Overview of 2026 Congressional Requests

Support Medicare Reimbursement for EMS Treatment in Place (TIP)
Please support H.R. 2538 and S. 3145, the Comprehensive Alternative Response for Emergencies (CARE) Act, sponsored by Reps. Mike Carey (R-OH), Lloyd Doggett (D-TX), Carol Miller (R-WV), and Pat Ryan (D-NY) in the House and Sens. Susan Collins (R-ME) and Peter Welch (D-VT) in the Senate. This bill would create a pilot program to test and evaluate the Treatment in Place (TIP) model of providing the right care, at the right time and in the most cost-effective manner to patients under the Center for Medicare and Medicaid Innovation (CMMI). To learn more or to cosponsor the CARE Act in the House, please contact Ryan Dalbec in Rep. Carey's office at Ryan.Dalbec@mail.house.gov or Afton Cissell in Rep. Doggett's office at Afton.Cissell@mail.house.gov. In the Senate, please contact in Sen. Collins' office a Katherine_Huiskes@collins.senate.gov or Jahnessa Ryea in Sen. Welch's office at Jahnessa_Ryea@welch.senate.gov.

Support Mobile Integrated Healthcare (MIH) Community Paramedicine (CP) Programs
Please support H.R. 4011, the Community Paramedicine Act, sponsored by Reps. Emanuel Cleaver (D-MO) and Diana Harshbarger (R-TN). 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 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 or Peter Stein in Rep. Harshbarger's office at Peter.Stein@mail.house.gov.

Support FY2027 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 are often 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 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 the Rural EMS Training and Equipment Assistance (REMSTEA) grant program for rural public and non-profit EMS agencies and fire departments to purchase equipment, provide training, and meet other critical needs. Please include $33 million in the FY2027 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.

Please Support H.R. XX/S. XX, the Reimbursing Emergency Services for Critical Use of Emergency Blood (RESCUE) Act
Please support H.R. XX/S. XX, the Reimbursing Emergency Services for Critical Use of Emergency Blood (RESCUE) Act, which directs the Center for Medicare and Medicaid Services (CMS) to create an add-on payment for blood products administered by EMS under Medicare and Medicaid. The extra payment will be at cost for the unit of blood and the supplies needed to administer it. The RESCUE Blood Act seeks to make lifesaving prehospital blood transfusions accessible to all and affordable for EMS agencies. To learn more or to cosponsor the RESCUE Act, please contact Dan Butler at dan.butler@mail.house.gov in Rep. Kean's office.

Ensure all EMS Practitioners are Counted
Please support H.R. 3791 and S.XX, the EMS Counts Act, sponsored by Reps. Glen GT Thompson (R-PA) and John Mannion (D-NY) in the House, and soon to be introduced by Sens. Susan Collins (R-ME) and Andy Kim (D-NJ) in the Senate. 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. To learn more or to cosponsor the EMS Counts Act in the House, please contact Faith Tuttle in Rep. Thompson's office at Faith.Tuttle@mail.house.gov or Ben Picciano in Rep. Mannion's office at Ben.Picciano@mail.house.gov. In the Senate, please contact Michael Mets in Sen. Collins office at Michael_Mets@collins.senate.gov or Marshall Berkardt in Sen. Kim's office at marshall_berkhardt@kim.senate.gov.

Support H.R. 3443, Addressing Critical Challenges Facing EMS
Please support H.R. 3443, legislation that addresses critical issues faced by Emergency Medical Services (EMS) professionals and patients, focusing on three main areas: "wall time", the availability of essential EMS medications (EEMs) and blood and blood product (BBPs), and EMS Medical Director and EMS Clinician Workforce Support. To join as a cosponsor, please contact Alex Stepahin in Rep. Hudson's office at alex.stephanin@mail.house.gov or William Seabrook in Rep. Dingell's office at william.seabrook@mail.house.gov.

Support EMS Workforce
Please support H.R. 2220, the Preserve Access to Rapid Ambulance Medical Treatment Act "PARA-EMT" Act, sponsored by Representatives Marie Gluesenkamp Perez (D-WA) and Brad Finstad (R-MN). This bill would help address the Paramedic and EMT shortage 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. To become a cosponsor or to learn more, please contact Amy Lindardt in Rep. Gluesenkamp Perez's office at Amy.Lindardt@mail.house.gov or Meagan Daly in Rep. Finstad's office at Meagan.Daly@mail.house.gov.

