COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HOUSE VETERANS AFFAIRS & EMERGENCY PREPAREDNESS COMMITTEE
PUBLIC HEARING

STATE CAPITOL
HARRISBURG, PA

IRVIS OFFICE BUILDING
ROOM G-50

TUESDAY, MARCH 1, 2022
1:00 P.M.

PENNSYLVANIA - EMS SYSTEM IN CRISIS
STAKEHOLDER TESTIMONY

SUBCOMMITTEE MEMBERS PRESENT:

HONORABLE KAREN BOBACK, MAJORITY CHAIRWOMAN
HONORABLE LYNDA SCHLEGEL CULVER
HONORABLE MARK GILLEN
HONORABLE KEITH J. GREINER
HONORABLE JOE HAMM
HONORABLE ZACHARY MAKO
HONORABLE TIMOTHY O'NEAL
HONORABLE TRACY PENNYCUICK
HONORABLE JIM RIGBY
HONORABLE FRANCIS X. RYAN

HONORABLE CHRIS SAINATO, MINORITY CHAIRMAN
HONORABLE JENNIFER O'MARA
HONORABLE DAN K. WILLIAMS

NON-COMMITTEE MEMBERS PRESENT:

HONORABLE MARTIN CAUSER

MEMBERS PRESENT VIRTUALLY:

HONORABLE STEPHANIE BOROWICZ
HONORABLE FRANK FARRY
HONORABLE F. TODD POLINCHOCK
HONORABLE CRAIG WILLIAMS

HONORABLE CAROL HILL-EVANS
HONORABLE KRISTINE HOWARD
HONORABLE CHRISTINA D. SAPPEY
HONORABLE THOM WELBY

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Pennsylvania House of Representatives
Commonwealth of Pennsylvania

I N D E X

TESTIFIERS

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I N D E X

TESTIFIERS (CONTINUED)

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SUBMITTED WRITTEN TESTIMONY

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(See submitted written testimony and handouts online.)

P R O C E E D I N G S

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MAJORITY CHAIRWOMAN BOBACK: Good morning. We will now call this public hearing to order. Please silence all phones. Will everyone rise for the Pledge of Allegiance offered by Representative Christina Sappey?

ALL: I pledge allegiance to the flag of the United States of America. And to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MAJORITY CHAIRWOMAN BOBACK: We will begin with a few words from Representative Mark Gillen.

REPRESENTATIVE GILLEN: Thank you, Madame Chairwoman. I was driving in this morning, and I had occasion to hear a news broadcast, and then I further went online to see if I could get a visual on this. And there was a woman, an elderly woman. Perhaps you've seen the visual also; laying with at least one leg blown off and a long line of streaking blood in the hallway. This was a civilian in Ukraine. It was not a combatant. And then further, I saw clustered munitions being used against a civilian population, bombs exploding in Freedom Square in the Ukrainians second largest city. And as an American -- I speak for myself today. I was outraged. As a Pennsylvanian, we have a strategic relationship with the

Lithuanians, and one of the belligerents -- Lithuania has a long border with Belarus, and the Russian Enclave of Kaliningrad south of them. And the State Lithuania -- the Country of Lithuania is in a state of emergency. And so I think I'd like to raise, number one, the profile. This is not just a geography lesson where we try to figure out where these places are, but realize this is something a little bit closer to home.

So, whether we speak today as Americans or Pennsylvanians -- I was 30 years as an emergency medical technician, and seeing someone laying in a hallway, an innocent elderly woman with her leg blown off, I think we ought to recognize that this is outrageous. It's barbaric. It's terrorism, and it's a war crime, and it should be punished, and it should be spoken against.

And, if you would indulge me, Madame Chairwoman, I ask if you would bow your heads in a moment of silence right now of solidarity with those that are being harmed. Thank you, Madame Chair.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Representative Gillen. Good afternoon. My name is Representative Karen Boback. I am the Majority Chairman for the House Veterans Affairs & Emergency Preparedness Committee.

For housekeeping purposes, we do have members and

testifiers in attendance both physically and virtually, as well as public viewing via live stream. Due to the Sunshine Law requirements, if either of these platforms experience technical difficulties, we will pause the meeting in order to correct the issues.

For the members participating virtually, please mute your microphones. Please know that when you speak we all hear you. If you want to be recognized for comments, please raise the hand function. After being recognized but prior to speaking, please turn on your camera and unmute your microphone. After you have completed your question, please mute your microphone. Pardon me.

We are here today to engage in dialogue concerning the ongoing crisis present in Pennsylvania's EMS system. An array of economic hardships, personnel shortages and other issues currently plague our vital EMS services. Our EMS companies are unique from other healthcare providers, in that their services are required. They are required under state 911 law.

Their business model, by virtue of being dependent on receiving 911 calls is extremely unpredictable, and unlike most businesses, many must be available 24/7 for the work that has high stress and strain as factors, but low pay. Due to these funding needs, personnel shortages and low reimbursement rates by

government programs and insurers, are EMS system is in crisis, and therefore Chairman Sainato and I felt that a hearing on this ongoing crisis would be an excellent venue for discussion on these important matters, for both the committee members and various stakeholders.

So, I want to thank the members and our panelists for being here today. Our whole goal is hopefully -- hopefully to find a solution to the crisis.

Chairman Sainato, any opening remarks?

MINORITY CHAIRMAN SAINATO: Yes, thank you, Chairwoman Boback. I just want to echo your sentiments, and we thank you all for being here. You see how important this is to us, to have this many of our members here today. So, I thank them all for coming today, and those that are virtually. And we thank you as our stakeholders, because, you know, we do need to come up with a solution. You are very vital to our state, and what you do, and we do appreciate your efforts and everything that you do for us. And we need to find solutions, because this -- we are in a crisis mode, and it's not getting any better.

So, we look forward to testimony today. I do ask that everyone can please be precise. And even for our own members with questions, because we do have a very long agenda today. So we need to really move it along, because we want to get as much information out of this as possible

within the timeframe which we have. So, thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Chairman. Would the members and staff please introduce themselves? We'll start with Representative Frank Ryan and move to the left.

REPRESENTATIVE RYAN: Representative Frank Ryan, 101st District of Lebanon County, Pennsylvania.

REPRESENTATIVE RIGBY: Representative Jim Rigby, Cambria and Somerset Counties, 71st District.

REPRESENTATIVE CAUSER: Representative Marty Causer. I represent the 67th Legislative District in Potter, Cameron and McKean Counties. I am not a member of the committee, but I want to thank Chairwoman Boback for inviting me to join you today, and I appreciate the invitation very much.

REPRESENTATIVE WILLIAMS: My name is Dan Williams. I represent Chester County's 74th District.

REPRESENTATIVE SAPPEY: State Representative Christina Sappey representing the 158th in Chester County.

REPRESENTATIVE O'MARA: Good afternoon, I'm Jennifer O'Mara. I represent the 165th Legislative District in Delaware County.

REPRESENTATIVE GILLEN: Representative Mark Gillen. For the moment I represent Northern Lancaster and Southern Berks Counties.

REPRESENTATIVE CULVER: Linda Culver, representing the people of the 108th Legislative District, Northumberland and Snyder Counties.

REPRESENTATIVE MAKO: Zach Mako, 183rd, Lehigh, North Hampton.

MR. HILLMAN: Mike Hillman, Democratic Executive Director.

MR. O'Leary: Executive Director for Chairman Boback.

MR. HARRIS: Shawn Harris, Senior Research Analyst for the Committee.

REPRESENTATIVE PENNYCUICK: Tracy Pennycuick, representing the 147th in Northern Montgomery County.

REPRESENTATIVE HAMM: Joe Hamm, 84th Legislative District, Lycoming and Union County.

REPRESENTATIVE GREINER: Keith Greiner, 43rd District, Lancaster County.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Also joining us today virtually are Representatives Todd Polinchock, Craig Williams, Thom Welby, Carol Hill-Evans and Frank Farry.

I would also like to thank Chairman Causer who introduced himself already and Chairman Farry who is online for joining us today. They both have great backgrounds in fire and EMS services, and their passion and expertise for

today's discussions are very much appreciated. Thank you, both.

At this time we will call up our first testifier, Mr. Aaron Rhone, Acting Bureau Director of the PA Department of Health's Bureau of EMS. Welcome, Mr. Rhone, and thank you for being with us today. You may begin when you are ready.

DR. RHONE: Good afternoon Chairman -- Chairwoman Boback, Chairman Sainato and members of the Committee. I am Dr. Aaron Rhone, the Interim Bureau Director for the Bureau of Emergency Medical Services within the Pennsylvania Department of Health. I have over 20 years of certification in the Commonwealth as an EMS provider, and I would like to thank you for the opportunity to provide testimony today related to the various areas concerned within the emergency medical services industry within the Commonwealth.

Before I begin my testimony today, I would like to take a moment to recognize the tremendous work being done and being performed by our EMS providers across our Commonwealth. The Commonwealth's EMS professionals remain dedicated and steadfast in their work throughout this global pandemic, and for that I would be remiss also if I don't acknowledge their families who have shared their dedicated time of their loved one with us to protect the

health and safety on all Pennsylvanians.

As many of you are aware, the Department of Health Service is the lead regulatory agency for EMS within the Commonwealth, overseeing 13 regional EMS councils, approximately 1,300 licensed EMS agencies and over 40,000 certified providers. In 2021 alone, the Pennsylvania EMS system responded to over 2 million calls for service.

Throughout the course of my tenure in the Department, which is spanning about eight years through other sections, I will say that we have discussed, both internally in the state and across the nation with other partners, the fact of recruitment and retention. As I have noted in my testimony, every year the Bureau of EMS certifies approximately 2,000 to 2,300 individuals as the -- as an emergency medical technician, yet that number is often outpaced by people who have not renewed or recertified their certification.

In my testimony you will note that in Calendar Year 2020, 2,288 EMTs allowed their EMS certification to expire. That's either by choice, failing to complete free con ed that's offered by the Department, or they have moved on to other parts of the healthcare system.

Just one year later in 2021, 2,606 EMTs allowed their certification to expire for the same reasons.

Of note in my testimony, I want to draw your

attention to, of those EMTs who allowed their certification to expire, 63% of them were under the age of 40, and 44% were under the age of 30. This is alarming, because these EMTs are traditionally our next-step providers that move into those higher clinician roles of a paramedic or more, so them leaving our system leaves us great holes.

Additionally, I would like to call your attention to my testimony. We did a regulatory exception prior to the COVID pandemic allowing recertification of EMS providers by reducing the requirements for testing. In the way the Act is written and the rules and regulations allow, the testing requirement required someone who had expired prior to two years ago to take both the National Registry exam and also a cognitive -- a psychomotor exam; a hands-on practical examination.

By removing that barrier, we did allow approximately -- and bear with me -- 1,130 EMS applications to be processed, and there are still more to those. Unfortunately I hadn't had enough time to prepare all the data for today, so my apologies on that.

But, this increased the workforce by 1,200%, which is a remarkable case, but I will also draw your attention to the fact that of those we were only able to identify 223 individuals actively providing care as identified by a patient care record. And for the

Committee's edification, a patient care record would be any time EMS is engaged in providing care, they would write a documentation that outlines somewhat of a medical history and who all provided care. So of that, only about 20% of what we brought into the system through this exception have actually provided care. Based off of the predominant data available to us at the time for this testimony, most of these providers were in Northeastern Pennsylvania.

Outside of bringing providers back, one of the issues that we have is a funding issue as well. And I know other members of those testifying today will hit upon this as well, too. However, the $25 million appropriated in Act 10 of 2020 will be a much needed support; however, it's a small change impact to many EMS agencies.

The original testimony that was submitted had a typographical error, and I'm not certain if the Committee received it, but based off of the available agencies that would be able to receive funds under Act 10, it works out to be approximately $32,000 per agency. So it -- it's a little bit of help to them, but we're still woefully under-impacted based off of EMS that, Chairwoman Boback, as you identified, relies on calls for service to generate their revenue. We did see that transports are starting to balance out again, but it's still well below where we were.

Also in my testimony I referenced the fact of --

the increase of the fees associated for MSOFT. We have only seen traditionally over the months that were pre-COVID, so the 2018-19 Fiscal Year, about a 30% increase monthly revenue over what was collected in the last normal year.

While 2021 continued to be incredibly busy for us, we expect 2022 to be just as busy and our workload to increase. And as future -- continue to increase across the Commonwealth, the EMS system will provide us more work that we will need to ensure safe ambulance services for our community.

Whatever assistance, support and information is needed to assist the General Assembly, the Bureau of EMS stands ready to provide to you. I again appreciate the time to afford you the testimony and offer in my written testimony as well. At this time I will take any questions that the Committee may have.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Dr. Rhone. There's always this discrepancy with the qualifications, and when you lower the standards, how -- because we had to do that during the coronavirus, what happens insurance-wise? So if you say, well, now you're exempt from retaking a test or from taking the physical test, the verbal test, what are you doing as far as the insurance? I mean, is there a correlation there? Does the

insurance say, well, unless they're fully going through the protocol we cannot insure them?

DR. RHONE: So, if I understand your question correctly, Chairwoman, the insurance of the agencies is not something that we regulate. However, those providers who were reinstated through the process of continuing education and application are then vetted by agency medical directors and allowed to function within their EMS agency.

As far as those that had testing waivers such as not taking the hands on or the psychomotor exam, that was done nationally, across the board. Many states did this as well, too. This was not something unique to Pennsylvania, as it was a COVID safety issue to help ensure that those being tested were getting into the system faster.

So, I have not heard of any states -- and I have not heard of any issues from any of our regulated community about insurance not covering them or increasing their rates.

MAJORITY CHAIRWOMAN BOBACK: And I guess a follow-up question before we go on to the pay. So, if this could be done during a crisis, is there something with the qualifications that we're expecting? I mean, is that one of the major reasons why we don't have enough volunteers coming into the system, because they have to go through so many ropes, so to speak?

DR. RHONE: I don't believe that's the case. I believe where we're running into issues is the fact that, unlike 20 years ago when I obtained certification, families were capable of providing more hours in service and taking the extra education. There's an increased cost in education as well, too, and that's something that's outside of our purview and control. So, I am not sure if it's the family changes that require more parents working and children being more active in other outside curricular activities that are drawing on hours. But, I don't believe that it's prohibitive based off of the testing, because we're in line with most every other state as far as testing.

MAJORITY CHAIRWOMAN BOBACK: And I'm really happy to hear that. So if we go on with the pay. So the pay scale, where is this coming from? I know through the state there are certain grants, there are certain applications that many of our locals apply for. Is it done through municipal taxes? I mean, do they get reimbursed through Medicare, Medicaid? This is something that I'm always asked. So if you'd clarify that for our listening audience, please?

DR. RHONE: So I will say, Chairwoman, that each EMS agency across the Commonwealth, all of them receive funding and payment in different mechanisms outside of

those that are billing for service. So through the insurers they -- some do receive tax levy money. Some receive donations through a subscription process. There is no uniform process of how our EMS systems are receiving money outside of the grant process which is one of the only. But minus billing for insurance, there is no guaranteed windfall from those.

MAJORITY CHAIRWOMAN BOBACK: So maybe that's something else we have to look at. I mean, there should be like a constant variable that every municipal EMS would get the same type of funding in without, you know, going for broke, so to speak. You know, where are they getting it from? We need them. We need them 24/7, and that's the bottom line, so that's what we're looking for. And a hearing such as this, for those of you listening here at home, what comes from these hearings, hopefully, is good legislation to rectify some of the problems that we are hearing today. So, I thank you. Any other questions for Dr. Rhone?

REPRESENTATIVE O'NEAL: Do you mind if I --

MAJORITY CHAIRWOMAN BOBACK: Okay. Are these questions?

REPRESENTATIVE O'NEAL: Yes.

MAJORITY CHAIRWOMAN BOBACK: Okay. We are first joined by Representative O'Neal, and we have a question

from Representative Frank Ryan.

REPRESENTATIVE RYAN: Dr. Rhone, thank you very much for your testimony. You know, I specialize in keeping companies out of bankruptcy, and my days in the legislature are coming to an end fairly quickly. And, I am reminded about some of the structural problems in the system. And, since I've been in the legislature with SR6 and other types of recommendations, we know that the pressure that we're putting EMS under is a failed model, where really good people are keeping it together because they want it to keep together, and they feel a sense of community. And I use the expression we used to use frequently in the Marine Corps, that we've been doing so much for so long with so little, we're expecting people now to do everything with nothing. And my concern is, is that with the -- in your judgment, your professional judgment, what do we need to do to really fix this system? If you were devoid of having to deal with political influences and whatever, what would you do differently if you could do it differently?

It was interesting. I asked that same question of Dr. Rachel Levine about the opioid crisis, and her face lit up, and she gave a complete dossier about what she would do differently if we could start from the beginning, and it made sense. It really did.

And so, I would -- I want to ask you the same

question, because -- I'm going to be candid with you. After my time in the legislature, grants and things like that, they don't do it for me. They don't. Putting people in the position of having to go back and beg every year to provide a service to protect me makes absolutely no sense whatsoever. We have a surge capacity issue that became a problem. I recommended the -- during the COVID-19 crisis to mobilize a combat support hospital. There are 500-bed hospitals that could have been set up in Indiantown Gap to provide that stopgap measure to keep people from going back into nursing homes.

What would you do differently if you could start with a clean slate and say, how do we fix this to create a sustainable model of providing surge-capable emergency medical services in the Commonwealth, where we are not asking people to do fundraisers to provide care and support for the community?

DR. RHONE: Well, Representative Ryan, I would like to thank you for that question. I will say that if we could start from scratch and I wouldn't have to worry about the political oversights of it, I think Chairwoman Boback mentioned the fact that, you know, they should be able to have a standardized funding system.

We are defined as an essential service in law, but we're not funded at the essential service rates. It

still goes back to, as you mentioned, sir, the requirement to fund raise, and to do subscription services, and to accept payments at the rates that they're given. And in some cases while the direct pay legislation is there, I have heard from EMS agencies that it's a struggle for them to try to communicate with the insurer, and they're given a flat-fee rate and no negotiation rate that they were talked about in that passage. So funding as a whole, if I could fix it from the ground up, would start there.

I also believe that in our EMS system -- if I may paraphrase what you said about kind of doing more with less and it being a family type of event, and we continue to work those agencies. We need to work on leadership development within our EMS community, to work so that people understand that this isn't just a volunteer organization anymore, but still has business aspects associated with it. We have to have money management. We have to be able to understand how to perceive the cost of readiness and continue through those processes throughout the entire time that we're active as an EMS agency.

REPRESENTATIVE RYAN: I'd be happy to work with you and everybody here to get that done in the next nine months that I'm still here.

MAJORITY CHAIRWOMAN BOBACK: Was that it, Representative?

REPRESENTATIVE RYAN: Yes, ma'am. I'm [inaudible].

MAJORITY CHAIRWOMAN BOBACK: Thank you, thank you. I'd be glad to work with that, too. Leadership development, that's something -- we don't have that for the state?

DR. RHONE: So, if I might digress a little bit, my dissertation was fenced on the leadership development process of EMS, and it is not just Pennsylvania that doesn't have a true defined leadership program for EMS. Multiple states across the country don't have leadership.

The several times that you find a leadership discussion about what it is, it more focuses towards the fire service, more towards incident command, which are great aspects for what I call contingency leadership. That is the, we need to be boots on the ground, we need to make command decisions, we need to tell people what to do and how to do it. But, we also don't encompass the other areas of leadership such as servant leadership, where we have to empower people to grow within our system and be more active.

I can tell you from my experience when I was still on the street as an EMS provider that it was sometimes that family who was in charge, if it wasn't what they wanted, you weren't getting it through. So, there was

no understanding of being able to empower people without position or rank to be part of that agency.

MAJORITY CHAIRWOMAN BOBACK: Huh. Thank you, thank you. Another question from Representative Pennycuick.

REPRESENTATIVE PENNYCUICK: Thank you, sir. You mentioned 63% of those that let their license expire were under the age of 40, and 44% were under the age of 30. Do you have any sense of what caused them to not renew their license?

DR. RHONE: I can give anecdotal story.

REPRESENTATIVE PENNYCUICK: That's perfect.

DR. RHONE: But I don't have fact behind it.

REPRESENTATIVE PENNYCUICK: Sure.

DR. RHONE: I can tell you that in some cases those folks are running into similar issues. So, they are single working parents or, you know, split home parents where their time is there -- if it was today, for me, on an EMS agency, if I wasn't in this position I probably would have let mine expire, because I have a seven-year old, soon to be eight-year-old son who is active in sports, and I just don't have time to put every iron in the fire and give it the attention that it needs.

So, I have heard that from people across the Commonwealth. I've heard the -- you know, there's no

courses available for me to take in my backyard. You know, because of the fact of travel in some of our rural areas is difficult, the issue is, we still have the learning management system. We're training PA where they can do con ed for free online, but some of those are saying that they don't have the time based off of their internet access in parts of the Commonwealth. There's various factors as to why, so none of it is true fact. I would love, at some point in the near future, to survey some of them to find out why. But --

REPRESENTATIVE PENNYCUICK: Okay.

DR RHONE: -- unfortunately I think one of the key things I've seen more recently is those that are college-aged individuals are becoming certified as part of an athletic training program or physical therapy program, or prior to going to nursing school or PA school, so they have a little bit more of a medical background, and they are then not providing care while they're here or off in college.

