A PWW|AG and AIMHI Webinar

Ambulance Economics in Crisis: Cost, Rates, and Reimbursements

Questions and Answers

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Answering Your Questions

PWW|AG has been truly grateful for the reception, feedback, and meaningful conversations sparked from the AIMHI hosted webinar Ambulance Economics in Crisis; Cost, Rates, and Reimbursements. We hope you and your agency have been able to take what you learned and begin building a stronger financial future for your team and the communities you serve.

Following the webinar, **PWW|AG** EMS and Mobile Healthcare Consultant **Matt Zavadsky** and **Ryan Stark** reviewed the questions that came in and pulled together additional feedback and resources to help support your next steps.

Our Team

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Your Questions. Our Answers.

NOTE: The following are informal responses to general questions and should not be relied on as legal or accounting advice.

Has anyone thought or tried to legislate reciprocal Medicaid coverage for EMS services? People are more on mobile than they were in the past.

Interstate Medicaid reciprocity for EMS is very limited today. Medicaid is administered at the state level, so coverage typically only applies within the patient's home state unless specific exceptions apply. There have been discussions and small-scale efforts, especially in border regions, to allow cross-state reimbursement for emergency services, but these are usually handled through state-to-state agreements or waivers, not federal law. There's awareness and some localized progress, but no consistent, nationwide Medicaid reciprocity for EMS, making it a ripe area for advocacy moving forward.

Do you know if in their analysis addressed the selection bias in private/for-profit? While they have a significantly lower loss per run, closer to $300, it seems they would not exist in lower profitability market segments, so it is weighting toward profitable markets.

Exactly, this is why PWW|AG has submitted a FOIA request to CMS for access to the data submitted by the agencies so we can do our own analysis, based on the same data MedPAC is analyzing.

EMS doesn't have robust/accurate cost analysis the way hospitals do. That's why CMS wants to gather more data. It was obvious to me from the ground ambulance data collection project that the data is not accurate.

You're not wrong, the concern about EMS cost data accuracy is widely shared across the industry. Hospitals have decades of standardized cost reporting (e.g., Medicare Cost Reports), while EMS is just beginning to build that infrastructure. Many EMS agencies don't have cost accounting systems aligned to service lines, making accurate reporting difficult. Education for agencies will be crucial for future success.

Perhaps suggest doing a stratified analysis with public providers' data being analyzed separately from private providers.

Yes, stratifying the data (public vs. private) would likely improve accuracy and policy relevance. Public EMS providers (fire-based, governmental, district) have fundamentally different cost structures:

- Tax subsidy support
- Higher readiness costs due to deployment/staffing models
- Pension/benefit obligations

Private providers tend to have:

- More volume-driven models
- Different labor structures
- Less access to tax-based offsets

This is why PWW|AG has submitted a FOIA request to CMS for access to the data submitted by the agencies so we can do our own analysis, based on the same data MedPAC is analyzing.

Has MedPAC determined when the next ambulance cost reporting cycle will be?

No, they have not identified a “next cycle” yet. Right now, they are still evaluating the initial 4-year data collection (2020–2024 cohorts) and are required to report to Congress by June 2026 on whether the system should continue and how it should change.

Is there energy around making this an annual filing like hospital reporting?

Not really, at least not yet. MedPAC has focused more on data quality, burden, and usability than frequency. A major statutory question they’re answering right now is whether the system is even reliable enough to expand, not how often to collect it.

Bold statements like "we charge less than what it costs us to provide the service" does not really pass the sniff test. It sounds hysterical. And, it can't possibly be true otherwise everyone would go out of business.”

The **PWW|AG Q1 Financial Index Report** revealed that the average charge for an ALS-Emergency transport is across all payers is $1,199, which is below the median cost across all providers of $1,340, according to the **CMS Ground Ambulance Data Collection Survey (GADCS)**.

Is there any differentiation in rate schedules based on risk severity of the patient?

For Medicare there are minimal adjustments based on level of care delivered to a patient, such as ALS, BLS, ALS2 or SCT care, but the reimbursement differences are negligible, and are still below the cost of service. EMS reimbursement is procedure-and transport-based, not risk-based, which is a major disconnect compared to other parts of healthcare and a key reason high-acuity readiness isn’t adequately funded.

I cannot find the formula used for the GEMT "match" amounts - do you know where would I find this?

We have posted the national FMAP amounts on the PWW|AG Resources page for you. **You can find it here.**

You had mentioned your resource page had data regarding rates that various services charge. Where is that located?

This information is part of our EMS Financial Index Reports which can be found on PWW|AG’s Resources Hub - **Access it here.**

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Are most employer insurances ERISA because those companies have national presences?

It's not about geography; it's about funding structure. A large share of covered lives are in ERISA plans, but not simply because employers operate nationally. Self-funded (self-insured) plans are governed by ERISA. In these plans, the employer pays claims directly. Some fully insured plans are also subject to ERISA, and may also be governed by certain aspects of state law. These are plans where the employer buys coverage from an insurance company. These are subject to state insurance regulations. An important nuance is that a company can be national and still have a fully insured (state-regulated) plan. Additionally, a regional employer can be self-funded and fall under ERISA. Why does this matter for EMS? ERISA plans often limit the impact of state-level protections (like balance billing laws). This creates inconsistency in reimbursement and patient billing protections

Until we as an industry start being recognized as a true medical provider and healthcare profession, and stop being reimbursed as a "transportation service" we will never change the reimbursement models. Society needs to alter their perception of the EMS industry to be appropriately recognized as a medical profession that practices real emergency medicine, as an extension of the Emergency Departments to improve our reimbursement practices and regulations.

