Overview of 2025 Congressional Requests

Support Medicare Reimbursement for EMS Treatment in Place (TIP)
The goal of all healthcare should be to provide patients with the right care, at the right time, and in the most cost-effective manner. The historical payment model for EMS contradicts this goal by only reimbursing EMS if the most expensive means of response and transport – an ambulance – is used to take patients to the most expensive setting – the emergency department.

Please support the Comprehensive Alternative Response for Emergencies (CARE) Act, soon to be introduced by Reps. Mike Carey (R-OH) and Lloyd Doggett (D-TX). This bill would create a pilot program to test and evaluate the Treatment In Place (TIP) model under the Center for Medicare and Medicaid Innovation (CMMI). To learn more or to cosponsor, please contact Emily Graeter in Rep. Carey's office at Emily.Graeter@mail.house.gov or Afton Cissell in Rep. Doggett's office at Afton.Cissell@mail.house.gov.

Support Mobile Integrated Healthcare (MIH) Community Paramedicine (CP) Programs
MIH-CP is an innovative way for EMTs and Paramedics to provide patient-centered mobile care outside the hospital to lower health care costs and improve patient outcomes. EMS agencies across the nation are partnering with hospitals, primary care physicians, nurses, mental health and social services providers, and government agencies on programs that bring care to patients and help navigate patients to needed services.

Please support the Community Paramedicine Act, soon to be introduced by Rep. Emanuel Cleaver (D-MO) and others. This bill would create a grant program under the Secretary of Health and Human Services (HHS) to support Mobile Integrated Healthcare (MIH) Community Paramedicine (CP) programs. Eligible applicants in rural and underserved communities could receive grants to implement these services. To become a cosponsor or to learn more, please contact Brock Boze in Rep. Cleaver's office at Brock.Boze@mail.house.gov.

Support FY2026 Funding for SIREN Act Grants
In small towns, farming communities, and frontier areas, rural EMS agencies are a lifeline to the healthcare system for residents, who on average are older, have higher rates of chronic illness, and lower incomes. Rural EMS agencies often are forced to rely on community donations to supplement limited funding from municipal or county governments. While these donations help rural EMS agencies and fire departments maintain their operations, they have not kept pace with the rising costs that these agencies face. In many communities, EMS agencies have been forced to close their doors completely.

The Supporting and Improving Rural EMS Needs (SIREN) Act created a grant program specifically for rural public and non-profit EMS agencies and fire departments to purchase equipment, provide training, and meet other critical needs, called the Rural EMS Training and Equipment Assistance (REMSTEA) grant program.

Please submit a programmatic funding request to the Labor-HHS-Education Appropriations Subcommittee to support $33 million for SIREN Act grants in FY2026.

Support EMS Workforce Development
Emergency Medical Services (EMS) is facing crippling staffing challenges that threaten the availability of critical emergency healthcare services. The shortage of EMTs and Paramedics is resulting in longer 9-1-1 response times and delays in interfacility transfers, putting patients who need urgent health care at unacceptable risk. This shortage was exacerbated by the COVID-19 pandemic, but it is a long-term problem that has been building for over a decade.

Please cosponsor H.R. 2220, the Preserve Access to Rapid Ambulance Medical Treatment (PARA-EMT) Act, introduced by Reps. Marie Gluesenkamp Perez (D-WA) and Brad Finstad (R-MN), which would help address the Paramedic and Emergency Medical Technician (EMT) shortage. To become a cosponsor or to learn more, please contact Kat Gillespie in Rep. Gluesenkamp Perez's office at Katherine.Gillespie@mail.house.gov or Meagan Daly in Rep. Finstad's office at Meagan.Daly@mail.house.gov.

Ensure all EMS Practitioners are Counted
EMS consists of a diverse group of first responders and health care practitioners who often serve in dual roles, including Paramedics, Emergency Medical Technicians (EMTs), and dual-role Firefighter/EMTs and Firefighter/Paramedics. The current structure of the Standard Occupational Classification (SOC) – the system used by the Department of Labor (DOL) Bureau of Labor Statistics (BLS) – has led to an undercounting of EMS personnel due to the exclusion of dual-role firefighter/EMS personnel.

Please support the EMS Counts Act, soon to be introduced by Rep. GT Thompson (R-PA) and Sen. Susan Collins (R-ME). This bill would require DOL/BLS to make changes to the SOC system to accurately count the total number of EMS practitioners by accounting for those who also serve as firefighters. To learn more about the EMS Counts Act or to cosponsor, please contact Brian Arata in Rep. Thompson's office at Brian.Arata@mail.house.gov or Katherine Huiskes in Sen. Collins' office at Katherine_Huiskes@collins.senate.gov.

Extend Medicare Ground Ambulance Add-On Payments
Medicare currently provides temporary 2% urban, 3% rural, and 22.6% "super rural" add-on payments for ambulance services. These payments, which are set to expire on September 30, 2025, are essential to ensuring all patients have access to vital emergency and non-emergency care, but they still do not bring Medicare payment rates up to a level that covers the full cost of providing services.

Please support H.R. 2232, the Protecting Access to Ground Ambulance Medical Services Act, introduced by Reps. Claudia Tenney (R-NY) and Terri Sewell (D-AL), which would extend the add-on payments at their current levels of 2% urban, 3% rural, and 22.6% super rural until December 31, 2027, and support efforts to further raise add-on percentages. To learn more or to cosponsor H.R. 2232, please contact Jack Boyd in Rep. Tenney's office at Jack.Boyd@mail.house.gov or Cameryn Blackmore in Rep. Sewell's office at Cameryn.Blackmore@mail.house.gov.

Please support the EMS Caucus by joining or continuing your participation (House offices only)
The Congressional EMS Caucus, Co-Chaired by Reps. Richard Hudson (R-NC) and Debbie Dingell (D-MI), focuses on EMS issues and strives to form a cohesive bipartisan message in support for the EMS profession and patients nationwide. The EMS Caucus helps promote, educate, and increase awareness among decision-makers on the federal EMS policy. To join the Caucus, contact William Seabrook in Rep. Dingell's office at William.Seabrook@mail.house.gov or Alex Stepahin in Rep. Hudson's office at Alex.Stepahin@mail.house.gov.

EMS On The Hill Day

Please Support Medicare Reimbursement for EMS Treatment in Place (TIP)

REQUEST
Please support the Comprehensive Alternative Response for Emergencies (CARE) Act, soon to be introduced by Reps. Mike Carey (R-OH) and Lloyd Doggett (D-TX). This bill would create a pilot program to test and evaluate the Treatment In Place (TIP) model under the Center for Medicare and Medicaid Innovation (CMMI).

BACKGROUND:
The goal of all healthcare should be to provide patients with the right care, at the right time, and in the most cost-effective manner. The historical payment model for EMS contradicts this goal by only reimbursing EMS if the most expensive means of response and transport – an ambulance – is used to take patients to the most expensive setting – the emergency department.

Unfortunately, Medicare currently does ***not*** reimburse EMS practitioners for TIP. EMS is only reimbursed for care when a patient is brought to the hospital. The hospital emergency department is one of the most expensive places to receive care, with recent estimates of $2,500-$5,000 per visit, many times the amount it would cost to treat non-emergent patients in place. However, the current Medicare economic model incentivizes EMS transportation to a hospital emergency department, even when a less expensive level of care is appropriate.

Many patients who call 9-1-1 have non-emergency medical conditions that do not require transport to the emergency department and could be more appropriately managed on-scene, potentially in conjunction with a telemedicine physician or a subsequent referral to a primary care physician. Payment for TIP will allow EMS agencies to implement patient-centric protocols for patients who use the 9-1-1 system but have conditions that can be treated in the comfort of their home. This is especially important for people with disabilities and mobility limitations whose lives are upended when they must go to the hospital. TIP can facilitate referral of care to the patient's own caregivers, who know the patient and their medical history, as opposed to emergency department staff who typically do not know much about the patient.

