significant obstacle that delays patient access to emergency care services are rural hospital closures. To improve health care in rural communities, sustainable financing for rural hospitals and health systems is imperative. As a result, rural hospitals require increased attention from state and federal government to address barriers and invest in new resources in rural communities.

Providing certainty and stability in rural Medicare hospital payments is essential. Low reimbursement, low patient volume, sicker patients and challenging payer mix, common at many rural hospitals, puts added financial pressure on those facilities. The AHA supports **policies that promote flexible payment options and address financial challenges faced by the full spectrum of rural hospitals, which will allow them to provide high-quality emergency medical care for their patients.**

- **Making Permanent the Medicare-dependent Hospital (MDH) and Low-volume Adjustment (LVA).** MDHs are small, rural hospitals where at least 60% of admissions or patient days are from Medicare patients. MDHs receive the inpatient prospective payment system (IPPS) rate plus 75% of the difference between the IPPS rate and their inflation-adjusted costs from one of three base years. AHA supports making the MDH program permanent and adding an additional base year that hospitals may choose for calculating payments. The LVA provides increased payments to isolated, rural hospitals with a low number of discharges. AHA also supports making the LVA permanent. The MDH designation and LVA protect the financial viability of these hospitals to ensure they can continue providing access to care.

- **Reopen the Necessary Provider Designation for Critical Access Hospitals (CAHs).** The CAH designation allows small rural hospitals to receive cost-based Medicare reimbursement, which can help sustain services in the community. Hospitals must meet several criteria, including a mileage requirement, to be eligible. A hospital can be exempt from the mileage requirement if the state certified the hospital as a necessary provider, but only hospitals designated before Jan. 1, 2006, are eligible. AHA urges Congress to reopen the necessary provider CAH program to further support local access to care in rural areas.

- **Improve Access to Capital.** Access to capital is important to stabilize a vulnerable hospital or advance innovations in others. AHA supports expanding the USDA Community Facilities Direct Loan & Grant Program and creating a new Hill-Burton like program to update rural hospitals to ensure continued access in rural communities.

- **Strengthen the Rural Emergency Hospital (REH) Model.** REHs are a new Medicare provider type to which small rural and critical access hospitals can convert to provide emergency and outpatient services without needing to provide inpatient care. REHs are paid a monthly facility payment and the outpatient prospective payment system (OPPS) rate plus 5%. AHA supports strengthening and refining the REH model to ensure sustainable care delivery and financing.

- **Rebase Sole Community Hospitals (SCHs).** SCHs must show they are the sole source of inpatient hospital services reasonably available in a certain geographic area to be eligible. They receive increased payments based on their cost per discharge in a base year. AHA supports adding an additional base year that SCHs may choose for calculating their payments.

Medicare and Medicaid each pay less than 90 cents for every dollar spent caring for patients — with Medicare hitting a historic low of 82 cents for every dollar — according to the latest AHA data. Given the challenges of providing care in rural areas, reimbursement rates across payers need to be updated to cover the cost of care.

AHA supports the following policies to ensure fair and adequate reimbursement.

- **Medicare Advantage Payment Parity for CAHs.** The Medicare Advantage (MA) program has grown significantly in the past decade. MA enrollment, which traditionally has grown slower in rural areas, is now surpassing the growth rate in urban areas. For example, MA enrollment quadrupled between 2010 to 2023 in rural counties, compared to metropolitan areas which doubled in enrollment during the same period. Yet, MA plans are not required to pay rural providers, such as CAHs, at the same cost basis as fee-for-service Medicare; and they are increasingly paying below costs, straining the financial viability of many rural providers. Further, MA plans have the additional burden of prior authorization and other health plan requirements with which rural providers must increasingly contend — requirements that do not exist to nearly the same extent in fee-for-service Medicare and add additional costs for rural providers to comply. We support policies that support the long-term health of providers and facilities that care for patients in rural areas, which will need to consider the impact of MA enrollment in those communities.

- **Wage Index Floor.** AHA supports the Save Rural Hospitals Act (S. 803) to place a floor on the area wage index, effectively raising the area wage index with new money for hospitals below that threshold.

- **Make the Ambulance Add-on Payments Permanent.** Rural ambulance service providers ensure timely access to emergency medical care but face higher costs than other areas due to lower patient volume. We support permanently extending

the existing rural, "super-rural" and urban ambulance add-on payments to protect access to these essential services.

- **Commercial Insurer Accountability.** Systematic and inappropriate delays of prior authorization decisions and payment denials by commercial insurers for medically necessary care are putting patient access to care at risk. We support regulations that streamline and improve prior authorization processes, which would help providers spend more time on patients instead of paperwork. We also support a legislative solution to address these concerns. In addition, we support policies that ensure patients can rely on their coverage by disallowing health plans from inappropriately delaying and denying care, including by making unilateral mid-year coverage changes.

- **Maternal and Obstetric Care.** We urge Congress to continue to fund programs that improve maternal and obstetric care in rural areas, including supporting the maternal workforce, promoting best practices and educating health care professionals. We continue to support the state option to provide 12 months of postpartum Medicaid coverage.

- **Behavioral Health.** Implementing policies to better integrate and coordinate behavioral health services will improve care in rural communities. We urge Congress to:
    - Fully fund authorized programs to treat substance use disorders, including expanding access to medication assisted treatment.
    - Implement policies to better integrate and coordinate behavioral health services with physical health services.
    - Enact measures to ensure vigorous enforcement of mental health and substance use disorder parity laws.
    - Permanently extend flexibilities under scope of practice and telehealth services granted during the COVID-19 public health emergency.
    - Increase access to care in underserved communities by investing in supports for virtual care and specialized workforce.

Bolstering the Workforce

Recruitment and retention of health care professionals is an ongoing challenge and expense for many hospitals. Nearly 70% of the primary health professional shortage areas are in rural or partially rural areas. Hospitals and health systems need a robust and highly-qualified staff to handle medical care in emergency situations. To achieve this goal, targeted programs that help address workforce shortages in rural communities should be supported and expanded. Workforce policies and programs also should encourage nurses and other allied professionals to practice at the top of their licenses. Below are listed a variety of different proposals and pieces of legislation Congress should consider enacting to tackle the workforce shortage crisis.

- **Graduate Medical Education.** We urge Congress to pass the **Resident Physician Shortage Reduction Act of 2023 (H.R. 2389/S. 1302)**, legislation to increase the number of Medicare-funded residency slots, which would expand training opportunities in all areas including rural settings to help address health professional shortages.
- **Conrad State 30 Program.** We urge Congress to pass the **Conrad State 30 and Physician Access Reauthorization Act (H.R. 4942/S. 665)** to extend and expand the Conrad State 30 J-1 visa waiver program, which waives the requirement to return home for a period if physicians holding J-1 visas agree to stay in the U.S. for three years to practice in federally-designated underserved areas.
- **International Workforce.** The AHA supports the recapture of and **expedited visas for foreign-trained nurses and doctors.**
- **Loan Repayment Programs.** We urge Congress to pass the **Restoring America's Health Care Workforce and Readiness Act (S. 862)** to significantly expand National Health Service Corps funding to provide incentives for clinicians to practice in underserved areas, including rural communities. AHA also supports the **Rural America Health Corps Act (H.R. 1711/S. 940)** to directly target rural workforce shortages by establishing a Rural America Health Corps to provide loan repayment programs focused on underserved rural communities.
- **Boost Nursing Education.** We urge Congress to invest significant resources to support nursing education and provide resources to boost student, faculty and preceptor populations, modernize infrastructure and support partnerships and research at schools of nursing. AHA also supports expanding the National Nurse Corps.
- **Health Care Workers Protection.** We urge Congress to enact the **Safety from Violence for Healthcare Employees Act (H.R. 2584/S. 2768)** to provide federal protections for health care workers against violence and intimidation.

Conclusion

We thank you for the opportunity to comment on ways to improve emergency medical care for patients, particularly those in rural and underserved areas. We look forward to continuing to work with you on this important issue.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

March 18, 2024

The Honorable Jason Smith
Chairman
Committee on Ways and Means
1139 Longworth House Office Building
U.S. House of Representatives
Washington, D.C. 20510

Dear Chairman Smith:

On behalf of the American College of Emergency Physicians (ACEP) and our nearly 40,000 members, thank you for the opportunity to share our comments for today's field hearing, entitled, "Access to Health Care in America: Ensuring Resilient Emergency Medical Care." Ensuring all patients have access to lifesaving emergency care, especially those in rural and underserved areas, is a key priority for ACEP and we are grateful for the opportunity to share our perspective on this critical issue.

As you well know, rural and underserved communities have their own unique sets of needs and challenges in providing appropriate, high-quality, and timely care, particularly for emergency care. Rural emergency departments (EDs) provide critical services for their communities while often operating under different constraints and with more limited resources than higher-density urban areas. These services include facilitating earlier evaluation and entry into the health care system, stabilization and initiation of treatment, and coordinated transfer to a tertiary care facility.

Among the challenges affecting patient outcomes and the practice of emergency medicine in rural areas are the ED patient "boarding" crisis, where admitted patients are held in the ED when there are no inpatient beds available; staffing issues, including recruitment, retention, and high variability in rural ED staffing; complexity and system fragmentation in transferring patients to appropriate settings; limited access to primary and specialty care; limited technological resources, including broadband, and continued closures of rural hospitals and other health care facilities that limit access to care in these communities.

ACEP thanks you for your continued attention to the health care needs of our patients, especially those in rural and underserved communities. We appreciate the opportunity to share our insights and suggestions in the following pages on policies that will help improve patient access to high-quality lifesaving emergency care.

Should you have any questions, please do not hesitate to reach out to Ryan McBride, ACEP Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

Aisha T. Terry, MD, MPH, FACEP
ACEP President

WASHINGTON, DC OFFICE
901 New York Ave, NW
Suite 515E
Washington DC 20001-4432

202-728-0610
800-320-0610
www.acep.org

Emergency Department "Boarding"

Patient "boarding" occurs when a patient continues to occupy an ED bed, even after being seen and treated by a physician, while waiting to be admitted to an inpatient bed in the hospital, or transferred to a psychiatric, skilled nursing, or other specialty facility. As our health care system becomes increasingly strained, these patients must stay in the ED for days or even weeks on end, waiting for a bed to become available so they can be admitted or transferred. Patients being boarded in the ED limits the ability of ED staff to provide timely, high-quality care to all patients, forcing other newly-arriving patients with equally important emergency conditions to wait in the ED waiting room for care, with wait times as long as eight or even twelve hours rapidly becoming a new norm, and patients even dying during these ways as staff struggle to keep up with an unsupportable volume of sick patients to care for.

Boarding has become its own public health emergency. Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen, waiting for admission into an inpatient bed in the hospital, waiting to be transferred to other specialized facilities that have few to no available beds, or, waiting simply to return to their nursing home. And this breaking point is entirely outside of the control of highly-skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Even patients sick enough to need intensive care may board for hours in ED stretchers not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for *months* in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. But boarding does not just affect those waiting to receive care elsewhere. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician.