Support H.R. 2196, Honor Our Emergency Medical Services
Please support H.R. 2196 and S. 2546, legislation to extend the authorization to establish a National EMS Memorial, sponsored by Reps. Richard Hudson (R-NC) and Stephen F. Lynch (D-MA) in the House. On March 16th, the House passed H.R. 2196 by a voice vote. Senate sponsors are Sens. Eric Schmitt (R-MO) and Christopher Coons (D-DE). If you are interested in signing on, please contact Alex Stepahin with Rep. Richard Hudson at Alex.Stepahin@mail.house.gov or Ryan Smet with Rep. Stephen F. Lynch at Ryan.Smet@mail.house.gov. In the Senate, please contact Peter Dudziak in Sen. Schmitt's office at Peter_Dudziak@schmitt.senate.gov or Kailyn Broughton in Sen. Coon's office at Kailyn_Broughton@coons.senate.gov.

Support H.R. 7623, Freedom House Ambulance Service Congressional Gold Medal Act
Please join Reps. Summer Lee (D-PA), Mike Kelly (R-PA), and Debbie Dingell (D-MI) in sponsoring H.R. 7623, Freedom House Ambulance Service Congressional Gold Medal Act, to recognize the Freedom House Ambulance Service's dedication to their community and contribution to the field of emergency medical services. To learn more or to cosponsor this bill, please contact Tori DeLeonardo in Rep. Lee's office at Tori.DeLeonardo@mail.house.gov.

Support the EMS Caucus (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. For additional information or to join the EMS Caucus, please contact Alex Rosemond in Rep. Hudson's office at Alex.Rosemond@mail.house.gov or Molly Burns in Rep. Dingell's office at Molly.Burns@mail.house.gov.

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

REQUEST
Please support H.R. 2538 and S. 3145, the Comprehensive Alternative Response for Emergencies (CARE) Act, sponsored by Reps. Mike Carey (R-OH), Lloyd Doggett (D-TX), Carol Miller (R-WV), and Pat Ryan (D-NY) in the House and Sens. Susan Collins (R-ME) and Peter Welch (D-VT) in the Senate. 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 (ED). Unfortunately, Medicare currently does ***not*** reimburse EMS practitioners for TIP. Medicare only reimburses EMS 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 ED, 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 home. Sometimes these patients have chronic conditions like asthma or diabetes that require medication. EMS agencies can assess these patients, provide medication and treatment, and leave them comfortably and safely at home. With Medicare reimbursement unavailable, EMS agencies receive no payment for the clinical time, supplies, and medication that goes into providing this care.

TIP 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.

Many State Medicaid programs and commercial payers are reimbursing EMS agencies for TIP – Medicare reimbursement is needed to facilitate widespread adoption of TIP.

To learn more or to cosponsor the CARE Act in the House, please contact Ryan Dalbec in Rep. Carey's office at Ryan.Dalbec@mail.house.gov or Afton Cissell in Rep. Doggett's office at Afton.Cissell@mail.house.gov. In the Senate, please contact Katherine Huiskes in Sen. Collins' office at Katherine_Huiskes@collins.senate.gov or Jahnessa Ryea in Sen. Welch's office at Jahnessa_Ryea@welch.senate.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 H.R. 4011, the Community Paramedicine Act, sponsored by Reps. Emanuel Cleaver (D-MO) and Diana Harshbarger (R-TN). 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 and address the root causes of chronic disease. 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 make communities healthy. 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 lack sustainability and have been forced to shrink their scope or close 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 or Peter Stein in Rep. Harshbarger's office at Peter.Stein@mail.house.gov.

ADDITIONAL INFORMATION

Lower Costs, Improved Outcomes

According to the Department of Health and Human Services, six in ten Americans have at least one chronic disease. 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, February 15, 2019, https://www.hfma.org/operations-management/cost-reduction/63296/

Please Support FY2027 Funding for SIREN Act Grants

REQUEST

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

Please include $33 million in the FY2027 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 are often 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 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 wages in an incredibly competitive labor market.