TIP will also shorten task times for EMS agencies struggling with workforce shortages, help decompress overcrowded hospitals and emergency departments, and meet patients' needs without long waits at the hospital. Many hospitals hold EMS personnel for hours waiting for an available bed in the emergency department, keeping EMS responders from getting back into service and ready for the next emergency in the community.

To learn more or to cosponsor the CARE Act, please contact Emily Graeter in Rep. Carey's office at Emily.Graeter@mail.house.gov or Afton Cissell in Rep. Doggett's office at Afton.Cissell@mail.house.gov.

ADDITIONAL INFORMATION:

Reimbursing EMS agencies for TIP will save Medicare billions of dollars

CMS issued a waiver for ambulance services to allow for treatment reimbursement in lieu of transport during the COVID-19 public health emergency. Medicare also paid for TIP during the Emergency Triage, Treat, and Transport (ET3) demonstration program. These opportunities gave EMS the flexibility to navigate patients to the right care in the right setting, and the results were very promising.

An external analysis of the CMS ET3 TIP model identified an average net savings to Medicare of $537.51 for each patient encounter when a patient was treated in place instead of being transported by ambulance to the hospital emergency department.

Medicare beneficiaries make up about 40% of patients treated by EMS and between 12.9 and 16.2% of Medicare-covered 911 transports involve medical conditions that do not require a hospital ER visit.[1] Using those figures, NAEMT estimates between 2.17 and 2.82 million emergency department visits by Medicare beneficiaries each year would be potentially eligible for TIP, saving Medicare between $1.5 and $1.95 billion annually.

[1] "Giving EMS Flexibility in Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings," *Health Affairs* December 2013, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0741

Please Support Mobile Integrated Healthcare (MIH)
Community Paramedicine (CP) Programs

REQUEST

Please support the Community Paramedicine Act, soon to be introduced by Rep. Emanuel Cleaver (D-MO) and others. This bill would create a grant program under the Secretary of Health and Human Services (HHS) to support Mobile Integrated Healthcare (MIH) Community Paramedicine (CP) programs. Eligible applicants in rural and underserved communities could receive grants to:

- hire community paramedicine personnel;
- purchase necessary equipment, including personal protective equipment, uniforms, medical supplies, and vehicles;
- pay for certification courses; and
- conduct public outreach and education on the patient-centered outcomes that can be achieved through community paramedicine.

BACKGROUND

MIH-CP is an innovative way for EMTs and Paramedics to provide patient-centered mobile care outside the hospital to lower health care costs and improve patient outcomes. EMS agencies across the nation are partnering with hospitals, primary care physicians, nurses, mental health and social services providers, and government agencies on programs that bring care to patients and help navigate patients to needed services. Examples of these services include in-home check-ups, post hospitalization follow-up care, health education, care coordination, medication reconciliation, and preventive care. These programs improve patient access to primary care, diagnostic testing, specialized service referrals, social services, and transportation to medical appointments.

These MIH-CP services are key to providing the coordinated approach needed to slow health care cost increases and stem declines in population health. EMTs and Paramedics want to use their skills and resources to help solve the problems plaguing healthcare systems and communities. Unfortunately, even though MIH-CP programs lead to successful patient outcomes and significant cost savings, many are forced to shrink their scope or close altogether due to lack of funds. As Medicare and Medicaid transition away from fee-for-service payment to models that are based on patient outcomes rather than the volume of services delivered, MIH-CP programs will play a key role in the future of health care.

The Community Paramedicine Act will help EMS providers and their health care partners start and sustain programs that lower costs, deliver patient-centered services, and improve outcomes. To become a cosponsor or to learn more about the Community Paramedicine Act, please contact Brock Boze in Rep. Cleaver's office at Brock.Boze@mail.house.gov.

ADDITIONAL INFORMATION

Lower Costs, Improved Outcomes

Studies have shown that MIH-CP programs can save thousands of dollars per patient per year by helping people lead healthier lives and decreasing healthcare emergencies. For example, community paramedicine visits can help a person living with heart failure, asthma, COPD, or diabetes avoid acute emergencies and reduce their utilization of EMS and hospital emergency rooms. A study in eastern Massachusetts showed that their community paramedicine model saved over $1,900 per case and nearly $6 million in a year.[1]

MIH-CP programs are especially important for Medicare beneficiaries who are homebound, medically fragile, or live in rural areas where access to care is limited and EMS agencies have become the only easily accessible healthcare resource. Over 57 million Americans must travel a lengthy distance to reach their nearest physician. Rural Americans experience the most travel time, as only 11% of physicians work in rural settings. Many inner-city urban communities face similar challenges.

Intervention before patients need emergency care can save our healthcare system billions of dollars by keeping patients healthier and avoiding unnecessary disease exacerbations that lead to hospitalization.

Relieving Strain on 9-1-1 Systems and Emergency Departments

MIH-CP can also prevent emergency service misuse by intercepting nonurgent medical needs before patients resort to calling 9-1-1 or going to the emergency department. Some of the most successful CP programs target frequent 9-1-1 callers, and those efforts result in a measurable decrease in unnecessary 9-1-1 calls and emergency department visits. This is particularly important as communities contend with having too few ambulances and over-crowded emergency departments.

Amid unprecedented nursing and hospital staff shortages, long wait times, and overcrowded hospitals, it is imperative that we provide MIH-CP programs with the resources to help meet the healthcare needs of their communities outside of the hospital.

[1] Lamos Ramos Hegwer, “Community Paramedicine Saves Organization $6m in 1 Year”, Healthcare Financial Management Association, Feb. 15, 2019

Please Support FY2026 Funding for SIREN Act Grants

REQUEST

The Supporting and Improving Rural EMS Needs (SIREN) Act created a grant program specifically for rural public and non-profit EMS agencies and fire departments to purchase equipment, provide training, and meet other critical needs, called the Rural EMS Training and Equipment Assistance (REMSTEA) grant program.

Please include $33 million in the FY2026 budget for SIREN Act grants to provide much needed resources to already strained EMS agencies working to provide life-saving medical care to the patients in their communities.

BACKGROUND

In small towns, farming communities, and frontier areas, rural EMS agencies are a lifeline to the healthcare system for residents, who on average are older, have higher rates of chronic illness, and lower incomes. Rural EMS agencies often are forced to rely on community donations to supplement limited funding from municipal or county governments. While these donations help rural EMS agencies and fire departments maintain their operations, they have not kept pace with the rising costs that these agencies face. In many communities, EMS agencies have been forced to close their doors completely.

In the wake of exponential increases in expenses for medical supplies, equipment, fuel, and medications, even the most well-resourced EMS agencies and fire departments across the United States are struggling to stretch their budgets to maintain their operations. Many are also facing crisis-level challenges in recruiting and retaining personnel, fueled in part by low unemployment and an incredibly competitive labor market.

Coupled with declines in primary care and hospital service availability, greater distances between healthcare facilities, low reimbursement rates, and the ongoing opioid and fentanyl crisis, these circumstances have created a perfect storm of financial challenges for rural EMS agencies.

The REMSTEA program, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a critical lifeline for these budget-challenged rural EMS agencies and fire departments. REMSTEA grants have provided much-needed funding to assist agencies in procuring medication and medical supplies, recruiting and retaining personnel, increasing service levels from Basic Life Support to Advanced Life Support, and even replacing older ambulances with newer and safer models.

Since the inception of the program in 2018, 170 awards ranging from $92,000 to $200,000 have been made to rural communities. The funds have been used to maintain, improve, or expand the level of emergency medical care provided to the residents of those communities – activities that were only possible with the support from the REMSTEA program.