To illustrate the stark reality of this crisis, ACEP asked its members to share examples of the life-threatening impacts of ED boarding. The stories paint a picture of an emergency care system already near collapse. While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses, paramedics, and other health care professionals. Below are several excerpts from anonymous emergency physicians describing the negative impacts of boarding on patient outcomes, including potentially avoidable deaths:

> *"We are a very rural hospital with only family practice and emergency physicians - there are no specialists within 90 miles…Recently I had a woman with abdominal pain in the* ER. *When she arrived she had normal vital signs and was not really very sick. Testing showed that she had an infected gallbladder - a simple problem for any surgeon to treat. We called 27 hospitals before one in a different state called us back when a bed finally opened up. She spent thirty six hours in our* ER, *and was in shock being treated with maximum doses of drugs to keep her alive when she was transferred. She didn't survive."*

> *"My shop is 34 bed rural tertiary care center that serves an area greater than 20,000 square miles. Month after month our boarding issues continue to exacerbate and have surpassed critical levels many months ago. We are frequently the largest in-patient ward in the hospital. Currently we average 28 boarding patients in our department and this has been as high as 41 boarded inpatients and 31 patients in the waiting room less than a week ago…Due to these challenges we have fully implemented "waiting room medicine", closed down our Provider in Triage, instead all providers pickup patients in the waiting room. Nearly 50% of our patient encounters now result in discharge from the waiting room. Finally, it is not at all uncommon to have patients in the waiting room with SarsCoV-2, pending orders for heparin, diltazem, or other vasoactive medications. In the past month we have had SAH [subarachnoid hemorrhage, or brain bleed], Fournier gangrene, hip fractures, septic shock all being treated in the waiting room with no available beds to move them into."*

> *"At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have include last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room…In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding. Our boarding numbers have unfortunately skyrocketed in the wake of COVID as a consequence of increasing surgical volumes and decreasing inpatient nurse staffing."*

We need a health care system that can accurately track available beds and other relevant data in real-time, appropriate metrics to measure ED throughput and boarding, contingency plans and "load balancing" plans for boarding/crowding scenarios, and fewer regulatory or other "red tape" burdens that delay necessary care. Recognizing all EDs are different and there is no one-size-fits-all solution to this multifactorial problem, ACEP has helped develop and supports a broad range of potential legislative

and regulatory solutions that will alleviate the burdens and overall strain on EDs caused by patient boarding. We strongly urge Congress to direct its attention to this critical issue and work with us and other stakeholders through roundtables, hearings, and legislation to provide both short- and long-term solutions to this public health crisis.

Geographic Payment Differences

The Medicare Physician Fee Schedule (PFS) includes payment adjustments based on several factors to account for geographic variations in the cost of providing care in different areas. Among the three Geographic Practice Cost Indices (GPCIs), the physician work GPCI adjust payments based on the relative costs associated with a physician's labor (time, skill, and effort) compared to the national average. For years, Congress has almost annually set a GPCI work "floor" of 1.00 to help any localities with a low work GPCI, often rural and underserved areas, by increasing Medicare payments to physicians practicing in these localities.

Without an extension of the current work floor, rural communities will be the hardest hit, as physicians practicing in these communities will see an *additional* payment reduction on top of other impending cuts to Medicare physician reimbursement. As you well know, rural communities face significant, unique challenges in recruiting and retaining physicians, and continued payment cuts will only serve to further destabilize the health care safety net in communities where access to care is already limited. ACEP appreciates Congress' recent work to extend the work floor through December 31, 2024, and urges Congress to, at the very least, maintain the current 1.00 Medicare work floor going forward.

Sustainable Provider and Facility Financing

The recently established Rural Emergency Hospital (REH) designation for facilities in rural areas, a concept for which ACEP has long advocated, also has the potential to improve access to quality emergency care in certain rural areas, especially those affected by recent hospital closures. ACEP believes that all services delivered in REHs should be overseen by board-certified emergency physicians, though we acknowledge that this is not always possible due to existing workforce shortages in rural areas. We have urged CMS to require that in cases where a board-certified emergency physician is not available, a physician with training and/or experience in emergency medicine (such as a family physician) provide the care or oversee the care delivered by non-physician practitioners.

Under the REH designation, covered outpatient department services provided by an REH receive an additional five percent payment for each service. Beneficiaries will not be charged a copayment on the additional five percent payment. CMS considers all covered outpatient department services that would otherwise be paid under the Outpatient Prospective Payment System (OPPS) as REH services in these facilities. REHs will be paid for furnishing REH services at a rate that is equal to the OPPS payment rate for the equivalent covered outpatient department service, increased by five percent. REHs may provide outpatient services that are not otherwise paid under the OPPS as well as post-hospital extended care services furnished in a unit of the facility that is a distinct part of the facility licensed as a skilled nursing facility; however, these services are not considered REH services and therefore are paid under the applicable fee schedule and do not receive the additional five percent payment increase that CMS applies to REH services. Finally, REHs also receive a monthly facility payment, and this payment amount will increase in subsequent years by the hospital market basket percentage increase.

ACEP supports this payment approach as it aligns with the methodology outlined in the Consolidated Appropriations Act of 2020. However, we also note that the statute only addresses additional *facility* payments to REHs under the OPPS—not added reimbursement for physicians and other clinicians under the Physician Fee Schedule (PFS) who actually deliver the services in REHs. The additional money the hospitals receive is for their own unique rural needs and therefore does not flow down to the emergency physicians that staff those rural EDs (especially because most emergency physicians are not salaried direct employees of the hospital). **In order to incentivize physicians and other clinicians to work in rural areas and appropriately staff REHs, ACEP strongly recommends that CMS consider creating an add-on code or modifier that clinicians could append to claims for services delivered in REHs. CMS could consider setting the value of this add-on code or modifier at five percent of the PFS rate for each Current Procedural Terminology (CPT) code that is billed—consistent with the additional OPPS payment that the statute provides.** However, to date CMS has not established such a code or modifier. We therefore urge the Committee to consider and support this approach as well to help ensure that REHs are appropriately staffed.

Aligning Sites of Service

In rural or underserved communities where there is no access to a hospital or REH, freestanding emergency departments (FSEDs) could help alleviate issues of limited access to emergency care. There are two distinct types of FSEDs: a hospital outpatient department (HOPD), often referred to as an off-site hospital-based or satellite ED, and independent freestanding emergency centers (IFECs). HOPDs are owned and operated by medical centers or hospital systems, and under federal law and regulations, if the medical center or hospital system accepts Medicare or Medicaid payments for emergency services at an HOPD, the HOPD falls under the same rules and regulations of CMS as the ED of the medical center or hospital, and therefore must comply with all CMS Conditions of Participation (CoPs).

IFECs may be owned by any individual or business entity. Some states have created licensing criteria to govern IFECs that closely follow or mirror the intent of the Emergency Medical Treatment and Labor Act (EMTALA), as well as other rules and regulations. Many states still do not currently address licensing rules for IFECs, and, currently, CMS does not recognize IFECs as EDs, meaning that CMS does not allow for Medicare or Medicaid payment for the technical component of services provided by these facilities (physicians may submit professional fees and be reimbursed under Medicare for the professional component, however).

ACEP believes that any FSED facility that presents itself as an ED, regardless of whether it is an HOPD or IFEC, should:

- Be available to the public 24 hours a day, seven days a week, 365 days per year;
- Be staffed by appropriately qualified emergency physicians;
- Have adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility;
- Be staffed at all times by a registered nurse (RN) with a minimum requirement of current certification in advanced cardiac life support and pediatric advanced life support;
- Have policy agreements and procedures in place to provide effective and efficient transfer to a higher level of care if needed (i.e., cath labs, surgery, ICU); and,
- Receive the same level of reimbursement for both the physician and technical component fee as a traditional hospital-based emergency department.

Further, ACEP believes that all FSEDs must follow the intent of the EMTALA statute and that all individuals arriving at an FSED should be provided an appropriate medical screening examination (MSE) by qualified medical personnel including ancillary services, to determine whether or not an emergency exists.

Under regulatory flexibilities provided under the COVID-19 public health emergency (PHE), CMS issued waivers in April 2020 to allow IFECs to enroll as Medicare-certified hospitals and receive reimbursement under Medicare as a method of expanding provider capacity. But with the expiration of the COVID-19 PHE on May 11, 2023, this waiver also expired and IFECs are no longer able to be reimbursed for the technical component under Medicare, despite a recent study finding that IFECs did not increase overall utilization of emergency care services and that payments were actually more than 20 percent *lower* than for those in hospital-based EDs. We therefore encourage the Committee to consider and support the bipartisan "Emergency Care Improvement Act," (H.R. 1694), introduced by Representatives Jodey Arrington (R-TX) and Vicente Gonzalez (D-TX), to permanently recognize these facilities under Medicare and Medicaid.

Health Care Workforce

Workforce shortages are especially pronounced in rural and underserved areas throughout the country, and numerous barriers to providing equitable care in these communities persist. Among these are the inability to recruit qualified and sufficiently experienced, educated, and trained physicians, nurses, ancillary support staff, and other health care providers. Despite a 28 percent increase in emergency medicine residency positions over the past 10 years, there has been no corresponding increase in emergency medicine residency trained or emergency medicine board certified physicians working in rural EDs. Like the other issues noted here, this too is a complex problem due to a variety of factors, including limited opportunities for exposure to these communities during residency training, fewer full time employment opportunities overall due to ED staffing requirements and continued rural facility closures, a lack of recruitment tools and incentives such as those provided for primary care professions, among many others. Additionally, rural EDs, compared to their urban counterparts, are resource limited, financially stressed, and experience higher interfacility transfer rates. And while the COVID-19 pandemic increased the use of telehealth, rural areas

still suffer from inconsistent availability of telehealth access and structural challenges like limited or functionally nonexistent broadband access. Transportation issues also limit many individuals' ability to reach hospitals, and emergency medical services (EMS) in rural areas also experience significant transportation delays due to issues with crew availability.

In order to attract more emergency physicians to rural and underserved communities, Congress can build off of existing designations and programs aimed at bolstering the rural health care workforce. Congress should consider establishing an Emergency Medicine Health Professional Shortage Area (HPSA), based on the existing criteria for HPSAs for mental health and primary care professionals (42 CFR Part 5), as well as ensuring that emergency physicians are eligible for student loan repayment assistance through the National Health Service Corps (NHSC) Loan Repayment Program for qualifying service in an approved site within such an emergency medicine HPSA.

Another challenge in recruiting qualified health professionals to rural areas is that while an individual physician may seek or be afforded such an opportunity, their spouse or partner may not have the same employment opportunities, ability to move, or may face other barriers like occupational licensing and credentialing. Congress could help facilitate such transitions by implementing employment assistance programs similar to those that already exist for members of the Armed Services and their spouses. This could include federal hiring preferences and priority placement programs, licensure and recertification reimbursement, employment fellowship opportunities, and additional relocation and placement support for qualified spouses and partners.

Some have proposed expanding the scope of practice of nonphysician professionals in order to increase access to care, especially in rural and underserved communities. However, in reviewing the actual practice locations of nurse practitioners and primary care physicians, it is clear nurse practitioners and primary care physicians tend to work in the same large urban areas. There remain significant shortages of nurse practitioners (NPs) in rural areas – the very problem with physician access that scope expansion has sought to address. This occurs regardless of the level of autonomy granted to NPs at the state level.

