



MEDPAC & AMBULANCE COST DATA:

THE FUTURE OF EMS REIMBURSEMENT

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MEDPAC & 2026 REPORT

MEDPAC & THE BIPARTISAN BUDGET ACT OF 2018



IN GENERAL.—Not later than March 15, 2023,

and as determined necessary by the Medicare Payment Advisory Commission thereafter, such Commission shall assess, and submit to Congress a report on, information submitted by providers and suppliers of ground ambulance services through the data collection system under subparagraph (A), the adequacy of payments for ground ambulance services under this subsection, and geographic variations in the cost of furnishing such services.

A report under clause (i) shall contain the following:

- “(I) An analysis of information submitted through the data collection system.
- “(II) An analysis of any burden on providers and suppliers of ground ambulance services associated with the data collection system.
- “(III) A recommendation as to whether information should continue to be submitted through such data collection system or if such a system should be revised under subparagraph (E)(i).
- “(IV) Other information determined appropriate by the Commission.

IN GENERAL.—Not later than March 15, 2023,

and as determined necessary by the Medicare Payment Advisory Commission thereafter, such Commission shall assess, and submit to Congress a report on, information submitted by providers and suppliers of ground ambulance services through the data collection system under subparagraph (A), the adequacy of payments for ground ambulance services under this subsection, and geographic variations in the cost of furnishing such services.

A report under clause (i) shall contain the following:

- (I) An **analysis** of information submitted through the data collection system.
- (II) An **analysis** of any burden on providers and suppliers of ground ambulance services associated with the data collection system.
- (III) A **recommendation** as to whether information should continue to be submitted through such data collection system or if such a system should be revised under subparagraph (E)(i).
- (IV) Other information determined appropriate by the Commission.

Thomas Diller, M.D., M.M.M.

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NETWORK
MAITLAND, FL
TERM EXPIRES IN 2028

Lynn Barr, M.P.H.

BARR-CAMPBELL FAMILY
FOUNDATION
LAHAINA, HI
TERM EXPIRES IN 2027

Paul N. Casale, M.D., M.P.H.

WEILL CORNELL MEDICAL
COLLEGE
NEW YORK, NY
TERM EXPIRES IN 2027

Cheryl L. Damberg, Ph.D.

RAND CORPORATION
SANTA MONICA, CA
TERM EXPIRES IN 2027

Stacie B. Dusetzina, Ph.D.

VANDERBILT UNIVERSITY
SCHOOL OF MEDICINE
NASHVILLE, TN
TERM EXPIRES IN 2027

R. Tamara Konetzka, Ph.D.

UNIVERSITY OF CHICAGO
CHICAGO, IL
TERM EXPIRES IN 2026

Michael E. Chernew, Ph.D.

CHAIR
HARVARD MEDICAL SCHOOL
BOSTON, MA
TERM EXPIRES IN 2026

Joshua Liao, M.D., M.Sc.

UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER
DALLAS, TX
TERM EXPIRES IN 2027

Brian Miller, M.D., M.B.A., M.P.H.

JOHNS HOPKINS UNIVERSITY
BALTIMORE, MD
TERM EXPIRES IN 2026

Gregory P. Poulsen, M.B.A.

INTERMOUNTAIN
HEALTHCARE
SALT LAKE CITY, UT
TERM EXPIRES IN 2028

**Betty Rambur, Ph.D., R.N.,
F.A.A.N.**

UNIVERSITY OF RHODE
ISLAND
KINGSTON, RI
TERM EXPIRES IN 2026

Scott Sarran, M.D., M.B.A.

HARMONIC HEALTH; TRIPLE
AIM GERIATRICS
COOK COUNTY, IL
TERM EXPIRES IN 2028

Gina Upchurch, R.Ph., M.P.H.

SENIOR PHARMASSIST
DURHAM, NC
TERM EXPIRES IN 2027

Robert A. Cherry, M.D., M.S.