In FY2024, SAMHSA received more than 90 REMSTEA grant applications – more than triple the total number submitted since the program's first awards were made in FY2020 – but only had funding available to make 62 awards. There is clearly a strong ongoing need for this program, and we expect that the number of applicants will only continue to grow in FY2026 and beyond.

Please submit a programmatic funding request to the Labor-HHS-Education Appropriations Subcommittee to support $33 million for SIREN Act grants in FY2026.

Please Support EMS Workforce Development

REQUEST
Please cosponsor H.R. 2220, the Preserve Access to Rapid Ambulance Medical Treatment (PARA-EMT) Act, introduced by Reps. Marie Gluesenkamp Perez (D-WA) and Brad Finstad (R-MN), which would help address the Paramedic and Emergency Medical Technician (EMT) shortage.

BACKGROUND
Emergency Medical Services (EMS) is facing crippling staffing challenges that threaten the availability of critical emergency healthcare services. The shortage of EMTs and Paramedics is resulting in longer 9-1-1 response times and delays in interfacility transfers, putting patients who need urgent health care at unacceptable risk. This shortage was exacerbated by the COVID-19 pandemic, but it is a long-term problem that has been building for over a decade.

Career EMS workers routinely leave EMS for careers with higher pay. In addition, the pipeline of EMS workers has been stretched thin as highly trained Paramedics are being hired by hospitals to offset the nursing shortage. And volunteer EMS workers are coping with rising call volumes at a time when fewer people are volunteering to serve their communities. The 2024 Ambulance Employee Workforce Turnover Study by the American Ambulance Association (AAA) and Newton 360 – the most sweeping survey of its kind involving nearly 20,000 employees working at 258 EMS organizations – found that overall annual turnover among Paramedics and EMTs ranges from 20-30 percent.

To help combat this trend, the PARA-EMT Act (H.R 2022) would:

- Provide $50 million to the Office of the Assistance Secretary for Preparedness and Response (ASPR) for grants open to all ambulance service providers to fund Paramedic and EMT recruitment and training, including employee education and peer-support programming to reduce and prevent suicide, burnout, mental health conditions, and substance use disorders.
- Reduce barriers that prevent U.S. military veterans from becoming certified as civilian Paramedics and EMTs.
- Request that the Secretary of Labor (in coordination with the HHS Secretary) conduct a study on the current and projected EMS workforce shortage and report their findings.

To learn more or to cosponsor H.R. 2220, the PARA-EMT Act, please contact Kat Gillespie in Rep. Gluesenkamp Perez's office at Katherine.Gillespie@mail.house.gov or Meagan Daly in Rep. Finstad's office at Meagan.Daly@mail.house.gov.

ADDITIONAL INFORMATION

Key Reasons for the EMS Workforce Shortage

Some of the most common reasons for the EMS workforce shortage include:

- A need for more EMS responders to meet increasing demand for ambulance service due to aging communities, substance use disorder, behavioral health challenges, and chronic care needs.
- Low wages for career EMTs and Paramedics, despite the tremendous responsibilities that come with the job.
- A very limited capacity to raise wages, due to the declining financial health and negative fiscal outlook facing most EMS ambulance services. Many insurers – including Medicare and Medicaid – pay EMS agencies less than their actual cost of providing care and transportation.
- A decline in the number of new volunteers to replace long-time volunteers aging into retirement.
- Significant delays in turning patients over to hospitals due to emergency department crowding.

EMS On The Hill Day

Please Ensure all EMS Practitioners Are Counted

REQUEST
Please support the EMS Counts Act, soon to be introduced by Rep. GT Thompson (R-PA) and Sen. Susan Collins (R-ME).

This bill would require the Department of Labor (DOL) Bureau of Labor Statistics (BLS) to make changes to its system to accurately count the total number of EMS practitioners by accounting for those who also serve as firefighters.

BACKGROUND
EMS consists of a diverse group of first responders and health care practitioners who often serve in dual roles, including Paramedics, Emergency Medical Technicians (EMTs), and dual-role Firefighter/EMTs and Firefighter/Paramedics. These professionals respond to more than 40 million calls for service annually, and they are critical to ensuring public health and safety.[1]

The current structure of the Standard Occupational Classification (SOC) – the system used by DOL/BLS – has led to an undercounting of EMS personnel due to the exclusion of dual-role firefighter/EMS personnel. The failure to capture the number of Firefighters who are cross-trained as EMTs and Paramedics has led to a substantial undercounting of EMS practitioners. This data is used to make funding and other policy decisions, so this undercount has significant ripple effects.

To appropriately count the total number of EMS practitioners, the SOC must account for the fact that a significant portion of EMS practitioners also serve as firefighters, performing both sets of duties as their primary role.

This bill would require the Secretary of Labor to revise the SOC System by dividing the general occupational category of “Firefighter” into three sub-categories. Specifically, the bill directs BLS to revise the broad description under the occupational series ‘‘33-2011 Firefighters’’ of the 2018 SOC to include the following new occupations: (1) Firefighters. (2) Firefighter/EMTs. (3) Firefighter/Paramedics. These changes will address the chronic miscounting of EMS personnel by allowing firefighters to identify themselves as cross-trained EMS practitioners.

To learn more or to cosponsor the EMS Counts Act, please contact Brian Arata in Rep. Thompson’s office at Brian.Arata@mail.house.gov or Katherine Huiskes in Sen. Collins’ office at Katherine_Huiskes@collins.senate.gov.

[1] https://www.ems.gov/assets/COVID-19_EMS_911_Briefing.pdf

ADDITIONAL INFORMATION

Many Fire Departments Provide EMS Services

Many fire departments provide multiple types of EMS services. In fact, over the past four decades, EMS has become a core function of the American fire and emergency service. According to data from the National Fire Protection Association (NFPA), in 2021, nearly three-quarters of all 9-1-1 calls to fire departments were for medical emergencies[2]. These 26.3 million responses have pushed the fire service to become the largest providers of EMS nationwide.

According to the U.S. Fire Administration, of the nation's more than 30,000 fire departments[3]:

- 60.9% of fire departments provide Basic Life Support
- 40.4% of fire departments provide Emergency Medical Services (EMS) non-transport response
- 21.7% of fire departments provide Advanced Life Support
- 21.1% provide EMS ambulance transport

Dual-Role Firefighter/EMTs and Firefighter/Paramedics are Undercounted

In 2020, the National Association of State EMS Officials (NASEMSO) – with support from the U.S. Department of Transportation, National Highway Traffic Safety Administration, Office of Emergency Medical Services – released the 2020 National Emergency Medical Services Assessment[4]. With responses from all 50 states as well as Guam, the Northern Mariana Islands, and the U.S. Virgin Islands, this assessment showed 1,052,842 licensed EMS professionals in the United States, approximately 917,000 of whom are EMTs or Paramedics. In contrast, the May 2020 BLS data[5] shows 257,700 EMTs and Paramedics. This reflects an undercounting of more than 795,000.

[2] https://www.nfpa.org/education-and-research/research/nfpa-research/fire-statistical-reports/fire-department-calls
[3] https://apps.usfa.fema.gov/registry/summary
[4] https://nasemso.org/wp-content/uploads/2020-National-EMS-Assessment_Reduced-File-Size.pdf
[5] https://www.bls.gov/oes/2020/may/oes292040.htm

Please Extend Medicare Ground Ambulance Add-On Payments

REQUEST

Please support H.R. 2232, the Protecting Access to Ground Ambulance Medical Services Act, introduced by Reps. Claudia Tenney (R-NY) and Terri Sewell (D-AL), which would extend the add-on payments at their current levels of 2% urban, 3% rural, and 22.6% super rural until December 31, 2027, and support efforts to further raise add-on percentages. These payments are set to expire on September 30, 2025. Senate companion legislation will be introduced in the near future.