We believe the gold standard for care in an emergency department is via a physician-led emergency care team, with that care performed or supervised by a board-certified/board-eligible emergency physician. Physician Assistants (PAs) and NPs can and do serve integral roles as members of the emergency care team, but do not replace the medical expertise provided by emergency physicians. The physician-led emergency care team is the safest care model for our patients and particularly important for Medicare beneficiaries, who are some of the most medically vulnerable patients in our population, often suffering from multiple chronic conditions or other complex medical needs and account for nearly 20 percent of ED encounters each year.

While non-physician practitioners are indispensable partners in a care setting, there are meaningful differences in the training that each member of the care team receives. In fact, there is evidence that scope expansion can lead to overprescribing and overutilization of diagnostic imaging, or other services. For example, in states that allow independent prescribing, nurse practitioners were 20 times more likely to overprescribe opioids than those in prescription-restricted states. In another study, non-physicians were found to have ordered more imaging over a 12-year period, according to another study. Scans increased more than 400% by non-physicians, primarily nurse practitioners and physician assistants. Specifically in the emergency department, an October 2022 Stanford University study found that nurse practitioners use more resources and achieve worse outcomes than physicians, especially when dealing with complex patients – a 7 percent increase in cost of ED care, an 11 percent increase in length of ED stay, and a 20 percent increase in 30-day preventable hospitalizations. This can have a devastating effect on the patients overall health care and further strain the health care system.

Supporting physician-led health care teams is also aligned with most state scope of practice laws. For example, over 40 states require physician supervision of or collaboration with PAs. Most states require physician supervision of or collaboration with nurse anesthetists, and 35 states require some physician supervision of or collaboration with nurse practitioners, including populous states like California, Florida, New York, and Texas. These states represent more than 85 percent of the U.S. population. Moreover, despite multiple attempts, in the last five years no state has enacted legislation to allow nurse practitioners full-immediate independent practice.

We also hope the Committee's examination of current health care workforce shortages will include a focus on the ongoing nursing shortages and the perverse incentives created by a growing over-reliance on over-priced nurse staffing agencies that have resulted in exorbitant increases in costs to already-strained health care systems. The extreme physical and mental toll of the COVID-19 pandemic response has inflicted enormous trauma and stress on physicians and nurses, resulting in increased burnout and dissatisfaction for those on the front lines and greater attrition in the health care workforce. This has left many health systems, who even before the pandemic often had to rely on mandatory overtime and other stopgap measures to ensure an adequate nurse workforce, desperate to fill workforce gaps by relying on nurse staffing agencies, some of whom have imposed extreme rate hikes to supply travel nurses to hospitals. This in turn draws off even more nurses previously employed in hospitals,

given the higher pay and greater autonomy over their own working conditions. In many cases, facilities have been left with no other choice than to pay substantially inflated rates in their attempts to maintain staffing levels capable of meeting their community's needs. We appreciate Congress' recent attention to this issue and encourage continued investigation and oversight of potentially anticompetitive practices occurring in the health care workplace.

We believe that the ongoing challenges in recruiting and retaining all levels of health care professionals in rural and underserved areas are more complex, and that this persistent issue requires more innovative solutions to incentivize physicians and other health care professionals to work in these communities. We would welcome the opportunity to work with you and your colleagues to find more effective and durable solutions to these longstanding workforce challenges to ensure that Americans in rural and underserved areas have access to high-quality emergency care, recognizing the level of expertise and training required for independent practice of emergency medicine and supporting the provision of physician-led team-based care.

March 20, 2024

The Honorable Jason Smith
Chairman of the Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Members of the Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

Re: ATA Action Statement for the Record for House Ways and Means Committee Hearing "Enhancing Access to Care at Home in Rural and Underserved Communities"

On behalf of ATA Action, the American Telemedicine Associations affiliated trade association focused on advocacy, thank you for your continued support of telehealth and holding this critical hearing to examine different in-home technologies, such as remote monitoring, and programs like the Acute Hospital Care at Home Program that would increase access to health care services especially in rural health and underserved communities.

Telehealth plays an essential role in our evolving healthcare system that has proven to expand access to care, reduce costs, assist with provider shortages, and overall help the health care system become more efficient and effective.[1] We appreciate that Congress understands the value of telehealth and continues to hold relevant bipartisan hearings to collect important information on virtual care as you contemplate telehealth policies post CY2024. ATA Action urges Congress to act sooner rather than later this year on telehealth to provide certainty for patients and providers across the country and provide U.S. healthcare systems enough time to implement appropriate virtual tools, technologies, programs, and processes moving forward.

Specifically, we urge Congress to make permanent the Medicare telehealth flexibilities implemented during the COVID-19 Public Health Emergency (PHE), including:

- **Removal of Antiquated Geographic and Originating-Site Restrictions**
  Prior to the pandemic, a patient had to be in a designated rural area and in a healthcare clinic in order to have been able to receive reimbursable telehealth services under the Medicare program. During the PHE, the United States Department of Health and Human Services (HHS) waived these restrictions, thus allowing patients in any geographic area (not just rural) to receive telehealth services in any location, including in their homes. We urge Congress to permanently remove the Section 1834(m) geographic and originating-site restrictions to ensure that all patients can access care where and when they need it.

- **Ensure that Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Continue to Furnish Telehealth Services**
  FQHCs and RHCs provide critical health care services for underserved communities and populations across the United States. During the pandemic, FQHCs and RHCs serve as distant sites and can be reimbursed for telehealth services. ATA Action urges Congress to ensure that the

[1] PRINT_ATA-TAW-Hill-Day-handout_9.11.23.pdf (americantelemed.org)

roughly 1,400 FQHCs and 4,300 RHCs can continue offering telehealth services permanently while receiving fair reimbursement.

- **Permanently Expand the List of Eligible Medicare Providers**
  During the pandemic, physician therapists, speech-language therapists, and occupational therapists were able to provide telehealth services and be reimbursed by Medicare. ATA Action is supportive of this flexibility and believes all practitioners should have the option to utilize virtual care when clinically appropriate and be reimbursed for the services rendered. We encourage Congress to consider enacting the Expanded Telehealth Access Act (H.R. 3875, S.2880) which would permanently allow all therapist services rendered via telehealth to be reimbursed by Medicare and give the HHS secretary authority to expand the list of telehealth providers.

- **Maintain Audio-only Coverage**
  Congress and the Centers for Medicare and Medicaid Services (CMS) have expanded access to care since the pandemic, specifically for those lacking broadband or elderly individuals, by temporarily covering for audio-only services. ATA Action is modality, service, and provider neutral, meaning we believe any licensed provider should have the option to utilize different technologies to deliver care services so long as it meets the standard of care and is clinically appropriate. For this reason, we encourage Congress to ensure audio-only coverage is maintained permanently.

- **Repeal the Telemental Health In-person Requirement**
  ATA Action applauds Congress for expanding access and allowing telemental health services to be a permanent part of the Medicare program through its passage of the Consolidated Appropriations Act, 2021, Pub.L. 116–260. However, also included was an unnecessary and unexpected guardrail, an in-person requirement. This provision, which would go into effect after 2024, requires providers to see their patients in person no more than six months prior to conducting a telemental health visit. ATA Action strongly opposes statutory in-person requirements, as they create arbitrary and clinically unsupported barriers to accessing affordable, quality health care. Requirements such as these could negatively impact those in underserved communities and populations who may not be able to have an in-person exam due to provider shortages, work, lack of childcare, and/or dearth of other resources.

  Over 160 million people in the US live in designated mental health professional shortage areas.[2] Many counties have no mental health professionals at all. We cannot ignore the importance of providing all Americans, regardless of whether they have seen a provider in person, with the opportunity to access life-saving health care. We strongly urge Congress to enact the Telemental Health Care Access Act (H.R. 3432), which would remove the statutory telemental health in-person requirement, allowing patients to receive care where and when they need it, especially when they are most vulnerable.

- **Preserve the Medicare Acute Hospital Care at Home Program (AHCaH)**
  As COVID-19 spread quickly, Congress and CMS needed to find ways to free up hospital beds and prevent mass spreading. As a result, the AHCaH program was created which essentially allows patients with acute diagnosis to be treated within their homes rather than at the hospital.

[2] Shortage Areas (hrsa.gov)

Since the implementation of this waiver, more than 300 hospitals across 129 health systems in 37 states are operating under the waiver—with no guarantee of payment permanence.[3] Clinical outcomes of the AHCaH program have been outstanding. Lower readmission rates, high patient satisfaction, and lower costs of care are some of the proven benefits of this program.[4] We applaud Congress for extending this program through CY2024 along with the other Medicare telehealth flexibilities but urge Congress to act permanently to ensure Medicare beneficiaries will not lose access to HaH programs that have demonstrated to provide excellent clinical outcomes and lower the costs of care.

- **Reinstate Virtual Cardiac Rehabilitation (CR)**
  We applaud Congress for recognizing the importance of telehealth and extending a majority of the flexibilities through the end of CY2024. Unfortunately, there was a critical telehealth flexibility omitted leaving a tremendous gap in care. This flexibility allowed patients to complete cardiac rehab programs from home rather than having to travel to a hospital, rehab center, or physician's office. This expired at the end of the PHE on May 11, 2023, which led many of these virtual CR programs to shut down. These virtual CR programs cannot be reopened unless Congress takes immediate action. Therefore, it is imperative that this issue is addressed as soon as possible by enacting the Sustainable Cardiopulmonary Rehabilitation Services in the Home Act (H.R. 1406, S.3021) which would permanently restore access to virtual cardiac rehabilitation for hundreds of thousands of Medicare beneficiaries.

Fortunately, Congress agrees with the principles (above) in a bipartisan, bicameral fashion and have introduced numerous important pieces of legislation to make various flexibilities permanent. Our top priorities, due to their comprehensive native and widespread support, are the CONNECT for Health Act (H.R. 4189, S. 2016) and the Telehealth Modernization Act (H.R. 7623, S.3967). Again, we urge Congress to come together to pass permanency legislation well before the end of 2024.

As Congress contemplates telehealth policy, we wanted to provide the Committee with key studies and research that dispel myths that telehealth leads to increased health care costs, overutilization, and is more suspectable to fraud, waste, and abuse than in-person care. For example:

- **Telehealth is Cost Effective:** Telehealth has been proven to reduce costs for hospitals and provider organizations, as well as for consumers. Several recent studies have shown that a telehealth consultation is as good as, and in some instances better than in-person care. Telehealth also enables consumers to receive care sooner, hence reducing disease progression and costs of care.[5,6,7]

- **Telehealth Does Not Lead to Overutilization:** Telehealth has proven to reach vulnerable and underserved patients that otherwise would never have received care in the first place due to limited transportation, childcare, time off of work, etc. Many studies have proven that utilization of telehealth has decreased and leveled off since the midst of the pandemic.[8]

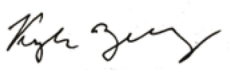
---

[3] "Approved Facilities/Systems for Acute Hospital Care at Home." CMS QualityNet. January 26, 2024. https://qualitynet.cms.gov/acute-hospital-care-at-home/resources.
[4] Acute-Hospital-At-Home-Background-10.22.pdf (americantelemed.org)
[5] Li, KY, Kim, PS, Thariath, J, Wong, ES, Barkham, J, & Kocher, KE. (2023). Standard nurse phone triage versus tele–emergency care pilot on Veteran use of in-person acute care: An instrumental variable analysis. *Acad Emerg Med.*;*30*: 310-320.
[6] Ascension. (n.d.). Task Force on Telehealth Policy. https://connectwithcare.org/wp-content/uploads/2020/08/Ascension-Telehealth-Data.pdf
[7] National Committee for Quality Assurance. (n.d.). Findings and Recommendations: Telehealth Effect on Total Cost of Care. https://www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/taskforce-on-telehealth-policy-findings-and-recommendations-telehealth-effect-on-total-cost-of-care/
[8] Patients-Providers-and-Plans-Increase-Utilization-of-Telehealth-Recent-Stats-2.18-2.pdf (americantelemed.org)

- **Telehealth is Not More Vulnerable to Fraud, Waste, and Abuse (FWA):** Telehealth is not more susceptible to FWA than in-person services. The Office of Inspector General (OIG) recently released a report that found Medicare telehealth did not increase fraud, waste, and abuse. Specifically, during the first nine months of the PHE -- March 2020 to November 2020 -- Medicare practitioners correctly billed for telehealth evaluation and management services in 95% of cases. There have been a few recent OIG and Department of Justice (DOJ) Medicare cases that have been mislabeled as "telefraud" when it is traditional telemarketing scams which have been around for decades. ATA Action does appreciate and understand this valid concern but there are current federal and state mechanisms and guardrails in place that are working to protect consumers and oversee providers.[9]

ATA Action is here as a resource and looks forward to continuing to work with the Committee to ensure that the appropriate telehealth policies are permanently implemented in a timely manner without arbitrary and unnecessary barriers to care such as in-person, brick and mortar, or geographic requirements. Thank you for all your historic and current work on telehealth. Please reach out to kzebley@ataaction.org if you have any questions.