Coupled with declines in primary care availability, rural hospital closures, 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 obsolete ambulances with newer and safer models. Since the inception of the program in 2018, more than 230 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.

SIREN grants awarded in FY 2024 were for a two-year project period with a maximum grant of $200,000 per award year. Therefore, no new grants were awarded in FY 2025.

A new SIREN grant application round is expected to begin in FY 2026.

ADDITIONAL DETAILS
Amount Requested: $33 million
Department: Health and Human Services (HHS)
Agency: Substance Abuse and Mental Health Services Administration (SAMHSA)
Account: Substance Abuse Treatment Programs; First Responder Training; Rural EMS Training and Equipment Assistance (REMSTEA) grants program

Report Language: *First Responder Training.*— $33,000,000 is provided to make awards to rural public and non-profit fire and EMS agencies to train and recruit staff, provide education, purchase equipment (including medications such as naloxone and protective equipment), and other activities as reauthorized in the Supporting and Improving Rural EMS Needs Reauthorization Act (Public Law 118–84).

Federal Funding History
FY2026: $13.5 million
FY2025: N/A
FY2024: $11.5 million
FY2023: $10.5 million
FY2022: $7.5 million
FY2021: $5.5 million
FY2020: $5 million

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Please Support H.R. XX/S. XX, the Reimbursing Emergency Services for Critical Use of Emergency Blood (RESCUE) Act

REQUEST:

Please support H.R. XX/S. XX, the Reimbursing Emergency Services for Critical Use of Emergency Blood (RESCUE) Act, which directs the Center for Medicare and Medicaid Services (CMS) to create an add-on payment for blood products administered by EMS under Medicare and Medicaid. The extra payment will be at cost for the unit of blood and the supplies needed to administer it. The RESCUE Blood Act seeks to make lifesaving prehospital blood transfusions accessible to all and affordable for EMS agencies.

BACKGROUND:

Severe hemorrhage is the leading cause of preventable trauma deaths in the United States. In the last ten years, EMS agencies have increasingly begun carrying whole blood or other blood products to give to bleeding patients before they arrive at the hospital. Now, patients who would not have survived their traumatic injuries or internal bleeding are recovering and walking out of the hospital to resume their lives.

CMS does not currently reimburse EMS agencies for blood products administered by Paramedics before arrival at the hospital, creating a financial barrier that limits the adoption of this lifesaving intervention. A unit of prehospital blood can cost EMS agencies as much as $1,800 per unit administered. Even the highest currently available CMS EMS reimbursement (ALS 2) does not cover the full cost of care for a seriously ill or injured person and certainly does not contribute to the cost of pre-hospital blood administration.

The RESCUE Blood Act directs CMS to create an add-on payment for blood products administered by EMS Paramedics under Medicare and Medicaid. The payment will be at cost for the unit of blood and the supplies needed to administer it, allowing agencies to afford this lifesaving care.

- **Saves Lives:** Early blood administration significantly improves survival in hemorrhagic shock.
- **Closes a Policy Gap:** Hospitals are reimbursed for blood products above cost; EMS agencies are not reimbursed at all.
- **Supports Rural Trauma Systems:** While all patients, regardless of geography, benefit from prehospital blood, rural and frontier communities with long travel times to trauma hospitals benefit most from early blood access.
- **Cost-Effective:** Early stabilization of patients in hemorrhagic shock reduces downstream costs from complications and prolonged hospitalizations. At-cost reimbursement to EMS is less expensive than hospital blood reimbursement.

This legislation modernizes EMS prehospital reimbursement policy to reflect current medical science, save lives, and strengthen America's emergency medical and trauma care systems.

The RESCUE Blood Act is endorsed by the following organizations: The International Association of Fire Chiefs, The International Association of Fire Fighters, The National Association of EMTs, and the Prehospital Blood Transfusion Coalition.

To learn more or to cosponsor the RESCUE Act, please contact Dan Butler at dan.butler@mail.house.gov in Rep. Kean's office.