BACKGROUND

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. Ambulance services across the nation, especially in rural areas, are facing unprecedented fiscal challenges. Medicare currently provides temporary 2% urban, 3% rural, and 22.6% “super rural” add-on payments for ambulance services. These payments are essential to ensuring all patients have access to vital emergency and non-emergency care, but they still do not bring Medicare payment rates up to a level that covers the full cost of providing services.

The cost of the equipment, goods, and services purchased by ambulance services is rising at a rate much faster than general inflation. This includes annual double-digit percentage increases in the price of replacing old ambulances. Years of below-cost Medicare reimbursement have hampered efforts by ambulance services to hire new staff, update equipment, replace aging ambulances, 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 stress on their systems.

The closure and downsizing of hospitals and the shortage of primary care physicians, especially in rural communities, has placed significant new demands on ambulance services. At the same time, the EMS workforce exited the pandemic strained by a depleted number of EMTs and Paramedics and increasing call volume.

The Fiscal Year (FY) 2025 Continuing Resolution extended the current Medicare payment add-ons through September 30, 2025. An additional extension through the end of 2027 is necessary to analyze ongoing data collection and reform the ambulance fee schedule.

To learn more or to cosponsor H.R. 2232, please contact Jack Boyd in Rep. Tenney’s office at Jack.Boyd@mail.house.gov or Cameryn Blackmore in Rep. Sewell’s office at Cameryn.Blackmore@mail.house.gov.

ADDITIONAL INFORMATION:

Ground Ambulance Data Collection Underway

Ground ambulance service organizations are currently providing their revenue and cost data to the CMS Medicare Ground Ambulance Data Collection System (GADCS). This data is intended to help Congress determine how to reform the Medicare ambulance fee schedule.

CMS released a preliminary report in December 2024 stating that the aggregate data from the GADCS confirmed that the cost per transport of providing ambulance services to Medicare patients is higher than revenue per transport.

However, the multi-year data collection project is behind schedule, and reform of the ambulance payment system is likely more than several years away. Ground ambulance service organizations cannot wait that long for additional relief.

Medicare Productivity Adjustment Has Compounded Reimbursement Insufficiency

Since 2011, Medicare has reduced the Ambulance Inflation Factor – which is tied to Consumer Price Index for All Urban Consumers (CPI-U) – by a "productivity adjustment" equal to the 10-year moving average of changes in the economy-wide private non-farm business multi-factor productivity index (MFP).

In short, this adjustment assumes that providers can utilize new technology and improve efficiency to offset the impact of inflation. Unfortunately, that assumption is not correct for a variety of reasons:

- The labor-intensive nature of EMS makes it difficult to achieve productivity gains, particularly in rural areas. Because emergencies can occur at any time, ambulance services must maintain preparedness for emergencies 24 hours a day, seven days a week, and cannot reduce staffing levels or reduce hours.
- As more ambulance services close, those remaining are spread thinner over wider geographies. The further an ambulance service is stretched, the less likely that an ambulance will always be available to respond to every emergency.
- Far from breaking even, ambulance services lost a staggering $440 million in Medicare reimbursement from FY2012-23 due to the productivity adjustment, according to a recent study commissioned by the American Ambulance Association.

EMS On The Hill Day

Congressional EMS Caucus

The EMS Caucus helps Congress understand EMS issues and promotes policies that help EMS practitioners provide life-saving medical care in emergencies, cost-saving care management in non-emergent or emergent situations, and disaster response at any time. Highly trained EMTs and Paramedics are on the front lines 24-7-365. Despite low pay and no pay for community volunteers, they face the elements and potential hazards without reservation when a person is ill or injured.

EMS practitioners provide immediate, often lifesaving, medical care. They provide compassionate care at people's most vulnerable moments of need. These practitioners are specially trained to assess patient needs, and with physician oversight, ***navigate patients to the right care, in the right place, and at the right time***. All communities, whether rural, urban, or suburban, deserve access to the high-quality out-of-hospital medical care that EMS provides. Unfortunately, a growing number of communities have under resourced and diminished EMS systems.

When people call 911 they expect an ambulance to respond quickly. In medical emergencies, getting EMS there swiftly can mean the difference between life and death or disability. But nearly 4.5 million rural Americans live in what are known as ***ambulance deserts*** and can wait 25 minutes or longer for an emergency medical crew to arrive from a faraway community. Similar delays can be found in overtaxed urban EMS systems. In communities of all types there are shortages of EMS practitioners and equipment and with fewer ambulances available and fewer EMS professionals to staff them, communities are struggling to meet the need.

EMS is evolving to best meet the needs of communities and delivery models throughout the country and are counting on the evolution of federal policy and funding to help EMTs and Paramedics meet those needs. **The EMS Caucus strives to ensure Members and staff have the background, data, and other information needed to make effective policy decisions.** The EMS Caucus brings a disciplined focus on these issues to foster a bipartisan effort to support EMS practitioners nationwide.

For additional information or to join the EMS Caucus, please contact Alex Stepahin in Rep. Hudson's office (Alex.Stepahin@mail.house.gov) or William Seabrook in Rep. Dingell's office (William.Seabrook@mail.house.gov)

Sincerely,

Rep. Richard Hudson
Rep. Debbie Dingell

Congressional EMS Caucus

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EMS On The Hill Day

Medicaid and Emergency Medical Services

Communities across the nation rely on 24/7/365 availability of EMS for the sick, injured, elderly, and disabled and Medicaid is either the largest or second largest payer for the majority of ambulance services, especially in rural and underserved communities.

As Congress completes the Budget Resolution and Budget Reconciliation we ask you to remember that EMS receives significant funding from the Medicaid program and that Congress consider the impact that reducing state Medicaid funding will have on the availability of ambulance service throughout the country. We ask Congress to protect the Medicaid program from reductions. EMS agencies are already struggling with below cost Medicare and Medicaid reimbursement that has resulted in ambulance deserts and delays in lifesaving care.

NAEMT brings achievable savings and efficient solutions to the table through support of Treat-in-Place (TIP) and Mobile Integrated Healthcare-Community Paramedicine (MIH-CP) initiatives.

Twenty States will have Medicaid ambulance provider taxes in place during 2025, according to the Kaiser Family Foundation 2024-2025 State Medicaid Budget Survey. The states are Alabama, Arkansas, California, Georgia, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Vermont, Washington, West Viriginia, and Wyoming. NAEMT is concerned that any new federal restrictions on provider taxes could trigger State Medicaid ambulance payment reductions.

NAEMT Urges Caution in Budget Resolutions Reducing Medicaid Spending

Feb 22, 2025

As the Congressional Budget Committees draft their Fiscal Year 2025 Budget Resolutions, the National Association of Emergency Medical Technicians (NAEMT) urges caution in reducing Medicaid spending.

Communities across the nation rely on 24/7/365 availability of Emergency Medical Services (EMS) for the sick, injured, elderly, and disabled. In many communities, EMS is the safety net for care.

EMS receives significant funding from the Medicaid program, and we ask that Congress consider the impact that reducing this support will have on the availability of ambulance service throughout the country and reject Medicaid reductions. EMS agencies are already struggling with below cost Medicare and Medicaid reimbursement that has resulted in ambulance deserts and delays in lifesaving care.

NAEMT can bring achievable savings and efficient solutions to the table through support of Treat-in-Place (TIP) and Mobile Integrated Healthcare-Community Paramedicine (MIH-CP) initiatives.

WHAT IS **EMS?**

The National Association of Emergency Medical Technicians (NAEMT) is pleased to present this introduction to EMS. Inside, you'll learn more about:

- EMS operations, staffing, delivery, and regulations
- EMS funding and reimbursement
- The services EMS provides: ground and air medical 911 response, interfacility transports, community paramedicine, and public health and safety education

EMS responds to calls for help, 24/7, in almost every community in the United States. EMS stands for emergency medical services. EMS practitioners include paramedics, EMTs, and others who respond to emergency calls, assess patients, provide treatment, and transport patients to medical facilities for further care.