REPRESENTATIVE PENNYCUICK: Thank you. I just have one more question, Madame Chair. What is the average salary of a EMT?

DR. RHONE: I don't know that off the top of my head, ma'am. I would have to research that, because --

REPRESENTATIVE PENNYCUICK: Okay.

DR. RHONE: -- that's not something we catalog --

REPRESENTATIVE PENNYCUICK: We track.

DR. RHONE: -- and keep.

REPRESENTATIVE PENNYCUICK: Okay, thank you. Thank you, Madame Chair.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Representative Rigby?

REPRESENTATIVE RIGBY: Thank you, Madame Chair. Thank you, Doctor, for your testimony. I'm going to kind of be all over the board, so try to stay with me.

First, I think one of the problems that EMS deals with -- I just spoke to my local EMS provider. We received a phone call in the office, because a gentleman couldn't get a ride home from the hospital at 3:00 in the morning, because they no longer provide that service. They have to wait until 8:00 a.m. until they can put a crew on. And a problem they run into is the billing process, because the person you're transporting gets the check, not the provider. Therefore, a lot of times the provider never sees that check, and the only way to get it then would have to take legal action. Am I correct on that?

DR. RHONE: You are correct, sir. And there was legislation introduced for direct payment for those to prevent that over the course of, I believe, the last three to four --

REPRESENTATIVE RIGBY: Yeah, we've --

DR. RHONE: -- years.

REPRESENTATIVE RIGBY: We've discussed it with insurance in great detail. I think it needs to go -- we need to go back to that. But -- so yeah. So that's still a problem, and that's what they told me. That's why they had to take their nightshift off, because they're not getting paid. Which another problem they run into is if you go on a call and you don't transport, and then you go back to station, you can't -- so you've taken your vehicle out of service, and you've missed the opportunity for a call. It goes to another department, and you're returning back to station. And again, should be able to bill even for a non-transport if you get the call. So, I think those are things that we need to look into.

And then the other thing, we're talking about certifications and the renewals, and a lot that don't recertify. Has anybody looked in it -- to an option of hours served versus the recert? So, you know, if I'm an active EMT provider and that's my full-time job and I do it daily, I mean, X amount of hours should be credited to training or recertifications, which would bring that retrain down some and may make it more attractive for folks to stay in; make it a little bit easier for them to renew their certifications. Just a thought.

DR. RHONE: So, if I understand your question correctly, sir -- and thank you for it -- that for each hour served as a clinician caring for an individual should relate into their required continuing education credits?

REPRESENTATIVE RIGBY: I believe we could use that to back off the amount of training or recertification that's required.

DR. RHONE: So, my concern with that would be the fact that the continuing education process is to continue to advance our EMS clinician. So, it's not designed to be a penalty to the clinician for not being able to function in the field. But, the world of EMS and the world of healthcare around us continues to advance every day. So if we have new treatment protocols coming up and more information coming out, it behooves our providers to understand that. So, I would be hesitant of removing continuing education requirements in lieu of hours of service.

REPRESENTATIVE RIGBY: How much of the recert though is repetitive -- is -- from years past? I -- when I was in law enforcement, we'd do our annual updates, and we address all new laws, and I'm sure EMT addresses all new diseases and treatment and equipment that comes out. Is there stuff that is repetitive that they see year after year that possibly the training could offset those things?

DR. RHONE: So, repetitive every two years they would get a protocol update. So when we update EMS protocols across the Commonwealth, they would be required to take that training, much like you experienced in your law enforcement career, sir. The other aspects of that is, a provider is free to choose their continuing education courses. There is not a requirement that certain things are repetitive. Obviously based of the requirement for bloodborne pathogens and other things that fall under OSHA protections. They have those, but those count towards their renewal cycle, but providers are encouraged to go beyond that. And I will say that we have even taken the approach that if a provider is in college for a nursing degree or some healthcare-related field, they can submit their college credits --

REPRESENTATIVE RIGBY: Okay.

DR. RHONE: -- to have that carry over as well, too. So, it's not merely what's available on the learning management system. Our regional councils are tasked with and perform continuing education in communities across the Commonwealth, and we have multiple con ed sponsors, or continuing education sponsors, that are EMS agencies that they can submit their own training program for different topics that are relevant to their area to improve their system.

REPRESENTATIVE RIGBY: Okay, thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Next we have Representative Causer.

REPRESENTATIVE CAUSER: Thank you, Madame Chair. And thank you, sir, for your work at the bureau. You know, the EMS system, as we know, is in a state of crisis. And in rural Pennsylvania it's almost coming apart at the seams. It's beyond a state of crisis, and it comes down to, really, personnel issues and funding issues. And, when looking at the training side of things, you know, the numbers that you provided are pretty striking. People that, you know, maybe aren't staying in the profession -- and I'm thinking about the training classes and about -- my question deals with the coordination of the classes. And what can we do better to coordinate classes across the state? Because it seems like a haphazard system right now. I'll give you an example. My daughter is a college student at Erie, and she said, dad, I want to take an EMT class, and I can't find one anywhere. How would she -- I mean, so I got on the internet, and I was looking for an EMT class in Erie, and I couldn't find one either. I mean, so we need personnel, but we don't have a very cohesive system for people to be able to find a class. And then beyond that, people who are already certified who may have let their certification expire, what can we do to make the

process easier to get them back in? Because, you know that those people -- some of them will never come back, but some of them could come back in if the process was easier to get them certified again.

DR. RHONE: So I'll address twofold. The education programs -- we have accredited educational institutes across the Commonwealth. The issue at hand, as you kind of alluded to, is trying to find them and have them run. I believe that without fact -- and it's truly perception that a lot of that is based off of the available enrollments. Many of the community colleges have to have a set number of individuals prior to doing the course, which causes some to be canceled, or them not to be held in certain locations. That's something that's far outside of our purview as far as the educational student requirements and independent business processes that each of those ed institutes would use.

In regards to -- if I'm correct, to your question regarding getting more people back into the system, in the regulatory exception that we did pre-COVID, while the test requirement for both the cognitive and psychomotor exams was waived for a period of 18 months, there is a second part of that provision that eliminates the requirement if they have expired within a year, I believe, of the cognitive exam. So, we have reduced the ability to have

someone go out and take a test. It's now more so getting them back engaged in the system. And I think part of the problem is -- and unfortunately there is not a good, strong social network presence from the regulator in this case providing information to those individuals. While we have our regional councils, and they do an excellent job of providing information, there is still a disconnect between us as the department and the bureau and our regulated community.

So, there's times where we operate in what appears to be a vacuum or bubble to our regulated community that I think we internally need to address.

REPRESENTATIVE CAUSER: I guess that's what I'm getting at. There should be one place in the state for people to go to. If they went to one website, and every class was listed on that website, and they could easily sign up for a class at that one place -- and obviously the bureau is the place where that should be. That only makes sense. And the same with a refresher to try to get people into the system. You know, cutting through the red tape so that they can get back into the system I think is important.

And, to dovetail on what Representative Ryan was saying, you know, are there specific regulatory suggestions, regulatory relief suggestions that your bureau

would have, or even statutory relief suggestions that we as legislators could be considering to try to make that process easier?

DR. RHONE: And a rough answer to that, sir -- and I don't want to overstep. I would prefer to also include my staff in some of those discussions, because they hear a lot of the constituent concerns. While I still am holding both roles as both the interim director and the program manager for system operations, I have an education manager who is hearing things as well, too. And, having some of that as far as we could provide back would be something I could do, but it -- I don't want to discount their knowledge and their ability of making some of those informed decisions.

REPRESENTATIVE CAUSER: We certainly have a lot of work to do. Thank you, sir, and thank you, Madame Chair.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Chairman Causer. If you would share -- excuse me. When you take it to your staff -- because that's truly -- what a great idea, a one-stop shop. You know, just go to the department, see what's -- what qualifications are necessary. Assumptions always are that you go to a department anytime, and you get to see the criteria needed, and if it's not there, if you would share that with your

staff. And I realize you're interim, sir, but if you would share with my committee what you find, we would appreciate it.

DR. RHONE: I definitely will, ma'am.

MAJORITY CHAIRWOMAN BOBACK: Thank you. We were just joined by Representative Kristine Howard virtually, and we have a question from Chairman Gillen.

REPRESENTATIVE GILLEN: Thank you, Madame Chairman. Thank you so much for being here. Appreciate your lucid testimony. As I perused the internet prior to coming in here. I looked at the range of salaries in Pennsylvania, and it's all over the map. So, you know, ZipRecruiter has one number, but I would guess in the mid-30s is probably the median salary if I blended everything that I saw online; somewhere in the range of 33 to 42. But, some are being paid substantially lower. I drove by a sign on Route 422. Godiva Chocolate is paying $17 an hour. I realize the fringe benefits there are probably excellent also, being a chocolatier. But, if you're not able to be competitive, and you're asking someone to do life-saving work, you know, that -- high degree of stress, odd hours, I think it's logical to assume why some are stepping out of the profession.

Now, you -- 16 years old you can be an emergency medical technician in Pennsylvania. Do you feel like we

need to do additional buttressing of programs for the young people, high school students to draw them into the profession?

DR. RHONE: I would say that any way we could get more people who are passionate about healthcare, and realizing that the public safety side of healthcare is just as good as being a nurse would be beneficial to our system. Obviously, recruiting people in and whatever we could do to get more people in, I have often said in colleague conversation that if I found a silver bullet that I could get more people certified faster and put them on the street and keep them there, I probably wouldn't be sitting here today. But, I do want to include the fact that if we can get more high school programs involved, if we can get more community at younger age involved with -- obviously looking at child labor laws and everything else, that's a beneficial process to our system.

REPRESENTATIVE GILLEN: Thank you, Director. Thank you, Madame Chair.

MAJORITY CHAIRWOMAN BOBACK: And I apologize Secretary Gillen. I misspoke. I think I advanced your position, so thank you.

REPRESENTATIVE GILLEN: That will be next January.

MAJORITY CHAIRWOMAN BOBACK: There you go,

Secretary Gillen. Thank you. Another question from Representative O'Neal.

REPRESENTATIVE O'NEAL: Thank you, Madame Chair. And, you know, I -- it came to mind. I'm not sure how familiar you are with the situation, but members of our military who practice in the medical community, Army medics, what have you who then leave the military service and come to Pennsylvania have to go through the entire EMT program to be certified in Pennsylvania. You know, you talk about a silver bullet to get more people certified and into the field. Somebody who's been essentially practicing in the medical field doing what -- in a lot of cases what EMTs in Pennsylvania do then are told they have to start from scratch. What would be your position as far as developing some sort of a program to recognize the military service?

DR. RHONE: So I can tell you right now, if any member of our military comes in with a national registry certification that they earned while they were in the military, they are able to do a certification by endorsement, which would allow them to have the certification that is equivalent to their national registry. So, if that means that they were certified in the military as an EMT, they would hold a Pennsylvania EMT certification.

The problem at hand though is there are some military medic programs that only provide an EMT certification, but allow them to do some advanced skills such as IV insertion. So, there's a difference in what they were tested to at the national registry, which was what we would use to certify them here.

REPRESENTATIVE O'NEAL: Well, I completely agree with that. I -- you know, I have -- I am actually one of your statistics. I at one point in time had a certification for -- as an EMT, but it has since expired. And I was -- I also served in the Army, and I was not a medic in the Army, and we used to give each other IVs, and yet EMTs in Pennsylvania can't do that. So I completely agree with that.

And that is the problem. The problem is that many medics in the military are not nationally registered EMTs. That doesn't mean they don't have experience that covers probably what amounts to a large majority of what an EMT in Pennsylvania. Just so happens that I have a piece of legislation that helps make this happen, so I have to put a little plug in for that, Madame Chair. So, thank you.

DR. RHONE: Thank you, sir.

MAJORITY CHAIRWOMAN BOBACK: Good legislation, I might add. Thank you, Representative. Next question is

from Representative O'Mara.

REPRESENTATIVE O'MARA: Thank you very much. So, I -- building on the concept that Representative Ryan suggested, without political ramifications, just speaking to what you believe, what are your thoughts on regionalization of EMS and trying to have mergers across the state, so we have less providers that cover larger areas?

DR. RHONE: There are multiple aspects to that. I have seen it work in multiple places, but I've also seen it fail in multiple places too, because of geographic coverage areas and things like that. So, unfortunately that's a question that there's no true successful answer without a trial-and-error period.

I can honestly tell you that in some places that there -- regionalization is occurring with some of our EMS agencies, where they've absorbed other agencies. They worked through community partnerships, and they are working. But Commonwealth wide, it would require a lot of change in legislation to allow for those authorities to exist to oversee them. I'm pretty sure that multiple municipalities would still want to have a seat at the table to ensure how their systems are running. So, I don't know what the successful rate would be to that.

REPRESENTATIVE O'MARA: Thank you. And just to

be clear for everyone here, that's not what I'm pushing. I just was curious on what the answer was. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Representative. Once again, thank you so much for taking your precious time with your busy schedule to be with us today, Dr. Rhone. And, thank you for your expert testimony before this entire committee. And if there is any follow-up, if you get it to my office, I'll make sure committee members are apprised. Thank you, sir.

DR. RHONE: I appreciate it. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Our next panelists are from the Ambulance Association of Pennsylvania. Mr. Don Dereamus, Legislative Committee Chairman, and Mr. Chuck Cressley, Legislative Liaison. Welcome to you, both. Thank you for being here today. I'm saying both. I think -- there we go. Thank you.

MR. CRESSLEY: I'm a little slow. I'm sorry.

MAJORITY CHAIRWOMAN BOBACK: Take your time. And who would like to start?

MR. DEREAMUS: I would.

MAJORITY CHAIRWOMAN BOBACK: Okay, whenever you're ready. Thank you.

MR. DEREAMUS: Good afternoon. Chairwoman Boback, Chairman Sainato and members of the Committee, my name is Donald Dereamus. I am a board member and

legislative chair for the Ambulance Association of Pennsylvania. Accompanying me today is my Legislative Co-Chair, Charles Cressley. And it's good you put this partition here.

MR. CRESSLEY: I agree.

MR. DEREAMUS: Heather Shore, our executive director, unfortunately couldn't be here, and she sends her apologies, because she has some personal issues to deal with.

Let me open by offering our sincere gratitude to the General Assembly and the Governor for Act 10 of 2022 creating a $25 million grant program for Pennsylvania EMS agencies. These funds are critical at the moment; however, this is analogous to a Band-Aid applied to a trauma patient when multiple torniquets are needed.

Emergency Medical Services is an essential component of Pennsylvania's healthcare system. We are the only healthcare provider mandated by law to respond as dispatched to a request for service.

In 2021, the EMS system in Pennsylvania was comprised of 1,259 agencies that responded to 2,447,932 calls for service, or emergency respondents to incidences. The overwhelming majority is calls for services where emergency response to incidences -- sorry. A nonviable EMS system impacts 911 emergency response, the movement of

critically ill patients between acute care and specialty care hospitals, and the movement of patients between hospitals, skilled nursing facilities and other medical care. Any failure in this system directly impacts morbidity and mortality.

For several decades we have known that the funding model for EMS was inadequate and, now, unsustainable. The crisis in our EMS system predates the pandemic. Preliminary survey data shows 53% of respondents reported a budget deficit since 2018, with most reporting multiple years of budget deficits. Thanks to many factors now exacerbated by the impact of COVID-19 on transport volume, cost, staffing and more, these financial struggles have become dire.

EMS agencies across the Commonwealth are shut down or forced to alter their level of service. Our organizations are -- and clinicians are on the brink in just months, weeks or even days from insolvency.

The below cost reimbursement rates for Medicare, medical assistance and the constant non-negotiated rates with insurance company put pressure on how we operate and our ability to survive. The reality is that EMS is a business. Like it or not, like any business, income must at least equal or exceed cost for us to remain solvent.

For the remaining time I will provide the members

information on the assistance needed from the General Assembly, the administration and county and local municipal leaders. I hope you gain a true understanding of the gravity of these issues facing our state's EMS system, as they are momentous.

On a daily basis, we hear reports of poor patient outcomes in many areas of the Commonwealth that are directly related to the lack of EMS resources statewide. Your commitment during this legislative session along with the EMS provider community and other stakeholders will determine our future, and will have a direct effect on the wellbeing and lives of all the residents and visitors in the Commonwealth.

Funding: why we need the funding for the cost of readiness. The cost of maintaining an EMS service are based on the need to maintain a readiness to respond which is expensive. EMS statute and regulation of Commonwealth requires an EMS agency to staff a unit 24/7, 365. Staffed ambulances at a station, awaiting a call, or returning unloaded from a call or a transport only generate cost.

Ambulances that respond on fire calls, public assist, standbys and other non-patient responses only generate cost. The lower the utilization rate of the ambulance translates to a higher cost of service just to be ready to respond. These costs are amplified in rural areas

with longer transport times and smaller EMS agencies with minimal call volumes. Rural areas also require twice the number of staffed ambulances to perform the same number of calls as their urban counterparts.

Since 2008, the borough, township and third-class-city codes have stated that these units of local government shall be responsible for ensuring that fire and emergency medical services are provided within the borough, township or third-class city by means of extent determined, including the appropriate financial and administrative assistance for these services.

Preliminary survey data reported that 60% of these EMS agencies receive municipals subsidy or a contribution, but 48% also report these subsidies provided less than 20% of that agency's budget. There is a novel EMS grant program occurring currently in Pike County that is leveraging local municipal funds with matching county funds returned to the local municipality to assist them in the provision of EMS in their communities. This EMS grant program has garnered participation from every municipality in that county and may be a model for the rest of the Commonwealth. EMS agencies need a universal sustainable funding mechanism to cover the cost of readiness and operations in general. Our proposals passed Senate Bill 698 that Senator Baker -- gives the counties the ability to

perform public safety authorities to include EMS, and we should probably amend that to remove fire, just to get it through. There is also a co-sponsor memo in the House from Representative Guenst; I hope I'm pronouncing that correctly. And that's a comparison bill to Senate Bill 698.

Develop legislation for a universal county municipal funding match mechanism for EMS administered by the county with funds to return to the municipality through a grant for the provision of EMS designated by the municipality.

Funding: why we need changes in EMS reimbursement. The principal mechanism for an EMS agency to generate revenue is through reimbursement for treatment and transportation, either emergency or non-emergency. The AP surveyed our members on fully loaded cost in 2020. Fully loaded cost are the counting of the minimum reimbursement required per transport for an EMS agency to break even. The data returned a high amount of $2,300 per call, to the lowest of $174 per call. The mean cost was $662, with a median cost of 545. Compared to the median current reimbursement rates and in consideration of patient transport of ten miles, it is calculated that Medicaid currently reimburses 44% of our cost, and Medicare 67% of our cost. And Medicare and Medicaid are a -- the largest

part of our transport volume.

Since the passing to the Patient Protection and Affordable Care Act, commercial insurers have mirrored Medicare rates into their fee schedules. All other insurers, Worker's Comp, auto, those are based on state law, also pay a percentage based on Medicare. The National Emergency Medical Services Advisory Committee report on EMS funding and reimbursement in 2016 stated that based upon a subtotal of the payer mix above, most providers receive below-cost reimbursement for 72% of all their transports. The charity care delivered to the uninsured and the undercompensated care resulting from below-cost Medicare and Medicaid reimbursement. Therefore, uncompensated care, if left unaddressed, threatens the stability of the entire EMS safety net.

Additionally, the study cited uncompensated care of charity care in EMS nationally, and they estimated that you're looking at $2.8 billion in charity care from EMS nationally. The amount of uncompensated care absorbed by ambulance service is extensive. The $2.9 billion of uncompensated care is about half the total amount paid, 5.2 billion to [inaudible] service by Medicare in 2010.

Let me reiterate again: EMS is a business, and income must be at least equal or exceed the cost for us to remain solvent. If we receive below-cost reimbursement for

72% of all our transport that represent a portion of this $2.8 billion in total uncompensated care, how as a business are we supposed to survive?

We are also living with the failure in implementation of Act 103 of 2018, the statute codified Title 40 requiring that a managed care plan shall pay all reasonably necessary costs associated with emergency services provided during the period of an emergency, subject to all copayments, coinsurances and deductibles. And a managed care plan may not deny a claim for payment solely because the enrollee did not require transport or refused to be transport. This is the Treat no Transport Bill that was passed.

The payment was also codified that it shall be in accordance with current managed care contract rates. Unfortunately, managed care organizations have failed to follow the statute, and there is no consistent coding requirement or standardized payment in accordance with contracted rates. The APS attempted administrative remedies through the PA Insurance Department and the PA office of the Attorney General to no avail. Our proposals for reimbursement increase the medical assistance rate to a minimum of Medicare rates to pay all loaded mileage. And, Representative Causer has a co-sponsor member out for that now, and we appreciate that greatly.

Past [inaudible] passed Bill 1293 requiring direct payment for insurers regardless of in-network participation. Exempt of collection of copays for emergency ambulance service, and limit the level of copays to non-emergency ambulance to medical transportation at no more than 20%. Reform medical assistance payment policy and regulations for ambulance service to be consistent with Medicare guidelines. Our Medicaid guidelines are currently from 1980. They have not been renewed -- or changed. We're running under 1980 guidelines.

For Representative Causers who -- old like me, they probably still remember the voluntary ambulance certification certificate, and they still list that in our guidelines, and it hasn't been around since 1985.