EMS On The Hill Day

Please Ensure all EMS Practitioners Are Counted

REQUEST

Please support H.R. 3791, the EMS Counts Act, sponsored by Reps. Glen GT Thompson (R-PA) and John Mannion (D-NY) in the House, and soon to be introduced by Sens. Susan Collins (R-ME) and Andy Kim (D-NJ) in the Senate. 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 in the House, please contact Faith Tuttle in Rep. Thompson’s office at Faith.Tuttle@mail.house.gov or Ben Picciano in Rep. Mannion’s office at Ben.Picciano@mail.house.gov. In the Senate, please contact Micheal Mets in Sen. Collins’ office at Michael_Mets@collins.senate.gov or Marshall Berkardt in Sen. Kim’s office at marshall_berkhardt@kim.senate.gov.

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.

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

National Association of EMS Physicians

Support for H.R. 3443: Addressing Critical Challenges Facing EMS

H.R. 3443 addresses several critical issues facing Emergency Medical Services (EMS) clinicians and patients. The proposal focuses on three primary areas: (1) "wall time," (2) the availability of essential EMS medications (EEMs) and blood and blood products (BBPs), and (3) EMS Medical Director and EMS Clinician (e.g., EMT and paramedic) Workforce Support. These challenges affect EMS systems' ability to deliver timely, high-quality care when minutes count for patients with emergency medical conditions. These issues are particularly important as Congress examines efforts to modernize the EMS system, including through the Rural Health Transformation Program and other potential reforms. **To join as a cosponsor of the bill, please contact Alex Stephanin in Rep. Hudson's office (alex.stephanin@mail.house.gov) or Molly Burns in Rep. Dingell's office (molly.burns@mail.house.gov).**

1. Wall Time

"Wall time" refers to the period when EMS personnel must remain with a patient at the hospital until care is formally transferred to hospital staff—often waiting "against the wall" in the emergency department. Extended wall times delay EMS units' return to service, reducing their availability to respond to other emergencies and straining already limited EMS resources.

H.R. 3443 requires HHS to issue EMTALA clarification to hospitals addressing wall time and to clarify how the "presents to a hospital" standard applies in these circumstances, as well as to report to Congress on strategies to address emergency department overcrowding and patient boarding that contribute to these delays.

2. Availability of Essential EMS Medications and Blood & Blood Products

Shortages of essential EMS medications continue to threaten EMS agencies' ability to provide emergency care. Agencies are experiencing shortages of everything from IV fluids to sedatives. When shortages occur, medical directors must continually revise protocols based on available drugs and concentrations, while paramedics must adjust to alternative medications or dosing regimens—raising the risk of medication errors in a fast-paced, high-acuity environment. While the underlying issue for many drug shortages is that prices are too low to sustain a reliable supply, the opposite is true for blood and blood products, which can be prohibitively expensive for EMS agencies to carry—even though they can be life-saving, particularly in rural areas with long transport times.

H.R. 3443 establishes a CMMI demonstration program to evaluate separate payment for essential EMS medications to prevent shortage and for blood and blood products, helping ensure EMS agencies have access to these critical tools when minutes matter most.

3. EMS Medical Director and EMS Clinician (e.g., EMT and paramedic) Workforce Support

EMS clinicians and EMS medical directors are critical components of the health care system. Physician EMS medical director oversight is essential to ensure that EMS agencies provide high-quality and safe patient care. Yet under the current EMS system, medical directors are not always consistently compensated for this work. At the same time, EMS agencies face challenges attracting and retaining clinicians, contributing to workforce pressures across the emergency care continuum.

H.R. 3443 directs MedPAC to conduct a study examining the level and structure of support associated with EMS medical direction and the broader EMS clinical workforce. The study aims to better understand current challenges and inform policymakers about potential approaches to supporting clinicians who oversee and deliver high-quality emergency medical care. It does not mandate changes to reimbursement; instead, it provides Congress with data to guide future policy discussions.

Please Support EMS Workforce Shortage Initiatives
for the Hiring, Retention and Training of Paramedics and EMTs

REQUEST

Please support H.R. 2220, the Preserve Access to Rapid Ambulance Medical Treatment Act "PARA-EMT" Act, sponsored by Representatives Marie Gluesenkamp Perez (D-WA) and Brad Finstad (R-MN). This bill would help address the Paramedic and EMT shortage by:

- Providing funding for the Administration for Strategic Preparedness and Response (ASPR) for grants open to all ambulance service providers to fund Paramedic and EMT recruitment and training and retention initiatives, including employee education and peer-support programming to reduce and prevent:
  - Burnout;
  - behavioral health disorders;
  - substance use disorders; and
  - suicidal ideation
- Reducing barriers that prevent Veterans who are military medics from becoming certified as Paramedics/EMTs.
- Requesting the Secretary of Labor (in coordination with the HHS Secretary) to conduct a study on the current and projected EMS workforce shortage and report their findings.