Kind regards,



Kyle Zebley
Executive Director
ATA Action

[9] Telehealth-Integrity.pdf (americantelemed.org)

Coalition for Patient-Centered Care

April 1, 2024

Representative Jason Smith
Chairman
House Committee on Ways & Means
1011 Longworth House Office Building
Washington, DC 20515

Representative Richard Neal
Ranking Member
House Committee on Ways & Means
372 Cannon House Office Building
Washington, DC 20515

RE: "Access to Health Care in America: Ensuring Resilient Emergency Medical Care"

Dear Chairman Smith and Ranking Member Neal:

The Coalition for Patient-Centered Care (CPCC) appreciates the Committee holding this hearing on the important issue of ensuring access to healthcare in America, with a particular focus on access to emergency medical care. We believe that any discussion about the access to high value healthcare must include a recognition of the harmful effects of private equity firms' acquisitions of healthcare systems and physician groups.

The CPCC represents a diverse group of healthcare industry stakeholders who stand together in opposition to private equity's acquisition of independent physicians that can result in an emphasis on profits and revenue growth over patient interests.

The CPCC is comprised of over 5,000 physicians from across the country who are on the front lines of providing patient-centered care. Our membership has first-hand experience with the negative impact of these deals. Our members have observed that often after a private equity firm takes over an independent physician group, the quality of care for patients goes down, the cost of care to public and private payors goes up, and employee working conditions worsen. The bottom line is that private equity interferes with the social contract between a doctor and their patient and, consequently, with patients' access to high-quality and high-value care across medical specialties.

Impact of Private Equity Acquisitions of Independent Healthcare Providers

We believe that everyone benefits when physicians have the freedom to exercise their best judgment as to the delivery of care and can work directly with their patients to make medical decisions and deliver patient-centered care. Private equity firms do not share this ideal. They seem to be more concerned with maximizing investor profits than advocating for patients. Unfortunately, current U.S. tax law incentivizes private equity firms to acquire healthcare

providers and gives them an advantage over other would-be acquisition partners by providing the firms with substantial tax breaks.

Private equity firms have been particularly active in acquiring independent physician groups, including emergency medicine. More than half of all specialists in several U.S. markets are owned by private equity firms according to a recent study by the American Antitrust Institute, the Petris Center at the University of California, Berkeley, and the Washington Center for Equitable Growth.[1] As the *New York Times* summarized, the study found that "[i]n more than a quarter of local markets — in places like Tucson, Ariz.; Columbus, Ohio; and Providence, R.I. — a single private equity firm owned more than 30 percent of practices in a given specialty in 2021."[2] The article added, "[i]n 13 percent of the markets, the firms owned groups employing more than half the local specialists."[3]

The CPCC's experience—consistent with independent research, public reports, and even a recent investigation turned enforcement action by the Federal Trade Commission (FTC)[4]—is that, after a private equity firm takes over an independent physician group, there are generally adverse effects. These effects often include decreased quality of care for patients, increased cost of care for public and private payors, and deteriorating working conditions for employees.

Regarding higher costs, there is significant evidence that private equity acquisitions of healthcare providers result in higher prices without any evidence of an increase in quality or access to care. For example, a recent study concluded that, after hospital outpatient departments and ambulatory surgery centers contracted with a physician management company (PMC), prices paid to anesthesiologists increased, and were substantially higher if the PMC received private equity investment.[5] Consistent with the study's findings, the FTC recently brought a lawsuit against private equity firm Welsh Carson, highlighting the harmful price effects of private equity

---

[1] Richard M. Scheffler et al., Monetizing Medicine: Private Equity and Competition in Physician Practice Markets (July 10, 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

[2] Reed Abelson & Margot Sanger-Katz, *Who Employs Your Doctor? Increasingly, a Private Equity Firm.*, The New York Times (July 10, 2023), https://www.nytimes.com/2023/07/10/upshot/private-equity-doctors-offices.html?auth=login-google1tap.

[3] *Id.*

[4] Press Release, Federal Trade Commission, FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas (Sept. 21, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across.

[5] Ambar La Forgia et al., *Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners*, 182 JAMA Intern Med. 396 (2022), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2789280.

acquisitions of independent physician groups. According to FTC Chair Lina Khan, "private equity firm Welsh Carson spearheaded a roll-up strategy and created [U.S. Anesthesia Partners (USAP)] to buy out nearly every large anesthesiology practice in Texas. . . . [T]hese tactics enabled USAP and Welsh Carson to raise prices for anesthesia services—raking in tens of millions of extra dollars for these executives at the expense of Texas patients and businesses."[6]

Impact of Private Equity on Access to Emergency Medicine

Hospitals are a critical source of emergency care for patients, so, it is no surprise that hospital closures negatively impact access to emergency medical care. A 2022 Moody's Investors Service report found that almost 90% of financially stressed healthcare companies are owned by private equity.[7] A recent article titled, *When Private Equity Comes to Town, Hospitals Can See Cutbacks, Closures*, describes some of the negative effects of private equity on hospitals as follows:

> Prospect Medical Holdings, the for-profit hospital chain that owns Crozer-Chester hospital, was majority-owned by private equity firm Leonard Green & Partners from 2010 until 2021. Under Leonard Green's ownership, Prospect loaded its hospitals with massive debt and then used the proceeds to pay shareholders more than half a billion dollars in dividends, according to an investigation by the Rhode Island attorney general's office.
>
> Leonard Green & Partners sold its controlling interest in the chain in 2021. . . . Meanwhile, Prospect's hospitals — most of them serving economically vulnerable communities such as Upland — slashed services, laid off hundreds of workers and, in some cases, closed permanently.[8]

Where private equity was once viewed as a reliable last resort for troubled hospitals, that is no longer the case. Combined with increased scrutiny on private equity tactics, ailing hospitals

---

[6] Federal Trade Commission, *supra* note 4.

[7] Healthcare Stress Report, Moody's Investors Service, Healthcare – North America: Credit Stress is Rising, Setting the Stage for More Downgrades and Defaults (Dec. 12, 2022), https://www.documentcloud.org/documents/23452687-moodys-healthcare-stress-report?responsive=1&title=1.

[8] Anna Claire Vollers, *When Private Equity Comes to Town, Hospitals Can See Cutbacks, Closures*, New Jersey Monitor (Jan. 18, 2024), https://newjerseymonitor.com/2024/01/18/shell-game-when-private-equity-comes-to-town-hospitals-can-see-cutbacks-closures/.

are finding themselves left without access to buyers of last resort, which has threatened to leave low-income communities without critical care such as emergency rooms.[9]

Conclusion

This issue is particularly important and appropriate for the House Ways and Means Committee to consider, as lower quality of care and increased costs have a direct and significant negative impact on federal government spending and, in turn, all American taxpayers. In 2022, 18.7% of Americans were covered by Medicare.[10] When private equity-owned healthcare providers offer lower quality care for higher prices, this contributes to significant increases in the overall cost of care for Medicare patients, putting additional and unnecessary strain on the federal budget.

We commend the Committee for holding this important hearing and, moving forward, urge you to prioritize addressing the harmful impact that private equity has on access to care as a critical part of your work.

Sincerely,

The Coalition for Patient-Centered Care

---

[9] Lauren Coleman-Lochner & Steven Church, *Private Equity is No Longer a Reliable Last Resort for Troubled Hospitals,* Bloomberg (Sept. 12, 2023), https://www.bloomberg.com/news/articles/2023-09-12/troubled-pennsylvania-hospital-reveals-failure-of-private-equity-deals?embedded-checkout=true.

[10] Preeti Vankar, *Percentage of U.S. Americans Covered By Medicare 1920-2022*, Statista (Sept. 20, 2023), https://www.statista.com/statistics/200962/percentage-of-americans-covered-by-medicare/#:~:text=Medicare%20is%20an%20important%20public%20health%20insurance%20scheme.by%20Medicare%2C%20an%20increase%20from%20the%20previous%20year.

U.S. House Committee on Ways and Means Field Hearing:
"Access to Health Care in America: Ensuring Resilient Emergency Medical Care"
March 18, 2024

Statement for the Record by the Emergency Department Practice Management Association

The Emergency Department Practice Management Association (EDPMA) is the nation's only professional trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes, billing, coding, and other professional support organizations that assist healthcare clinicians in our nation's emergency departments. Together, EDPMA members see or support approximately 60% of all annual emergency department visits in the country.

EDPMA thanks the Committee for its interest in our country's emergency care safety net, including its ongoing focus on providing for the resources required to deliver and sustain 24/7 access to emergency care in every emergency department. In recent years, the resources available to deliver and sustain the emergency care system have been significantly eroded by implementation of the *No Surprises Act* (NSA). EDPMA strongly supports the patient protections provided by the NSA, but has been disappointed by implementation of key provisions affecting providers. **The implementing Departments recently proposed improvements to the independent dispute resolution (IDR) process that – if finalized and implemented correctly – will help address several pressing issues with IDR, but additional work is needed to improve the transparency and methodology of Qualifying Payment Amount calculations and to ensure insurer compliance with key statutory provisions.** Further detail is below.

Improvements to Independent Dispute Resolution

In November 2023, the Departments of Health and Human Services, Treasury, and Labor issued a proposed rule containing much-needed policies to improve the IDR process.[1] If finalized, these policies would encourage negotiations prior to IDR, better ensure that initiated disputes are in fact eligible for federal IDR, and accelerate payment determinations made via IDR. Although EDPMA, together with the American College of Emergency Physicians, suggested improvements to some of the proposed policies, the proposals were generally responsive to several of the main concerns expressed by the provider community in the last two years.[2] Additionally, if finalized, these policies could reduce the number of initiated IDR disputes, which will help alleviate the extensive backlog.

---

[1] Proposed Rule, "Federal Independent Dispute Resolution Process" (Nov. 3, 2023). Accessible: https://www.federalregister.gov/documents/2023/11/03/2023-23716/federal-independent-dispute-resolution-operations.