Pressure needs to be placed on the PA Insurance Department and the administration to develop payment policy consistent with the intent of Act 103 of 2018.

Funding: huge issue. Why we need funding in support of EMS operations. As we have shown, reimbursement, our primary method of funding, fails miserably in covering the cost of readiness, as well as the cost of EMS operations. Since 2002, implementation of the Medicare annual fee schedule costs the residents 70% while reimbursement rates have only risen 27% during the same time period. In my organization we have seen a tremendous

increase in overhead from a low of 8% for supplies to a high of 104% for insurance, and that's general liability insurance.

Current national policy in our world affairs have our driven our budget of fuel cost to an increase by 40%. Result of national economic policy and an EMS workforce shortage has also driven up and created artificial wages well beyond historic and regional wage structures for our business. EMS agencies have increased their wages to attract EMS providers, even though they do not have the revenue to support these increases. This has created a Russian roulette scenario where EMS agencies are gambling their revenue will increase to offset the wage increases they have been forced to invoke to attract EMS providers.

EMS budgets were strapped prior to COVID, but during the first year of the pandemic a geographic representation of the state revealed an average lost revenue of $959,000. Our budgets also took a major hit in 2021, as some facets of the EMS rebounded, like emergency calls increase, while non-emergency medical transportation and paratransit [phonetic] work failed to recover.

My service has also seen a huge percentage increase in personal protective equipment in the period of 2019 to 2021, from a low of 18% for PPE kits, to a high of 238% from all the surgical masks. I understand that during

the pandemic each EMS provider is wearing an M-95 mask, safety glasses and at least one pair of gloves on every call. That relates to $7.61 per call solely for PPE. Prior to the pandemic, the per-call cost for PPE would be merely $0.55 for a pair of gloves for each crew member.

Proposals for funding: Representative Ortitay has House Bill 743, and Senator Pittman on the Senate side has Senate Bill 944 to provide additional relief from lost revenue related to the COVID-19 pandemic. Increase reimbursement from all payers, or investigate the feasibility of an adequate statewide fee scheduled are reviewed annually against Medicare ambulance inflation factor.

Workforce, the third major issue. Why we need assistance to help with EMS workforce shortage. EMS in the Commonwealth and nationally is facing a crippling workforce shortage, a long-term problem that has -- building for a decade. Nationally, an EMS workforce survey found that overall turnover among paramedics and EMT ranges from 20 to 30%. My organization mirrors this result with an employer turnover rate of 27.5%, and a two-year-turnover rate of 44%.

EMS agencies are competing with other related markets and the artificial increase in wages because of our current national economic policy. We are failing to

attract a workforce with significant pay increases, sign-on bonus, employee recruitment bonuses and generous benefit packages.

The pandemic exacerbated this shortage and highlighted our need to better understand the drivers of workforce turnover. There are many factors contributing to this issue. In a survey conducted by the AP, the top four reasons for EMS providers leaving the workforce were wages, burnout, career change and COVID. In that same survey it was revealed that 97% of those surveys had unfilled positions in their agency.

Our survey also discovered that 67% of the respondents say workforce challenges were either somewhat worse, 25%, or much worse, 42%. EMS agencies will continue to face continued workforce challenges, especially with the aging seasoned clinical providers and the failure of younger generations to enter the profession -- before-mentioned reasons.

Any solution to our workforce challenge will need to be based on sufficient reimbursement for EMS treatment and transportation, appropriate funding from municipal sources and tuition waivers for people entering our profession. Our proposals, House Bill 612, Representative Struzzi creates a tuition assistance program, but it means -- it needs to be amended. And there's a lot of

tuition assistance programs, but they're all directed towards volunteer. We do still have a volunteer EMS component, but the majority of it is career.

Senator Ward, Judy Ward, has Senate Bill 149 that also creates a tuition credit program, but that's also volunteer only and needs to be expanded to career staff.

Amend and pass House Bill 2097, Representative Hamm who is here today, to permanently reduce the minimum staffing level for BLS ambulances for the entire Commonwealth. There is currently a exemption, currently, right now that will run out on July 1st, where we will have to return back to the minimum staffing requirement, which will be two EMTs on each truck. There is areas that will lose ambulances because of that requirement.

Representative Deluca has House Bill 2161 which is a frontline worker loan forgiveness program, and moving any funding or reimbursement mechanism previously cited.

I realize this is a tremendous amount of information and data to digest, but I will end this with EMS agencies have done a tremendous job with minimal assistance from the Commonwealth, county or local government, because it's our mission. Public safety folks are very adept at making something out of nothing. The time has come when we cannot adapt, improvise or overcome anymore. If we do not receive supporter assistance,

patient outcomes will be poor or fatal. As I stated in the beginning of the testimony, a nonviable EMS system impacts 911 emergency response, the movement of critically ill patients between acute care and specialty care hospitals, and the movement of patients between hospitals, skilled nursing facilities and other medical care. Any failure in the system directly impacts morbidity and mortality. We have reached critical mass, and our system is failing.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Mr. Dereamus. Mr. Cressley, did you have any comments before we go onto questions.

MR. CRESSLEY: Yeah. With all due respect [inaudible].

MAJORITY CHAIRWOMAN BOBACK: I don't see any hands going up. Anyone from the insurance lobby here? No hands went up.

MR. CRESSLEY: [inaudible]. Oh, okay. The -- they are the primary stakeholder in this issue for us, because, you know, with the MA program, that's all going to be MCO and formed out to commercial insurance people. We've met with those guys on a bunch of issues. I'm sure you deal with them on a daily basis, and you know their demeanor and their attitude towards us. And, they have to be a willing partner in this whole process. There are people dying in Pennsylvania because we aren't there.

There are people that are going to die today because we are not there. We're all responsible for that. I'm a little upset that they aren't here today, because they are one of the key players as we move forward to fix this system, and you know that.

I'm going to give you the cliff notes on why this happened. In 2002 we got a new reimbursement system. It was negotiated rulemaking at the Federal level for CMS. Was binding for CMS, but not binding for the commercial insurance industry. They accepted the process. CMS did a bunch of work, a ton of work to develop a rate structure, and I'll talk about that briefly, but it wasn't -- that rate structure was not binding to the commercial environment.

Our reimbursement rates for our levels of service are all over the board. There is not one specific rate. If you have an MI in Punxsutawney where I'm from, depending on your insurer, I'll get 47% of our cost, or I'll get 60% of our cost.

In 2007 the GAO put out a report that CMS was paying us between 6 and 16% below the cost of providing the service depending on our geographic location or the service that we provided. We cost shifted to the commercial guys, and they weren't happy about that, but it held us instead until the ACA came out when they were allowed to cost shift

back to the patient with large deductibles and copayments. That forced us to go back to the patient to collect large sums of money.

I've been called into the chairman's office in the House of -- the chairman of the insurance committee's office for a $500 bill that we got yelled at about, and we were -- we weren't treated appropriately, I believe. It was a copayment that that person had to pay. It was their insurance coverage, and we noted that, and then we were asked to leave, okay?

So, at that point we -- since 2007 we've been really delivering service to the entire Commonwealth below the cost of providing it. How many people could stay in business for another 12 years below the cost of doing it? And we're at our wit's end right now. It's over. And if there is not action by this group in the General Assembly -- and I know you guys support us -- we're not going to be there.

This is like -- you know, you look at emergency services: police and fire and EMS. Police, they get all kinds of coverage when things happen. Fire, there's a big fire or a chemical spill, they're -- it's all over the news. You never see EMS on the news, because we save one life at a time, usually.

This is like hypertension. It's a silent killer,

and it's happening in Pennsylvania every day. I implore you -- and I know you guys are supporting us, but this issue, this isn't about EMS. This is about the residents and the visitors of the Commonwealth. This is about the end user. We're not serving the end user, and it's not just rural EMS. The City of Pittsburgh's budget for EMS was $24 million last year. They brought in $13 million. They have a tax structure that I guess they can handle it. In the Northern Tier of Pennsylvania that doesn't exist, so I would ask you as we go through this process to take into account the demographics of Pennsylvania and look at how we can manage this in those particular areas. It's not just as simple as going out and saying, the cost of business is doing this in Philadelphia, and it's this in Northern Pennsylvania. In fact, it could be more expensive for us, because it takes twice as many units for us to run the same number of calls in an urban environment as it does in a rural environment.

So there's -- this is a complex issue that's going to require all the stakeholders in the room, the most important stakeholder for us right now is the insurance industry, because I know you guys are on our side.

MAJORITY CHAIRWOMAN BOBACK: Thank you. And my question is along those lines, I believe. And for our viewing audience, I was asked to ask this question. I am a

rural legislator. I am from the Northern Tier, and there are times when two ambulances will be called to a place, a home, and in the end perhaps there's no fee for the first ambulance.

MR. CRESSEY: Right.

MAJORITY CHAIRWOMAN BOBACK: But the second one that must come, perhaps because of the condition of the patient, they leave the scene after they check them out, and then the constituent is billed twice. It seems as if the first bill is taken care of, the one where the person is taken to the hospital, but the second one -- perhaps a specialty service. I don't know.

MR. CRESSEY: Right. Except --

MAJORITY CHAIRWOMAN BOBACK: But there's -- it's a large amount of money, and how do we help these people? And why are there two? Obviously there must be a condition. And why are there two bills, and why are there no copays? Can you set me straight on this, please?

MR. CRESSEY: Yes, because there is no structure in place to manage that, first of all. It -- essentially, in Rural Pennsylvania, for efficiency, there's usually a group of paramedic -- a group of paramedics services and then a group of BLS services, because it's much more efficient to manage that way. So, if a BLS ambulance gets dispatched on a call and it's an ALS-level call, an ALS

ambulance or car will be dispatched to that to assist them. And it comes down to, do those services work well enough together to manage that fiscal aspect of the call? And it becomes very difficult when it's not enough for one service.

So when that happens, obviously the second service that comes says -- it's an advance life support call, but they're -- it's Medicare which is 72% of our business -- or Medicaid, they only accept one bill -- Medicaid accepts two, but Medicare only accepts one. So, one service has to bill for that on the Federal level and then split that. If there's no agreement, that's where the rub is, and there is no process to manage that.

MAJORITY CHAIRWOMAN BOBACK: And that's something that we need to rectify.

MR. CRESSLEY: Absolutely.

MAJORITY CHAIRWOMAN BOBACK: And if you have any suggestions -- again, we're talking retired people.

MR. CRESSLEY: Right.

MAJORITY CHAIRWOMAN BOBACK: You know, out in Rural Pennsylvania they have no recourse, and they don't have the money --

MR. CRESSLEY: Right.

MAJORITY CHAIRWOMAN BOBACK: -- to pay for two services, let alone one.

MR. CRESSLEY: That's correct.

MAJORITY CHAIRWOMAN BOBACK: Correct, Chairman?

MR. CRESSLEY: And that's right back --

MAJORITY CHAIRWOMAN BOBACK: So --

MR. CRESSLEY: Yeah, right back to my comment on that we can't collect that money from these individuals, even if it's just one ambulance. They do not have the resources to manage that. So --

MAJORITY CHAIRWOMAN BOBACK: Well, if you --

MR. CRESSLEY: And that --

MAJORITY CHAIRWOMAN BOBACK: If you could help us -- I see a lot of head shaking up here. We need that, especially those of us in Rural Pennsylvania, because it's catastrophic as far as the finances. There are no finances there. And then one person even had their home put on alert that they would have to go -- how could that be? And her complaint was, but the second ambulance didn't do anything. They checked me out, but they didn't take me anywhere. They just --

MR. CRESSLEY: Right.

MAJORITY CHAIRWOMAN BOBACK: -- got in the car and left. So again, that's why we're here today, and that's why we have a listening audience. And any way you could help us with this debacle, that's what we're looking for.

MR. CRESSLEY: We are committed to the entire system.

MAJORITY CHAIRWOMAN BOBACK: Thank you.

MR. CRESSLEY: Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Another question from Representative Ryan.

REPRESENTATIVE RYAN: And my hearts actually go out to you all tremendously. You know, in hearing your testimony, there's a big understanding, I hope, from a cost perspective as a CPA that people should be aware of, and that's the difference between the cost of unplanned demand versus the cost of planned demand. If I know you're going to need to pick me up and transport me at 8:00 a.m., and I can schedule that a week in advance, it's a significantly lower cost. You can program it in. But, heart attacks don't operate quite that way, so you get the unplanned demand. And the other one is the surge productive capability.

What I'd like to hear from you though, because I think people need to hear this, what does failure look like? Because, I don't believe we're attending to the issues in government in general. I believe our Chair is trying to get to the systemic issues, but we -- I love the analogy, we're putting a Band-Aid on someone that needs a tourniquet. And that surge production and surge capability

is so critical. So, what will it be like when this thing starts to fail and services can't be provided? What's going to happen? What will the constituents and citizens of Pennsylvania hear when they call in need of emergency services?

MR. CRESSLEY: I -- from my perspective, it's not started, it is there. It is there in this Northern Tier. Yesterday, in my -- at my service two patients had to wait over 45 minutes for an ambulance. Two weeks ago we traveled 42 miles with the last -- I'm from Jefferson County, Pennsylvania -- with the last ambulance from our service area to go 42 miles to a cardiac arrest to pronounce somebody dead, and left an entire county without EMS; happens every day. Every day in the Northern Tier it's happening. It's happening everywhere, really, but it's predominant in the rural environment.

So, four years ago I'd --

REPRESENTATIVE RYAN: So it's a life threatening situation that we're --

MR. CRESSLEY: People are dying.

REPRESENTATIVE RYAN: -- currently in? People --

MR. CRESSLEY: People are dying.

REPRESENTATIVE RYAN: So, that's what I wanted to hear people saying.

MR. CRESSLEY: People are dying.

REPRESENTATIVE RYAN: Because we need -- that's what we need to stop. So people are dying --

MR. CRESSLEY: People are dying.

REPRESENTATIVE RYAN: -- because of this?

MR. CRESSLEY: Yes, sir.

REPRESENTATIVE RYAN: And I asked the question previously, what do we need to fix? What would you do if you could start with scratch? Because, let me give you an example. If I walk into a restaurant, I don't say, I'd like this, and by the way, the Federal Government is going to pay this portion of it, my insurance carrier is going to pay the other portion of it. My portion of the bill will be 20%, and I'll take care of the tip. If we -- you'd have every single restaurant going bankrupt imaginable. And I'm a CPA. I couldn't conceivably imagine developing a system of reimbursement this complicated and this absurd. And oh, by the way, if I don't get the bill processed fast enough, you're not going to get paid at all.

MR. CRESSLEY: Right.

REPRESENTATIVE RYAN: Which is even more -- so how do we fix this? Because, the Band-Aid days are over. It's failing.

MR. CRESSLEY: Right, right.

REPRESENTATIVE RYAN: Is that correct? Am I hearing you right, it's failing?

MR. CRESSLEY: It's -- it has failed. It is not failing, it has failed.

MR. DEREAMUS: Not only has the process --

REPRESENTATIVE RYAN: Okay.

MR. CRESSLEY: And --

MR. DERAMUS: -- [inaudible].

MR. CRESSLEY: -- I think we need to work towards, really, some type of cost fee schedule. You know, based on cost, a fee schedule. Some type of fee schedule that is consistent across the board that's going to provide a viable funding stream for us. We can't rely on low hanging fruit and for you guys to work on things for us every year. And I know you have done that diligently, but we have not attacked the root issue. There is no reliable recurring funding stream that will keep any ambulance service in business right now.

REPRESENTATIVE RYAN: What would you --

MR. DEREAMUS: Yes --

REPRESENTATIVE RYAN: What would you recommend? Because there's --

MR. CRESSLEY: I think we need to work towards a fee schedule.

REPRESENTATIVE RYAN: Okay. A fee schedule for service, or a fee --

MR. CRESSLEY: For service.

REPRESENTATIVE RYAN: See, the -- and, Madame Chairman, may I have just a little bit of latitude, Madame Chair?

MAJORITY CHAIRWOMAN BOBACK: Yes, sir.

REPRESENTATIVE RYAN: You -- a fee for service, the problem with it is, is that -- you know, that's based upon what happens. We had -- we ran --

MR. CRESSLEY: Right.

REPRESENTATIVE RYAN: -- into that problem. I was on a hospital board --

MR. CRESSLEY: Yeah.

REPRESENTATIVE RYAN: -- of directors for 28 years. And a fee for service doesn't pay me to keep people healthy, it pays me to get people better once they become a problem. So, we want to solve the problem.

MR. CRESSLEY: Right.

REPRESENTATIVE RYAN: I mean, from what -- some of the different things I've looked at in other states -- Kansas has got an interesting model. Kansas says that this is a healthcare system-wide issue, and EMS is paid for by the healthcare systems which then builds that into their insurance rates. And so then you would -- the EMS provider would provide your budget to the -- I don't know the group that it goes to, but we take a look at the budgetary cost, and the budget would be approved, and that's what you live

under --

MR. CRESSLEY: Right.

REPRESENTATIVE RYAN: -- so that you don't have runaway spending.

MR. CRESSLEY: Right.

REPRESENTATIVE RYAN: And so what I'm trying to get to is, how do we do that? Because a fee for service in my mind, if you don't have any cardiac cases it's -- it's not encouraging me to promote good health. It's not encouraging me to stop people using the ambulance service as a taxi service because they're not happy with something that's going on. If -- be it a fraudulent call, or an inappropriate call, or whatever the case may be.

MR. CRESSLEY: Right.

REPRESENTATIVE RYAN: So, I -- you know, I'm hoping that we can come up with a solution that says how do we provide you with stable funding, with the internal control being that we know what your budget is so that you don't have runaway budgets, because we've seen that as well.

MR. CRESSLEY: Right. And I think part of -- you know, if you have read any of the EMS white papers that are out there.

REPRESENTATIVE RYAN: I've seen them.

MR. CRESSLEY: They're all about integration of

EMS into the healthcare system. Nobody wants a rural EMS service that's losing them $300,000 a year. They don't want to integrate us into that health system.

REPRESENTATIVE RYAN: If we can build it into the insurance rates, then that would be a different model? Yes or no? I'm -- I don't know --

MR. CRESSLEY: It would be. Yes, it would. If -- it would, but what -- the trend in urban and suburban is for health systems to gobble up EMS services. That's not going to happen.

REPRESENTATIVE RYAN: Right.

MR. CRESSLEY: You know, that's not going to happen in Rural Pennsylvania.

REPRESENTATIVE RYAN: Okay.

MR. CRESSLEY: And that is the real problem with Rural Pennsylvania. You know, we only have one cost center. We got to transport a patient. I mean, the Treat no Transport Bill really didn't help us, and we can talk about that later. But --

REPRESENTATIVE RYAN: Right.

MR. CRESSLEY: -- if we transport a patient, we're paid. Our volume is so low right now, and the payment rates are so low and variable that it's not -- that's not going to work, and nobody is going to -- no health system is going to come in and save us. We've

already talked to them.

REPRESENTATIVE RYAN: Right.

MR. CRESSLEY: And so, how we integrate into that whole system both from the financial side and the clinical side is really the process that we need to take a look at. And I appreciate, you know, your comments.

REPRESENTATIVE RYAN: Yeah.

MR. CRESSLEY: But we have to have willing stakeholders that want to do that.

REPRESENTATIVE RYAN: Yeah, yeah. Mark my words. I'm going to say this to everybody. And you all know it, and you'll start to nod your heads. We're going to have a mass-casualty event in Pennsylvania one day, and we're not going to be able to respond at all.

MR. CRESSLEY: I cover --

REPRESENTATIVE RYAN: You won't even begin to be able to get people to the hospital.

MR. CRESSLEY: Yeah. Our service covers 11,000 square miles, 50 miles of I-80. In the last three years we've had three accidents. One was 27 cars, one was 35, and one was 50. And right now I got one ambulance that's going to that. And it -- and the rest -- the rest of the units that come to that are going to be at least 45 to an hour away. We get calls from healthcare systems to transport patients back from tertiary care to long-term

care facilities. At times, almost every time, we're at least the 25th to 35th ambulance service they called to transport a patient, because nobody has the resources.

REPRESENTATIVE RYAN: And I promise you, my last question. When you talk about two ambulance services responding to one call, I'd just ask -- have to ask you this question. When you get a phone call for ambulance services, does the person on the other end asking you for help -- are they always crystal clear with you about what's going on?

MR. CRESSLEY: No, and they --

REPRESENTATIVE RYAN: Right.

MR. CRESSLEY: -- change their story on the way to the hospital sometimes, too.

REPRESENTATIVE RYAN: Yeah, I understand. That's why --

MR. CRESSLEY: Yeah.

REPRESENTATIVE RYAN: -- I think everybody needs to hear that --

MR. CRESSLEY: Yeah.

REPRESENTATIVE RYAN: -- as well.

MR. CRESSLEY: Yeah, yeah, so I really --

REPRESENTATIVE RYAN: You know, and thank you.

MR. CRESSLEY: -- appreciate your --

REPRESENTATIVE RYAN: And my --

MR. CRESSLEY: Very, very good questions. Thank you.

REPRESENTATIVE RYAN: My hat's off to you all. And I'm -- I know our Chair -- I want to really commend our Chair for the interest in resolving this problem, but I would hope that we can get to an issue where we are funding the budget and finding a way to then get that paid outside of this. Because, this is no way to run a business, if we call it a business.