UCLA HEALTH
LOS ANGELES, CA
TERM EXPIRES IN 2028

**Wayne J. Riley, M.D.,
M.P.H., M.B.A.**

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YORK DOWNSTATE
BROOKLYN, NY
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**Kenny Kan, F.S.A., C.P.A.,
C.F.A., M.A.A.A.**

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Mandated report: Payment for ground ambulance services

Jeff Stensland and Dan Zabinski

March 6, 2025

- 1** Ambulance Response No Transport
- 2** MedPAC Commission should not be making clinical decisions (BLS v. “ACLS”)
- 3** TIP or CP program initiatives impacting governmental cost per care (Gina Upchurch)
- 4** More data analysis around who was included versus excluded (54% of organizations excluded)
- 5** Discussion around rural and super-rural (this didn’t track with other payment systems)
- 6** Cost by LOS, stratify by E v. NE
- 7** Loaded versus unloaded mileage, specifically in rural areas
- 8** Chairman: “Look at the value of the data and the cost of imposing data collection activity”

Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System

Dan Zabinski, Jeff Stensland

December 5, 2025

- 1** Several Commissioners asked questions regarding the “why” around data collection since ambulance was “such a small sector to the overall spend.”
- 2** MedPAC noted that the level of granularity in the data was much more than what was needed.
- 3** One commissioner noted, as summarized by the Chairman at the end of the meeting, to simplify the data collection process, if a recommendation is noted to continue it.
- 4** Shared service calculations appeared to be problematic.
- 5** Chairman opined on fixed and variable costs. Indicated this would be discussed further in the March meeting. Keep variables for access and quality. Regression framework should be the simplified solution.
- 6** One commissioner noted that he was not a proponent of continued data collection process. “It creates a massive burden and creates a compliance problem versus a service option.”
- 7** Chair summed up the call by mentioning ALS1 emergency and the cost. Cut back on the number of variables requested. Data sampling is warranted, but maybe not on an annual basis. He also mentioned that maybe to “collect data that is reported to the states...”



Advising the Congress on Medicare issues

Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System

Dan Zabinski

March 2, 2026

Chair's draft recommendation

- The Congress should direct the Secretary to continue collecting cost and revenue data from suppliers and providers of ground ambulance services.
 - Data collection should focus on information essential to assessing both the accuracy of Medicare payments and Medicare beneficiaries' access to care; and
 - The Secretary should pursue opportunities to streamline data collection to minimize burden on suppliers and providers.

- 1** A lot of discussion by MedPAC commissioners and staff around “economies of scale”
- 2** Lynn Barr, MedPAC Commissioner, from Hawaii had concerns about the tone of the analysis in the report. Several commissioners made a comment about the “tone” of the report.
- 3** Rural was a focus by several of the Commissioners as the cost ratio in urban and rural did not have a significant variable.
- 4** Dr. Tamara Konetzka from Illinois had questions about the capture of volunteer and rural. She believed that BLS non-emergency and complexity should be more noted in the final report.
- 5** Dr. Konetzka also made a comment that agreeing to data collection by the EMS community is not something that other healthcare providers agree to and, was supportive of the Chair’s draft recommendation.
- 6** Several questions regarding the minimum elements needed to produce meaningful, usable, and actionable data.
- 7** Dr. Miller made a few comments relative to the administrative burden on healthcare providers related to cost data collection, specifically small business versus large business. Frequency would help mitigate some of the burden.

8 Dr. Miller also made mention again about healthcare providers providing “free labor and care” for healthcare provided when an ambulance response no transport occurs for Medicare FFS beneficiaries.

9 One Commissioner suggested that while aggregate data provided context, detail was important in order to make informed decisions.

10 The Chairman made it a point to clarify that this report was not going to make a comment on if the current payment structure should change or not.

Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System

Dan Zabinski

April 9, 2026

Reported revenues relative to costs vary by ownership

Type of ownership	Revenue-to-cost ratio (trimmed, weighted by transports)	Revenue-to-cost ratio (full dataset)
For profit	1.11	1.03
Nonprofit	1.02	0.91
Government	0.98	0.71

Note: The reported revenue-to-cost ratios are the median for each group. "Revenue" is revenue from all sources, and "cost" is cost from providing services to all patients. The results from the trimmed dataset are weighted by number of transports for each organization.

Source: MedPAC analysis of data from the Ground Ambulance Data Collection System, 2022-2023.

- Revenue-to-cost ratios using full dataset and dataset trimmed for outliers (median values)
- Results from trimmed dataset were weighted by number of transports for each organization
- Government organizations have lower ratio than for-profit and nonprofit organizations

Among all service-area categories, reported revenues are higher than costs from weighted data

Characteristic	Revenue-to-cost ratio (trimmed, weighted by transports)	Revenue-to cost ratio (full dataset)
Service-area location		
Urban	1.11	1.01
Rural	1.02	0.91
Super rural	1.03	0.94
Quartile of transports		
Lowest quartile	0.77	0.79
Q2	0.86	0.86
Q3	0.98	0.99
Highest quartile	1.10	1.05

Note: Q (quartile). These results exclude government-owned organizations. The reported revenue-to-cost ratios are the median for each group. "Revenue" is revenue from all sources, and "cost" is cost from providing ground ambulance services to all patients. Results from the trimmed data were weighted by number of transports for each organization.

