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

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

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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.