MR. CRESSLEY: Thank you very much. I appreciate that.

MAJORITY CHAIRWOMAN BOBACK: Thank you, both. Representative Sappey?

REPRESENTATIVE SAPPEY: Thank you, Madame Chair. And, thank you so much for being here and for bringing this information to us today. As somebody who had a family member responded to and taken care of by EMS over the holidays, I am so incredibly grateful to all of you for what you do. And I think one of the things I -- I'm -- this is so front of mind for me and for my colleagues here from the Southeast. I think a lot of us think of the Southeast as a very congested area. And yes, there are parts of it that are very congested, but in Southern Chester County and parts of Rural Coatesville and Montgomery County, we've got some major rural areas. And

one of the things that we're seeing are hospital closures. So we're seeing our folks diverted, and that's a huge problem adding to response time, and then the waits in the emergency room. So, that's one of the things I think -- I'm sure we're going to hear about that at some point today as well.

But the -- I'm interested in the fee for service model, particularly because we have so many different Pennsylvanias [phonetic]. The cost of living in the Southeast is very high, and we can't keep volunteer firefighters in our houses in my area, because they can't afford to live in Chester County. They're still living at home with their parents, and after the age of 35, 40 that's really not, you know, something we're looking --

MR. CRESSLEY: Absolutely.

REPRESENTATIVE SAPPEY: No one's looking for that model. So, you know, cost of living in these different regions of Pennsylvania I think needs to be factored in, but, you know how is it fair for those doing the work? And so again, seeing as hospitals are closing, I don't think absorbing EMS into hospital networks is a good idea, because they're not working. So, that's kind of just a big --

MR. CRESSLEY: Right, yeah.

REPRESENTATIVE SAPPEY: -- broad thought there.

But the fee -- I'm interested in how that might -- the fee thing might work. Thank you.

MR. CRESSLEY: You want to handle that one?

MR. DEREAMUS: Go ahead.

MR. CRESSLEY: I mean, the fee schedule would be based -- right now CMS is doing a national survey to define costs for EMS across the country. Unfortunately, it's going to be too late for Pennsylvania, because it's -- it -- COVID stopped that study for a year. It's starting again, and by the time -- it's going to be two or three years until they have that data. We won't be here in two or three years. And -- but their -- that was their focus, to define the cost for providing EMS in different areas geographically, and try and adjust their schedules to make it work, because they know it's not working.

And in fact, I have a -- every now and then CMS gives us an overpayment, and they want that money back. I can't -- I don't know why, but two years ago -- it used to be a nice letter where you owe this money back. You know, this one's a couple hundred dollars. But, starting last year they put a note -- you -- this first statement says, this is to let you know that you received a Medicare payment in error which has resulted in overpayment. The attached enclosure explains how this happened. The second statement is, note: if you have filed a bankruptcy petition

or involved in a bankruptcy proceeding, please go to -- follow the instructions found at the end of this letter. That goes to every ambulance service in the country. That tells me, and it should tell you, that there is a problem, when they have to put that disclaimer in there. We're in trouble.

And their fee schedule -- obviously they admit their fee schedule is not one that will keep us alive. And they're trying to work on it, but unfortunately it's going to be too late for the end users here in Pennsylvania.

REPRESENTATIVE SAPPEY: Is there something we could do --

MR. CRESSLEY: I think --

REPRESENTATIVE SAPPEY: -- you know, outside of --

MR. CRESSLEY: I think that --

REPRESENTATIVE SAPPEY: -- CMS?

MR. CRESSLEY: I think that our partners here in Pennsylvania, the stakeholders in the insurance industry have to understand the problem, and they have to be an active participant in this. Because, they really control the payment structure for us everywhere now, other than CMS.

REPRESENTATIVE SAPPEY: Okay, and just -- and this is a -- might put you on the spot, and forgive me. If

we regionalized a pay schedule, like you're going to get, you know, the reimbursement --

MR. CRESSLEY: Right.

REPRESENTATIVE SAPPEY: -- here is X, and in the Southeast where --

MR. CRESSLEY: Right.

REPRESENTATIVE SAPPEY: -- the cost of everything is more is --

MR. CRESSLEY: Right.

REPRESENTATIVE SAPPEY: Does that cause -- would that cause resentment, or an influx of people to, you know, start moving around from, you know, region to region? Is that -- would that be an issue?

MR. CRESSLEY: That could be -- yeah, that could be a potential. It happens now. I've lost two paramedics to urban areas, because they're going to make more money.

REPRESENTATIVE SAPPEY: Uh-huh.

MR. CRESSLEY: But, I would assume, when you look at the data that we gave you to indicate that in Rural Pennsylvania you need twice as many medic units to do the same thing in a city. I would think that that would normalize that rate across the board, quite frankly, because you have the same amount of employees basically running the same amount of calls. But in the city they're more efficient, because we're going -- I mean, we spend 35,

40 minutes with a patient in Rural Pennsylvania, the sickest patients, either waiting for a helicopter or going to a hospital, and in the cities it's a ten-minute drive. So their turnaround is just so much different. It's a different environment for turnaround, and so it makes them much more efficient than we are. But that doesn't mean that the law doesn't exist in Rural Pennsylvania, what has to be there. So it could be in the end, and it may be -- it -- because of those resources it may be more expensive in Pennsylvania than to do it in the city.

MR. DEREAMUS: And Medicare currently does that now. They have an urban rate, a rural rate and a super-rural rate.

MR. CRESSLEY: And --

MR. DEREAMUS: The problem is their definition of rural for Chester County isn't going to fit, because they use the Goldsmith Modifying Factor, and you have to be extremely rural to get a rural rating.

MR. CRESSLEY: Right.

REPRESENTATIVE SAPPEY: Okay, thank you --

MR. CRESSLEY: So --

REPRESENTATIVE SAPPEY: -- very much.

MR. CRESSLEY: So I -- you know, it's hard to get into the weeds in this forum with that, but we're willing to get into the weeds on all these issues as we move

forward.

REPRESENTATIVE SAPPEY: I'm sure we all are. Thank you so much.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Last question in this segment is Chairman Causer.

REPRESENTATIVE CAUSER: Thank you, Madame Chair, and thank you, gentlemen, for being here today. You gentlemen are not paper pushers. You came out of the ambulance to come here today, so thank you for what you do every single day.

I think there needs to be greater recognition of the situation that we have. And we often hear, you know, our system is in crisis, we have to do this, we have to do that. But, I don't think the general public --

MR. CRESSLEY: They have no idea.

REPRESENTATIVE CAUSER: -- really realizes the dire straits that we're in. And when you reference Rural PA, it's -- it is coming apart at the seams. I mean, when people are waiting up to an hour for an ambulance and then finally throw themselves in a car and get driven to the hospital, the system is truly --

MR. CRESSLEY: Right.

REPRESENTATIVE CAUSER: -- falling apart. And in Rural PA, I think, Chuck, as you stated, no hospital system is coming to take over the EMS service. In a more urban

area, in certain circumstances they might, because they're feeding their hospital.

MR. CRESSLEY: Right.

REPRESENTATIVE CAUSER: They might.

MR. CRESSLEY: It's a captive --

REPRESENTATIVE CAUSER: But in Rural PA it's not going to happen. And so we need systematic changes. There's no question about that, but I think it does start with a recognition that this is a vital service.

MR. CRESSLEY: Right.

REPRESENTATIVE CAUSER: And the general public just says, okay, if I call 911 somebody's going to come, but in many areas that is not the case. I -- Representative Ryan brought up a mass-casualty incident. In Rural PA a mass-casualty incident is a problem right now. You said you had one ambulance to send to a mass incident right now, today, on Interstate --

MR. CRESSLEY: Maybe.

REPRESENTATIVE CAUSER: -- 80.

MR. CRESSLEY: Maybe.

REPRESENTATIVE CAUSER: Maybe one ambulance.

MR. CRESSLEY: Right.

REPRESENTATIVE CAUSER: So, but the public doesn't realize that, and that's something that I think we can help with. The funding structure -- you know, right

now a medical assistance ALS call, we're reimbursing you guys $300.

MR. CRESSLEY: Uh-huh.

REPRESENTATIVE CAUSER: $300, and then we tell you, oh, we're not going to pay you for the first 20 miles. That's our state Medicaid system.

MR. CRESSLEY: Right.

REPRESENTATIVE CAUSER: We're not going to pay you for the first 20 miles. Oh, if you go more than 20, yeah, we'll give you two bucks a mile after that. So, I mean, there's got to be a recognition here, too, that we can do better. That's why I'm sponsoring an increase in the Medicaid payment. But, there has to be a recognition that this is a vital service. And I guess -- so that's more along the lines of a statement than a question, but if you'd like to add anything to that --

MR. CRESSLEY: Well, yeah, I --

REPRESENTATIVE CAUSER: -- you're welcome --

MR. CRESSLEY: -- I -- and when -- and thank you, Representative Causer, because he -- I was able to meet with leadership a few weeks ago, too, and one of the things we talked about was public awareness. And that only -- not only affects educating the public, but it can also help to motivate people to come help us. Not -- and it's not just that you know what the -- what's going on with the EMS

system. The EMS system is in crisis, and we need your help, also. So, public awareness is going to be vital as we move forward and try and encourage people to enter the system. I believe that that's absolutely necessary.

It's -- this issue is like hypertension. Hypertension's called the silent killer, and this is the silent killer, because it only happens one person at a time, and nobody knows about it, all over the Commonwealth every day.

MAJORITY CHAIRWOMAN BOBACK: Okay.

REPRESENTATIVE CAUSER: Thank you both, gentlemen. And --

MAJORITY CHAIRWOMAN BOBACK: And that is precisely --

REPRESENTATIVE CAUSER: -- thank you, Madame Chair.

MAJORITY CHAIRWOMAN BOBACK: -- why we -- you are quite welcome. Precisely why we put it out into the media, in crisis, our EMS in crisis, and that's created quite a stir. It's our part now. We have to keep the stir going, your part and ours. And I want to thank you both very much --

MR. CRESSLEY: Thank you.

MAJORITY CHAIRWOMAN BOBACK: -- for your expert testimony. Thank you for coming before the Committee. We

all have your numbers, so don't expect -- don't be surprised if you get a few phone calls from our members here today and those in abstention.

MR. CRESSLEY: We would be very happy if that happened.

MAJORITY CHAIRWOMAN BOBACK: Thank you.

MR. CRESSLEY: Thank you.

MR. DEREAMUS: Thank you.

MAJORITY CHAIRWOMAN BOBACK: And for those waiting, we are going to do our best to get us back on track. But as you can see, this is all high area of interest for each and every one of us who hopefully will introduce legislation to at least help rectify some of the problems.

Our next panelist is Mr. Chris Chamberlain, Vice President of Emergency Management at the Hospital Association of Pennsylvania. Welcome, and thank you for being with us today, Mr. Chamberlain. And when you are ready, you may begin.

MR. CHAMBERLAIN: Okay, good afternoon, Chairwoman Boback, Democratic Chairman Sainato and Honorable Members of the Committee. Thank you for the opportunity to participate in this hearing today to consider emergency medical services crisis in Pennsylvania.

My name is Christopher Chamberlain. I serve as

Vice President of Emergency Management at the Hospital and Health System Association of Pennsylvania, or HAP. HAP advocates for approximately 240 member hospitals and health systems across the Commonwealth, as well as the patients and communities that they serve.

In addition to my role at HAP, I'm a 30-year certified Pennsylvania EMS provider and still do that on occasion, a former emergency department registered nurse, and a hospital EMS liaison. And I'm also currently a member of the executive board of the Pennsylvania Emergency Health Services Council. You may be aware of the council's good work and know that, like HAP, it is deeply concerned about the status of emergency medical services across the Commonwealth. You invited me to participated in my role at HAP today, so that's the perspective by which I will be speaking with you this afternoon.

The most important thing you can hear today, and I'm sure you've been hearing it and will continue to hear it through the other speakers, is that emergency medical services are an essential part of Pennsylvania's continuum of care. Each EMS service flexes to meet the unique needs of the community it serves. EMS is a critical component -- critical component of the safety net that protects the health of the Commonwealth.

As hospitals, we rely on EMS in a variety of

ways. Of course the ability to move patients is something that hospitals fundamentally rely on every day to ensure that Pennsylvanians can reach emergency, trauma and post-acute services. We also rely on EMS providers to transport patients efficiently and safely from our hospitals to other appropriate care settings that frees up beds so they can be used by others who need acute or specialty care.

However, while safe, stable transportation is essential, emergency medical services personnel are also indispensable in many other ways. They are truly credentialed healthcare professionals who are capable of assessing complex illnesses and injury situations. Using medical protocols and a lot of their talent, they make critical, rapid decisions in situations where a single mistake means that a patient ends up at the wrong facility, receives the wrong treatment, or potentially a lot worse. These individuals truly are healthcare providers, and they deliver this care under some of the most difficult and challenging conditions.

In many communities, EMS personnel regularly provide care outside of the hospital, and outside some of their normal duties. They do this through programs like Community Paramedicine, where they offer opportunities for patients to remain healthy and well without the need to

come to the hospital.

Throughout the pandemic, we saw EMS providers assist with critical actions like vaccine clinics and testing sites for example. They provided critical public health support as hospital capacity has been stretched to the breaking point. These roles clearly demonstrate the critical nature of EMS and their role as frontline healthcare workers.

Speaking of which, if you will allow me to digress just for a moment, now is a great time for me to pause and thank each of you on the Committee for your action a few weeks ago to reach across party lines and work in concert with the Governor to provide unanimous support to deliver $25 million directly to frontline hospital workers, and then, critically of importance to today's discussion, to also quickly act to provide another $25 million to support the Commonwealth's EMS programs which we've heard is appreciated and perhaps a really good start.

I don't have to tell you that healthcare providers are exhausted. Additionally, violence and abuse against healthcare workers, including EMS providers, is on the rise. We thank you for coming together to show them that the states leaders and, by extension, Pennsylvania citizens see them, recognize their hard work and support the sacrifice they make to keep us all safe.

As you know, from town to town throughout Pennsylvania you will find varying ways the EMS programs exist, and some of the previous speakers have talked about this. Some of the EMS systems are part of the municipal government, alongside or working within their police and fire departments. Still others are part of a hospital or health system, or perhaps part of a regional EMS operating plan. Still more are private, nonprofit organizations that operate independently. For this reason it's extremely difficult to define exactly what emergency medical care looks like, or how an EMS provider intersects with its local hospital in any given community across the Commonwealth.

Some hospitals for example have dedicated professional staff to assist EMS in the emergency department, often called EMS liaisons, and in my introduction I mentioned that I previously served in that role. EMS liaisons work both sides of the ER doors, so to speak, and provide that connection both clinical and operational between the hospital and the EMS communities. Within the bounds of the law, some hospitals strive to support their EMS by replacing supplies that may have been used to attend to the patient's care. Some hospitals have tried to support their EMS in the ways that they support their own staff, by providing meals when appropriate, you

know, as just one example.

Other hospitals though don't have the staff or the resources to support these types of efforts for EMS. Another challenging effect of the various ways EMS services are organized throughout the Commonwealth is the lack of a consistent and comprehensive financial support system for this vital work, and again, some of our previous speakers have talked to that.

Some communities provide for police and fire services, but may contribute little or nothing to their EMS. And I've heard it asserted at times that because EMS can bill for services that they don't need government or other sources of financial support. This of course is a very dangerous misunderstanding. We've talked already about, and you can see my testimony reiterating the point about how some of the reimbursement structures for EMS are built around transportation, and our speakers previously talked about that. It puts them in a very difficult position to try to get paid.

EMS organizations are also suffering from healthcare -- the healthcare worker crisis for -- crisis that hospitals and the rest of the healthcare continuum are experiencing. EMS services are short staffed as well, and in some instances they have to wait longer in the emergency rooms, with less support from hospitals which have always

valued and prided themselves in having good EMS relationships, and that's been a real struggle that we've seen in our ERs.

HAP strongly encourages you to look for solutions to the healthcare staffing crisis as a whole. We thank the House of Representatives for passing House Bill 1868 to ease the professional licensure for veterans and military spouses which can assist in increasing the number of people qualified for EMS and other healthcare professions. And we hope that you can continue to urge your Senate colleagues to finish that important work.

We thank the General Assembly for its work to enter into a number of interstate licensing compacts for nurses for example, and urge the House to complete the Senate's good work on Senate Bill 861 to authorize Pennsylvania to join the EMS Compact. We also respectfully ask for you to ensure that the compacts are fully -- excuse me -- fully operationalized as soon as possible.

Encourage you to continue to explore and promote opportunities for education, mid-career retraining, scholarships, loan forgiveness and other incentive programs to recruit and retain healthcare providers into the workforce. And as I've already stated before, we believe that EMS professionals are essential parts of the healthcare workforce.

Of course, HAP fully supports EMS professionals, but we also believe that it may be beneficial for the Commonwealth to invest in building a responsive and flexible system that allows those who are interested to be able to pursue EMS employment as an entry into the healthcare workforce, and with opportunities to potentially advance in both skill and financial security if that's of interest.

To summarize, the Hospital and Health System Association of Pennsylvania supports efforts to ensure that communities have strong, efficient and sustainable emergency medical services. And finally, I'd like to thank the hospital emergency services liaisons, emergency medical services liaisons from several Pennsylvania hospitals and health systems who spent time with me in the recent weeks to ensure that I had a clear understanding and up-to-date understanding of what the Commonwealth's EMS situation is, so I could accurately share this testimony with you today.

Thank you again for the opportunity to share HAP's perspective as it relates to Pennsylvania's EMS, and as it relates to the state's overall healthcare workforce crisis. We appreciate the chance to offer our thoughts about some of the ways we believe you may be immediately effective in supporting all Pennsylvanians on this critical topic. And, I am happy to respond to any questions you may

have today.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Thank you for your excellent testimony. I have a quick one. I was made aware that EMS companies often receive inadequate or no pay at all as a result of improper billing codes being used by the hospitals to identify medical services. Could you comment on current procedures and standards that will ensure that proper billing codes are employed going forward?

MR. CHAMBERLAIN: Yeah, thank you, Madame Chair. I know that, you know, those issues arise a lot of times with the interface that occurs between the ambulance and the emergency department. There -- you know, typically, as I spoke about in the EMS liaison role, there is an exchange of information. There is, you know, a sharing of the patient's billing and insurance information when they arrive. Oftentimes there is a process where the hospital will then register that patient and may assign a code, a diagnosis code or code to that patient's complaint. When that then comes back out and is shared with the EMS agency, there sometimes can be discrepancies.

So, I don't I'm prepared to speak about the intricacies of that process today, but I do know that that's an issue, and it's certainly something that we can work with our member hospitals to help address.

MAJORITY CHAIRWOMAN BOBACK: And that's all we ask. Thank you. And if we could be an asset to you in any way, let us know.

MR. CHAMBERLAIN: Great. Thank you --

MAJORITY CHAIRWOMAN BOBACK: Thank you.

MR. CHAMBERLAIN: -- Madame Chair.

MAJORITY CHAIRWOMAN BOBACK: Any questions? All right, once again, thanks again for taking such precious time out of your daily schedule. It was very good testimony, and we've learned by it. Thank you.

MR. CHAMBERLAIN: Thank you.

MAJORITY CHAIRWOMAN BOBACK: Our next panelist is Mr. Don Lynch, Chief/Director of Operations of Harleysville Area EMS. Hello, Mr. Lynch.

MR. LYNCH: Hello.

MAJORITY CHAIRWOMAN BOBACK: And welcome.

MR. LYNCH: Thank you.

MAJORITY CHAIRWOMAN BOBACK: And you may start whenever you're ready.

MR. LYNCH: [inaudible]. There we go. I'm sorry. Good afternoon, Chairman Boback and Chairman Sainato and members of the House Veterans Affairs and Emergency Preparedness Committee. My name is Don Lynch. I am the Chief/Director of Operations with Harleysville Area EMS, and of Trappe Fire Company EMS as well.

Both Harleysville and Trappe are located in the northern part of Montgomery County, and I would like to thank you the opportunity for speaking today in regards to EMS in crisis within the Commonwealth, or at least in the southern part of the portion of the state that I am familiar with.

I've been in emergency services for the past 33 years, starting off as a junior firefighter in 1989. I have served with Harleysville Area EMS for the past 18 years, eight of those years as a paramedic, and ten of those years as the chief. I've also served simultaneously for this past year as the Chief of EMS for the EMS division of Trappe Fire Company #1, but I'll get back to that -- of why in a little bit.

Harleysville Area EMS is a nonprofit EMS organization that operates two advanced life support ambulances out of two EMS stations in -- one in Harleysville, and one in Green Lane 24 hours a day, seven days a week, and serves a population of approximately 45,000 people in seven different municipalities.

Harleysville Area EMS was originally a one-ambulance organization, until 2014 when we merged with community ambulance of Green Lane as a single BLS ambulance company who could no longer afford to provide EMS service to the community that it served, due to the cost of paying

employees and continual rising cost of operating an emergency 911 ambulance service.

Every few years throughout the Commonwealth and in Montgomery County, we are seeing emergency ambulance organizations close their doors, because they can no longer afford the cost of providing emergency 911 ambulance service. One of the major causes of this is due to the low and fixed reimbursement models for services from insurance companies and through Medicare and Medicaid.

