Energy and Commerce Member Day
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Testimony of Chairman Mark Green (TN-07)

Thank you, Chairwoman McMorris Rodgers and Ranking Member Pallone, for this opportunity to testify to the Committee about my bills addressing the alarming condition of our rural health systems.

I know that you have heard the same sobering stories from constituents, physicians, hospital administrators, and parents – our rural hospitals are entering a financial and workforce crisis. As an emergency care physician and

former CEO of an emergency department management and staffing company, I've seen first-hand how desperate the situation has become, and it's only gotten worse in recent years.

Rural hospital closures and limited access to emergency medicine significantly impact my home state of Tennessee. According to US News and World Report, Tennessee has seen more hospital closures than any other state besides Texas. In fact, the Tennessee Hospital Association estimates that 45% of Tennessee

hospitals are at risk of imminent closure. This is an impending disaster not just for the loss of care, but also the loss of jobs.

According to the American Hospital Association, over 130 rural hospitals across the country closed their doors from 2010 to 2021, and according to a GAO report from December 2020, the median distance of travel rural patients must drive to receive care increased by 20 miles – adding an ever-expanding barrier to essential inpatient and emergency care.

In order to combat this worrying trend, I introduced three pieces of legislation as part of my broader rural healthcare initiative – two of which fall within this Committee's jurisdiction.

My first piece of legislation targets a specific issue in the hospital system – ER departments. HR 1129, the Rural ER Access Act, would repeal a subsection under title 42 US Code of Federal Regulations that prohibits free-standing emergency departments from operating more than 35 miles from a hospital.

This 35-mile perimeter rule was instituted in the 1990s to monitor the safety of ER patients. HHS was concerned that if ERs operated too far from a self-standing hospital, then emergency patients would have no other medical options should the self-standing ER department fail in its mission to treat and triage.

However, speaking as an ER physician who practiced medicine in rural areas across America, I know how advanced our medical technology is, and I know how desperate some situations are. This antiquated rule is now

hindering patient access rather than saving patient lives. Keep in mind, this arbitrary mileage was imposed by DC bureaucrats with little knowledge of its real impact. Congress must weigh-in to correct this outdated rule.

Furthermore, by eliminating this mileage requirement, free-standing ERs can provide the frontline emergency care rural communities most desperately need. These facilities provide a crucial safety net during an emergency, particularly in rural communities where the nearest hospital is many miles away. Moreover,

keeping a free-standing ER open and operational will keep jobs in the community and help support the local economies of hard-to-reach areas.

We also must address the workforce burnout amongst our medical providers by enacting HR 5213, the Reducing Medically Unnecessary Delays in Care Act.

This legislation is endorsed by the Medical Group Management Association and the American Academy of Family Physicians, and it

seeks to unburden our doctors from the bureaucratic red tape that is prior authorization.

According to the Medical Group Management Association, quote "72% of medical groups report that the clinicians assigned to complete their peer-to-peer reviews by the plans are not from a relevant specialty to the treatment or disease in question — resulting in dangerous delays and flat-out denials." End quote.

My bill would reform the practice of prior authorization in Medicare and Medicare

Advantage. Only board-certified physicians in the relevant specialty should make these critical decisions about care. Specifically, my bill directs Medicare, Medicare Advantage, and Medicare Part D plans to comply with requirements that restrictions be based on medical necessity and written clinical criteria.

Medical decisions must be decided by a medical professional. Meaning, no accountant or government bureaucrat should ever have the power to remove an option of care, because

removing options from the physician's toolbelt is a medical decision.

Furthermore, with the advancement of AI in the medical field, there are growing concerns that computers will be the ones making these medical authorization decisions – tying the hands of trained physicians. This would be catastrophic to physician autonomy and patient care.

These bills aim to restore our rural health systems and save our patients from needless and dangerous delays in care. With this Committee's

help, I look forward to improving our medical system.

Madam Chair, and Ranking Member, I look forward to working with you on these bills in the hopes of bringing them to markup.

Thank you and I yield back.