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The Sky Is Not Falling

A Practical Path Forward for EMS Supplemental Payment Programs

By Donna Newchurch and Asbel Montes
Co-Founders & Managing Partners, Bridge Partners LLC

Bridge Partners LLC is a healthcare consulting firm focused on innovative financing methodologies that help emergency medical services providers deliver sustainable care in the communities they serve.

Recent federal activity surrounding Medicaid State Directed Payments and supplemental payment programs has understandably raised concerns among EMS providers, state associations, and Medicaid financing teams. **Section 71116 of Public Law 119-21**, commonly referred to as **OBBB**, changed the statutory framework for certain Medicaid managed care State Directed Payments. **CMS has now issued proposed rule CMS-2449-P**, which would implement that statute and, in some areas, go beyond it. The proposed rule is still open for comment, and CMS has expressly requested feedback on several key interpretive and operational issues. From the **Bridge Partners** perspective, the message is simple.

> *"The sky is not falling—but the environment is changing."*

THE DISTINCTION

OBBB Section 71116 establishes Medicare-based payment limits for certain Medicaid managed care State Directed Payments involving four categories of services: inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers. **CMS-2449-P** proposes to extend similar limits more broadly, including to all State Directed Payment services by 2029 and to certain targeted Medicaid fee-for-service practitioner supplemental payments, including provider types such as GEMT providers. That fee-for-service proposal is not directly contained in OBBB and represents a separate regulatory action by CMS.

This distinction matters. Congress gave CMS a specific statutory mandate. CMS is now using the rule-making process to interpret that mandate and to propose additional policies based on its broader Medicaid authority. That means providers, states, and associations have a meaningful opportunity to comment—not only on the financial impact of the proposal, but also on whether CMS's proposed approach properly balances its statutory responsibilities.

> *CMS's responsibility extends beyond limiting spending—it must also protect access, quality, and the long-term stability of Medicaid services.*

Those statutory responsibilities are not one-dimensional. CMS is not only responsible for limiting spending. Under the Medicaid statute, CMS must also consider proper and efficient operation of the Medicaid program, actuarially sound managed care payments, payment methods that promote efficiency, economy, and quality of care, and payment levels sufficient to enlist enough providers so that Medicaid care and services are available at least to the same extent as services available to the general population in the same geographic area. The Medicaid statute also requires medical assistance to be furnished with reasonable promptness to eligible individuals. That broader legal framework is where **Bridge Partners** believes there is room for a better policy conversation.

WHY THIS MATTERS

Program integrity matters.
Transparency matters.
Accurate calculations matter.

> *Program integrity and access are not competing priorities—they should reinforce one another.*

Providers should not expect CMS to approve unlimited supplemental payments simply because states have historically relied on them. But the answer should not be a blunt policy that treats all providers, all communities, and all supplemental payment programs the same. **EMS is not a typical provider type.** Ambulance services maintain 24/7 readiness, respond regardless of ability to pay, serve large rural geographies, and frequently care for uninsured, underinsured, Medicaid, and medically vulnerable patients.

Many EMS systems are also operating in communities with workforce shortages, hospital closures, limited specialty access, Health Professional Shortage Area designations, Medically Underserved Area designations, and significant transportation barriers.

In that environment, reimbursement policy should be tied to access.

A BETTER POLICY MODEL

Bridge Partners urges CMS to consider targeted supplemental payment models that incorporate objective access-based criteria. Rather than relying exclusively on broad Medicare-based caps, CMS could permit states to design programs that support providers serving a disproportionate share of vulnerable patients or medically underserved communities. Eligibility could be tied to measurable thresholds such as the percentage of uninsured and underinsured patients in the provider's payer mix, Medicaid utilization, rural or frontier status, HPSA or MUA designation, ambulance desert status, low population density, extended transport times, or other objective indicators of access risk.

What this approach prioritizes

- ✓ Objective access-based criteria
- ✓ Support for medically underserved communities
- ✓ Transparent, measurable eligibility standards
- ✓ A reimbursement model aligned with access and quality

This type of structure would not be a blank check. It would be a disciplined, data-driven approach that aligns reimbursement with Medicaid's statutory responsibilities for access and quality. Providers seeking supplemental payments would need to demonstrate need, cost, service area characteristics, payer mix, access risk, and the relationship between the payment and continued availability of care for vulnerable populations.

For EMS, that is a fair conversation.

PREPARING FOR WHAT'S NEXT

The reality is that uninsured and underinsured patients do not exist outside the healthcare system. They are part of the same local healthcare ecosystem that Medicaid beneficiaries rely upon. When EMS agencies absorb significant uncompensated and undercompensated care, those losses affect staffing, response readiness, fleet replacement, training, quality improvement, and the ability to respond to Medicaid patients. A policy that ignores that reality may satisfy a narrow payment formula while still weakening access to care.

> *"This moment should be viewed as an opportunity—not a catastrophe."*

That is why this moment should be viewed as an opportunity, not a catastrophe. EMS providers and associations should use this period to examine their internal operations, cost structure, and data. Providers should understand their true cost of readiness, payer mix, uncompensated care burden, Medicaid shortfall, staffing costs, response volumes, transport patterns, and community access role. They should be prepared to demonstrate not just what they are paid, but why those payments are necessary to preserve access.

THE PATH FORWARD

This also means improving internal controls. Revenue surveys must be accurate. Cost data must be defensible. ACR calculations, assessment methodologies, payment schedules, managed care payments, fee-for-service payments, and quality metrics should be documented and auditable. Supplemental payment programs that survive increased federal scrutiny will be the ones that can clearly show how funds are calculated, distributed, monitored, and tied to access or quality.

> *The next generation of supplemental payment programs must be better designed, better documented, and more closely tied to access, quality, and vulnerable populations.*

The proposed rule is not the end of EMS supplemental payments. It is a signal that the next generation of these programs must be better designed, better documented, and more closely tied to access, quality, and vulnerable populations.

CMS should use this rule-making process to create a path that protects program integrity while recognizing the realities of EMS delivery, rural healthcare access, and care for uninsured and underinsured patients. States and providers should respond by building programs that are transparent, compliant, data-driven, and targeted to the communities where Medicaid access is most at risk.

For EMS, the goal should not be to preserve every historical payment structure exactly as it exists today. **The goal should be to build a stronger, legally defensible model that ensures ambulance services remain available to the patients and communities that need them most.**

NEXT STEPS

Bridge Partners can provide EMS providers with a comment-letter framework and suggested language that can be tailored to reflect each provider's unique service area, patient population, payer mix, and operational capacity. These materials will give providers a starting point for comments supporting the development of appropriate, transparent, and data-driven supplemental payment programs that reflect the considerations discussed above.

ABOUT US

At Bridge Partners, our mission is to strengthen the financial sustainability of EMS through innovative reimbursement strategies that preserve and expand access to high-quality emergency and non-emergency care for communities across America.

We are committed to serving as a long-term strategic partner to your organization and EMS systems nationwide, working collaboratively to develop, implement, and manage compliant reimbursement programs that support operational excellence, enhance financial stability, and ensure EMS providers have the resources necessary to care for the patients and communities you serve.

If you have any questions or would like to discuss what these developments could mean for your organization, please feel free to reach out. We would be happy to continue the conversation.

Warm regards,

Donna Newchurch & Asbel Montes
Co-Founders & Managing Partners

Coming July 13: A template comment letter and instructions on how to submit your comments will be sent to help providers respond to the proposed rule.