Source: MedPAC analysis of data from the Ground Ambulance Data Collection System, 2022-2023.

Summary

- GADCS is a comprehensive dataset
- Stakeholders support continued collection of GADCS data
- GADCS could be streamlined to ease reporting burden
- Difficult to evaluate adequacy of payments
 - Substantial revenue from sources not related to billing for services
 - May be underreporting of revenue from some sources
 - First year of data collection; may include errors
 - Little information about access to care and quality
- Analysis suggests AFS adjustments not well targeted

Note: GADCS (Ground Ambulance Data Collection System), AFS (ambulance fee schedule).

APRIL MEDPAC TAKEAWAYS

- 1** One commissioner mentioned the data shows economies of scale for large ambulance providers and that the tax payers are not benefiting from this.
- 2** Mentioned that ambulance providers were treating patients but not receiving payments and that healthcare providers should be paid for their work.
- 3** A new commissioner was confused on the different type of models and asked a question about this and should there be a different reimbursement system based on organization.
- 4** One commissioner abstained from the vote. (This is a “polite” no.)
- 5** One commissioner made a comment that there are instances where private EMS performs 911 calls.

GROUND AMBULANCE DATA COLLECTION SYSTEM REPORT FROM CMS

WARNING:

**DO NOT CONFUSE THIS DATA
COLLECTION INSTRUMENT WITH A
COST REPORTING INSTRUMENT**

Limitations

The data collection system was NOT designed to do the following for ground ambulance services:

- 1 Assess the quality or clinical outcomes**
- 2 Determine Medicare payments under the Ambulance Fee Schedule (AFS)**
- 3 Determine guidelines for Medicare coverage**
- 4 Provide information on communities' broader first response financing needs**
- 5 Quantify the extent of uncompensated care**