[2] EDPMA and ACEP's full comments are accessible here: https://www.acep.org/siteassets/new-pdfs/advocacy/12.21-acep-and-edpma-idr-operations-comments.pdf.

However, the Departments' proposed effective dates for certain improvements will leave providers subject to the existing flawed approach for an unnecessarily long duration. For example, if finalized and implemented effectively, the proposed rule will greatly improve the batching process and thus enable IDR entities to more efficiently resolve large numbers of similar disputes. However, the batching changes would only become effective for disputes with Open Negotiation periods starting on or after August 15, 2024 or ninety days after the final rule's effective date, whichever of the two dates is later. That is an unnecessarily long delay for process improvements that have the potential to dramatically improve the efficiency of the IDR process and seems unwarranted in light of the standard sixty-day implementation timeline for major regulations.

Problematic Implementation of the Qualifying Payment Amount Concept

The Qualifying Payment Amount (QPA) is defined in statute as the median of a health plan's contracted rates for a particular item or service by insurance market and in a particular geographic area. However, EDPMA members have found that the plans' QPA calculations in no way reflect market-based, contracted rates. Following a recent court ruling striking down portions of the Administration's QPA methodology, the Administration provided insurers with the discretion to calculate QPAs using their own "good faith" interpretation of the statute and remaining regulations. Furthermore, IDR entities were provided no instruction on how to reevaluate QPAs previously calculated based on the struck-down methodology. Finally, the Administration stated that it will provide only very limited enforcement for health plans on QPA calculation issues until May 1, 2024, at the earliest. Although the aforementioned proposed rule does require enhanced disclosure of QPAs – which EDPMA supports – that will not, in and of itself, address the substantive concerns with QPA calculations.

Lack of Enforcement for Insurer Noncompliance

Several of the law's key provisions are routinely ignored by health plans, with seemingly no consequences. One of the most egregious examples of noncompliance is nonpayment by the plans following a payment determination made via IDR. The statute requires the health plan to pay the clinician within thirty days following a payment determination, but data from EDPMA members shows that health plans frequently pay late, or never pay at all. It is difficult to believe that the NSA's authors carefully crafted a balanced IDR process only for health plans to ignore its outcome. However, there is no enforcement mechanism to ensure compliance with the payment deadline, which has emboldened plans to continue this behavior, creating significant cash flow challenges for medical practices.

****

We hope this outline of the most pressing NSA implementation challenges is helpful as you assess the strength of our nation's emergency network. Although implementation of a major new law is never without challenges, implementation of the NSA has been unusually chaotic, a situation that has benefited the plans but disrupted the financial stability of emergency clinicians. EDPMA thanks the Committee for its ongoing bipartisan NSA implementation oversight and looks forward to continuing our work with you on this topic.

Charles N. Kahn III
President and CEO

STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives
Committee on Ways and Means

Re: "Access to Health Care in America: Ensuring Resilient Emergency Medical Care"
March 18, 2024

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Committee on Ways and Means hearing entitled *Access to Health Care in America: Ensuring Resilient Emergency Medical Care*. We appreciate the Committee's leadership in examining the challenges and opportunities surrounding emergency care services and how to strengthen access to emergency care in America.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH strongly supports preserving access to emergency care for all individuals across the nation, especially in rural and underserved areas. In these regions, where health care resources may be scarce, emergency departments serve as critical lifelines. Emergency departments provide immediate medical attention to patients, regardless of their ability to pay or insurance status, and play a pivotal role in responding to unforeseen emergencies, natural disasters, and public health crises.

Protect Access to Rural Health Care

The FAH urges Congress to protect access to emergency care in rural areas, recognizing the unique challenges these regions face. Rural communities often contend with limited health care infrastructure and vast geographical distances, making timely access to emergency services a matter of life and death. Emergency departments serve as vital hubs for urgent medical care in these areas, offering critical interventions during medical emergencies, accidents, and natural disasters. Without accessible emergency care, residents in rural areas are left vulnerable, facing potentially devastating consequences due to delays in treatment.

A recent study found that more than 600 rural hospitals – nearly 30% of all rural hospitals in the country – are at risk of closing in the near future[1]. This risk of closure is exacerbated by many factors such as the recent UnitedHealth Group Change Healthcare cyberattack. This attack has resulted in massive payment gaps for providers nationwide, including rural providers, due to providers' inability to submit claims and receive payment causing an immediate need for relief. We urge Congress to adopt a rural health agenda that includes the following legislation:

- Enact the *Save Rural Hospitals Act* which would establish a non-budget neutral national minimum area wage index of 0.85, ensuring that rural hospitals receive fair payment for the care they provide and allow them to compete for and retain high-quality staff.,
- Make permanent the Medicare Dependent Hospital (MDH) and Low Volume Hospital (LVH) Adjustment Payment Programs to sustain access to hospital care for over 60 million Americans who live in rural communities.
- Eliminate the remainder of the scheduled Medicaid DSH cuts to ensure access to quality care for the most vulnerable patients and the essential hospitals that serve them.
- Oppose *the Patient Access to Higher Quality Health Care Act of 2023* as a solution to rural access and reject efforts to weaken the existing ban on self-referral to physician-owned hospitals (POHs). Not only are POHs mired in conflict of interest, but allowing POHs would result in over-utilization of Medicare services at significant cost to patients and the Medicare program and would weaken the delicate patient balance of existing rural hospitals.
- Reign in prior authorization abuses by Medicare Advantage plans that harm patients by eroding access to and affordability of medically necessary care and require rural hospitals to divert precious resources and time to respond to care denials and delay tactics
- Enact workforce programs like *The Conrad State 30 and Physician Access Reauthorization Act* and the *Healthcare Workforce Resilience Act* to encourage qualified doctors and nurses to practice in rural and underserved areas.

These policies would help rural hospitals adapt to the unique headwinds they face and allow them to continue to serve the millions of Americans who depend on them for health care.

Ensure Adequate Implementation of the No Surprises Act

The FAH urges Congress to ensure proper implementation of the *No Surprises Act* to mitigate managed care abuses that continue to jeopardize patient access to care. Effective implementation, particularly in addressing the impact of surprise billing on emergency care, is critical to mitigating the real-world consequences for patient care from the insurance industry misusing the law's independent dispute resolution (IDR) process. Successful implementation of the *No Surprises Act* will ensure insurance companies act in good faith during the IDR process and pay providers appropriately for emergency care and other critical services. Congress must prioritize and closely monitor the implementation of the *No Surprises Act* to uphold its promise of protecting access to patient care.

Reject Site-Neutral Cuts to Medicare

The FAH strongly opposes any policies that threaten access to health care, including so-called "site-neutral" payment policies that would decrease Medicare payments to hospitals. These payment cuts do not take into account the fact that hospitals are already only paid 80 cents on the dollar by Medicare and hospitals require more funding than other sites of care because they treat sicker, lower-income patients with more complex

[1] Center for Healthcare Quality & Payment Reform: https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.

and chronic conditions, provide 24/7 access to care in the community, and are held to a higher regulatory and safety standard. Additionally, these cuts disproportionately impact patients in rural and underserved communities where hospitals are already at risk of closing or reducing service lines such as emergency rooms and maternity care.

If site-neutral payment cuts were to be enacted, rural hospitals would particularly be impacted by the financial strain, forcing difficult decisions regarding the viability of operations in rural areas. Site -neutral reductions would put the entire health care infrastructure at risk and, therefore, would threaten patient access to emergency care.

We thank you for your focus on rural health and look forward to working with the Committee on these critical issues.

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

Written Comments before the Ways and Means Committee
Access to Health Care in America: Ensuring Resilient Emergency Medical Care
By Richard W. "Rick" Snyder, II, MD
President, Texas Medical Association
March 18, 2024

My name is Dr. Rick Snyder, and I am a cardiologist from Dallas and the president of the Texas Medical Association (TMA). On behalf of the TMA, we thank Chairman Smith, Ranking Member Neal and the Ways & Means Committee Members for the opportunity to provide written testimony in response to the field hearing on Access to Health Care in America: Ensuring Resilient Emergency Medical Care.

TMA is a private, voluntary non-profit association of more than 58,000 Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. TMA's members practice in all medical specialties. Today, its vision is "Improving the health of all Texans."

TMA greatly appreciates today's discussion as access to physician-led care is central to furthering TMA's vision. To that end, we regularly advocate for bills directed at improving access to physician - led care at the state level, such as bills related to: (1) Texas' physician student loan repayment program; (2) the interstate medical licensure compact; (3) telemedicine payment parity; (4) graduate medical education funding; and (5) tort reform. All of these measures directly affect patient access to physician-led care (both inside and outside emergency department or facilities) in our state.

At the federal level, TMA has also advocated for the removal of the ban on the creation and expansion of physician owned hospitals (POHs), which was enacted as Section 6001 of the Patient Protection and Affordable Care Act. We strongly contend that this provision inappropriately restricts patient access to care. It also limits job growth and competition. POHs exist in both rural and urban areas and include full-service general acute care and specialty hospitals. These entities can aid in boosting patient access to care and the quality of that care, as local physicians not only treat patients but also are heavily involved in making decisions about hospital operations, staff, equipment, training, and procedures that can best serve their patients and community. Thus, we urge the Committee to re-evaluate this arbitrary ban.

In terms of emergency care specifically, TMA has also been a proponent of strengthening the prudent layperson standard that protects patients when health insurers review claims for emergency services. Without this protection, patients would be deterred from seeking medically necessary care in the emergency department as health plans could later deny coverage based upon the patient's failure to appropriately self-diagnose a complex medical condition (e.g., when a patient mistakes heartburn for a heart attack).

TMA has also been very engaged in legislative and regulatory advocacy related to "surprise" medical billing and network adequacy at both the state and federal level, as these two issues greatly impact patient access to care and coverage of care. In 2019, TMA supported Texas' surprise billing legislation as passed (i.e., Senate Bill 1264, 86th Texas Legislature, Regular Session), demonstrating our commitment to: (1) protecting the patients from surprise medical bills and (2) taking the patient out of the middle of these surprise billing disputes.

Notably, TMA also supported the patient protection intent of the federal No Surprises Act (NSA) when it was signed into law in December 2020. However, the implementation of the Texas and federal surprise billing laws has been very different. While Texas' surprise billing legislation (which is a "specified state law" under the NSA) has generally been viewed to be working in practice, TMA (much like physicians in Texas and throughout the nation) has been very concerned with the flawed implementation of the NSA and its detrimental impact on both patients and physicians.

My comments today will largely focus on issues surrounding the implementation of the NSA, as TMA has taken a leadership role in seeking redress for concerns regarding the rules implementing the NSA. Before delving into that, however, I first want to express our great appreciation for this Committee's efforts to provide oversight over the flawed implementation of the NSA. It is critical that the Biden Administration implement the law as passed by Congress. We appreciate the Committee recognizing this need and shining light on the concerns expressed by patients and physicians regarding the NSA's flawed implementation.

As this Committee knows, the NSA was bipartisan legislation that was carefully negotiated to protect patients and to establish a fair independent dispute resolution (IDR) process (i.e., one not skewed towards either health insurers or physicians and health care providers).