BACKGROUND

Extreme Shortage of Paramedics and EMTs

- Our country's emergency medical services (EMS) system is facing crippling staffing challenges that threaten the provision of crucial emergency healthcare services.
- The widespread shortage of Paramedics and Emergency Medical Technicians (EMTs) is a long-term problem that has been building for over a decade and exacerbated by the COVID-19 pandemic.
- The 2024 Ambulance Employee Workforce Turnover Study by the American Ambulance Association (AAA) and Newton 360 - involving nearly 20,000 employees working at 258 EMS organizations — found that overall turnover among Paramedics and EMTs ranges from 20 to 30 percent annually.
- The shortage is resulting in longer 9-1-1 response times for ambulances to reach patients in need of emergency care, delays in urgent interfacility ambulance transport to receive a higher level of care, and interruption of the routine interfacility ambulance transportation system that is needed to support throughput in entire health care system moving.
- The pipeline for EMS clinicians entering the health care profession has been stretched thin as baby boomers age into retirement and low EMT and Paramedic wages fail to keep up with rising costs.
- The shortage is exacerbated by a growing number of hospital closures, especially in rural communities, which is placing increased demands on the EMS system.

Reasons for the EMS Workforce Shortage

- A need for more EMS responders to meet increasing demand for ambulance service due to aging communities, substance abuse, 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.
- Highly trained Paramedics are being hired by hospitals to offset the nursing shortage.
- Significant delays in turning patients over to hospitals due to emergency room overcrowding.

To learn more or become a cosponsor, please contact Amy Lindardt in Rep. Gluesenkamp Perez's office at Amy.Lindardt@mail.house.gov or Meagan Daly in Rep. Finstad's office at Meagan.Daly@mail.house.gov.

Please Support H.R. 2196/S.2546, Honor Our Emergency Medical Services

REQUEST

Please support H.R. 2196 and S. 2546, legislation to extend the authorization to establish a National EMS Memorial, sponsored by Reps. Richard Hudson (R-NC) and Stephen F. Lynch (D-MA) in the House. In the Senate, Sens. Eric Schmitt (R-MO) Christopher Coons (D-DE).

On March 16th, H.R. 2196 passed the House by voice vote. Action now turns to the Senate.

BACKGROUND

Each year across our nation the 850,000 men and women of Emergency Medical Services (EMS) answer more than 30 million calls to serve 22 million patients at a moment's notice and without reservation. As an element of the Emergency Services Sector, EMS stands on the nation's first line of defense in the prevention and mitigation of risk from local disturbances, terrorist attacks, man-made incidents, and natural disasters. These men and women, serving in both the public and private sectors as career and volunteer EMS providers, are a critical element of our nation's health systems, homeland security and national security efforts.

Statistics compiled by the United States Department of Labor and the National Highway Safety Administration indicate that emergency medical services providers die in the line of duty at a rate more than twice the national average for all occupational fatalities and during their careers experience an injury rate of nearly 100 percent. It is time to recognize the efforts of our EMS and memorialize the selfless and ultimate sacrifice made by more than 600 members of the nation's EMS, their families, and loved ones.

A bill establishing the National Emergency Medical Services Memorial Foundation for the purpose of establishing commemorative work on Federal land in the District of Columbia passed in the 115th Congress and was signed into law on November 3, 2018. A Commemorative Works Act authorization lasts 7 years and thus expired on November 3, 2025.

The EMS Memorial Foundation has worked diligently to get the necessary approvals, design the Memorial and identify a suitable site. Unforeseen circumstances, however, delayed the process and more time is needed to get the planned Memorial across the finish line.