Classification of Categories

Derived from PECOS and Medicare Claims files

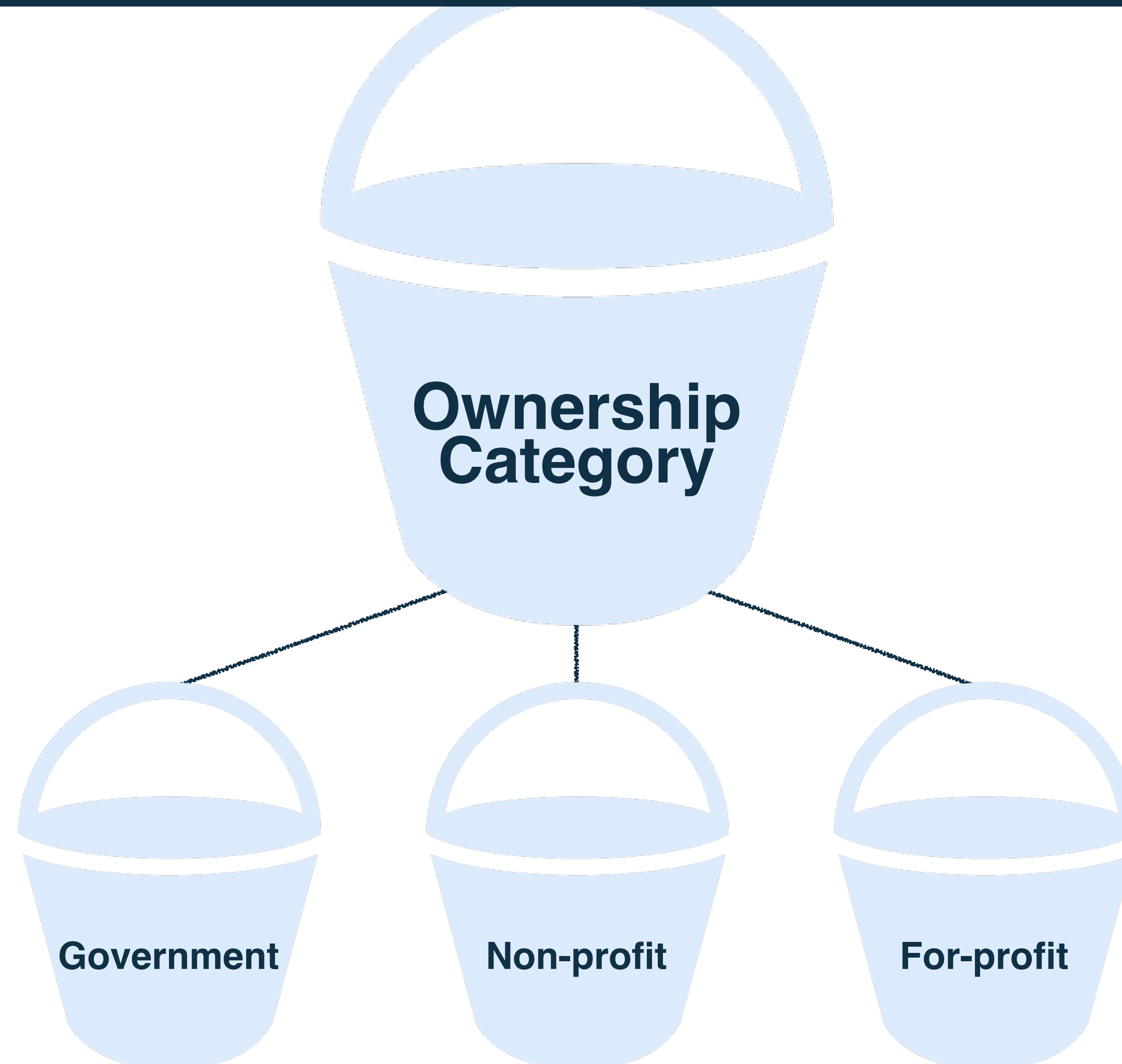
Provider or Supplier

Service Area

Ownership Category

Volume (FFS)

CMS used PECOS enrollment & Medicare FFS claims information for each NPI number for the three characteristics:





Ground Ambulance Industry
Trends, 2017–2022
An Analysis of Ground Ambulance
Organization Entrance and Exit
April 2024

5 Analyses Conducted from 2017 - 2022:

1. # of ambulance providers who billed Medicare FFS
2. Share of ambulance providers who entered, exited, and remained
3. Categorized ambulance organizations into 4 organizational characteristics: provider or supplier, ownership, service area density, and volume