EMS professionals save lives from heart attacks, strokes and overdoses; treat injuries due to motor vehicle collisions, shootings, stabbings and other violence; and provide care for patients of all ages with a range of serious medical conditions. Some EMS professionals also work with hospitals, mental health providers, substance abuse treatment centers, or hospice agencies to provide preventive or chronic illness care through community paramedicine and mobile integrated healthcare services.

EMS is a vital part of public health, healthcare and public safety, and an essential service to the community.

When the public needs help, EMS is there.

EMS also responds to public health crises and mass casualty incidents. These include natural disasters, such as floods, hurricanes, and tornadoes, and man-made disasters, such as terrorist attacks, explosions and active shooters. EMTs and paramedics bravely serve their communities in the face of localized outbreaks, socially spread illnesses, and global pandemics.

Statistics: National EMS Assessment 2020

42.6 M
Total # of EMS responses annually

30.9 M
Total # of transports

1.05 M
# of licensed EMS professionals nationwide

622,902
Emergency Medical Technicians (EMTs)

268,420
Paramedics

87,781
# of EMS vehicles
(ambulances, helicopters & other aircraft, quick response vehicles, rescue vehicles, fire trucks & all-terrain vehicles)

19,520
Estimated # of EMS agencies nationwide

EMS Operations

What is an EMS system?

EMS systems have multiple components that work together to benefit patients and communities. EMS systems may include:

- Emergency communications centers (dispatch)
- Fire departments/first responders
- Ground ambulance services
- Air medical services (helicopter EMS or fixed wing aircraft)
- Hospital emergency departments (adult and pediatric)
- Trauma centers
- Other specialty care centers, such as burn, cardiac, and stroke centers
- State EMS offices

All of the components within the EMS system must function cohesively to best serve the patient throughout the continuum of emergency care.

How is EMS regulated?

EMS is regulated by state law. Each state and U.S. territory has a lead EMS agency, known as the state EMS office. State EMS offices are often part of the state health department. They are responsible for licensing EMS agencies and personnel, and for the overall coordination and regulation of EMS in the state.

What types of agencies provide EMS?

EMS can be provided by public agencies or private companies. Public EMS agencies include fire departments, and city or county EMS agencies. Private ambulance services can be for-profit or nonprofit. Some ambulance services are run by hospitals.

Public and private EMS agencies often work together to provide patient care. For example: EMS personnel from a fire department may provide first response in a given area. The city or county government may also contract with a private ambulance company to provide transport and additional medical care.

NAEMT and other EMS organizations are working to change laws and regulations that require EMS to take every patient to a hospital emergency department. Instead, EMS could provide treatment in place (TIP) or transport to alternate destinations (TAD), when appropriate.

Volunteer or paid?

About 13% of U.S. EMS professionals are volunteers. Volunteer agencies are most often found in rural areas.

Rural areas with smaller populations are more likely to lack a sufficient tax base or volume of 911 calls to support paid EMS personnel. Many volunteer EMS agencies struggle to recruit and retain volunteers. Some ambulance services combine both volunteer and paid staff.

The various ways of providing EMS – public, private, hospital based, volunteer, paid, and so on – are known as "EMS delivery models."

Why are there so many types of delivery models for EMS?

How a community provides EMS is decided at the local level, based on resources and needs. Communities determine if they want to support a paid service, volunteer or a hybrid service; or if they want to contract with a private ambulance service to augment public resources.

Does EMS have to take patients to the emergency department?

When a member of the public calls 911 for help, laws in every state require EMS to respond. EMS is also obligated to take that person to an emergency department if the person wishes to go. EMS laws in many states prohibit EMS from taking patients to any facility other than the hospital.

However, these rules have changed temporarily in the past to address public health emergencies. Restrictions were lifted enabling EMS practitioners to provide at-home care to patients or take them to alternate destinations for care, avoiding transport to overwhelmed emergency departments.

EMS practitioners provided services ranging from preventive care to acute care in the home. Physicians acknowledged their contributions. "The American people owe a debt of gratitude for the heroic work they have done," stated an editorial in *JAMA Cardiology* on June 19, 2020.

Based on the proven safety and success of EMS efforts during times of crisis, NAEMT and other EMS organizations are working to permanently change laws and regulations that require EMS to take every patient to a hospital emergency department. Instead, EMS could provide treatment in place (TIP) or transport to alternate destinations (TAD), when appropriate.

EMS Staffing and Clinical Services

Who provides EMS?

EMS personnel include emergency medical responders (EMRs), emergency medical technicians (EMTs), advanced EMTs (AEMTs), and paramedics.

EMRs receive a minimum of about 40 to 60 hours of initial education. EMTs receive approximately 150 to 260 hours of initial education, while advanced EMTs receive 400 to 500 hours. Paramedics are required to have significantly more education, a minimum of 1,500 hours, often through a two-year college program.

Paramedics may also earn specialty certifications such as flight paramedic, critical care paramedic or community paramedic. These paramedics may care for critically ill patients being transported in medical aircraft, or by ground ambulance between facilities, such as from an emergency department to a burn hospital, or may provide post-acute patient care.

What is a Basic Life Support (BLS) versus an Advanced Life Support (ALS) ambulance?

Ambulance crews can be either Basic Life Support (BLS) or Advanced Life Support (ALS).

BLS ambulances are usually staffed by EMTs. ALS ambulances must be staffed by at least one paramedic. ALS ambulance crews can perform more medical interventions than BLS crews.

How are EMTs and paramedics licensed?

State EMS offices license EMS personnel. To become licensed, almost all states and U.S. territories require EMTs and paramedics to pass a national certification test, offered by the National Registry of Emergency Medical Technicians (NREMT). EMTs and paramedics must fulfill continuing education requirements every two years.

What is the role of an EMS medical director?

Every EMS agency has a medical director, often a board-certified emergency physician who provides medical oversight and develops protocols.

What medical services do EMTs perform?

EMTs can perform CPR, artificial ventilations, oxygen administration, basic airway management, defibrillation using an AED, spinal stabilization and/or immobilization, monitoring of vital signs and bandaging/splinting, and assisting with childbirth. EMTs can administer glucose, epinephrine for anaphylaxis, sublingual nitroglycerin for chest pain, albuterol for asthma, and naloxone for opioid overdoses. Advanced EMTs can perform additional services. There can be variations depending on state laws and EMS medical director decisions at the local level.

EMS faces a workforce shortage crisis, which has forced some EMS agencies to curtail their services. NAEMT and other EMS organizations are advocating for more resources to help with recruiting and retention so EMS agencies can continue to serve the public in the way the public has come to expect.

What medical skills does a paramedic perform?

A paramedic can perform all of the skills performed by EMTs and advanced EMTs, plus life-saving airway procedures including: endotracheal intubation, chest decompression, cricothyrotomy and direct laryngoscopy. Paramedics can also interpret 12-lead electrocardiographs (ECGs), perform manual defibrillation, maintain an infusion of blood or blood products, give thrombolytics (clot-dissolving medications), and monitor central lines.

The National Highway Traffic Safety Administration (NHTSA) publishes the National EMS Scope of Practice Model, which recommends which services can be provided at what level of credential. States and EMS medical directors use the scope of practice model as a guide.

What is community paramedicine and mobile integrated healthcare?

Many people call 911 for medical, psychological and social issues for which they need treatment and support, but not necessarily emergency care. EMS is often called to help people with chronic illnesses, such as congestive heart failure or diabetes, who lack primary care and instead rely on the emergency medical system. Others are elderly, isolated and lack social support, and call 911 because they don't know where else to turn. Substance abuse and mental health crises are other common reasons for EMS dispatch.