Please show your support for the men and women of Emergency Medical Services by co-sponsoring H.R. 2196 and S. 2546, extending the authorization to establish a National EMS Memorial, at no cost to the taxpayer. If you are interested in signing on, please contact Alex Stepahin with Rep. Richard Hudson at Alex.Stepahin@mail.house.gov or Ryan Smet with Rep. Stephen F. Lynch at Ryan.Smet@mail.house.gov. In the Senate, please contact Peter Dudziak in Sen. Schmitt's office at Peter_Dudziak@schmitt.senate.gov or Kailyn Broughton in Sen. Coon's office at Kailyn_Broughton@coons.senate.gov.

Please Support H.R. 7623, Freedom House Ambulance Service Congressional Gold Medal Act

REQUEST:
Please join Reps. Summer Lee (D-PA), Mike Kelly (R-PA), and Debbie Dingell (D-MI) in sponsoring H.R. 7623, Freedom House Ambulance Service Congressional Gold Medal Act, to recognize the Freedom House Ambulance Service's dedication to their community and contribution to the field of emergency medical services. To learn more or to cosponsor this bill, please contact Tori DeLeonardo in Rep Lee's office at Tori.DeLeonardo@mail.house.gov.

BACKGROUND:
Founded in 1967 the Freedom House Ambulance Service was the first emergency medical service in the United States to be staffed by paramedics with medical training beyond basic first aid. It was staffed entirely by Black men and women to provide economic stimulation to the people of Pittsburgh.

Freedom House Ambulance Service broke medical ground by training its personnel to conduct previously unheard-of standards of emergency medical care for patients en-route to hospitals. The paramedic training and ambulance design standards pioneered in the Freedom House Ambulance Service would set the standard for pre-hospital emergency care nationally and even internationally.

Please join us in recognizing the Freedom House Ambulance Service's dedication to their community and contribution to the field of emergency medical services.

Over 90 Supporting Organizations Including: National Association of Emergency Medical Technicians, National EMS Management Association, The National Association of EMS Physicians, National Association of EMS Educators, American Ambulance Association, The Vera Institute of Justice, American Paramedic Association, Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions, National Association of State Emergency Medical Services Officials, Pittsburgh Emergency Medical Services, City of Pittsburgh, UMPC Health System, Six Minutes to Live, National Registry of EMTs, New York State Volunteer Ambulance and Rescue Association, Community Emergency Corps, Florida EMS Association, 100 Black Men of Western PA, Institute of Fire Engineers - USA Branch, Missouri EMS Association, Freeport Fire-EMS, and Louisiana Public Health Association (LPHA).

To learn more or to cosponsor this bill, please contact Tori DeLeonardo in Rep Lee's office at Tori.DeLeonardo@mail.house.gov.

Please Join the Congressional EMS Caucus

REQUEST:
Please join the Congressional EMS Caucus, Co-Chaired by Reps. Richard Hudson (R-NC) and Debbie Dingell (D-MI).