As you're aware, there is an overhead cost to an emergency ambulance organization for being in a state of readiness. There is a cost of staffing an emergency ambulance 24 hours a day, seven days a week. There is a cost of having a minimum of two EMS providers, one paramedic, one EMT, on the ambulance, on duty and ready to respond. There is a cost of having a reliable ambulance fully stocked with medical equipment and supplies, fueled and ready to respond when needed. There is a cost to house an emergency ambulance, the equipment and the emergency medical staff.

So, no matter how many calls the ambulance crew responds to during a shift, or how many times it transports a patient to the hospital, there is an overhead cost, and unfortunately the current billing and reimbursement model for emergency 911 ambulance service does not cost the

basics -- cost of being ready.

It is my belief that EMS here in the Commonwealth has been on a steady and foreseen path of unsustainability for the past several years or more, only to find ourselves now in a true state of crisis. I do not believe that COVID-19 pandemic is the primary cause of the crisis, but because many EMS organizations have already been struggling to keep their doors open for the past several years prior to the pandemic. I do believe however that the COVID-19 pandemic exacerbated the day-to-day struggle, and many EMS organizations are finding themselves in financial hardship.

EMS is not only finding the pressure -- or only feeling the pressure of financial and reimbursement shortcomings due to the pandemic, but we are also experiencing personnel shortages like we have never seen before. The pandemic has caused many older seasoned EMS providers, EMTs and paramedics to have -- to leave the EMS field all together, due to an increased strain on the EMS provider and the EMS system in general during the height of the pandemic. Others have left EMS as a career during the pandemic in fear of catching COVID-19 and/or the fear of bringing it home to their families.

Another cause of the personnel shortage I believe is due to the low enrollment into EMS field by new EMTs and paramedics. I feel this is mainly due to EMS struggling to

maintain itself as a career. Very few EMS agencies throughout the Commonwealth can provide competent -- competitive wages, promotional opportunities, or be able to provide a pension or a contributing retirement program for their employees.

During 2020 and a portion of 2021, we struggled through the pandemic -- the COVID-19 pandemic as frontline workers in Montgomery County, and we did receive fantastic assistance and support from our county and EMS region. Because of this, I would like to thank the Montgomery County Commissioners, Department of Public Safety and the Montgomery County EMS Office and the region for all their assistance and guidance during the pandemic.

They provided not only to EMS, but to all emergency services within the county, the proper PPE needed to effectively respond to COVID-19 calls at no cost to the emergency service agency. The county also made vaccines available as a priority to all emergency service personnel throughout the county. For this I would very much like to thank them.

Now, as we are hopefully coming out of the pandemic, we are beginning to see the true state of the health of local EMS organizations. As I mentioned, EMS was already in trouble prior to the pandemic, but now EMS organizations big and small throughout my area of the

Commonwealth are truly in a state of crisis.

Late in 2019, Trappe Volunteer Fire Company #1 and Harleysville Area EMS began talking about spinning off the EMS division of the fire company and merging it with Harleysville Area EMS. The volunteer fire company could no longer -- no longer wanted to manage and operate an emergency 911 ambulance, because of the cost and lack of financial sustainment associated with it.

Throughout 2020, Trappe and Harleysville committed -- continued to discuss the idea of merging the EMS organizations together, but merely by -- by merely combining two financially struggling EMS agencies together, we would only create one large financially struggling EMS organization that would most likely fail in a short period of time.

Knowing that the two EMS organizations, Harleysville and Trappe, could not continue as is, we decided to move towards combining the two EMS entities and creating a new regional EMS organization. Knowing the financial side and the unsustainability reimbursement model by the insurance companies, our number-one source of income, something had to be different, and an additional source of long-term financial support must be identified.

As we move forward in the process of combining both Harleysville Area EMS and the EMS division of Trappe

Volunteer Fire Company, I was brought on -- I was brought on simultaneously as the chief of EMS for Trappe in an effort to begin the internal process of streamlining cost and planning the day-to-day EMS operations of the new organization.

We are actively working with all 12 municipalities that we are currently providing EMS emergency 911 ambulance service to in an effort to seek help in providing and committing to starting up a long-term financial assistance and support. It is our belief and hope that by combining our two EMS entities together and forming a new regional EMS organization, we will be able to partner with our municipalities that we proudly serve and figure out how to properly establish a long-term financial sustainment plan.

We believe this is needed to provide long term in a stable EMS organization, and will allow us to serve the communities with state-of-the-art prehospital emergency medical care.

As much as I believe EMS -- the EMS crisis is a local issue, it is equally a state issue. As we talk with the 12 municipalities that we serve, we are finding that the more rural townships and smaller boroughs do not have the financial means to help subsidize or pair their fair share to provide EMS to their communities. This was a

difficult -- or this was a different story when most EMS organizations in the small boroughs and rural townships were staffed by mostly volunteer, and contributions of just a couple hundred -- couple thousand of dollars each year by the townships and boroughs was sufficient. But today most of these community -- contributions by the municipalities have not increased; in some cases even decreased over the years in the amount they contribute to their local EMS. However, as you know, the cost of providing EMS has drastically increased and continues to increase each year.

I do not know what the exact answers are, but I do know for a fact that EMS agencies throughout the Commonwealth are truly struggling to remain open. EMS organizations want to continue to provide high quality prehospital emergency care to the communities that we proudly serve, but something soon needs to be done to help relieve these financial struggles.

I believe some of the answers are a combination of the following: having EMS recognized and properly supported as an essential emergency service to the state and local levels, regionalization of EMS services within multiple communities, working directly with out local municipal partners and state representatives to establish long-term financial sustainment programs for EMS organizations.

Again, I don't have all the answers, but as the EMS chief of two struggling EMS organizations within the Southeastern Region of the Commonwealth that proudly serves EMS services to 12 municipalities, and who are trying to do everything we can to keep our doors open, I can testify by firsthand knowledge that EMS, at least in my region of the state, is truly in a state of crisis.

Thank you, Representative Boback and Representative Sainato and members of the Committee for allowing me to open -- this opportunity to speak today on this very important issue. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you so much. And before I transfer over to our first question, I do want to commend you. 12 municipalities? I mean, that was a situation where you saw a problem and said where do we go with this? And, hopefully that will be the answer. Of course it's going to rely on funding and demand. We all know that, but at least you took a step. So you are to be commended. And, thank you for sharing this with us.

MR. LYNCH: Thank you.

MAJORITY CHAIRWOMAN BOBACK: With that, we -- I'd like to mention that Representative Stephanie Borowicz is joining us virtually, and our question goes out to Representative Pennycuick. I believe you are -- this is a constituent of yours, perhaps?

REPRESENTATIVE PENNYCUICK: Yes.

MAJORITY CHAIRWOMAN BOBACK: Okay.

REPRESENTATIVE PENNYCUICK: Thank you so much, Chief Lynch, for coming.

MR. LYNCH: Absolutely.

REPRESENTATIVE PENNYCUICK: And I commend you for recognizing that you needed to go regional. And we've talked extensively about how we fund and take care of our EMS system. And, 911 is required by law, but yet we voluntarily fund it through fundraisers and, you know, subscriptions. If you were in charge for a day, what would you suggest be a valuable way we could provide continuous funding that you could anticipate, depend on and kind of take that part of what you do off the table? Because I know financially that is a huge part of what you do every day.

MR. LYNCH: Exactly. The two ways that we are funded mostly is through billing of the insurance companies, and then a fund drive, a subscription fundraising, and then we get small contributions from the municipalities. Some municipalities are greater than others as a donation on a yearly basis, but that doesn't sustain us.

I thoroughly do think, and I am talking with the 12 municipalities and the Senator -- is with the

billing -- billing brings us up to about zero when it comes to payroll. We are a nonprofit organization. We do our -- have a volunteer board of directors and about a handful of volunteers, but they don't take regular shifts. We still provide 24 hours a day, seven days a week by career EMS, EMTs and paramedics. A volunteer that might want to come out, a volunteer EMT, he or her might ride as a third on the ambulance for maybe a portion of the shift. So, for a 12-hour shift, they might run for three to four hours as just a second set of hands, or a third set of hands.

Billing allows us to bring up to about 50% of our budget, or 60% of our budget. The fund drive brings up another 20% of our budget. We therefore have a shortage of -- about a 40% or 30% of our budget is a shortfall every year. Our ambulances are running about 180,000 on our newest ambulance, so we can't put money towards supplying or savings for new equipment. That's where I think working with -- or trying to work with our municipal partners -- of trying to figure out how to fill that stopgap. I don't have the capabilities. The Ambulance Association and you people have the ability to work the insurance side of it. I don't have a say on that, really, so I have to try to figure out -- is how can I keep my doors open, so I can continue providing EMS service? So, what I'm trying to

figure out is how to fill that stopgap of that 30%, and that's where I'm looking to our 12 municipalities to basically agree to or come in as partners to fill that. If that's a fee per household within the township or a fee per call volume -- somehow different ways. We have brought in, you know, personnel to kind of come in and help with this and to structure this, but there has to be a way that we fill the stopgap, and we -- or fill that gap in our budget. Because some years our billing is great -- you know, ups a little bit, some years our billing is down. This year our billing has been down about 40% from previous years, because we're used to seeing about a 90 day from the time we submit a bill to the insurance company, Medicare for example. We usually see about a 60 to 90-day turnaround. We're now seeing 140 to 190-day turnaround before we get money in from the --

REPRESENTATIVE PENNYCUICK: That's ridiculous.

MR. LYNCH: -- from them, because there is a delay, and we're told it's COVID, because a lot are still working from home, but that affects our cashflow. And when that affects our cashflow, we worry about payroll. As much as grants -- we really appreciate grants, and we really appreciate the -- you know, the 25 million that got approved for EMS. But like one of the gentlemen said, that works out to be about $32,000 for a EMS squad. That

doesn't cover one payroll. That doesn't cover two weeks of pay for my staff.

So, trying to figure out how to fill that gap, that's going to be the key, and that's what we're trying to work with our local municipalities, of how to try to fill that.

REPRESENTATIVE PENNYCUICK: Madame Chair, can I -- thank you. I have one more question. And I think this is very relevant in today's environment. What is the average salary of one of your EMTs?

MR. LYNCH: Our average? Our EMTs are at -- our full-time EMTs are $17.50 an hour for an EMT, $25 an hour for a full-time paramedic.

REPRESENTATIVE PENNYCUICK: Which I think is part of the problem.

MR. LYNCH: Absolutely.

REPRESENTATIVE PENNYCUICK: If you can make $17.50 with zero skills at Starbucks, we should be paying our EMTs that perform lifesaving skills a heck of a lot more than that. That might be part of our retention and burnout problem.

MR. LYNCH: Absolutely.

REPRESENTATIVE PENNYCUICK: And hopefully when we can have a steady funding stream, we'll have some stability within the workforce in EMS, and you can grow your future

leaders and your future paramedics, and your future, maybe physician's assistant. I don't know, but I think that's a problem.

MR. LYNCH: Yeah, there has to be --

REPRESENTATIVE PENNYCUICK: But thank you --

MR. LYNCH: -- something that keeps people in EMS, and it's not just a stepping stone. It's a career.

REPRESENTATIVE PENNYCUICK: Exactly.

MR. LYNCH: It should be made into a career.

REPRESENTATIVE PENNYCUICK: Absolutely. Thank you so much, Chief.

MR. LYNCH: Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Any benefits that go along with a low wage? And quite frankly, you save lives. I mean, we could pay you a million dollars. It still isn't appropriate, because you save lives. But with your salary on average, any benefits attached?

MR. LYNCH: There is full medical coverage that we provide to the employee at no cost to them. And that's kind of where right now the employee pool is very shallow within Montgomery County and throughout the entire Commonwealth. So, each EMS organization is trying to play this, you know, bump up the salary by a dollar or more, or $2, and they try to get people to shift from one

organization to another. Or, you know, we currently are providing full healthcare coverage to the employee and their family at no cost to them. So we're -- everybody is trying to compete for the same amount of paramedics and EMTs. There is a huge paramedic shortage right now, at least in the South Central Region of the PA -- of PA, and I think throughout the entire Commonwealth. And paramedics are -- 75% of our call volume is dispatched as ALS, advanced life support, therefore we have to respond as we are dispatched. So, even if we have a BLS ambulance, we still have to send a paramedic, either from our organization or another organization. And, ma'am, that's where you've saw -- seen the two ambulances.

MAJORITY CHAIRWOMAN BOBACK: Yes.

MR. LYNCH: Yeah.

MAJORITY CHAIRWOMAN BOBACK: Yes. Thank you. Thank you for that clarification. And again, thank you for your expert testimony. We truly appreciate your precious time. And once again, we all have your number, so don't be surprised if you don't get a few phone calls. And --

MR. LYNCH: Very good.

MAJORITY CHAIRWOMAN BOBACK: -- I want to thank you for being with us. Thank you.

MR. LYNCH: Thank you very much. I appreciate the opportunity.

MAJORITY CHAIRWOMAN BOBACK: Our next panelist is Mr. Mark Hamilton. He's from Tioga County. He is a commissioner, and he is representing the County Commissioners Association of PA. We want to welcome you, and thank you for being with us today. And whenever you are ready you may begin.

MR. HAMILTON: Okay, first of all, Madame Chair and members of the Committee, thank you very much for the invitation to be here and be a part of this today. As stated, I am Mark Hamilton. I'm Tioga County Commissioner, and I'm co-chair of the newly created Emergency Management and Veterans Affairs Committee for the County Commissioners Association of Pennsylvania.

I am also -- happen to be an EMT, a volunteer firefighter, EMT instructor. I have been involved with my local service for -- I hate to say -- oh, probably around 40 years or more, so I am very comfortable with the group here. We're all after the same thing here, I believe, today.

I want to -- I think it's important for me to take just a minute or so to explain why the County Commissioners are here as a part of this group. I was part of the SR6 Commission, and as I was giving reports back to our association, there became a lot of chatter with our commissioners around the table. And, we all realized that

we were all having the same problem, but it wasn't talked about before that. And that was, each of our counties saw that we were in a crisis with our EMS.

So, at that point we established a task force, and while the counties do not have any direct responsibility for EMS in Pennsylvania, we do recognize that our municipalities have varying capacities to organize, promote and provide emergency services. And, most of our services that provide emergency services are organized at the municipal level, but they're typically covering service territories outside of those boundaries, in part because a lack of service, in part because of differences in certification levels, and in part because of backup responses for other communities that are already out on their own emergency responses.

Issues with service capacity are shared between urban and rural areas. We all know that, but those challenges are not because of the same reasons in all of our different areas. And, while we know the training, certification, equipment has evolved considerably in tandem with evolution of the healthcare industry overall, the resource requirements for the system are increasingly unsustainable.

With all those things said, counties wanted to explore whether they could help address some of these

issues, focusing on EMS. So in 2019 we did develop our task force, which I had the honor of co-chairing. And, the task force, when we got started, we took those recommendations from SR6, and we -- first of all, we pulled out everything that we thought was relevant to the EMS system out of those recommendations, and then we broke them out into several categories, including retention, recruitment, reimbursement rates, coverage standards and capacity, service models, risk reduction, EMS Act and regulations, technology support and training requirements. And from there, after our work was done, we issued our own report and our own recommendations that -- and that has been the top issue for one of -- for the association ever since.

With that background laid, I want to take a moment to touch on what CCAP and Counties are doing now, and where we hope to go in the future. One of the primary recommendations of the task force was the need for the ability to foster and facilitate local solutions that fit individual community needs, and have the input of all the local officials and EMS providers. We all know that one size doesn't fit all across the Commonwealth.

The report calls for the encouragement of each county to convene forums of municipal officials, EMS providers, healthcare providers, health systems and other

appropriate stakeholders to review current coverage and coverage needs. From that work, counties identified the need for a toolbox to aid in discussions and provide best practices for solutions that best fit their local need.

CCAP has begun work with the community of economic and -- development with their chosen consultant on a pilot project to evaluate the current status of EMS in the Commonwealth. The goal of this study is to provide information on the current status of the EMS in certain county pilot regions of the Commonwealth, in hopes to be able to utilize the details from this study to develop resources and strategies to meet community EMS needs, and will ultimately assist with the development of a toolbox that we would use for other counties that will then be able to leverage the things in the toolbox to guide local evaluations.

We believe this study will be instrumental in not only fostering those local conversations, but also in forming on a more detailed scale what issues MES is facing, why, and identify opportunities for change and for growth.

For example, we know funding is an issue. It's already been talked about today a lot. But, this study would be able to help identify what exactly the funding issue is comprised of in that particular area and potentially offer creative and systematic solutions that

would propel us forward. We must understand the cost of readiness in each of our areas.

Building on the topic of funding, the EMS task force report calls for addressing system funding needs that support a variety of service models in the Commonwealth. And I won't go into too much detail, but I did want to touch just basically on two things in support of my other colleagues. And, one is that the HHS, the Human Services, is piloting a project now called ET3, and that stands for Triage, Treatment and Transport. And, I believe if we could get insurance companies on board to help fund this, in the long run this would save our service providers time in the field. It would save the insurance companies money, and it would also save our patients money.

The other thing is the direct pay for providers that we have talked about already. And I just wanted to add that the small volunteer company that I run with in 2020 lost $9,500 in our kitty, because we were not paid for those calls through the insurance companies, and multiply that across the state.

I highly commend the legislature for the great work that you have been doing in this area the past couple of years by passing many helpful bills, but if we are going to succeed in squelching this crisis, we need to double down on the heart or the meat of the matter in order to

acknowledge these funding challenges as something counties are really paying attention to.

Also, I need to mention the need for reauthorization of 911 funding. Counties are proud to provide this critical link of call taking and dispatch between the public and the first responders in emergencies. As you may know, the current authorization sunsets January 1, 2024. This year's deployment of the next gen 911 will significantly enhance emergency response through the new technologies that are coming forth, but with that technology cost and inflation, it will also come with a higher operational cost. This sunset may seem far off, but we must start working together now to be able to come up with a continued adequate funding for this vital service.

Additionally, and maybe the most important here, counties are continuing to support legislation to allow for the creation of countywide or municipal public safety authorities, including providing fire protection services and emergency medical services. It is important to highlight that Senate Bill 698 simply provides and codifies an option, not a mandate, for counties or municipalities to create public safety authorities that would continue to allow EMS agencies to retain their autonomy while finding ways to structure support and funding that work for their communities.

The county cannot simply take over service provision, but I want to stress that the counties want to work to bring stakeholders together, and to build buy-in and trust to whatever model the solution -- and solutions are ultimately developed locally.

As you've already heard today, the ability to utilize this model could dramatically change the EMS provision landscape by not tearing down our already existing providers, but by streamlining resources to ensure companies can remain in business while more adequately and efficiently serving residents locally.

We have heard of countless providers that are struggling to recruit and retain employees while remaining above water financially. Emergency medical services are critical lifesaving services that cannot go away. We all know that, so I want to continue to stress that Senate Bill 698 codifies an option that would have specific details decided on by the local providers and stakeholder organizations. Counties recognize and respect the need for local input and decision making, and believe SB698 protects that autonomy while more efficiently providing for our residents.

To conclude, I want to be clear once again that counties are not seeking to take over the responsibility for EMS, but we do fully believe we are the right size to

offer resources and alternatives, and to help with bringing stakeholders to the table. In many counties this collaboration between counties and municipal leaders and local service providers is already occurring without a statewide solution to funding, workforce and other capacity-related issues, local entities must become -- must come together to ensure lives are not lost and sustainable solutions are being found and created.

I look forward to continuing this dialog as we work together to bolster the EMS system in Pennsylvania. And, I want to let you know that counties are standing by to participate in any discussions on solutions. Thank you for your time, and I will be happy to take any questions.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Mr. Hamilton. My understanding is that COVID dollars, Federal dollars, have come into every one of the communities, and that some of those dollars can be allocated for EMS for lifesaving services. Is that correct? And if so, how are the counties using that funding to supplement services such as this?

MR. HAMILTON: Well, some of the COVID dollars in our county were given to our providers, and I believe that's the case in most of our counties. The problem is that's a one-time gift, a one-time shot.

MAJORITY CHAIRWOMAN BOBACK: Approximately how

many? Is it based on the size of the county, the population, the need?

MR. HAMILTON: On the amount of dollars?

MAJORITY CHAIRWOMAN BOBACK: Yes.

MR. HAMILTON: Yes, that was based on population.

MAJORITY CHAIRWOMAN BOBACK: Thank you, thank you. Another question from Chairman Causer.

REPRESENTATIVE CAUSER: Thank you, Madame Chair, and thank you, Commissioner Hamilton, for your great work. And, I've had a chance to read the report that your task force put out from CCAP, and that was very informative. And, having you here today to offer a rural perspective also is, I think, very important.

MR. HAMILTON: Thank you.

REPRESENTATIVE CAUSER: One part of your testimony that I think is a potential solution is the legislation that would create EMS authorities. And as you stated, it is an option, and it may work in some areas and not in others, but I think that that is an important option that particularly in Rural PA may be an effective model. So, thank you for your work on that. Wanted to offer you the opportunity to give your thoughts a little more on how that could be developed and how it could be used in Rural PA to try to regionalize and provide service.