To improve care for these patients and relieve strain on EMS and emergency departments, some EMS agencies offer programs known as mobile integrated healthcare or community paramedicine (MIH-CP). EMS typically partners with hospitals, hospices, home health or behavioral health agencies to provide services such as:

- Post-hospital discharge follow-ups to prevent hospital admissions or readmissions.
- Care coordination to navigate patients to the best sources of health care or social services to meet their needs.
- Transport to destinations for care other than emergency departments.
- Telemedicine to connect patients with physicians at other locations.

What major issue is facing the EMS workforce?

EMS faces a workforce shortage crisis, which has forced some EMS agencies to curtail their services. EMS organizations are advocating for more resources to help with recruiting and retention so EMS agencies can continue to serve the public in the way the public has come to expect.

EMS Finances and Reimbursement

How is EMS funded?

EMS has two main sources of revenue: local taxes/municipal budgets and fee-for-service reimbursements from Medicare, Medicaid and commercial insurers.

Public EMS agencies typically receive taxpayer support to help fund operations and pay staff, as well as billing a fee-for-service to patients, insurers, Medicare, and Medicaid. Volunteer organizations may also receive some tax support. Private ambulance companies typically receive little to no taxpayer support but instead rely on fee-for-service billing.

What services can EMS bill for?

Largely, for transporting patients to a hospital, not for providing medical care. On any given day, EMS may restart a heart due to cardiac arrest; resuscitate a child after a near-drowning; or stop life-threatening bleeding. EMS administers medications, splints compound fractures, and opens airways to enable severely injured patients to breathe.

Yet EMS is classified as a *transportation* provider, not a healthcare provider, by CMS and insurers. EMS is paid a fee for transporting a patient to the hospital (either at a Basic Life Support or Advanced Life Support rate), plus mileage.

There are a few exceptions. Some commercial insurers pay EMS for some out-of-hospital patient care services, and a handful of states now allow EMS reimbursement for providing some patient care services to Medicaid recipients. But, these exceptions are minimal.

What happens when EMS responds, but the patient does not want to go to the hospital?

If EMS provides care on scene but does not transport the patient to the hospital, EMS does not receive reimbursement.

Responses without transports are common. Of the 42.6 million EMS responses that occurred in 2018, only 30.9 million resulted in transports, according to data from state EMS offices. That means over 11 million responses were uncompensated.

In addition to responses without payment, maintaining 24-7 readiness to respond is also costly for EMS agencies. Many EMS agencies also provide other services at no charge to the community, such as public education around injury prevention, car seat installation, CPR and emergency preparedness.

How is reimbursing EMS only as a transportation provider, and failing to compensate EMS for providing medical care, hurting patients and communities?

Emergency departments are a very expensive source of care. Incentivizing EMS to take patients only to the emergency department drives up healthcare costs. Instead, EMS should be incentivized to deliver the right care, at the right time, in the right place.

How are NAEMT and other organizations working to change this outdated EMS reimbursement model?

Through legislation that reimburses EMS for providing treatment in place (TIP) and transport to alternate destinations (TAD).

Treatment in place allows EMS practitioners to provide care for patients in their homes or on scene, rather than immediate hospital transport. The idea is to provide timely and appropriate medical care, while minimizing unnecessary hospital visits. This alleviates strain on healthcare resources and reduces costs. Patients also benefit by avoiding unnecessary exposure to the hospital environment and long emergency department wait times.

EMS is reimbursed for transporting patients, not for providing medical care. This must change.

Treatment in place may include pain management, wound care, medication administration or monitoring vital signs. EMS practitioners must follow established protocols and guidelines to ensure patient safety. Treatment in place may be used in combination with telemedicine, in which EMS practitioners on scene can consult with a physician in clinics or hospitals.

Transport to alternate destinations can also reduce hospital overcrowding and costs while providing patients with faster access to the right care for their condition. Alternate destinations may include urgent care centers, mental health facilities, substance use treatment centers, or other specialized care centers, depending on patient needs and the resources available in the community. TAD protocols and guidelines help EMS providers determine when it's appropriate to transport a patient to an alternative destination.

The Case for EMS Reimbursement **for TIP**

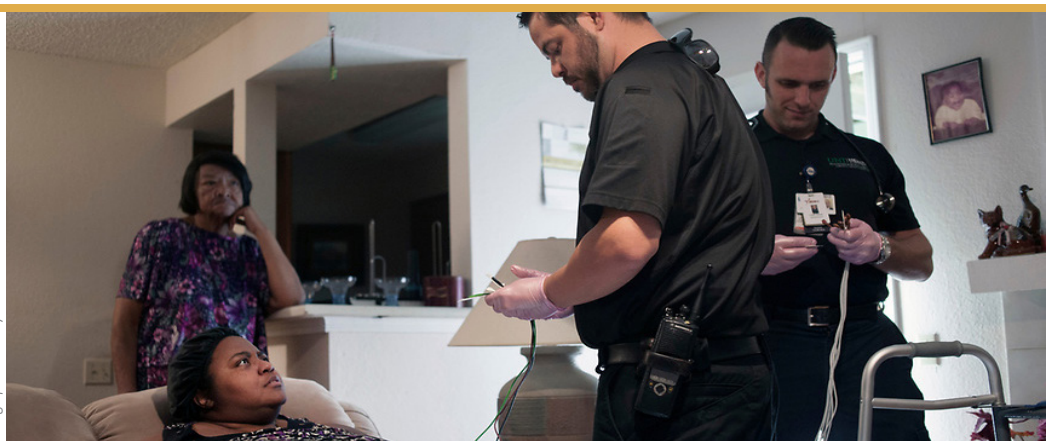


Image provided by Brandon Thibodeaux

An external analysis of the Centers for Medicare and Medicaid Services (CMS) ET3 TIP model identified an average Net Savings to Medicare of $537.51 for each patient encounter. **TIP could annually save Medicare between $1.2 and $1.5 billion.** Ambulance services also conducted on-scene treatment without transport to a hospital under a pandemic authorized waiver. The Congressional Budget Office (CBO) reported that **CMS saved more than $18 million under this waiver**, after paying the ambulance agencies to achieve a 193% cost to savings ratio.

The national average Medicare fee schedule for a basic life support emergency ambulance service is $447.56[1], and of this allowed amount, Medicare pays 80%. Based on this data, the average Medicare expenditure per ambulance treatment without transport claim is estimated at $358.05. CMS paid ambulance services $20 million under this waiver. Using the per call payment estimate, the number of ambulance treatment without transport claims that the $20 million expenditure represents is ~55,858 ambulance claims ($20 million ÷ $358.05). In simple terms, there were 55,858 Medicare beneficiaries who were not seen by a hospital emergency department (ED), and instead were cared for by ambulance agency personnel.

The most recent Healthcare Cost and Utilization Project (HCUP) report from the Agency for Healthcare Research and Quality (AHRQ) reveals the average expenditure for ED visit for patients aged 65 or older is $690[2]. Using this data, **the estimated savings to Medicare derived from the 55,858 Medicare beneficiaries who were NOT seen in an ED was $38,542,020 (55,858 beneficiaries × $690/ED visit). A 193% cost to savings ratio.**

The National Association of State EMS Officials (NASEMSO) identified 42 million EMS responses in 2018[3]. Medicare beneficiaries typically represent 40% of patients treated by emergency medical services (EMS), or 16,800,000 patients. A study of Medicare beneficiaries transported by ambulance to the ED published in Health Affairs in 2013[4] found that an estimated 12.9 –16.2 % of Medicare covered 911 EMS transports involved conditions that were probably nonemergent, or primary care treatable.