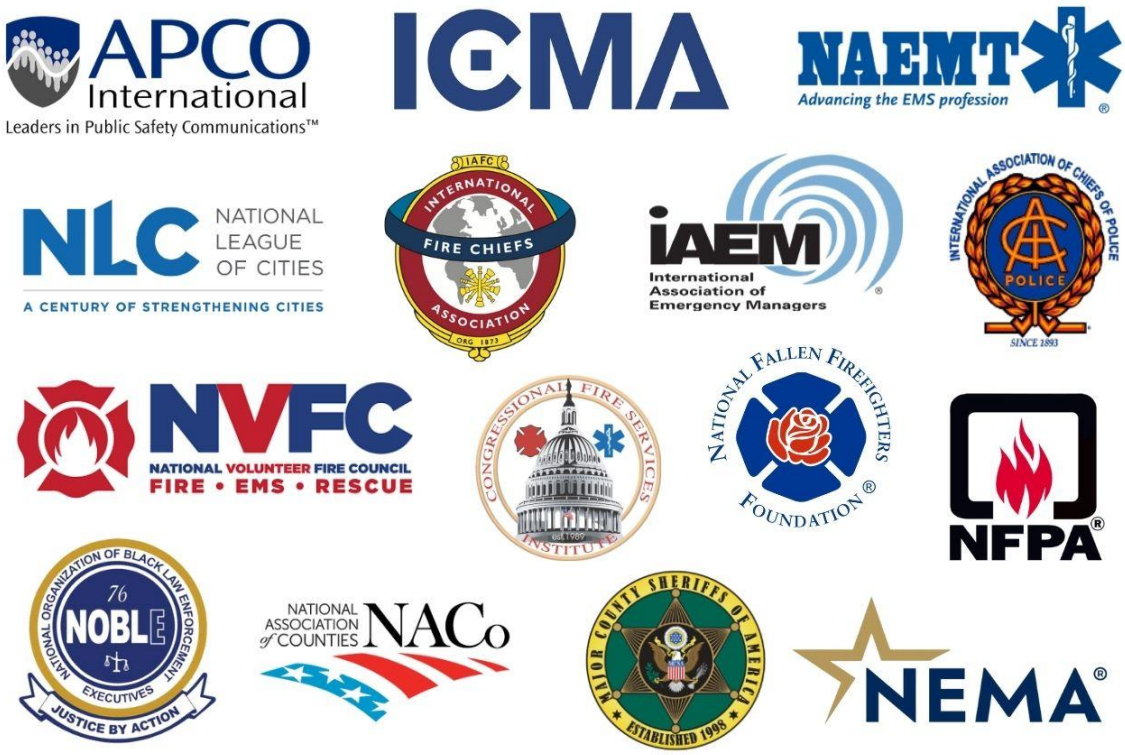
BACKGROUND:
The EMS Caucus helps Congress understand EMS issues and promotes policies that help EMS practitioners provide life-saving medical care in emergencies, cost-saving care management in non-emergent or emergent situations, and disaster response at any time. Highly trained EMTs and Paramedics are on the front lines 24/7/365. Despite low pay and even 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 compassion 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 9-1-1 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, and 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 Rosemond in Rep. Hudson's office at Alex.Rosemond@mail.house.gov or Molly Burns in Rep. Dingell's office at Molly.Burns@mail.house.gov.



Recommendations for Preserving the Federal FirstNet Network

1. Length of Extension of Sunset of FirstNet Authority

1. Extend the sunset for 10 – 20 years.
2. Do not set the sunset date at the same time as the FirstNet contract renewal (15 years extension) – it creates too much uncertainty in changes in conditions of the contract during the federal contracting process.
1. Preferably aim for the sunset to expire on September 30 (the end of a fiscal year) and not during an election year.
2. Establish a recurring 10-year renewal of the First Responder Network Authority's authorization, contingent upon the Secretary's confirmation that it has fulfilled its statutory duties and subject to congressional oversight.

2. Redlines About Federal FirstNet Governance to Protect

1. Maintain the authority of the federal FirstNet Board.
    i. It has representatives from public safety; the federal government; and industry.

1. Congress should consider adding the NTIA Administrator to the FirstNet Board (as a representative of the Department of Commerce).
2. NTIA should ensure geographical diversity to the FirstNet Board.
3. NTIA should return to setting up staggered terms for the FirstNet Board members.
4. For the Cabinet-level officials on the FirstNet Board, they should be required to attend or send Executive Schedule official as a designate.

2. Maintain the role of the Public Safety Advisory Committee.
    1. It speaks for the public safety end users of the network and provides important guidance to the FirstNet Board members.
    2. The PSAC should not be designated as a FACA committee to ensure candid discussions between the PSAC members, the federal FirstNet staff, and the contractor of the NPSBN, which is AT&T.
    3. NTIA should work to improve the business processes for federal FirstNet.
        1. It is important that staffing and financial decisions (and financial transactions) should be administered in an efficient manner, so that the federal FirstNet network can be managed as efficiently as a commercial network (actually, more efficiently, because the federal FirstNet network is a life safety system for use during emergencies).
        2. The AT&T sustainability payments should be used for improvements to maintain and improve the federal FirstNet network.
3. The contract should not be renegotiated mid-contract nor should non-contracted carriers be allowed access to the federal FirstNet core.
    1. The federal FirstNet network already can share voice and text data with other carriers.
    2. The federal FirstNet network's requirements for priority access and ruthless preemption remain key components of the network.
4. Federal FirstNet should continue to be required to modernize the network and maintain its ability to adapt to new technology, including upgrading the 5G core and eventually evolving the network to 6G capability.