MR. HAMILTON: I think the authority model exists

now and has been very successful in other areas such as solid waste authorities, transportation authorities especially in the rural areas. And, this bill would simply add, you know, fire and EMS to that. One of the things that that would do, it would give a county or a multi-municipal authority the ability to put a per capita tax on. And -- but it wouldn't have to, and that's where -- that's where -- we see the model as being very, very straightforward, just giving them the ability to do that, and it would be put together at the local level, with seeing that you would have providers on that board of the authority. You would have the local townships on the board of that authority, and possibly a county commissioner. And, that authority would be formed at that level with what they thought their needs were.

So I -- you know, I mentioned that they could put a tax on, but they wouldn't have to. If they can come up with a model that they think are working, and -- they could just -- the authority would say, okay, we want to give you a grant writer for everybody in the county, for every provider in the county. Or if we want to help you with billing, we're going to do a centralized billing. And so it could be tailored to exactly what that locale wants and needs.

REPRESENTATIVE CAUSER: Seems to me that that's a

potential solution, and especially in Rural PA, that should be an option, so I appreciate that very much. And, I think that county commissioners definitely need to have a seat at the table in this discussion. And, you know, you're the ones that are actually dispatching emergency services, so --

MR. HAMILTON: Correct.

REPRESENTATIVE CAUSER: -- to have a seat at the table and be a partner in this effort is important. So, thank you for your service and for being here today. Thank you, Madame Chair.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Mr. Chair. And thank you, Mr. Hamilton, for your wonderful testimony and some great ideas for us. Thank you.

MR. HAMILTON: Thank you.

MAJORITY CHAIRWOMAN BOBACK: Thanks for all you do. Our next panelists are from West Grove Fire Company. We have Mr. Justin Gattorno, Mr. Gary Vinnacombe, Mr. Neil Vaughn. We welcome you, and when you do address us, please give us your title. You all have titles which I did not give. So, feel free.

MR. VINNACOMBE: Good afternoon, and thank you for having us [inaudible]. Good afternoon. Thank you for having us. My name is Gary Vinnacombe. I'm the EMS Manager from West Grove Fire Company. I'm joined by Chief

Justin Gattorno and President Neil Vaughn.

Our agency serves just under 100 square miles in Southern Chester County. Typically we see an average increase of 100 calls per year for the last ten years, so our landscape has really changed a lot year to year. As an emergency services agency, we do a ton of planning. We're always planning, we're always forecasting. And like all my other colleagues that have spoken today, we were pretty significantly impacted by COVID-19, both from a staffing perspective, a financial challenge perspective. So, that was kind of our first roadblock in our planning for the way we're going to operate our department every day and in the future.

Coming out of a pandemic with 90 days' notice, we were informed that our local hospital would be closing. Jennersville Regional Hospital which had been open since 1959 in our first two coverage area. To give you a little bit of a perspective, it's surrounded by a nursing home, two multi-building senior living facilities and a recently constructed 55-and-older senior living community. Our department transported over 1,000 patients to Jennersville Hospital in 2021. And monthly, Jennersville saw about 1,400 patients that came in on their own means or from other EMS services in our area.

So, with the timing of this our budget was

already was done, our staffing plan was done. Now we find out in the next 90 days the entire face of our service is going to change. We did modeling and projections, which led us to ask for a 15% increase to our municipalities. Shortly after that happened, things started taking shape. We thought we knew how things were going to look. We learned that a second hospital in Chester County was going to be closing, Brandywine Hospital. While that doesn't directly impact our day-to-day operation, it more impacts the western part of Chester County. The only behavioral inpatient unit in Chester County was now closing. Behavioral health patients were not going to have anywhere to go to seek treatment in the county.

Typically, our behavioral health patients spend an inordinate amount of time in the emergency department, waiting for placement, trying to find a social worker, trying to find an available bed, and we knew this was only going to further compound the problem.

It led us to meet with our stakeholders, our municipalities, our mutual aid agencies, other healthcare facilities; where did they anticipate sending their patients? So, as a county it took us from five hospitals to three. Two of the three hospitals that we now go to on a regular basis are out of the Commonwealth of Pennsylvania.

Our transport times -- to understand a transport time, that's the amount of time when we leave the scene and arrive at the hospital -- was typically eight minutes. That's now expanded to 30 to 40 minutes. Our turnaround times -- that's the time that we arrive at the hospital, and then we're available to go into service for the next call. That went from 13 minutes to roughly an hour, and that's on average.

When we talk about our turnaround times, that's the time to decontaminate the truck, especially, again, with being in a pandemic, restocking the truck, and then the biggest variable that we've seen is what we call our extended wall times, and that's days where we wait two hours at the nurse's station with a patient on the stretcher, because the hospital doesn't have anywhere to put the patient. The longest we've seen is about two and a half hours. There's days where one to two hours is the norm, and there's days where all of the hospitals are facing that. So, while we do our best to tell patients, hey, this is the situation we're going into, it could be an extended wait. It's the case for all of the surrounding hospitals when that does happen.

With having a hospital in our district and being able to respond to emergencies that come in while we're already there, a 13-minute turnaround time to an hour was a

big impact. Our total call times went from about 46 minutes when we transported to Jennersville to about two hours, which is 150% increase. And what that does is it generates more second and third emergencies. That's when an emergency occurs when one of our ambulances is already on an emergency. So, we saw a significant spike in second emergencies, a significant spike in third emergencies. It leads to increased fuel use, increased wear and tear on an ambulance.

And proactively we ordered a new ambulance. We're six months into our order, and our chassis just went on the line. We're understanding that there's a significant delay, and that we may not see our ambulance until 2024. There's 32 ambulances in a similar fashion waiting for a chassis and to go onto the production line.

The other thing we see with these extended transports is it poses a significant safety threat. The safety of EMS providers is always at the top of our priority. Intoxicated patients who may become combative, behavioral health patients who may become combative, and then the wintertime threat of icing, snow and poor road conditions. The overarching theme with what we're faced with is 1,400 people a month from just Jennersville now need a place to go. Some of them don't know of any other hospital, so they call 911. Some of them don't know what

to do, because their basic medical care isn't available. They use 911 as a resource. The other thing that we always worry about is our unstable patients, the true unstable patient that has severe bleeding or a compromised airway that we would normally be able to take to a close hospital, get a rapid intervention done by a physician, and then transfer that patient to a more appropriate facility. So if you have a patient with a severely traumatic injury, hanging blood, being able to stabilize within a scope of practice higher than an EMS provider such as a physician, and then transferring those patients, that close hospital no longer exists. This has had a tremendous impact on our day-to-day operations, our staff and our financial obligations.

EMS provider wellness, which is always very important to me -- most of our EMS providers are working multiple jobs. I can say with confidence that over 75% of them are working two full-time jobs or the equivalent of that. That's overtime, that's extra shifts, and when you have transport distances so significant and waits so long at the emergency room, that leads to these staff members not getting out of work on time. That presents issues with childcare. That presents issues with a social life, all the things that are important to maintaining a healthy work/life balance. So we see an increased fatigue amongst

our providers, and we see increased burnout as a result of the 60% transport times that have increased.

A lot of our providers work 24-hour shifts, so you can imagine after being at work for 24 hours finding out that you're staying two hours longer because there's a significant wait at the hospital, you can imagine what that does to somebody. These can lead to depression, anxiety, PTSD, all of which are exacerbated by a lack of sleep and too many hours.

We see people leaving for non-medical careers. We see people not staying an EMS because of low wages, no room for advancement and, as my other colleagues have said today, use the instance of stepping stone to nursing, being a PA or being a physician.

Despite the public health emergency that this created in our area, our message continues to be to the community, everything is going to be okay. We respond to emergencies every day. We take our resources that we have available. We take our training and our knowledge, and we continue to make the response every day. So when people wonder, where does this coverage come from? The coverage comes from the EMS providers that really care about the community and come in to work that extra day on their day off, because they want to make sure these trucks are hitting the street, and that people are getting an

ambulance and care when they call 911.

We've seen the firsthand effects of how hospital closures can affect the EMS system, and how hospital closures can affect the community. Our biggest fear is what happens when we lose more EMS services. And if we don't continue to work towards a resolution for the EMS system, we're going to be faced with that same challenge. I cringe to think what would happen if we lost an -- singular, one -- EMS service in Chester County.

We can't plan for a pandemic, and we can't plan for two hospitals closing, but through evaluating our operations, our budget and taking care of our staff, we continue to do the best we can every day. Funding that is sustainable is the most important piece to our existence. The stagnant reimbursements, the remaining competitive, trying to retain staff with incentives, wages and benefits, and the increase in operating costs are the three biggest things that plague our department.

Every year we see a 3 to 5% increase in our operating costs, and every year we don't see an increase in reimbursements from Medicare, Medicaid and our commercial insurers.

So, that concludes my testimony. I thank you for your time and taking time to understand this problem. I know the hospital closure is unique to our piece today, and

we appreciate you taking the time to listen to it.

MAJORITY CHAIRWOMAN BOBACK: I had a similar situation. And of course, as I mentioned before, I am a rural legislator, and the problem becomes, even though they were allowed to keep the emergency room open, it's still picking up one of the constituents and taking them to the nearest hospital after that, you know, if there's no triage, or it's done via the ambulance or the EMS. And it's just -- to think in 2022 we've come to this.

My only question is, it sounds like you're all operating -- and not just your testimony, but others -- that it seems like it's always, like, in debt. So, how do you keep yourself -- get yourself out of the hole, keep yourself from going into the hole? I mean, is it just, you know, fundraisers?

MR. VINNACOMBE: So, our funding comes from a culmination of municipal funding, our billing and then our fundraisers. We're very fortunate in our department that we receive excellent support from our municipalities. We work cohesively with them. We meet quarterly with them. They understand our challenges, and maintaining that level of transparency has really opened a gateway to having a successful relationship with them. And when something like this happened, first with COVID-19 and the follow-up of the hospital closure, it wasn't like we needed to take time

into introductions and get to know each other. We worked together on such a regular basis that it was just us sitting at the table, saying here's the problem and coming up with a formidable solution.

MAJORITY CHAIRWOMAN BOBACK: Thank you.

MR. GATTORNO: But at some point the municipalities reach a saturation point.

MAJORITY CHAIRWOMAN BOBACK: Yes.

MR. GATTORNO: And we're not quite there yet, but the -- that point is going to come sooner or later. So, that sustainable funding is -- that's really important, because we did have some good leadership that set up this billing formula with our municipalities, and it's worked well for us.

But, you know, we talked -- on the way up here we talked about some of the same situations that were spoken of before us. You know, we see a sign for Chic-Fil-A hiring at $19 an hour, and we're -- we just increased our rates to start at $19 an hour. You know, so -- and we're trying to stay competitive with some of our neighboring agencies as well.

So, those costs on our end continue to go up, and, you know, it's difficult to go back to our municipalities time after time again. Again, we have to -- you know, at some point there's going to be a saturation

point.

MAJORITY CHAIRWOMAN BOBACK: I understand. Well, God Bless you all. You're the ones who save lives. I want to thank you. The testimony was wonderful, but you're out there every day saving lives. Thank you. Was there a question? Okay, Representative Sappey. Excuse me.

REPRESENTATIVE SAPPEY: Thank you so much for making the trip up here.

MR. VINNACOMBE: Thank you for having us.

REPRESENTATIVE SAPPEY: I really appreciate it, and your testimony is so important to share. Can you touch on how natural disasters might impact you to help some of us on the Committee understand? I mean, Pennsylvania obviously has a lot of diverse geography.

MR. VINNACOMBE: Sure.

REPRESENTATIVE SAPPEY: And, you know, we -- I think we've experienced some really intense weather events in the last couple of years in the southeast. Can you talk about how that impacts you?

MR. VINNACOMBE: Sure. So, a great example of that is we just had -- last year we had a tornado come through our neighboring Town of Oxford. There was an ambulance on the Route 1 Bypass that had a patient having a heart attack in it. They were on their way to Chester

County Hospital, and because of all the trees that came down and the flooding, the only -- the hospital they could physically get to was Jennersville, and fortunately the patient was able to be treated there. So, when we talk about the poor road conditions, and we talk about the ice and the snow, we think of that just along the same lines. Certainly there's a way to get to another hospital. There's a lot of different routes you can take, but now we're into two hours, three hours, and we're into not knowing, what are the roads like? Are there trees down, and what type of impacts the storm caused in other areas as it passed through.

One of the things that I think we do really well is communicate with our 911 center. They kind of have an overall picture of what the county looks like when something like that happens, and more live-in-time updates on road closures and things like that. But the bottom line is, if we have a severe disaster with a lot of casualties -- fortunately there were no injuries that we treated as a result of the tornado coming through, but that is certainly going to pose a threat to the welfare and -- of the public.

MR. GATTORNO: Flooding events as well. We had -- Ida I believe it was that came through, and we -- that cuts off -- essentially for us, that cuts off access

to Chester County Hospital, to the northern hospitals to us. So it leaves us with, really, only one or two choices, and that's having to go south into Delaware to reach some of these other -- to reach other hospitals.

REPRESENTATIVE SAPPEY: And I believe there's another over-55 community coming in --

MR. GATTORNO: Correct.

REPRESENTATIVE SAPPEY: -- to your area. So you're probably going to see an increase in calls. I'm just guessing.

MR. VINNACOMBE: That's correct.

REPRESENTATIVE SAPPEY: So, that's all interesting stuff to take into consideration. Thank you.

MR. VINNACOMBE: And thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Representative Rigby?

REPRESENTATIVE RIGBY: Thank you, Madame Chair. Thank you, gentlemen, for being here today. You know, we talk about retention and recruitment, and I'm texting back and forth with one of my providers locally. And, you know, he brings up -- in our area -- and you talk about 24-hour shifts. Well, we have guys that because they can't afford to pay the benefits because they're smaller municipalities, are working two or three different agencies. So they'll do an eight-hour shift here, and then they go to the other.

And they're working a 24-hour shift, a full 24 hours, jumping to -- just to make ends meet, working 80-plus, 90 hours a week because of no benefits. And this really is going out to Mr. Hamilton that was here with the County Commissioners Association. You know, is it a possibility to put a designated, say a two mil [phonetic] tax on that would be specifically for EMS, and then those funds would be dispersed based off of population? Because that's how those funds would be gathered. But, that certainly would help offset some of the financial problems that we're running into with EMS providers locally, unless I'm off base on that. But, I too have been involved with the fire service since '77, so it's been a long time.

MR. VINNACOMBE: Understood.

REPRESENTATIVE RIGBY: You know, and we're right, the pancake sales, and the boot drives and all those things are just -- they're just not cutting it.

MR. VINNACOMBE: I'll defer to President Vaughn.

MR. VAUGHN: You know, any sort of funding formula that we can come up with is certainly advantageous to our agencies. Taking one hat off, I'm a municipal manager in our neighboring Delaware County, and we do have a dedicated fire and EMS tax for our services. Doesn't cover, obviously, 100% of their operations, but it does give them something to help offset their costs. So, you

know, everything that we're hearing today -- and, you know, from our colleagues, I think the common theme is there's not one solution. You know, I -- you know, whatever we can do -- SR6, you know, keeps getting mentioned, where that was a laundry list of initiatives, and we need to expand upon that and keep working towards that, because it's not just going to be one item to fix the problem. It's going to be multitudes.

MAJORITY CHAIRWOMAN BOBACK: Thank you. With that, gentlemen, once again, thank you for your service first and foremost, and for your wonderful expert testimony. Well, as we keep on saying, crisis. There's a crisis, and hopefully the word will get out and reach the right ears, so thank you.

MR. VINNACOMBE: Thank you. Thank you very much for having us.

MR. VAUGHN: Thank you.

MR. GATTORNO: Thank you.

MAJORITY CHAIRWOMAN BOBACK: The next panelist is Mr. Adam Johnson, Director of the Office of Emergency Services in Cameron County. Welcome, sir, and thank you for being with us today.

MR. JOHNSON: Thank you.

MAJORITY CHAIRWOMAN BOBACK: You may begin when you are ready.

MR. JOHNSON: All right, good afternoon. Thank you for allowing me the opportunity to speak before the Committee regarding the ongoing EMS crisis in Pennsylvania. I'm Adam Johnson, the Director of Emergency Services in Cameron County. I'm also an EMT, a volunteer fire chief and the Public Safety Program Coordinator for the Northern Pennsylvania Regional College.

Cameron County has a population of 4,547 residents spread throughout 396 square miles. Approximately 28% of that population is 65 years or older. The county is covered by two EMS agencies, the Cameron County Ambulance Service located in Emporium, and the Sinnemahoning Volunteer Fire Department located in Sinnemahoning.

The Cameron County Ambulance Service in 2021 responded to 873 calls for service. 820 of them were 911 dispatches. The Sinnemahoning Fire Department is volunteer and has been out of service due to lack of manpower. The closest mutual aid EMS agency, as well as the closest hospital, is 20-plus miles. My intent today is to summarize some of the common obstacles faced in the retention and recruitment, as well as provide some insight into operational challenges faced by local EMS agencies. Most importantly, I hope to provide some perspective as to the nature of rural EMS.

The current EMS business model is failing to provide financial stability regardless of the size and/or the organizational structure. The reimbursement rates for government payers are far below the actual cost of operations. Alternative funding such as fundraisers, subscription services can no longer keep up with the increasing operational costs. Since EMS systems have been historically self-sufficient, many municipal ballot -- budgets -- excuse me -- lack funding for this type of service.

While some municipalities have utilized other funding sources such as Act XIII or the Impact Fees or ARPA Funds, these are not sustainable sources. Unlike other healthcare providers, EMS agencies cannot base staffing decisions on office hours. Requests for service occur at all hours, any day of the week. Also, unlike a staffed emergency room, the agency must go to the location of the patient regardless of road conditions, inclement weather, distance or remoteness. EMS agencies must therefore be ready to respond 24/7, plan for the unexpected and be properly equipped according to their response area.

For example, given the remote locations faced by some EMS agencies, a four-wheel-drive ambulance may be necessary. This type of ambulance limits what can be purchased and increases the overall cost. Since these

remote locations are generally found in rural areas of the state, it is an increased cost on an already financially distressed service.

In rural areas transport times can be significant. Transporting 20, 30 or in some cases 50 miles one way removes the ambulance from service for long periods of time. Should another ambulance response be needed, the response time could be upwards of 30 minutes and in some cases approaching one hour if mutual aid is requested. This places additional pressure on the system, as mutual aid organizations are also facing the same difficulties.

As training hours and costs have increased, there are fewer certified providers coming into the EMS system. Should an individual choose to become an EMT, there are no incentives to remain in the local area. EMTs associated with rural agencies can find starting wages in the 10 to $15 range, or asked to be a volunteer, although volunteer EMS agencies are becoming fewer every year.

As available providers decrease, competition among agencies increase. This has resulted in the closure of EMS agencies as the cost of operations becomes overwhelming. This is where a missed opportunity occurred. When the COVID-19 PA Hazard Grant Program was announced in July of 2020, many EMS agencies hoped they'd be eligible to provide a extra $3 an hour for the covered ten-period week

for their employees. Unfortunately, no EMS agencies were awarded grants under this program. Since this program would have put money into the EMS providers' pockets unlike other operational grant programs, it was seen as a lack of acknowledgement and support of their frontline duties.

The final SR6 report detailed the reduction in available providers, while also noticing highest losses in BLS agencies occurred in rural populations, due in part to a lack of available staffing. Additionally, it was recommended that EMS regulations be reviewed with consideration factors involving economic conditions and geography.

In April of 2019, I had requested in a staffing waiver from the Bureau of EMS on behalf of CCAS for the -- using the following scenarios. Scenario A: an ambulance is dispatched for a patient with difficulty breathing. The primary crew is not available, as they are engaged on another call. Only one off-duty EMT and a volunteer emergency medical services vehicle operator, an EMSVO, is available. As this was not a BLS crew under the current regulations, the call was turned over to the next closes EMS agency 20-plus miles away, which caused a transport delay of 30 minutes.

Or Scenario B: an ambulance is dispatched for a patient with difficulty breathing. Again, the primary crew

is not available. The off-duty EMT and the EMSVO are available. They respond in the second ambulance, evaluate, treat the patient and begin transport to the hospital, where they intercept with an ALS provider en route, allowing for the ALS provider and the EMT to finish transport.

At the time, regulations resulted in Scenario A being played out on multiple occasions. Unfortunately, the Bureau felt it lacked the necessary authority at that time to grant this waiver, based on the requirements of the EMS Act. This type of restriction establishes an extraordinary set of circumstances that impairs the health, safety and welfare of the public by delaying transport.

One year later, the passage of Act 17 of 2020 corrected this issue, however that waiver is temporary. I therefore urge you to support pending legislation making this authority permanent.

I leave you with this recent example occurring within our county, showing how these impacts can be compounded. The first EMS call received at 1:02 p.m., with four additional calls being received over the next 50 minutes. The first, second and fifth calls were handled by the Cameron County Ambulance Service, and the other two were covered by mutual aid. However, without the BLS staffing waiver in place, the second call would have been

turned over to mutual aid, delaying response times. And you can see the domino effect that would have occurred there.

Therefore I have the following recommendations. Continue to allow for BLS staffing waivers. As indicated previously, this waiver has allowed agencies to staff calls that would otherwise be turned over to mutual aid. Delaying care and/or transport is counter to the goal of the EMS system.

Support or cosponsor Representative Causer's Medicaid Reimbursement Bill. Current reimbursement rates for ALS is $300, and BLS $180 are inadequate. Additionally, providers should be paid for all loaded miles. Recent hospital diversion activity has resulted in increased mileage that may not be reimbursed. Further, roam [phonetic] EMS agencies are transporting longer distances, which is exacerbated by EMS agency and hospital closures.