Applying the 12.9% – 16.2% of the 16.8 million EMS responses for Medicare beneficiaries in 2020 as potentially eligible for treatment in place without transport would prevent between 2.17 and 2.82 million ED visits by Medicare beneficiaries. **This represents between $1.5 and $1.95 billion annual savings to Medicare.**

1. https://www.cms.gov/medicare/payment/fee-schedules/ambulance
2. https://hcup-us.ahrq.gov/reports/statbriefs/sb268-ED-Costs-2017.pdf
3. https://nasemso.org/wp-content/uploads/2020-National-EMS-Assessment_Reduced-File-Size.pdf
4. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.0741

An external analysis of the CMS ET3 model by their contracted evaluator (Booz Allen) identified an average Net Savings to Medicare (NSM) of $537.51. Using the same application of ED reduction of 2.17 and 2.82 million ED visits by Medicare beneficiaries, TIP could annually save Medicare between $1.2 and $1.5 billion .

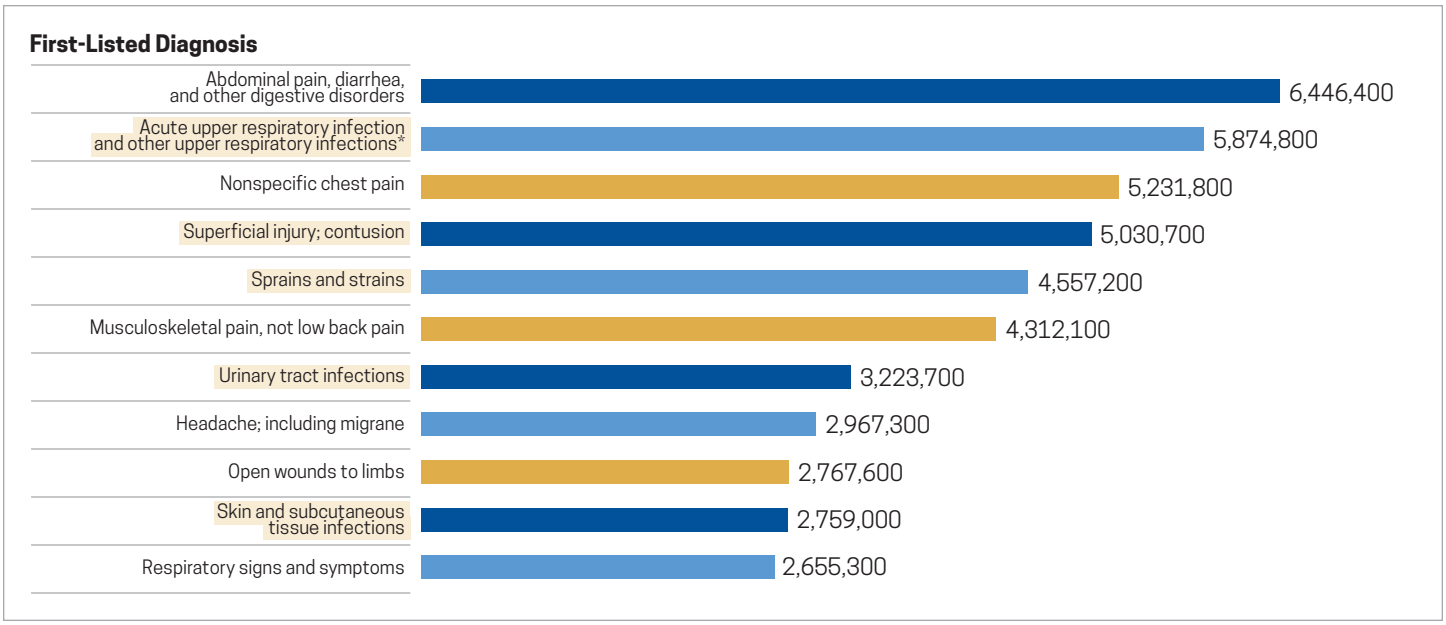
Figure 1: Average Net Savings to Medicare per Intervention by Quartile

Data presented at ET3 Model Quality Workgroup Session #2 on March 21, 2023.

Quartile	Measure Score Range	PBP Percentage	Number of Participants	Number of ET3 Interventions	Average PBP per Intervention	Average NSM per Intervention
1	11.4-18.1%	3%	4	252	$11.89	$570.55
2	>18.1-20.4%	2%	3	319	$8.36	$536.79
3	>20.4-23.4%	1%	4	303	$4.19	$514.86
4	>23.4-28.9%	0%	4	120	--	$527.85

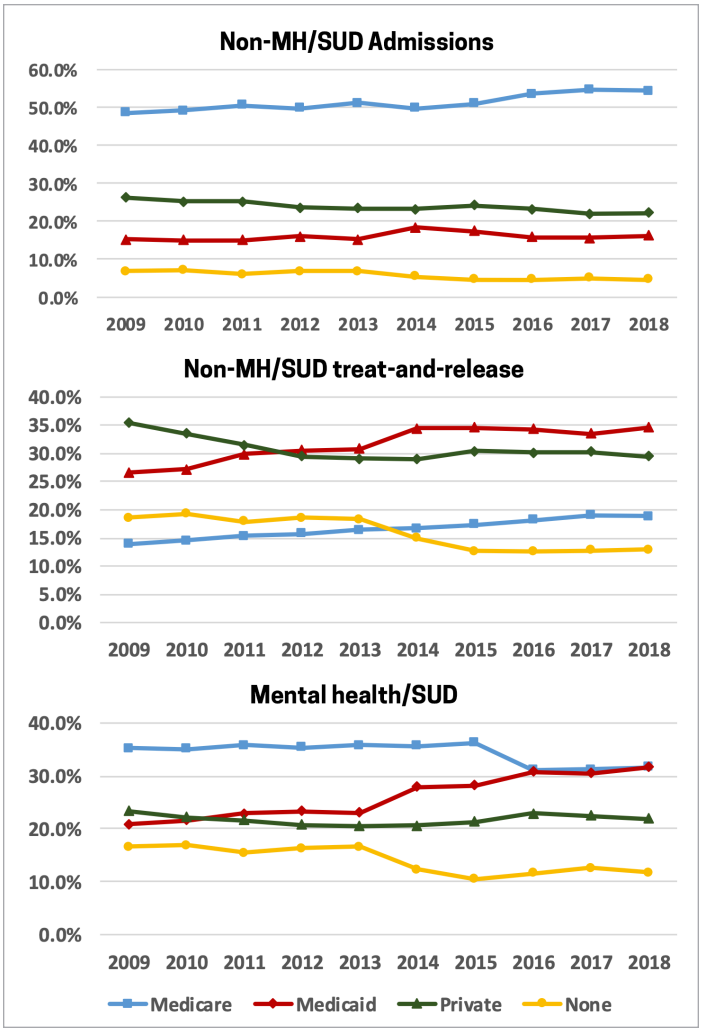
Source: Analyses of Medicare Part A and Part B claims for the period January 2021 to July 2022

Figure 2: Top 20 first-listed diagnoses with the highest number of treat-and-release ED visits, 2018



Note: The highlighted diagnoses represent conditions that may have a high likelihood of being able to be referred to resources other than an ED.

Figure 3: Percent of ED visits by type and expected payer, United States, 2009-2018



Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2019-2018. Primary payer is shown here categorized as Medicare, Medicaid, private insurance, and none (self-pay or no charge). Very small numbers of other are not shown. The mental health/SUD categorization relies on ICD-9-CM codes from 2008 until the third quarter of 2015 and ICD-10-CM codes from 2016 to 2018. There are known discontinuities between these two coding systems that include a transition period as the new codes were adopted. For this reason, care should be taken in interpreting changes before and after the ICD transition.

https://aspe.hhs.gov/sites/default/files/private/pdf/265086/ED-report-to-Congress.pdf

The Mobile Integrated Healthcare Umbrella

RIGHT CARE | RIGHT PLACE | RIGHT TIME

Mobile Integrated Healthcare-Community Paramedicine (MIH-CP) is an evidence-based, cost-saving, and innovative way for EMTs and Paramedics to provide patient-centered care outside the hospital and improve patient's health status, in collaboration with other health care professionals.