We could not agree more. Hence the recent discussions regarding billing for treatment in place (TIP) and deceased on scene. Agencies that are NOT billing for these types of services could be feeding the belief that we should only paid for transportation.

If a patient is transported in a state other than their residence state, which state law related to balance billing applies? The state of residence, or the state in which the call occurred?

This is a "two-fold" answer. While generally the state where the ambulance service occurred governs, the insurer and the EMS agency are likely subject to different requirements.

Insurer. The insurer is subject to regulation by State A where the patient lives. If State A prohibits balance billing and requires the insurer to pay a particular amount, the insurer would be allowed to limit its payment to the provider to what that state law establishes (for example, "325% of Medicare for noncontracted provider").

Provider. However, the EMS provider in State B where the service occurred would generally NOT be subject to State A's balance billing law prohibitions. That means the EMS agency may generally take all appropriate steps to collect its full charge beyond what the insurer paid. State A generally has no basis to enforce a provider balance billing limitation on out-of-state EMS providers unless that provider has some sort of "nexus" to the state – e.g., it is enrolled, licensed, or regularly conducts business in the state or it performs activities that would subject the provider to the insurance laws of State A. It is extremely important that you check with local counsel licensed in your state to determine whether a balance billing law applies.

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As we know, many of the states with Balance Billing laws have language referring to some percentage of Medicare rates. Does that make it MORE difficult for the Medicare rates to get a needed adjustment?

Tying payments to Medicare creates a double-edged sword, it can make rate increases more politically and financially complex, but it also reinforces that getting Medicare right is critical because so much else depends on it. Many state balance billing laws peg allowable payments to a % of Medicare rates (e.g., 125% - 420%). That creates a benchmarking effect across the market. But there's another side... These laws also implicitly validate Medicare as the "floor" or reference point. That can actually strengthen the argument that Medicare rates must be accurate and adequate. If Medicare is too low, it drags down the entire reimbursement ecosystem.

Do you have any recommendations for states that have laws essentially preventing charity/hardship (Arizona) from being allowed a the application of us actually billing what it costs to provide our widgets?

Yes, this is a real and frustrating policy conflict, especially in states like Arizona. The issue isn't that charity care is prohibited, it's that EMS sits in a regulatory gap between rate regulation and consumer protection laws. The fix is potentially not deregulation, but clarification and safe harbors that preserve fee integrity, while allowing structured, defensible financial hardship relief. The issue isn't that charity care is "illegal", it's that state rate-setting and balance billing frameworks can unintentionally constrain how (and when) you apply discounts or write-offs. A few practical suggestions might be to separate "fee setting" from "collections policy", push for explicit EMS financial assistance safe harbor, and standardize hardship policies statewide.

To become involved in GEMT services what percentage of your transports need to be Medicaid?And does GEMT affect Medicaid HMOs?

There is no minimum percentage requirement. The GEMT program is based on providing services to Medicaid beneficiaries and being an eligible provider type. The practical reality is the higher your Medicaid volume, the more financially meaningful GEMT becomes. Agencies with very low Medicaid utilization may find the administrative effort outweighs the benefit.
Does GEMT apply to Medicaid HMOs (Managed Care)? It depends on the state, but increasingly, yes (with caveats). Medicaid has two worlds; FFS and Managed Care (MCOs / HMOs). Historically, GEMT applied primarily to FFS claims, but CMS has allowed states to incorporate managed care claims into GEMT calculations, but states must have approved methodologies and payments must comply with federal rules (e.g., actuarial soundness, no duplication).

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For those agencies who make themselves "in-network", what does their reimbursement compare to those who stay out of network?

This is a REALLY good question, and we will try to analyze this in an upcoming EMS Financial Index Report. Generally, the basis of an in-network agreement is that the provider accepts a lower reimbursement in return for higher patient volume. Obviously, for agencies that are predominantly 911 based, that model is illogical, which is why most agencies that do primarily 911 service derive no benefit from in-network agreements, unless there are other benefits other than volume, such as direct payments in states that do not already require that.

Since Centers for Medicare & Medicaid Services only reimburses for the transport component, from your experience is it more effective and compliant to increase the base transport fee to account for routine supplies like oxygen, gauze, and other materials, or to continue sending itemized bills for those items?

For Medicare, itemizing routine supplies is not allowed. The Medicare Ambulance Fee schedule is bundled, meaning base rates (BLS, ALS1, ALS2) include routine supplies and services. Items like oxygen, gauze, IV supplies, etc. are not separately billable to anyone where Medicare is the primary payer. Therefore, ensure your charge structure (base rates) appropriately reflects the full cost of providing the service, including routine supplies. However, some Medicaid and commercial payers may reimburse itemized ancillary charges where those payers are the primary payers, so be sure you are doing all you can to properly obtain full reimbursement from payers who do reimburse for itemized ancillary charges.

If we are fire-based and our data was "thrown out," do any of these numbers help me determine our rates/reimbursement or should I talk to someone in person?

A few national associations, such as AIMHI and the American Ambulance Association are meeting with MedPAC to address this specific issue, asking them to include all reports in their analysis. The CMS GADCS report DOES provide data related to costs and reimbursement for multiple types of agencies, and can and should be referenced in advocacy efforts. This is why PWW|AG has submitted a FOIA request to CMS for access to the data submitted by the agencies so we can do our own analysis, based on the same data MedPAC is analyzing.

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