Adopt and create an EMR, or emergency medical responder to EMT bridge course. Give classroom credit to EMRs wanting to seek EMT certification. This is an existing pipeline of potential EMTs that could be leveraged with a shorter training commitment. This should also result in a decreased cost of training.

Clarify prearrival ambulance diversion criteria

and authority. The EMS system is overutilized as a means of transport to hospital for nonemergent conditions. These calls tie up resources that would otherwise be available for emergency responses. Current BLS protocols allow for PSAP 911 center diversion prior to arrival based on EMT protocols. Unless diverted by the PSAP or 911 center, calls are solely based on a first-come-first-served basis. It appears as though some PSAPs are hesitant to divert these resources. Additional research into prearrival diversion based on call classification by field units should occur.

Criteria and guidance should be developed to ensure prearrival diversion is appropriate, not based on patient-specific information such as the name, address and call history.

In conclusion, I appreciate the Committee's interest in finding solutions to this crisis. And once again, thank you for the opportunity to provide a rural perspective on the issue.

MAJORITY CHAIRWOMAN BOBACK: Chairman Causer?

REPRESENTATIVE CAUSER: Thank you very much, Madame Chair. And thank you, Adam, for your testimony. You wear many hats in Cameron County, and I appreciate your testimony.

I thought maybe coming from a truly very rural

area and trying to provide service, maybe you could expand a little bit on the situation in Cameron, so that the Committee has a full grasp of the situation of providing service there, such as -- and I think you alluded to some of this. You know, there's no ALS providers in Cameron County. The distance to a hospital is significant. And so maybe, you know, you have Cameron County Ambulance Service. You did state that Sinnemahoning Ambulance is out of service. So, can you expand a little bit with some more detail on exactly what it's like providing service in a truly rural county?

MR. JOHNSON: Sure. And as you alluded to, we have two hospitals that primarily they transport to. And Cameron County Ambulance is a BLS service, so we rely on ALS intercept to provide that ALS service. UPMC Cole which is in Coudersport in Potter County is 30-plus miles from Emporium, and we would intercept with a medic out of Coudersport Ambulance. They have one that also provides service to Potter County and parts of Tioga County. So they may or may not be available. If we're going to Penn Highlands Elk which is in St. Mary's, so we're looking at 20 miles, we would intercept, generally, with St. Mary's Ambulance Service who does have additional resources, however they're becoming few and far between.

I just saw an add for St. Mary's Ambulance

Service this morning, and they're looking at hiring a paramedic at a rate of $21 an hour. So again, we go back to the wages. It's tough to be competitive with the amount of providers in the area.

And then if we have a cardiac issue, they're being now diverted to Penn Highlands DuBois to the cardiac, which is 50-plus miles. So, if we have that one BLS ambulance, generally we're going to intercept with that medic from St. Mary's, taking him out of service -- him or her out of service, and then transporting that 50-plus miles to Penn Highlands DuBois, resulting in two resources being out of the system for, you know, two to three hours based on travel time and whether or not they can get the patient in directly.

With the southern part of the county being covered by the volunteer fire department and those municipalities down there, without them having that manpower, that results in, then again, the ambulance service in Emporium having to cover the entirety of the county with the one ambulance that's staffed 24/7.

REPRESENTATIVE CAUSER: So it definitely demonstrates the limited resources that are available. You have one BLS ambulance service for the county. They're heading off to Coudersport to meet with a medic who is taking that medic, their only medic, out of service for

that whole county. And you could have multiple counties without service, you know, at one time, or limited service. And like you stated, if you're heading off to DuBois --

MR. JOHNSON: Correct.

REPRESENTATIVE CAUSER: -- 50 miles one way, so that's taking that ambulance out of service for a long time. So, I appreciate you sharing that expertise. And certainly the recommendations that you suggest in your testimony are important for this Committee to consider. So, thank you very much for being here with us today.

MR. JOHNSON: You're welcome.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Chairman. Another question from Representative Dan Williams.

REPRESENTATIVE WILLIAMS: Just a comment, thank you, Madame Chair. And, Mr. Johnson, thank you for your testimony. I know the day has been long. But you did -- in my mind, you raised a -- something, because you articulated, I think, the sort of rural distinctions in providing services in relationship to four-wheel-drive vehicles, off-road vehicles. And in my district, Coatesville is a urban-sector city, third class, where they were doing water rescues during Ida. And so I'm wondering, are we also -- are we beginning to see this change in terms of cost by way of equipment that's going to be required? Because many of the rescues that took place relative to

ambulance services were done by boat in an urban space, which is unusual. I'm just curious. Thoughts about that?

MR. JOHNSON: Yeah. So, you know, obviously equipment costs have increased, and with the fire services also, you know, having similar issues of both manpower and funding. As the needs of the community change, so does the needs of the EMS agency or the rescue services that are providing that service.

And going back to that, my point is that ambulance has to have the equipment that it needs to do the job on it at the time. They can't go to the stockroom and say, oh, I need this, so this -- you know, I'm going to run back to the station and grab it. Unfortunately we don't have that opportunity to do that. I think you're seeing a greater dependence on EMS agencies, at least in my area relying on fire departments to provide lift assist. That's becoming a big problem. As the patients are more difficult to move or remove from their house, they rely on that, which increases the need for volunteer firefighters especially to leave work to assist these EMS agencies.

Locally there was -- last year we had 56 requests from the fire department for just lift assists, to assist EMS agencies. So we're seeing that as well, where it's being passed between the two services.

REPRESENTATIVE CAUSER: I appreciate it. Thank

you.

MR. JOHNSON: You're welcome.

MAJORITY CHAIRWOMAN BOBACK: Thank you. I do want to say, I think I would be remiss if I didn't comment. I like how you started out, and you said the EMS business model is failing, number one, because that's what we've heard so far today. Number two, you gave us specific scenarios that I was able to relate to. I think we all were. And number three, the recommendations that you gave, and out of the recommendations, two of our own members and of course Chairman Causer, they have legislation to address that.

So, bottom line is we're listening. We're hearing what you have to say, and we really appreciate you being here. Thank you for your testimony.

MR. JOHNSON: You're welcome. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Our next panelist is Mr. Andrew Stern who is Township Manager of West Hempfield Township. Welcome, Mr. Stern, and whenever you're ready you may start.

MR. STERN: Thank you. Thank you, and good afternoon. I am very happy and excited to be here, so thank you. I wish this was not the occasion that I had to be here in front of you, being that this is a crisis, but I've waited probably 15, 20 years to have this rise to the

occasion to a committee meeting such as this.

Brief introduction about myself. I am the Manager of West Hempfield Township in Lancaster County, but I am also am EMT and have been since the mid-1990s. I've also been an emergency coordinator, emergency management coordinator most of my 30-year career. I have been a patient, EMT, EMS chief, fire chief, firefighter, township manager. I've done it all, looked at it from all the perspectives, and I've known for many years that this day would come that we finally call this a crisis, which it is.

As an emergency coordinator, I've seen fire, EMS, police, dispatchers, other entities all work together to try and make the best of our resources which are often scarce. But as a township manager now, which is the perspective that I am going to provide to you -- you've obviously heard today and you're aware that the state law requires us to provide emergency medical service. And ironically, we're required to provide emergency medical service and fire service, not police. And I am not at all here to put down police. I love our police, and I support our police, but our police are the best funded of our emergency services, at least in our community, even though they are not required, and our emergency medical services are the least funded, and they are required. And so that sometimes seems a little backwards, although again I very

much support the police, so don't take that the wrong way.

EMS is not an easy job, and I mentioned I have had an EMS license since the mid-1990s. I have not been on an ambulance in many years. EMS is not an easy job. Many of you are aware of that. I would have a difficult time going back on an ambulance, although I have considered it recently, and I may still do so. But, it takes a significant amount of time for initial training. There is difficult testing requirements, and I'm not saying that we shouldn't have those requirements, but they are difficult; significant time for ongoing continuing education, significant field training time before you can be on your own. You can't just take a class, take a test and you're on an ambulance. There's a lot more to it. The time that I received my EMS license, I was able to do some hospital time at York Hospital, and unfortunately or fortunately had the opportunity to practice on folks who were not going to make it. And, I mean, that sounds grim and gory, but that's how you get experience, and I was grateful for that.

Takes a significant time commitment, as you've heard today. Whether volunteer or paid, there's EMTs spending 80, 90, 100 hours a week away from their families, devoting time to their communities. You have potential for exposure to diseases. I will admit, when I was on ambulance, I was scared to death of needlesticks and not

knowing what I may or may not bring home to my family.

Exposure to difficult events: you know, we haven't really heard that today, but we've all, in EMS, witnessed things that we shouldn't have had to witness, but someone has to. I've held dead babies in my hands. I've held severed heads in car accidents. I've seen things that I wish I never saw and I'll never forget. I could write a list today of every fatality that I was exposed to.

There's ever changing rules and protocols that we're expected to follow, adopt, understand. Again, I am not saying that those aren't appropriate, but it's additional things that we need to do.

And increased amount of abuse of emergency service by the general public. We heard a little bit of that from the gentleman before me. We -- the ambulance when I was chief was yellow. It was affectionately referred to as the Yellow Cab.

Just as I was waiting to testify today, I had -- my February report came through from our EMS provider. 40% of our calls in February -- over 40% were Class 3 non-emergency calls. Title 35 of state law defines an emergency medical service. My opinion, Class 3 non-emergency calls, these are scraped elbows, broken pinky fingers, pinched toes. They're not worthy of an ambulance, yet our dispatchers, they have to dispatch an ambulance, as

we have heard today. They're taking our time, the Class 3 calls. No lights, no sirens.

They're our slowest response, longest travel times. Many of them are not going to be transported to the hospital, so we are not going to get paid for them. The ones that are transported to the hospital are going to be low priority for triage, which means are EMTs are going to be held hostage as we've heard earlier at the hospital for two, three hours, and it's taking away our ambulances' ability to respond to true emergencies, which I believe Title 35 already clearly defines. So I'm not asking you to redo the law. The law is in place. The Department of Health needs to come up with protocols and regulations to make clear that our ambulances need to be reserved for true emergencies. We need to have alternatives for the non-emergencies: Ubers, taxis, non-emergency transports.

Likewise, once we get to these calls that are not true emergencies, not life-threatening emergencies, there needs to be an opportunity for these patients to be taken places other than our overcrowded ERs. They should be able to be transported to urgent care facilities, medical practices, family doctors, but we can't do that. We have to transport -- with the exception of some special rules during COVID, we have to transport to a hospital ER which many times they're not happy to see us arrive.

Hospitals: love hospitals. We all need hospitals when we need hospitals, but they're overcrowded, understaffed. They have their own challenges. I don't want to take away from their challenges, but our EMTs are being held hostage. I really thought we'd hear more people say that today, but in the Lancaster County Area EMTs are being held for two to three hours waiting to hand off the patient. That's not acceptable. I understand the hospitals don't know what to do with the people, but our EMTs sitting in a hallway with a Class 2 or 3 patient waiting and waiting and waiting while they hear call after call for a life-threatening emergency and they can't leave, the EMT is wondering the legalities of what if I do just leave and go deal with the cardiac arrest? Who's liable? So these issues too I believe there's already laws in place to address, but nobody's addressing them.

So as a township, what are my options? We do have an ambulance parked at our municipal building, not always staffed. Our ambulance service ended last year, and we were fortunate that our local hospital -- well, Penn State Health which is local took over that ambulance service, but they're not fully staffed yet. I could create my own ambulance service. You've heard today that salaries are about $19 an $20 an hour. I could start my own ambulance service, hire eight EMTs, pay them 30, $40 an

hour. Is that going to help? No, because I'm going to steal the EMTs from our neighboring municipalities. Their ambulances will go out of service, mine goes in service. Guess what? When they have an ambulance call and they don't have an ambulance, my EMTs with my ambulance are going to go back to their municipality to help their residents. So did we help the problem? Not at all. So, money is a huge issue today, but it's not the only issue, because, you know, competition does not necessarily benefit all of us.

We definitely need to pay our EMTs a better wage. You know, my average police officer is probably about $95,000, which I think is very appropriate. EMTS, 35, $40,000. They're both out there saving lives. Are the jobs equal? Perhaps not, but is it worth a $60,000 difference between EMTs and police officers? I don't know. They're both emergency services. They're both out there saving lives. They're both putting their lives at risk.

There are -- you know, as I said earlier, EMS is not an easy job. It has its challenges. So I'm not just here to complain, whine, vent. I am, but I also have some suggestions. Revisit training and certification requirements. We've heard a little bit about that today. Are the requirements appropriate? Are they providing the minimal levels needed without making the process

unnecessarily burdensome and difficult? I believe some of you are aware, some of the requirements that you're tested on, EMTs in Pennsylvania, are for skills that we're not even allowed to use in Pennsylvania. That's problematic.

Pennsylvania Department of Health should change the protocols and testing requirements to match our neighboring states. I'm in Lancaster County. We're close to Maryland. Maryland's EMTs have different requirements than Pennsylvania. Why not all have the same requirements, the same testing? There is already a national registry for emergency medical technicians that Pennsylvania is part of. If you are going to train us and test on those skills, let us use those skills.

Revisit Title 35 to clarify that emergency medical services are only for true emergencies. We're not a taxi cab. We don't have enough ambulances. We don't have enough EMTs. Help those folks. Have the dispatchers -- give them the ability to send alternative transportation to the folks that can't get to a hospital. I don't want to sound -- that I don't have a heart for people who have a very minor injury and have no way to seek medical attention. There should be a way, it's just not an emergency ambulance.

Revisit EMS protocols to allow EMTs to deny transport if the emergency transport is really not

required. A lot of folks -- and we heard it earlier today -- have very, very minor issues. They don't need to go to a hospital, but they have no other options. They feel that if an ambulance takes them to the hospital they'll get right in, and they'll get treated, great care, and that's a lot better option than any of their other options, but it can't happen.

Pennsylvania Department of Health should create protocols to allow less severe injuries to go to urgent care and non-emergent facilities. Revisit hospital and emergency room laws to require timely handoffs, so that we're not held hostage. That just infuriates me. I mean, picture yourself if you were EMTs in an ER with a patient on a stretcher, sitting there for two and a half, three hours in a hall with a patient, waiting and waiting and waiting as your pager goes off repeatedly for true emergencies that you can't go to. You heard the gentleman before me talk about diverts. Yes indeed, I think that's a great idea to divert ambulances, but once they arrive with a patient they can't be diverting. They're stuck with that patient until they're released from the hospital, so that needs to get resolved. It's just not acceptable.

If you're following along, I'm on #7, the last of my suggestions: clarify the law who's legally responsible for a patient from the EMT brings the patient into an

emergency room. Again, if you're in that hall for two and a half hours, you have a cardiac arrest a block, two blocks, mile, however far from the hospital, and you just come to the conclusion, I need to leave, I'm going to leave my patient with the broken pinky finger in the hall and go help save a life, who is legally responsible at that point? I don't know.

While I recognize that implementing some of these changes are easier than others, we can and must do what we can to solve the problem. This crisis is not new. We might be calling it a crisis for the first time, but this has been a rabbit hole for years and years and years. It's getting worse. At the very least, you know, we've heard some ideas today with Medicare, Medicaid reimbursements, in order to bring the funds in to keep the dying ambulance services from actually dying. Once they're gone -- it's easy to close an ambulance service. I've done it in my career. It's really hard to start a new one. You know, we've heard people are waiting two, three years to get an ambulance. You can't just hire eight EMTs, a couple paramedics, buy a, you know, 250, $300,000 ambulance and be in service next week. So, we can't allow these ambulance services that are not surviving to leave us.

As a township manager, I personally experience complaints from my residents. Just about -- I believe it's

been two months now. I had a young mother crying in my office. I somehow am our designated hugger. And if you knew me you would especially find that humorous. But, young mother was crying in my office. She lives within a mile of our township building. She knew an ambulance was parked at our township building. Her toddler had significant seizures.

The toddler is fine, but as a young mother she certainly didn't know that. She sees her toddler having seizures. That would scare any parent, young or old. And she waited -- she said she waited nearly 15 minutes for an ambulance to arrive, which for her felt like hours, even though she knew there was an ambulance right down the street. What she didn't know was our ambulance was not in service because we didn't have the staff. This is sadly becoming increasingly common.

Early in my career, if we had a average response time of five or six minutes in a given month, my elected board at the time would have questioned me on why it's so slow. Now, most people in this room would probably jump in joy if our average response times were five or six minutes. Unfortunately, we're up to about 11 or 12 minutes in my township, and we are urban/suburban. It's just not acceptable.

Our jobs as public officials and public

administrators should be first and foremost health, safety, public welfare of those we serve. We need to fix this problem. I greatly appreciate your time and prioritizing this, but I would ask that that is not be something that we study for the next 17 years and put out reports, and more studies and more reports. It's only going to get worse. And as you've heard many times, people are going to die, and that just saddens me. So I appreciate your time. Hopefully you've heard from my voice I'm passionate about this, and I greatly appreciate your willingness to listen to us. I know it's been a long day and a lot more people after me, but thank you.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Mr. Stern, and I hope that you realize from the questions you heard from our very beginning today that we are very passionate also. And, I have little asterisks here, but one that I'm certainly -- I'm going to check into all of them. But one, who is responsible for a patient from the time you get there? That's a very interesting question. I would assume that you are as the EMT, because you have to be there with that patient, and yet you're not the cardiac doctor. So if that person should take, then what happens? So I heard you loud and clear, and we're going to see if we can do some clarifications and we can rectify some of the situations that you have to go through every day as an EMT

and a township official. Because, we know that you get -- your meetings are probably filled with people who want better services, faster services, but they don't understand. And it's up to all of us to let this be known, so thank you. I did I have a question over there, Representative? Do you have one? I'm sorry.

UNKNOWN: [inaudible].

MAJORITY CHAIRWOMAN BOBACK: Okay, thank you.

MR. STERN: I might not be here.

MAJORITY CHAIRWOMAN BOBACK: Go right ahead.

MR. STERN: I do have a board meeting tonight, so I apologize.

REPRESENTATIVE SAPPEY: Thank you. Just real quickly. And I'm sorry for everyone who does have a stronger understanding and background in this, but I just have a desire to understand these things.

So, in an area where -- you know, Southern Chester County, we're growing very quickly, and we're projected to grow significantly in the next ten years. A lot of that growth will be people over the age of 55, people over the age of 65 as we see continuing -- you know over-55 communities and continuing care communities. My understanding is we see a big increase in ambulance calls, EMS calls for those folks coming out of rehabs and the continuing care communities, you know, nursing communities.

Do you have to stay with them at the hospital as well? Is that --

MR. STERN: Absolutely.

REPRESENTATIVE SAPPEY: -- everybody across the board?

MR. STERN: Absolutely. As --

REPRESENTATIVE SAPPEY: It's a sprained ankle, a heart attack.

MAJORITY CHAIRWOMAN BOBACK: Wow.

REPRESENTATIVE SAPPEY: You name it, you have to stay?

MR. STERN: If -- so the EMS protocols as I understand it, fi I take a patient to a hospital, I have to hand off -- is the term -- the patient to the charge nurse over whoever is designated. That patient goes from being in my care to being in their care. Until that handoff occurs, it is my understanding that the patient is mine. So, it would not matter, you know, what -- who the patient is, what the issue is.

REPRESENTATIVE SAPPEY: Okay.

MR. STERN: It is my belief that the higher the triage priority, the faster that handoff would occur. Certainly if I take a patient in who is in cardiac arrest, we're not going to sit in the hall, I hope, for two and a half or three hours. If I take a patient in with a

sprained ankle, they're going to be low on the priority for triage, and I am more likely to sit in a hall for two and a half or three hours.

REPRESENTATIVE SAPPEY: Okay, thank you very much. And thanks to -- Chairman and the -- colleagues for your patience. Thanks.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Representative. Thank you, Mr. Stern --

MR. STERN: Yeah.

MAJORITY CHAIRWOMAN BOBACK: -- for sharing with us today. We appreciate your time. Thank you.

MR. STERN: Thank you.

MAJORITY CHAIRWOMAN BOBACK: Our next panelists are from the Pennsylvania Fire & Emergency Services Institute, Mr. Tony Deaven, and he is from Lower Allen Township EMS and a board member, also Jerry Ozog, Executive Director. We welcome you both. Thanks for being with us and for your patience. And when you are ready you may begin.

MR. DEAVEN: Good afternoon, and thank you for your patience and your time here today. Chairpersons Boback, Sainato and members of the Committee, my name is Anthony Deaven. I'll be providing testimony on behalf of Pennsylvania Fire and Emergency Services Institute. I've been an EMS for 31 years, working in all types of

organizations and systems as a provider and a chief officer.

First, thank you for passing Act 10. It does matter. It's really appreciated. It's $25 million for the system, and it has benefit. The challenges facing EMS today, as we've all heard, are not new. They've been discussed at all levels of government. Steps have been taken in attempt to address the challenges, but those steps have not been enough. The crisis we're facing is real and is happening as you've heard today.

We absolutely have devastating tide of cost increases, coupled with reduced or stagnant reimbursements, and we can't keep our head above water. This is resulting in the crisis. The pandemic did not cause this, it only intensified it.