Early intervention can save the healthcare system **billions** by preventing costly emergency care and hospitalizations. MIH-CP helps patients address gaps in care and prevent acute exacerbations of illness, rather than waiting until patients need 911. For example, community paramedicine visits can help a person living with heart failure, asthma, COPD, or diabetes avoid acute emergencies. Community Paramedics can:

- Work with frequent 911 callers to decrease preventable 911 calls and emergency room visits.
- Provide in-home visits to people who have chronic and complex medical conditions to prevent unnecessary ambulance transports and emergency room visits.
- Conduct post-hospital follow-up care to prevent hospital readmissions.
- Integrate with public health, home health, health systems, and other providers to increase provider-patient communication.
- Improve medication and self-care compliance through education and health promotion.

The potential value of MIH-CP is compounded in rural areas (ambulance deserts) and communities that lack sufficient access to health care.

Early intervention can save the healthcare system billions by preventing costly emergency care and hospitalizations.
Mobile Integrated Healthcare-Community Paramedicine helps.

Ready, Risk, Reward: Improving Care for Patients with Chronic Conditions by Premier analyzed nearly 24 million ED visits across 750 hospitals and found that approximately 4.3 million visits associated with patients with six common chronic conditions were potentially preventable. Annual savings of $8.3 billion could be achieved by providing coordinated care to these patients in non-emergency settings.

A 2023 NAEMT national survey of MIH-CP programs indicated the lack of sustainable funding, regulatory barriers, and ongoing EMS workforce shortages as primary reasons MIH-CP programs have not been sustainable.

https://naemt.org/docs/default-source/community-paramedicine/toolkit/mihcp-presentation_may-2023.pdf

Ready, Risk, Reward: Improving Care for Patients with Chronic Conditions

By assessing and stabilizing at-risk patients, Paramedics can avoid unnecessary Emergency Department visits

Generating Savings of Approximately $1,900 Per Case

Community Paramedicine saves $6 million in 1 year
82 percent decrease in ER visits

A MIH-CP program worked with the Commonwealth Care Alliance (CCA) in Massachusetts to reduce unnecessary emergency department use for dual eligible Medicare/ Medicaid beneficiaries. The program helped safely prevent an emergency department visit 82 percent of the time, saving over $1,900 per enrolled patient, and representing an expenditure savings of nearly $6 million in a year. https://www.hfma.org/operations-management/cost-reduction/63296/

Savings of over $1,000 per week per patient

South Jefferson Community Paramedics eliminate weekly unnecessary hospital visits: South Jefferson Rescue Squad Community Paramedics in rural Upstate New York recently encountered a non-compliant diabetic patient who called 911 for transport to the hospital about once per week. This patient was admitted to South Jefferson's MIH program and after a few home visits with the Paramedic, shared that he could not read the directions for his medication and was "guessing " when taking them. South Jefferson MIH providers set up the medications, and educated the patient on taking them. As a result, the patient has not called 911 again or been transported to the emergency room. Since completing the program, the patient has saved the healthcare system over $1,000 per week by avoiding ambulance trips to the emergency room.

ER cost avoidance of $439 per patient
Hospitalization cost avoidance of $2,139 per patient

Community Paramedics in Lincoln County Maine documented emergency department cost avoidance of $439 per patient and hospitalization cost avoidance of $2,139 per patient. One high-utilizer patient who received Community Paramedicine services went from a $5,895 cost in emergency department services to $0 following CP visits in one month. https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?article=1022&context=substance-use-research-and-evaluation

Savings of over $1,000 per week per patient

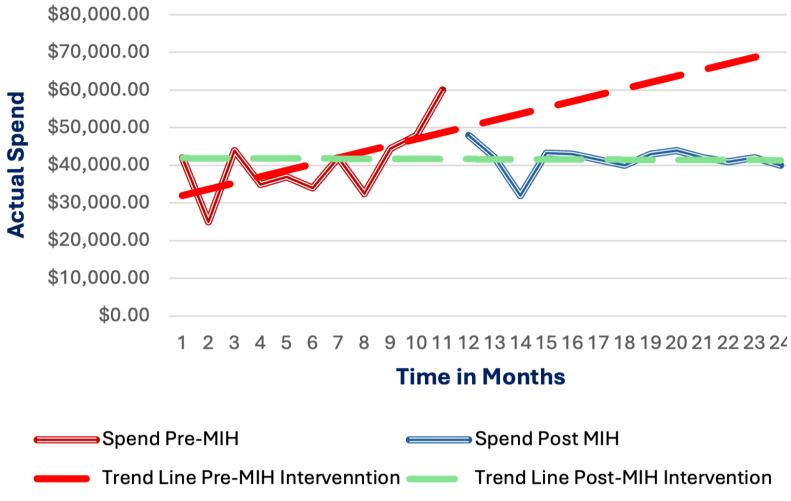
Integrating Fall Prevention Strategies into EMS to Reduce Falls and Health Care Costs for Older Adults: Paramedics with MedStar Mobile Healthcare in Fort Worth, Texas utilized the Stopping Elderly Accidents, Deaths, and Injuries (STEADI) prevention model during 911 responses, visits to high utilizers, and 30-day Hospital Readmission Avoidance programs. MIH-CP services, along with additional needed referral services, resulted in a 37.2% reduction in fall-related emergency calls and costs savings of $6 million or $15,000 per enrolled patient. https://pubmed.ncbi.nlm.nih.gov/38533419/

NAEMT
Advancing the EMS profession

Pre-MIH Intervention vs. Post-MIH Intervention

Actual Spend & Trend Line

MIH Cost Savings for Heart Disease Patients in Washington County, Missouri: The Washington County Ambulance District, working with Great Mines Health Center, enrolled individuals with heart disease in a HRSA funded MIH program. These Medicaid beneficiaries received 12 months of MIH services.



FirstNet Authority Reauthorization

The FirstNet Authority (FNA) oversees the Nationwide Public Safety Broadband Network (NPSBN), commonly known as FirstNet, the country's only dedicated public safety broadband network for public safety and first responders.

BACKGROUND

Established in the wake of the September 11, 2001 attacks, the **FirstNet Authority is responsible for the buildout, deployment and oversight of the operation of FirstNet** to ensure contractual compliance by its vendor partner.

Through a groundbreaking and rigorous competitive procurement process, the Authority secured a major wireless carrier—AT&T—to build out the network. **The FirstNet Authority-AT&T collaboration is one of the largest and most successful public-private partnerships ever.**

By February 2027, the FNA must be reauthorized by Congress to complete its contract and continue to support and advance this unique and critical network. As a February 2022 U.S. Government Accountability Office report stated, "**without legislative action, the public-safety network will be at risk and first responders could lose service.** Congress should consider reauthorizing FirstNet before the 2027 end date to ensure network continuity."

ASK

Reauthorize the FirstNet Authority to protect the communications on which public safety depends.

TALKING POINTS

A Critical Network

- 29,000+ agencies depend on FirstNet to provide reliable, priority connections during and after a disaster, at large events and across rural, remote and dense urban centers.
- Emergency responders demanded a single, nationwide network; FirstNet delivers this.
- In an increasingly complex, technology-driven world, responders require a state-of-the-art communication platform.

A Highly Efficient, Effective Public-Private Partnership

- This first-of-its kind network was created on schedule and on budget. The FNA has never sought additional funds from Congress.
- Eliminating the FNA will not save money for the federal government. FirstNet is funded through lease fees paid by AT&T and has no federal appropriation.
- The FNA-AT&T collaboration is one of the largest, most successful public-private partnerships ever.

Oversight and Continuity Are Necessary

- If the FNA is not reauthorized ahead of the February 2027 sunset date, there is a real risk that first responders will lose service.
- FirstNet's most critical and fundamental commitment is to support public safety. This promise must never be weakened.