Unfortunately, the clear intent of the NSA has not been appropriately reflected in its implementing rules. Federal agencies have repeatedly adopted rules that flouted the plain language of the NSA and the Administrative Procedures Act (APA) and placed a thumb on the scale during IDR in favor of health insurers.

As a result, TMA has filed four lawsuits against these federal agencies, challenging various aspects of the NSA rules and/or guidance that: (1) conflicted with the law; (2) tilted scales in favor of insurers in the federal IDR process and (3) made IDR cost prohibitive for many physicians. TMA was successful in all four challenges at the district court level, obtaining orders that voided the unlawful rule provisions and/or guidance with nationwide effect. It is important to note that this series of lawsuits would have been unnecessary if the agencies had adopted rules that were consistent with both the letter and intent of the law.

To aid in understanding TMA's litigation related to NSA rulemaking, I offer a brief summary of our lawsuits below.

- TMA I and TMA II challenged agency rules regarding the weighting of the "qualifying payment amount" or "QPA" in the federal IDR process. Under the NSA, the QPA is supposed to be the median of the payor's contracted rates for the same or similar service furnished by a physician in the same or similar specialty and in the same geographic region, as calculated by the payor. Congress never intended to give the QPA privileged status in IDR determinations, as reflected in both the plain language of the law and the legislative history (wherein it was one of several

factors to be considered in federal IDRs). Yet, in interim final rules challenged in TMA I, the federal agencies essentially rewrote the law by creating out of whole cloth a rebuttable presumption in favor of the QPA (thereby tilting IDR determinations in favor of health insurers). Notably, this language appeared nowhere in the NSA itself. When that rule language was struck down by the federal district court for the Eastern District of Texas, the agencies doubled down on this approach by adopting final rules that used different language but similarly privileged the QPA in IDR determinations. This prompted TMA's filing of its second lawsuit (i.e., TMA II).

- TMA III challenged four components of the QPA methodology under the federal agencies' rulemaking that conflicted with the law. More specifically, we successfully argued the federal rules permitted insurers to unlawfully deflate QPAs because they:
  - include "ghost rates" in their QPA calculations – i.e., contract rates with physicians and others who don't actually provide the particular health service;
  - allow insurers to include rates of physicians who are not in the same or similar specialty as the physicians in the payment dispute;
  - require insurers to use an amount other than the total payment in calculating a QPA when a contracted rate includes contingent payments such as risk sharing or incentive-based bonuses; and
  - permit self-insured plans to essentially opt in to a lower QPA for payment disputes with physicians by using the rates of other self-insured plans.

  TMA also challenged the lack of transparency surrounding the calculation of the QPA.

- In TMA IV we successfully challenged: (1) a 350% fee hike on the administrative fee for federal IDR and (2) batching rules that restricted IDR batching to the same service code (a limitation not imposed by the law), which creates a tremendous barrier to accessing the federal IDR process for medical specialties that have low dollar claims.

As of the date of these comments, TMA I is no longer an active case. The federal agencies did not move forward with their appeal of TMA's favorable district court decision in TMA I, as they instead adopted final rules that became the focal point of TMA's second lawsuit (i.e., TMA II). After TMA successfully challenged components of the final rules in TMA II at the district court level, the federal agencies appealed that decision to the U.S. Court of Appeals for the Fifth Circuit. Oral arguments have been held in TMA II and a decision is pending.

TMA III is also on appeal at the U.S. Court of Appeals for the 5th Circuit. But it is important to note that the federal agencies have already abandoned their appeal of two of the four QPA methodology challenges, i.e., the same or similar specialty and self-insured plan rule. Thus, the agencies are only appealing the inclusion of ghost rates and the exclusion of bonus and incentive payments in the calculation of the QPA. Oral arguments have not yet been scheduled in TMA III.

Finaly, in response to the favorable district court decision that TMA received in TMA IV, the federal agencies have issued new proposed rules related to administrative fees and batching. TMA submitted extensive comments in response to that rule proposal in January. While there were some improvements in the proposal, we continue to have concerns that the proposal did not go far enough to make the IDR process fair and accessible for physicians. We await the federal agencies' adoption of rules before assessing next steps.

TMA remains vigilant in monitoring the NSA rulemaking implementation, because each of the aforementioned rules dramatically impacts patients and physicians. TMA has stated repeatedly that unlawfully deflating the QPA and misrepresenting the QPA as reflecting the market in the IDR process would likely have a very detrimental impact on patient access to care and physician practice viability.

More specifically, outsized IDR consideration of a skewed QPA is likely to result in health plans exerting more pressure to lower in-network rates (effectively creating a race to the bottom) and health plan termination of long-standing physician contracts. This will compromise patient access to ***in-network*** care and is likely to lead to forced consolidation of physician practices to survive the payment cuts.

Physician practices in Texas and throughout the nation are already facing practice viability challenges in the aftermath of the COVID-19 pandemic. According to TMA's COVID-19 Practice Viability Survey of Texas Physicians, 63% of physician respondents reported their revenue had decreased 51% to 100% during the pandemic. Thus, before the adoption of some of the challenged rules, TMA raised patient access-to-care concerns, noting that that many small practices may simply be unable to keep their doors open under the added strain of unlawful rules that tilt the scales in favor of insurers. Nonetheless, the agencies moved forward with those rules, necessitating TMA's filing of litigation to address the agencies' overreach.

Furthermore, unlawful rules that make the IDR process cost-prohibitive threaten physician practice viability and therefore patient access to care, which is clearly counter to Congress' goal in passing the NSA.

TMA continues to hear concerns about other aspects of the NSA's implementation, including: (1) the challenges physicians are facing in terms of getting paid after a successful IDR decision; (2) concerns regarding a lack of transparency surrounding the QPA calculation; and (3) the need for QPA auditing. It is, therefore, critical that Congress continue to monitor the NSA's implementation in order to ensure that that the rules are promulgated consistent with the law and that these concerns are appropriately addressed. We very much appreciate the oversight work of the Ways & Means Committee. Once again, TMA thanks you for the opportunity to provide these comments.

Comments for the Record for the
U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Tax
OECD Pillar 1: Ensuring the Biden Administration
Puts Americans First
Thursday, March 7, 2024 at 2:00 PM

Michael Bindner
Center for Fiscal Equity

Chairman Kelly and Ranking Member Thompson, thank you for the opportunity to address this issue. These comments reflect those I provided to the Subcommittee in July 2023 on the Global Tax Surrender. I renew my offer to explain these principles further, as they would essentially fix global taxation - although you might consider this another form of surrender.

Pillar 1 interferes with how firms do business by taxing profits from one asset differently than it taxes others. I call foul. Most nations in the OECD, by most, I mean all but the United States, have value added taxes. Such taxes favor domestic workers, but are agnostic on how capital is employed to produce profit. Were it not for inertia, this regime should end the practice of corporate profit taxation entirely - although a separate employer-paid VAT to provide a platform to channel child and health benefits to employees through the employer (rather than the government) serves the same purpose.

Where international agreement is essential is in the replacement of capital gains taxation with an asset value added tax. An asset VAT moves taxation to transactions rather than portfolios. The SEC would collect the tax, not the IRS. This reform is the key to tax simplification. Agreement is necessary to prevent the gaming of rates to reward brokers in one country to attract traders from Wall Street. Wall Street will surely agree and put their PAC money to use in convincing members.

With capital gains taxes handled, the taxation of salaries, interest and dividends could be accomplished without personal income tax filing for most families, outside of business owners and the prepayment of income tax obligations to the Bureau of the Public Debt as an expiring investment (and at a discount). Tax benefits to families for child care, health care and the child tax credit could be distributed through employers. Business taxation would take only one form, regardless of ownership type, with most businesses filing returns to the states where their workers reside - which is how they remit income taxes they collect on the employees' behalf today.

Our OECD trading partners provide more generous subsidies to their workers, funded in part from their corporate and value added taxes. We propose channeling a Fair Tax style subsidy through two taxes, a (credit) invoice value added tax (turning the deduction for sales taxes paid into a full credit - which is essential the difference between a VAT and income tax based collections) and a subtraction value added tax to channel subsidies for health care and the child tax credit through employers rather than the Social Security Administration (as proposed for the Fair Tax).

Our second attachment, concerning trade, specifies that invoice VAT payments be zero rated at the border (and fully burdened at import), while subtraction VAT payments not be - because these payments benefit families, and therefore final consumers. To make these employer provided subsidies zero rated discourages their use by firms with high exports.

Such a rule should be universal so that U.S. workers are not put at a disadvantage - both due to inadequate pay and unfair price competition. Such unfair competition occurs whenever an OECD nation funds its family and health care subsidies using VAT collections. Standardization does not diminish sovereignty - it simply regularizes trade and does not dictate rates.

Our proposal for an **Asset Value Added Tax** will require international cooperation, however. Please see the third attachment. Part of trade is moving money around - including financial assets. An asset VAT as a replacement for capital gains and inheritance taxes must go farther than the border. It is too easy to shift to offshore stock exchanges where such taxes do not exist. International agreements on rates and enforcement structures are vital for such a tax to work.

The model for negotiating the CMT on a multi-national basis can be used for this effort, however it should be by treaty, not agreement, and the rate structure needs to be tighter. Again, please see the second attachment, which has been recently updated.

Taxation of dividends will be included in surtaxes to the Subtraction VAT for payments over $85,000 in taxes plus dividends in a given year, however individual filing for wage. dividend and interest income under $425,000 will not be required. Again, the capital gains tax will be abolished.

Small dollar dividend payments will not be taxed, although they will be reported so that the very wealthy do not use diversification for tax avoidance. Low dollar dividends are already taxed through the subtraction VAT base rate (which is mostly returned to employees). Having a great many diversified investments in order to avoid what would be a small tax on dividends received would cost more in brokerage fees than the taxes being avoided.

Dividend payments to employee retirement accounts would be taxed as higher incomes, but there would be no taxation of such accounts on the other end, just as Roth IRAs are not taxed.

Thank you, again, for the opportunity to add our comments to the debate. Please contact us if we can be of any assistance or contribute direct testimony.

Consumption Taxes

Subtraction Value-Added Tax (S-VAT). Corporate income taxes and collection of business and farm income taxes will be replaced by this tax, which is an employer paid Net Business Receipts Tax. S-VAT is a vehicle for tax benefits, including

- Health insurance or direct care, including veterans' health care for non-battlefield injuries and long term care.
-
- Employer paid educational costs in lieu of taxes are provided as either employee-directed contributions to the public or private unionized school of their choice or direct tuition payments for employee children or for workers (including ESL and remedial skills). Wages will be paid to students to meet opportunity costs.
-
- Most importantly, a refundable child tax credit at median income levels (with inflation adjustments) distributed with pay.

Subsistence level benefits force the poor into servile labor. Wages and benefits must be high enough to provide justice and human dignity. This allows the ending of state administered subsidy programs and discourages abortions, and as such enactment must be scored as a must pass in voting rankings by pro-life organizations (and feminist organizations as well). To assure child subsidies are distributed, S-VAT will not be border adjustable.

Invoice Value-Added Tax (I-VAT). Border adjustable taxes will appear on purchase invoices. The rate varies according to what is being financed. If Medicare for All does not contain offsets for employers who fund their own medical personnel or for personal retirement accounts, both of which would otherwise be funded by an S-VAT, then they would be funded by the I-VAT to take advantage of border adjustability.