EMS is unique across the Commonwealth: we've heard that today. It has a couple common threads. First of all, it is in crisis. Second of all, it's the safety net for the system. The third thing is -- and I'm not even sure it's health, but it's a business. And the question I would ask is, why? Police departments aren't businesses. Fire departments aren't businesses, and they're essential services, but EMS is considered a business, and we're held to a standard of providing public safety and public healthcare in a business model that is, as you've heard,

completely upside down, and nobody in their right mind would ever do. So it's challenging for us.

Testimony today is going to talk on issue which you've heard a little bit about, so I'm going to be direct and to the point, which is the cost of readiness. We need to be prepared to respond 24/7/365. That is a constant overhead that continually increases and does not go away. It's made up of people, facilities, buildings, insurance costs. Right now it's made up of inflation. It's made up of increasing fuel costs with all the world events. So we know we have that going on.

It's been a component of EMS since the beginning. It's now a financial weight. How does that play out? How do you make up the difference between reimbursements that are less than you're making and the cost to do business every day? You make that up by volume. Volume equates to running more calls per unit with the same staff to increase your call -- to increase your income. That has got effects. That takes your units out of service longer. That beats your personnel up longer. That creates second and third new calls to your district, brings in mutual aid. That creates systems where now we're having to develop systems to compensate for the fact that we're going two and three agencies deep just to go to a call.

All of these items must -- you know, we -- the

readiness cost is an unavoidable expense for EMS. Factors increasing the cost of readiness are salary which we've heard. Revenue is simply not available. You heard earlier today that we've had people increasing wages, which is happening everywhere. You're increasing wages because EMS company next to you did, and now you're trying to compete. Where are you getting the money from? Where's the money coming from? It's not coming from Medicare. It's not coming from Medicaid. I know that Representative Causer's got a bill on the floor that's getting support. We want to make it happen. It's a step in the right direction, but that's for the state. That doesn't cover anything to do with the Feds. And at the state level we need to do some things.

So, how do we manage to cover the cost of readiness at a local or state level? You heard today some testimony from the county commissioners about the county authorities. That's one option. What I'm asking today is to give us tools in a toolbox. It's not perfect for every single community. It won't be perfect for every single community. But as has been said here many times, this is not a silver bullet. It's not a magic pill. You're not going to get that. We're in a Commonwealth. We're dealing with local-level governments. As a result, everything has to be different. We have to give them tools and toolboxes.

So how do we do that? One of the ways we do that is, in the legislation fire services are -- or fire -- municipalities are allowed to create three mills [phonetic] for fire services. In that same legislation, municipalities are allowed to charge half a mil for EMS services. Very few do that. We have no idea what the numbers are. Very few do it, and probably even fewer know about it. But in that, what we're -- what it also says in that legislation, if I want to increase as a municipality beyond a half a mil, I have to go to the voters, and then I'm only allowed to go up to two mills. So I'm -- at best-case scenario, 2.5 mills if I get voters. That's just an unnecessary obstacle. And how does that play out?

We recently talked with the Borough of Chambersburg about some of their stuff, Chief Ulrich. They had a half a mil. They had to do away and restructure it to actually put an ambulance fee on, and they did that because Chambersburg is unique in the fact that it still has a lot of its own utilities. So they were able to leverage their utilities to charge an ambulance fee. It amounts to $7.50 a person a month, less than $100 a year to help sustain an EMS service, and the question is, are you willing to pay that for a safety net? And that's the question, is the willing to pay that, and more importantly, are -- is everybody in the state, local governments and

everybody else willing to deal with the consequences of fees, whatever you want to call them, taxes, however you want to call them, the consequences of that? The days of free EMS are over. They just don't exist. So what we're asking is, do the legislation. Make us at least on par with the fire service for three mills. Make it so that municipalities have that tool in their toolbox.

It may be a challenge for the rural agency. It probably is, but it may help urban and suburban areas generate the funding they need to support their systems. This has come to a head. EMS services are closing, and more will do that, and the only way to fix it is by having multiple tools, being able to be flexible, and being able to develop real solutions. And I appreciate everybody's hard work, and I appreciate everybody's attention to the issues today. You're all very knowledgeable. It shows. I've been here all afternoon. Questions have been great, and I appreciate it.

In closing, we look forward to working with the Committee this session. I thank everybody for their time, their service to the Commonwealth, and if you have any questions I'll be happy to answer them. That's all for today.

MAJORITY CHAIRWOMAN BOBACK: Chairman Causer?

REPRESENTATIVE CAUSER: Thank you, sir, very much

for your testimony. And, Jerry, it's good to see you. It's been a long time since we first met in Bradford at -- in 1990. But, appreciate the work of your organization. And the recommendations was interesting. I hadn't thought about the three mills. My township, as Jerry knows, is very rural. I live in a small township of 700 people, and in fact my township does levy a half a mill specifically for EMS service, but do you know how much that generates?

MR. DEAVEN: Not much, and that's the problem.

REPRESENTATIVE CAUSER: $11,000.

MR. DEAVEN: Right, right, right.

REPRESENTATIVE CAUSER: Now, it's a help to my -- to our service, absolutely, but it generates $11,000. So, not a lot of money, but interesting perspective to look at raising that to three mills. So, I appreciate -- I just -- I don't have a specific question, but I appreciate the suggestions that you made in your testimony, and I think that's valuable, as the Chairwoman has said, a valuable -- going forward for legislators to consider. So thank you.

MR. DEAVEN: Thank you, sir.

MR. OZOG: The other interesting thing that we found -- and we worked with the Career Fire Chiefs Association -- was that model in Chambersburg. And obviously that's a small demographic of municipalities that

have their own utilities. And they added that $7 user fee per month, per address. And that was able to generate over $1 million, which was -- it's a unique thing to do. And again, obviously in your area, McKean may benefit from the authorities model.

REPRESENTATIVE CAUSER: You know, I guess, Madame Chair, if I can ask one question, that does generate a question to your position on the authorities situation, you know, as an option in certain areas for municipalities or county governments to consider.

MR. OZOG: Yeah, our organization has gone on record with the hearings at the Senate that we did support that as an option in some municipalities. Absolutely.

REPRESENTATIVE CAUSER: It definitely seems like in Rural PA that that may be an option that's workable down the road, because there may be no other model that works. So, thank you. Thank you, Madame Chair.

MAJORITY CHAIRWOMAN BOBACK: Thank you, Mr. Chairman. And thank you gentlemen very much for your time and some great ideas. And you said it well, we are a Commonwealth, and we're composed of municipalities, and everything starts locally. So I -- this is information as we start to dispense of it with all of us through the Committee that we have today, and it goes into the public venue. At least people will be able to see it, start

talking and discussing, and at the other end it will be legislation. So, thank you for your time; very well spent.

They're still going to come up, right? Mr. Mateff is still going to come up?

MR. O'LEARY: Yes, yes.

MAJORITY CHAIRWOMAN BOBACK: Okay.

MR. O'LEARY: Yeah.

MAJORITY CHAIRWOMAN BOBACK: Next we have Mr. Robert Mateff. He is the Chief Executive Officer of Cetronia Ambulance Corps. Welcome, and thank you for being with us today. And thank you for your patience. You may start whenever you're ready.

MR. MATEFF: Thank you, Madame Chair. Thank you members of the Committee. Appreciate your time and patience as well. I'm going to summarize my testimony briefly and then look for any questions.

My name is Bob Mateff. I'm the Chief Executive Office of Cetronia Ambulance Corps. I've been involved in EMS for about 34 years. Things have certainly changed in those 34 years, from being a volunteer to mostly being career. During that time I also served as the Director of Emergency Management Services for North Hampton County, as well as the Deputy Director for the Pennsylvania Emergency Management Agency.

Cetronia is a very unique ambulance corps,

because I think we serve all the different populations. We have areas that are very rural in Eastern Burkes and Northern Lehigh County, as well as suburban townships, as well as supporting urban areas of the City of Allentown. So it gives us a little bit of a perspective as to how everyone lives.

When the saying -- I'm sure you've heard it today. When you've seen one ambulance corps, you've seen one ambulance corps. There are very few models that are the same. One of the things I have found is that people really do not understand how emergency medical services are paid for in the Commonwealth of Pennsylvania. There are those that believe they're municipal functions. There are those that believe they are supported by tax dollars. They believe that they are insured -- that we're completely filled by a fee for service, our insurance, and there are still those that really don't even understand exactly where we come from; are we a municipal service, are we not?

Cetronia Ambulance Corps started in 1955 as a community nonprofit. They started with 20 volunteers. Today we have a staff of over 150 associates that are full time and part time. We also have some volunteers that still manage to get out in the field, but most of them now volunteer in the office and help us out. We cover over 100,000 people in roughly 25% of Lehigh County's territory.

Now, you've heard a lot -- I've heard testimony today about ET3, the reimbursement model, fee for schedule. All of my colleagues have raised excellent points. We at Cetronia have tried to do things as innovative as we can to make sure that we remain relevant and fiscally viable to provide services to our residents. We have a state-approved apprenticeship program. Several years ago that program was full. We would have people waiting to get into that to start at our entry-level position, become EMTs, become paramedics, and really be able to walk them through a career in emergency medical services. We worked with our workforce board at Lehigh Valley. Today there are no applicants. Nobody is coming to our program. We are losing folks to other industries. We used to lose to each other; different ambulance corps, perhaps even the healthcare industry. We would lose them to hospital networks. Today we're losing them to manufacturing, retail, warehousing. One of the largest challenges we have in Lehigh Valley is competing for wages. We have warehouses and manufacturing, they're offering 20, $25 an hour as starting wages with significant sign-on bonuses. Based on our limited opportunity to raise money for our fee for service model, we can't compete with those wages, and we're looking for help. We understand that we need to think outside the box, we need to be creative with how we

come up with solutions, whether it's a utility model and how we become more efficient with our operations. We understand. And again, I've heard throughout the day. My colleagues have wonderful testimony about all the programs that are out there. So, I would submit the testimony for you. If you have any questions, I'd be more than happy to answer them.

MAJORITY CHAIRWOMAN BOBACK: I do have a clarification. State-approved apprenticeship program? You were allowed to offer that?

MR. MATEFF: Yes.

MAJORITY CHAIRWOMAN BOBACK: And that was for EMT?

MR. MATEFF: Yes. What we do is, we have a program that we work with the Department of Labor that allows us to bring people in from entry-level positions. They come in as a paratransit worker, which is our non-emergency work. Wheelchair is the most familiar. Then we train them. We have our own in-house training academy that's approved by the Department of Health. They become emergency medical technicians within about two years. They work in the field for about two years as an EMT, and then we subsidize their training to become paramedics.

MAJORITY CHAIRWOMAN BOBACK: So any organization can hopefully offer the same to those who are trying to

become EMTs?

MR. MATEFF: Yes.

MAJORITY CHAIRWOMAN BOBACK: Okay. See, I learned that today. Thank you.

MR. MATEFF: You're very welcome.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Do you have a question for him? No? Anybody else have a question? Okay. Well, that was a great synopsis, and we thank you so much. Once again, we have your information. We know where to get you if we need some clarification.

MR. MATEFF: Thank you very much.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Thank you for your time and for waiting for us. Thank you.

MR. MATEFF: You're very welcome. Thank you.

MAJORITY CHAIRWOMAN BOBACK: Next we have representatives from PA's State Association of Township Supervisors, Joe Gerdes, III, Director of Government Relations. Welcome.

MR. O'LEARY: Joe, bringing up the rear.

MAJORITY CHAIRWOMAN BOBACK: You're the grand finale.

MR GERDES: I know. I can clean up. I promise I will be brief. I can't add too much to all the great information. I've learned a lot here today. But, thank you for hearing me out and giving me a few moments. Good

afternoon, Chairman Boback, Chairman Sainato, members of the Committee. My name is Joe Gerdes. I'm Director of Government Relation of PSATS. Some of you may be wondering what happened to Elam. He retired, then the pandemic hit, and as I'll mention in a moment, I had some health issues. And if you haven't seen me, you will. I'll be hobbling to your offices soon. But, I appreciate the opportunity to speak to you today on behalf of the 1,454 townships that PSATS represents, with 95% of the land mass of Pennsylvania, we have a lot of rural and some urban, so I cover quite a bit of territory.

First I want to personally acknowledge the men and women of the emergency services in the Commonwealth of Pennsylvania. They do an amazing job keeping Pennsylvania safe every day, most often, as was mentioned earlier, without much fanfare.

As a stroke survivor, I have found myself, unfortunately, on the patient side of the equation twice in the past 17 months. Both times their care and expertise quite frankly saved my life. I'm indebted to a system that worked in my case. I know what the golden hour is; a system that works in most cases. I appreciate the leadership of Chairman Boback, Chairman Sainato, this Committee, its staff, Rick, Mike, Shawn, the folks that work every day to tackle this and make sure it works for

everybody in the future every day.

Under the second-class-township code, as you all know, townships are statutorily required to ensure fire and EMS services are provided to their communities. Our members take the oath to be caretakers of the health, welfare and safety of their members, and they take it very seriously. PSATS advises and educates our membership on best practices to communicate and partner with emergency services, most of them volunteers, to provide these essential lifesaving services in their communities.

In a state that is as large and as diverse as Pennsylvania -- again, also reiterated today. We must caution against trying to apply a one-size-fits-all solution to every municipality or region. We acknowledge that some areas of emergency services, particularly emergency medical services are crying for help. They're stressed, and we need the -- to make -- we need these important discussions to look for solutions to help give local governments the tools they need to assist in these services and assist quickly.

To be clear, funding is a fundamental challenge, but by no means the only issue. To address funding, new revenue options would be helpful to enhance a municipality's ability to help pay for EMS and other emergency services. For examples, PSATS members would like

to see an increase in the amount of the ambulance tax that they can levy under the second-class-township code from one -- from a half mil to 1.5 mills. These revenues could only be spent to support the ambulance companies and service their townships.

Also, allowing a municipality to charge a fee to state and Federal facilities that operate within the township will help to fray the cost of supplying these services. Another idea would be to provide municipalities with more options to raise revenues to support their emergency service organizations. Municipalities currently do not have many options, just broad based taxes such as the real estate and earned income tax and the local services tax which is up to $52 on those who work in a municipality, as you know. An increase in the ambulance tax, as I mentioned, would be a great start.

Training requirements and cost associated with certification are also an area of concern, as you've heard also today. Perhaps a program to provide tuition credits to Pennsylvania students to receive these certifications at Pennsylvania colleges and universities would help to attract the personnel needed for these services. Another option is to consider to work with public high schools and vocational technical schools to offer EMS training and certifications for our next generation of emergency service

providers.

We've also heard from stakeholders about the requirements of training, both for new certifications and continuing education. While we certainly want our EMTs and paramedics to be well trained, perhaps the levels of training need to be revisited to see if additional levels of certification would be appropriate, or if there are alternative ways of offering some of the training and certifications. We need more individuals willing to serve, and maybe providing tiers of training of certification would be helpful, as well as Commonwealth funding to help support those costs.

Another area of concern that we have heard is the level of certification needed for the ambulance itself, and the items that are needed to meet certification for basic life support and advanced life support, and the cost of this has led a lot of communities -- unable to serve and to disband, putting more stress on the neighboring communities that do have service to pick up the slack. These requirements should be reviewed to determine what is necessary for the various level of service.

Also as mentioned earlier, there is currently discussions to have a county authority discussion that PSATS has weighed in on. We have proposed a -- we are concerned that the proposals may not be flexible enough to

allow for one, two or more communities to come together and form an authority -- multiple authorities instead of just one county authority, particularly in the Southeast where several counties may work together. Again, one-size solution does not fit all in Pennsylvania.

Finally, working on efforts to recruit and retain personnel needed for emergency services is vital to keeping system staffed, so when the alarm is sounded there's someone there to answer. PSATS looks forward to continuing to work with you all to answer these very important questions on behalf of all of our constituents. Thank you.

MAJORITY CHAIRWOMAN BOBACK: And just a point of clarification. Top of your last sheet, it says that there are some instances where the ambulances actually take it upon themselves, instead of going for reimbursement in network, they will bill the patient directly. I've never --

MR. GEDES: Yes. I'm sorry. I look --

MAJORITY CHAIRWOMAN BOBACK: -- heard that before.

MR. GERDES: I think I skipped over that part. I apologize, Madame Chairman. It is a complicated system on how it is billed in the Commonwealth. If you are out of network --

MAJORITY CHAIRWOMAN BOBACK: Yes?

MR. GERDES: -- that bill -- your insurance provider may send a check to the patient directly, and in which case they are supposed to remand the check over to the service provider. I can tell you, as someone that went through a catastrophic injury, that when paperwork starts piling in from -- every bill, and every subsection of the medical system, it's a little bit overwhelming, and I think of myself as somewhat of a smart guy, but maybe not. It's a challenge. And to try and figure out -- you know, just like any doctor that you go to, and you get a bill, and you get your explanation of benefits, and it says that the doctor charged $800, and we're going to pay the doctor 100. And you're like, well, wait a second, where does this come from? Oftentimes that difference -- that bill -- to equate this with an ambulance service, that -- the change is going to -- or the discrepancy there comes to the patient, and a lot of folks are confused. I can admit, I was confused when I got a -- bills, and saying what is this for? It's showing that it was paid. It was what the insurance paid to the provider, not what the provider charged.

MAJORITY CHAIRWOMAN BOBACK: Thank you. Another question? Yes? Representative O'Mara?

REPRESENTATIVE O'MARA: Yeah. I wanted to address this, because I feel like it's been skirted around in this hearing, the idea of balance billing. And that is

really what you're talking about. From my discussions with local ambulance providers, they choose not to opt in to in network, because they want to retain the option of balance billing consumers, which is what they are able to do when they stay out of network. And I think for at least some of my colleagues that's a big concern, because I think your example with a doctor's office isn't entirely accurate, right? When I go to a doctor, before I receive the treatment, I am given the explanation of what my insurance is going to cover and what I will be legally responsible to pay for myself, and I can always choose to say no. But when you're calling an ambulance, at least for an actual emergency, you don't know what it's going to cost. That discussion doesn't happen. You need that emergency care right then and there, later to find out you're being charged thousands of dollars. And so, I just want to be very clear that we're -- what we're concerned about is the idea of balance billing. It's now illegal in Pennsylvania except for in the ambulance world. And while I do think we need to absolutely find solutions, and I think we've discussed many great ones today, I would be remiss to say going into an option that is just balance billing our constituents is really not one that is palatable for many in the legislature, and I think that's why we have been held up in that bill for the last couple of years. So I

just -- I wanted to address that rather than let this hearing go without at least discussing it. Thank you.

MR. GERDES: Sure, Representative. Your point is well taken.

MAJORITY CHAIRWOMAN BOBACK: Very, very good. Thank you, Representative O'Mara, because you're absolutely right. That's always been a bone of contention, which comes first, and how is it done, and who gets what? And thank you for bringing that forward. Thank you. And, Chairman Causer?

REPRESENTATIVE CAUSER: Thank you, Madame Chair. And thank you, sir, for your testimony, and thank you for all the great work for -- of our township supervisors all across the state. I don't have a question for you, but I did want to address the issue with balance billing, because it's not as simplistic as the prior speaker head mentioned in that EMS is different than every other healthcare provider. And, while you don't know what EMS provider is arriving when you call for an emergency, you don't know how much they're going to charge obviously, but they don't have a choice whether to come. They have to respond to every call. And the problem with this situation is should they just automatically say, okay, we'll be in network, then an insurance company might pay them pennies on the dollar for responding to that call. You've heard here with the

testimony today that we already have challenges with insurance companies. And we really need insurance companies to come to the table to help us craft a solution to the EMS crisis that we have in Pennsylvania. And we can't continue to have insurance companies paying ambulance services pennies on the dollar. And while none of us likes the situation with a constituent or a patient getting a large bill, at the same time we can't fix the issue with a sledgehammer. We've got to be more strategic. And I think that it's a complex issue, and one that we all need to sit around the table and try to work through for the patients' best interest, but also for the EMS providers' best interest, so that they can continue to provide this valuable service. So thank you --

MR. GERDES: Absolutely.

REPRESENTATIVE CAUSER: -- Madame Chair.

MR. GERDES: Absolutely.

MAJORITY CHAIRWOMAN BOBACK: Very well said, Chairman. Thank you again for clarification, and that's what we are here for today. Thank you. Anything else from my committee members? All right, with that thank you for your time. We look forward --

MR. GERDES: Thank you, Madame Chair.

MAJORITY CHAIRWOMAN BOBACK: -- to you coming to visit us on behalf --

MR. GERDES: Thank you.

MAJORITY CHAIRWOMAN BOBACK: -- of PSATS, and --

MR. GERDES: Thank you.

MAJORITY CHAIRWOMAN BOBACK: -- I do appreciate you waiting for us today for this --

MR. GERDES: Yes.

MAJORITY CHAIRWOMAN BOBACK: -- testimony.

MR. GERDES: Thank you for having me. Thank you.

MAJORITY CHAIRWOMAN BOBACK: So in the end, I want to thank everyone for their participation. I thought we had great information, great dialog with our members and staff. And, we do want to tell our viewing audience that we will continue to look at all of these issues that were brought up. That was the purpose of this event, and we'll see if -- how we are going to be able to address it legislatively and through our municipalities. I again thank everyone for their participation. It was a great day, and thank you.

(The hearing concluded at 4:50 p.m.)

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