I-VAT forces everyone, from the working poor to the beneficiaries of inherited wealth, to pay taxes and share in the cost of government. As part of enactment, gross wages will be reduced to take into account the shift to S-VAT and I-VAT, however net income will be increased by the same percentage as the I-VAT. Inherited assets will be taxed under A-VAT when sold. Any inherited cash, or funds borrowed against the value of shares, will face the I-VAT when sold or the A-VAT if invested.

I-VAT will fund domestic discretionary spending, equal dollar employer OASI contributions, and non-nuclear, non-deployed military spending, possibly on a regional basis. Regional I-VAT would both require a constitutional amendment to change the requirement that all excises be national and to discourage unnecessary spending, especially when allocated for electoral reasons rather than program needs. The latter could also be funded by the asset VAT (decreasing the rate by from 19.25% to 13%).

Attachment – Trade Policy

Consumption taxes could have a big impact on workers, industry and consumers. Enacting an I-VAT is far superior to a tariff. The more government costs are loaded onto an I-VAT the better.

If the employer portion of Old Age and Survivors Insurance, as well as all of disability and hospital insurance are decoupled from income and credited equally and personal retirement accounts are not used, there is no reason not to load them onto an I-VAT. This tax is zero rated at export and fully burdens imports.

Seen another way, to not put as much taxation into VAT as possible is to enact an unconstitutional export tax. Adopting an I-VAT is superior to it's weak sister, the Destination Based Cash Flow Tax that was contemplated for inclusion in the TCJA. It would have run afoul of WTO rules on taxing corporate income. I-VAT, which taxes both labor and profit, does not.

The second tax applicable to trade is a Subtraction VAT or S-VAT. This tax is designed to benefit the families of workers through direct subsidies, such as an enlarged child tax credit, or indirect subsidies used by employers to provide health insurance or tuition reimbursement, even including direct medical care and elementary school tuition. As such, S-VAT cannot be border adjustable. Doing so would take away needed family benefits. As such, it is really part of compensation. While we could run all compensation through the public sector.

The S-VAT could have a huge impact on long term trade policy, probably much more than trade treaties, if one of the deductions from the tax is purchase of employer voting stock (in equal dollar amounts for each worker). Over a fairly short period of time, much of American industry, if not employee-owned outright (and there are other policies to accelerate this, like ESOP conversion) will give workers enough of a share to greatly impact wages, management hiring and compensation and dealing with overseas subsidiaries and the supply chain – as well as impacting certain legal provisions that limit the fiduciary impact of management decision to improving short-term profitability (at least that is the excuse managers give for not privileging job retention).

Employee-owners will find it in their own interest to give their overseas subsidiaries and their supply chain's employees the same deal that they get as far as employee-ownership plus an equivalent standard of living. The same pay is not necessary, currency markets will adjust once worker standards of living rise. Attachment Three further discusses employee ownership.

Over time, ownership will change the economies of the nations we trade with, as working in employee-owned companies will become the market preference and force other firms to adopt similar policies (in much the same way that, even without a tax benefit for purchasing stock, employee-owned companies that become more democratic or even more socialistic, will force all other employers to adopt similar measures to compete for the best workers and professionals).

In the long run, trade will no longer be an issue. Internal company dynamics will replace the need for trade agreements as capitalists lose the ability to pit the interest of one nation's workers against the others. This approach is also the most effective way to deal with the advance of robotics. If the workers own the robots, wages are swapped for profits with the profits going where they will enhance consumption without such devices as a guaranteed income.

Asset VAT - The President's Fiscal Year 2023 Budget, June 7, 2022

There are two debates in tax policy: how we tax salaries and how we tax assets (returns, gains and inheritances). Shoving too much into the Personal Income Tax mainly benefits the wealthy because it subsidizes losses by allowing investors to not pay tax on higher salaries with malice aforethought.

Asset Value-Added Tax (A-VAT) is a replacement for capital gains taxes and the estate tax. It will apply to asset sales, exercised options, inherited and gifted assets and the profits from short sales. Tax payments for option exercises, IPOs, inherited, gifted and donated assets will be marked to market, with prior tax payments for that asset eliminated so that the seller gets no benefit from them. In this perspective, it is the owner's increase in value that is taxed.

As with any sale of liquid or real assets, sales to a qualified broad-based Employee Stock Ownership Plan will be tax free. This change would be counted as a tax cut, giving investors in public stock who make such sales the same tax benefit as those who sell private stock.

The repeal of capital gains taxes in the United States will lead to their repeal worldwide. If Asset Value Added Taxes are adopted, the rate should be negotiated so that investors who are able do not market shop for the lowest rate. The recent OECD compact on minimum rates is an example of how tax cooperation on capital can work for other types of asset taxation.

This tax will end Tax Gap issues owed by high income individuals. The base 20% capital gains tax has been in place for decades. The current 23.8% rate includes the ACA-SM surtax), while the Biden proposal accepted by Senator Sinema is 28.8%. Our proposed Subtraction VAT would eliminate the 3.8% surtax. This would leave a 25% rate in place.

Settling on a bipartisan 22.5% rate (give or take 0.5%) should be bipartisan and carried over from the capital gains tax to the asset VAT.A single rate also stops gaming forms of ownership. Lower rates are not as regressive as they seem. Only the wealthy have capital gains in any significant amount. The de facto rate for everyone else is zero.

With tax subsidies for families shifted to an employer-based subtraction VAT, and creation of an asset VAT, taxes on salaries could be filed by employers without most employees having to file an individual return. It is time to TAX TRANSACTIONS, NOT PEOPLE!

The tax rate on capital gains is seen as unfair because it is lower than the rate for labor. This is technically true, however it is only the richest taxpayers who face a marginal rate problem. For most households, the marginal rate for wages is less than that for capital gains. Higher income workers are, as the saying goes, crying all the way to the bank.

In late 2017, tax rates for corporations and pass-through income were reduced, generally, to capital gains and capital income levels. This is only fair and may or may not be just. The field of battle has narrowed between the parties. The current marginal and capital rates are seeking a center point. It is almost as if the recent tax law was based on negotiations, even as arguments flared publicly. Of course, that would never happen in Washington. Never, ever.

Compromise on rates makes compromise on form possible. If the Affordable Care Act non-wage tax provisions are repealed, a rate of 26% is a good stopping point for pass-through, corporate, capital gains and capital income.

A single rate also makes conversion from self-reporting to automatic collection through an asset value added tax levied at point of sale or distribution possible. This would be both just and fair, although absolute fairness is absolute unfairness to tax lawyers because there would be little room to argue about what is due and when.

Ending the machinery of self-reporting also puts an end to the Quixotic campaign to enact a wealth tax. To replace revenue loss due to the ending of the personal income tax (for all but the wealthiest workers and celebrities), enact a Goods and Services Tax. A GST is inescapable. Those escapees who are of most concern are not waiters or those who receive refundable tax subsidies. It is those who use tax loopholes and borrowing against their paper wealth to avoid paying taxes.

For example, if an unnamed billionaire or billionaires borrow against their wealth to go into space, creating such assets would be taxable under a GST or an asset VAT. When the Masters of the Universe on Wall Street borrow against their assets to avoid taxation, having to pay a consumption tax on their spending ends the tax advantage of gaming the system.

This also applies to inheritors. No "Death Tax" is necessary beyond marking the sale of inherited assets to market value (with sales to qualified ESOPs tax free). Those who inherit large cash fortunes will pay the GST when they spend the money or Asset VAT when they invest it. No special estate tax is required and no life insurance policy or retirement account inheritance rules will be of any use in tax avoidance.

Tax avoidance is a myth sold by insurance and investment brokers. In reality, explicit and implicit value added taxes are already in force. Individuals and firms that collect retail sales taxes receive a rebate for taxes paid in their federal income taxes. This is an intergovernmental VAT. Tax withheld by employers for the income and payroll taxes of their labor force is an implicit VAT. A goods and services tax simply makes these taxes visible.

Should the tax reform proposed here pass, there is no need for an IRS to exist, save to do data matching integrity. States and the Customs Service would collect credit invoice taxes, states would collect subtraction VAT, the SEC would collect the asset VAT and the Bureau of the Public Debt would collect income taxes or sell tax-prepayment bonds.

Contact Sheet

Michael Bindner
Center for Fiscal Equity
14448 Parkvale Road, Suite 6
Rockville, MD 20853
240-810-9268
fiscalequitycenter@yahoo.com

Subcommittee on Tax
OECD Pillar 1: Ensuring the Biden Administration Puts Americans First
Thursday, March 7, 2024 at 2:00 PM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

national partnership for women & families

Written Comment of the National Partnership for Women & Families

U.S. House of Representatives
Committee on Ways and Means
Field Hearing on Access to Health Care in America:
Ensuring Resilient Emergency Medical Care

March 22, 2024

Introduction

We are grateful that the House Committee on Ways and Means has created this opportunity to discuss the landscape of access to emergency medical care. At this critical moment in time, nearly two years after the Supreme Court overturned *Roe v. Wade*, that discussion must include the role of abortion care in treating emergency medical conditions.

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy organization based in Washington, D.C. Over the last five decades, we have worked to promote fairness in the workplace; reproductive health and rights; access to quality, affordable health care; and policies that help all people meet the dual demands of work and family. We aim to advance health and economic justice, especially for those individuals and communities that face structural oppression and barriers to opportunity and equity. We believe it is essential to prioritize equity in health care systems, in our economy, and in our workplaces to create environments fully capable of responding to the diverse needs of patients, workers, and all people, regardless of their background or resources. We are committed to supporting efforts to address health disparities and ensure that everyone gets access to quality medical care when they need it.

Access to emergency services, including abortion care, has an existential impact on patient outcomes. Health care providers must be permitted to provide timely, evidence-based care, which can include abortion, to protect a pregnant patient's health and life when they present with an emergency medical condition.[1] No matter where they live and despite any state abortion ban in place, pregnant people have the right to emergency care under federal law. Pregnant people experiencing emergency medical conditions who need abortion care as stabilizing

[1] Brief of Am. Coll. Of Obstetricians & Gynecologists, et al. as Amici Curiae in Support of Plaintiffs-Appellees, *State of Texas et al. v. Amanda Zurawski et al.*, (Tex. Nov. 21, 2023) (No. 23-0629); https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/amicus-briefs/2023/11-21-2023-state-of-texas-v-amanda-zurawski.pdf.

treatment must have access. Abortion is essential health care, and in many situations, the only treatment that can stabilize a patient experiencing an emergency.[2]

EMTALA Protects Abortion Access in Emergencies

Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986, which requires U.S. hospitals that receive Medicare funding to give necessary stabilizing treatment to people in emergencies, regardless of their ability to pay or whether or not they have insurance.[3] For nearly forty years, EMTALA has held health care systems across the country responsible for providing appropriate evidence-based medical care—including medically necessary, lifesaving medical intervention, such as abortion care. EMTALA explicitly states that a pregnant woman who is experiencing an emergency medical condition has a right to stabilizing treatment. While the statute does not list specific stabilizing treatments given the vast range of possible emergency scenarios, the determination of an emergency medical condition and the course of treatment necessary to stabilize such emergency conditions is the responsibility of the examining physician or other qualified medical personnel.[4]

Pregnant people can experience various medical complications for which abortion might be the necessary stabilizing treatment, including preterm premature rupture of membranes, severe preeclampsia, and ectopic pregnancies.[5] Denying pregnant patients the appropriate medical treatment places them at heightened risk for medical complications and severe adverse health outcomes. After the Supreme Court overturned the federal constitutional right to abortion in *Dobbs v. Jackson Women's Health Organization,* the Biden administration issued a memorandum further clarifying that EMTALA applies in cases where abortion is necessary to stabilize a patient, despite any state law prohibiting abortion.[6] Twenty-one states have implemented abortion bans or restrictions since *Dobbs,*[7] many of which can come into conflict with federal protections for emergency abortion care under EMTALA.

Obstacles to Access to Emergency Reproductive Care

When a state law prohibits abortion and does not include an exception for the health and life of the pregnant person—or draws the exception more narrowly than EMTALA's emergency

---

[2] Brief of Am. Coll. Of Obstetricians & Gynecologists, et al. as Amici Curiae in Support of Plaintiff, *U.S. v. State of Idaho*, (D. Idaho Aug. 15, 2022) (No. 1:22-cv-329); https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/amicus-briefs/2022/20220815-us-v-idaho.pdf.
[3] Emergency Medical Treatment & Labor Act (EMTALA), Centers for Medicare & Medicaid Services, accessed Mar. 20, 2024, https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act.
[4] 42 U.S.C. § 1395dd.
[5] Brief of Am. Coll. Of Obstetricians & Gynecologists, *Texas v. Zurawski*.
[6] "Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss," Centers for Medicare and Medicaid Services, July 11, 2022, https://www.cms.gov/files/document/qso-22-22-hospitals.pdf.
[7] "Tracking Abortion Bans Across the Country," *New York Times*, last modified Jan. 8, 2024, https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html.

medical condition definition—the Supremacy Clause of the U.S. Constitution makes clear that state law is preempted. However, even with administrative guidance and enforcement actions from the Department of Health and Human Services (HHS), providers and health care systems struggle to implement the requirements of EMTALA against the backdrop of abortion bans. Emergency physicians, in particular, experience significant confusion regarding their duty to patients under EMTALA in the face of laws criminalizing the provision of abortion care. In many cases, they are forced to weigh their obligation to provide ethical, high-quality medical care against the threat of legal and professional penalties.[8] Legislative interference into the provision of evidence-based care prevents physicians from being able to provide essential treatment to those in need and threatens the health, future fertility, and life of the pregnant person experiencing an emergency.

Since *Dobbs,* anti-abortion political actors have ramped up legislative and legal efforts to undermine abortion access in emergencies and exclude pregnant people from EMTALA's longstanding protections. The Supreme Court is currently considering a consolidated case—*Idaho v. United States* and *Moyle v. United States*—that will determine whether state abortion bans supersede EMTALA's emergency care requirements and if states can force doctors to turn away pregnant patients experiencing a medical emergency that requires abortion care.

In August 2022, the Department of Justice (DOJ) filed a lawsuit challenging the Idaho abortion ban on the grounds that it violated EMTALA because it did not include a health endangerment exception for the pregnant person.[9] A federal district judge blocked the state's ban, but the Ninth Circuit Court of Appeals reinstated it in September 2023. Immediately thereafter, another panel of the appeals court temporarily blocked the law pending further litigation. In response, the Alliance Defending Freedom—an extreme anti-abortion, anti-LGBTQ organization—filed an emergency application with the Supreme Court on behalf of the Idaho Attorney General to reinstate the abortion ban. The Court decided to allow Idaho to enforce its abortion ban while the case continues and to consider Idaho's stay request as a petition to review the case on the merits.[10] The Supreme Court will hear oral arguments in the case on April 24, 2024.

In a related case, Texas partnered with anti-abortion extremist organizations—American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) and Christian Medical and Dental Association (CMDA)—to sue HHS in July 2022 on the grounds that the EMTALA

---

[8] Daniel Grossman, et al. "Care Post-Roe: Documenting cases of poor-quality care since the Dobbs decision," ANSIRH, May 2023, https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf; Physicians for Human Rights, et al. "No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post-Roe Oklahoma," Apr. 2023, https://reproductiverights.org/wp-content/uploads/2023/04/OklahomaAbortionBanReport_Full_SinglePages.pdf.

[9] "Justice Department Sues Idaho to Protect Reproductive Rights," Aug. 2, 2022, https://www.justice.gov/opa/pr/justice-department-sues-idaho-protect-reproductive-rights.

[10] Docket for No. 23A470, accessed Mar. 20, 2024, https://www.supremecourt.gov/docket/docketfiles/html/public/23a470.html; Docket for No. 23A469, accessed Mar. 20, 2024, https://www.supremecourt.gov/docket/docketfiles/html/public/23a469.html.

guidance would force hospitals to provide abortions in violation of state laws banning such care.[11] The federal district court ruled for Texas, allowing Texas to prohibit abortion care in emergency situations. The Biden administration appealed, and the U.S. Court of Appeals for the Fifth Circuit upheld the district court ruling, preventing the enforcement of EMTALA in Texas, even when doctors determine that an abortion is necessary stabilizing care.[12] These cases have nationwide implications for access to emergency abortion care, and advance the anti-abortion movement's broader strategy to ban abortion altogether. Blocking physicians from being able to provide medically indicated, lifesaving treatment to pregnant people in need will cost lives.

Harms of Restricted Emergency Abortion Care

State laws restricting abortion care, especially in emergency situations, disproportionately harm those with the fewest resources who already experience barriers to accessing basic health care and economic security, including people of color, those with disabilities, transgender and nonbinary people, young people, people with low incomes, people living in rural areas, and those living at the intersection of these identities.[13] These patients are more likely to experience denials of care in violation of EMTALA and face significant barriers to traveling out of state to obtain abortion care for emergency medical conditions. Notably, Black, Indigenous, and other people of color (BIPOC), in particular, have historically experienced challenges accessing abortion care in a society where systemic racism and sexism, inequitable health care structures, and economic inequality are pervasive.

The economic hurdles associated with interstate travel for emergency abortion care can be impossible for pregnant people to overcome. Pregnant people are forced to travel long distances, often hundreds of miles, to obtain abortion care, meaning they have to pay for transportation, lodging, and childcare. These expenses can be in the thousands of dollars, depending on travel distances. On top of these high costs, many people seeking abortion face the prospect of losing wages or even their jobs when they need to take time away from work for abortion care and travel because the U.S. has no national policies guaranteeing paid sick days or paid family and medical leave.[14] Nearly three out of four workers do not have paid family leave at their jobs, about six in ten have no paid medical leave through an employer's short-term disability program, and almost one in four in the private sector do not have a single paid sick

---

[11] *State of Texas, et al. v. Becerra et al.* (5th Cir. May 1, 2023) (No. 23-10246); https://www.justice.gov/d9/2023-05/Texas%20v.%20Becerra%2C%20No.%2023-10246%20%28CA5%29%20-%20Record%20Excerpts%20-%20FINAL%20AS%20FILED.pdf.

[12] Brendan Pierson, "Texas, Biden Administration Square Off in Court Over Emergency Abortions," *Reuters,* Nov. 7, 2023, https://www.reuters.com/legal/government/texas-biden-administration-square-off-court-over-emergency-abortions-2023-11-07/.

[13] Elizabeth Nash, "State Policy Trends 2021: The Worst Year for Abortion Rights in Almost Half a Century," last modified Jan. 5, 2022, https://www.guttmacher.org/article/2021/12/state-policy-trends-2021-worst-year-abortion-rights-almost-half-century.

[14] J. Mason and P. Molina Acosta, "Paid Sick Days Enhance Women's Abortion Access and Economic Security," National Partnership for Women & Families, accessed Mar. 20, 2022, https://www.nationalpartnership.org/our-work/health/repro/reports/paid-sick-days-enhance-womens-abortion-access-and-economic-security.html.

day,[15] with Black, Latinx and Native workers and those in low-paid jobs the least likely to have access to paid leave.[16] Largely due to the bans and restrictions that took effect in the wake of *Dobbs*, patients have increasingly been forced to confront these financial barriers in order to access abortion. Nearly one in five abortion patients traveled out of state to obtain care in the first six months of 2023, compared with one in 10 abortion patients during a similar period in 2020.[17]

Furthermore, the health risks of traveling out of state to receive abortion care, especially in emergency situations when stabilizing care is needed immediately, can be prohibitive for patients. Many pregnant patients experiencing an emergency medical condition cannot travel long distances because of the risk of their health further deteriorating, because of the need to be close to a medical facility, or because the stabilizing treatment they need is time-sensitive and there is not enough time to travel hundreds of miles to receive treatment in an alternative health care setting.[18] The consequences of delay in care can negatively impact patient health and future fertility, subjecting them to greater risk of infection, complication, suffering, or death. The district court decision and amicus briefs from medical professionals and emergency care physicians in *Idaho v. United States* enumerate possible adverse health outcomes, which include severe sepsis requiring limb amputation, uncontrollable uterine hemorrhage requiring hysterectomy, kidney failure requiring lifelong dialysis, hypoxic brain injury, permanent fertility issues, and death.[19]

Conclusion

Attacks on emergency abortion care cause serious harm to the health, economic security, and well-being of individuals and families, especially for people of color and others who are marginalized. Every pregnancy is different, and it is critical that we allow health care professionals to use their best medical judgment, consistent with accepted clinical practices, to provide care that protects patient health throughout pregnancy. Pregnant patients are suffering from anti-abortion politicians' interference into the provision of essential medical care. These extremists manufactured a public health crisis as part of a concerted strategy to control

---

[15] National Partnership analysis of Bureau of Labor Statistics, *Employee Benefits in the United States Summary*, accessed Mar. 20, 2024, https://www.bls.gov/news.release/ebs2.nr0.htm.
[16] J. Mason and P. Molina Acosta, "Called to Care: A Racially Just Recovery Demands Paid Family and Medical Leave," National Partnership for Women & Families, accessed March 20, 2024, https://nationalpartnership.org/report/called-to-care-a-racially-just-demands-paid-family-and-medical-leave/; P. Gupta et al., "Paid Family and Medical Leave is Critical for Low-Wage Workers and Their Families," Center for Law and Social Policy, accessed Mar. 20, 2024 https://www.clasp.org/publications/fact-sheet/paid-family-and-medical-leave-critical-low-wage-workers-and-their-families/.
[17] K. Forouzan, A. Friedrich-Karnik, and I. Maddow-Zimet, "The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care," Guttmacher Institute, Dec. 7, 2023, https://www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care.
[18] Daniel Grossman, et al., "Care Post-Roe."
[19] *U.S. v. State of Idaho*, (No. 1:22-cv-00329-BLW) (D. Idaho, Aug. 24, 2022); https://casetext.com/case/united-states-v-state-2009

pregnant people and undermine their reproductive freedom, in spite of the grave impacts on their health and futures. Pregnant people need to be able to access abortion care without fearing for their lives, that is affirming of their dignity, free of logistical barriers, and embedded within trusted sources of care in their community—regardless of whether they are in emergency situations or not. We urge Congress to pass the Women's Health Protection Act to counter restrictions on abortion access and to allow people to make their own reproductive health care decisions, no matter where they live. If the Supreme Court decides against upholding EMTALA's protections for pregnant people who need abortion care in *Idaho v. United States* and *Moyle v. United States*, it would further empower extremists angling to ban abortion nationwide and jeopardize pregnant people's health, bodily autonomy, and equality under the law.