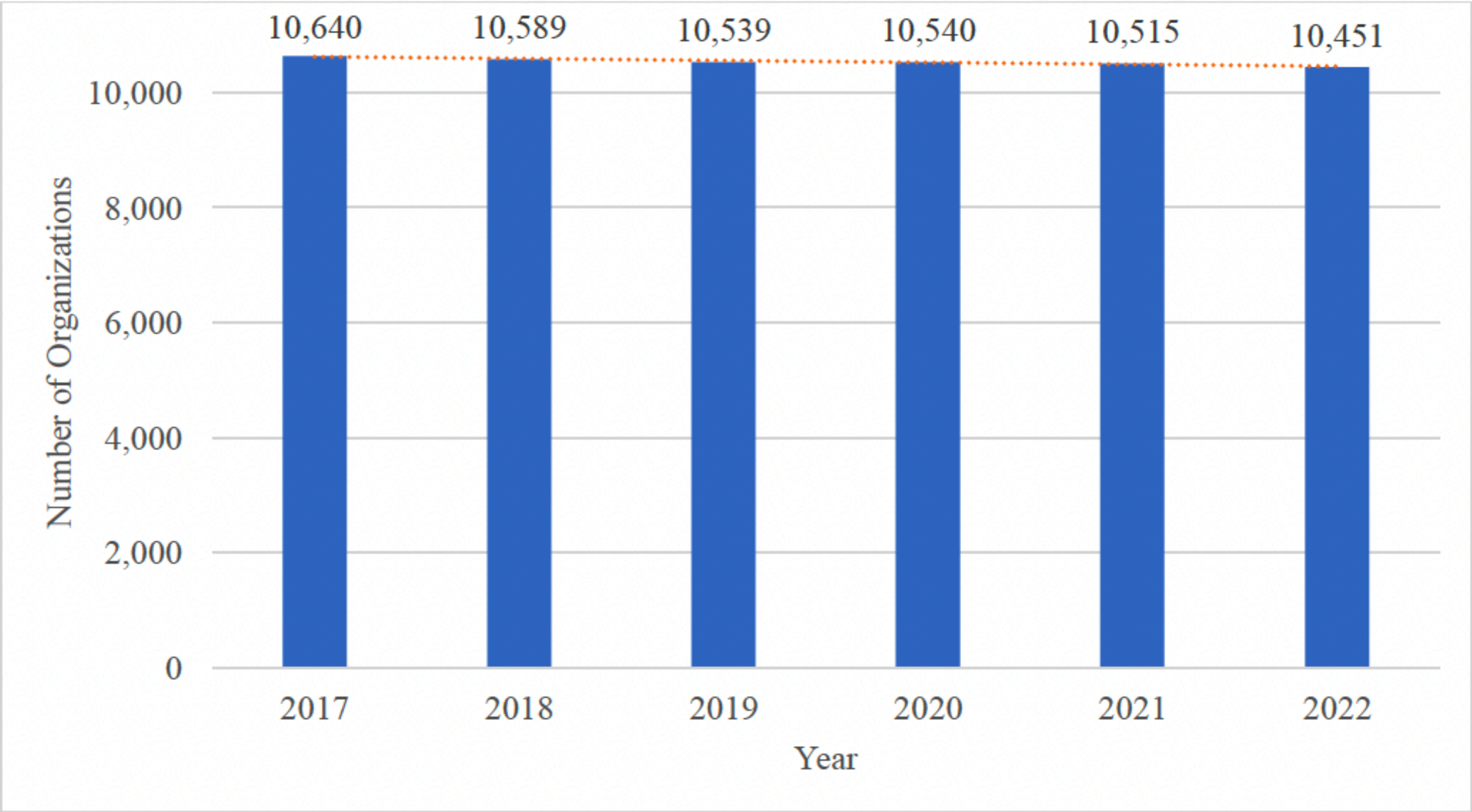


Ground Ambulance Industry
Trends, 2017–2022
An Analysis of Ground Ambulance
Organization Entrance and Exit
April 2024

5 Analyses Conducted from 2017 - 2022:

4. Estimated and predicted entrance and exits as a function of organization-level characteristics
5. Estimated county-level regressions that predicted county-level changes in total transport volume

Figure 1. NPI with Paid Medicare FFF Ground Ambulance Claims, 2017-2022



SOURCE: Authors' analysis of Medicare fee-for-service claims accessed via CMS' IDR (run date April 26, 2023, for 2017 data; April 27, 2023, for 2018 and 2019 data; March 21, 2022, for 2020 data; July 19, 2022, for 2021 data; and June 7, 2023, for 2022 data).



KEY TAKEAWAYS

93% of NPIs billed in a year subsequently billed in the following year

~4% of NPIs stopped billing in subsequent years

3% of NPIs billed for the first time in each year

Table 1. Organizational Characteristics of NPIs that Exited Between 2017-2021

	2017–2021 Sample Characteristics	2017–2021 Combined (% of exits)	2017 (% of exits)	2018 (% of exits)	2019 (% of exits)	2020 (% of exits)	2021 (% of exits)
Provider or supplier							
Supplier	94.4	88.3	88.1	86.0	89.0	87.9	90.3
Provider	5.6	11.7	11.9	14.0	11.0	12.2	9.7
Ownership							
For-profit	21.1	46.7	44.1	45.9	42.5	44.4	55.9
Government	50.6	22.3	21.8	23.0	22.7	23.5	20.6
Non-profit	28.3	31.0	34.2	31.2	34.8	32.2	23.5
Service area density							
Rural	28.2	27.1	25.5	30.2	30.5	25.4	24.0
Super rural	19.1	21.3	20.8	20.3	21.4	21.5	22.8
Urban	52.8	51.6	53.7	49.5	48.1	53.1	53.3
Volume							
Low	43.2	71.5	72.3	70.5	71.4	72.6	70.9
Medium	28.4	16.9	15.1	19.3	17.4	16.1	16.5
High	17.2	8.0	8.4	7.3	7.0	7.9	9.2
Very high	11.2	3.6	4.2	2.9	4.3	3.4	3.4
Total number of exits		1,959	404	414	374	354	413

Key Findings:

- **Nearly 1/2 of the exits were for-profit entities**
- **Non-profit organizations accounted for the 2nd largest exits**

SOURCE: Authors’ analysis of Medicare fee-for-service claims accessed via CMS’ IDR (run date April 26, 2023, for 2017 data; April 27, 2023, for 2018 and 2019 data; March 21, 2022, for 2020 data; July 19, 2022, for 2021 data; and June 7, 2023, for 2022 data) and PECOS data (run date May 2, 2023).

NOTE: Cells represent column percentages within each panel (i.e., under each heading). Percentages in the table may not add up to 100 because of rounding. Unit of analysis is an NPI within a year.



Table 2. Organizational Characteristics of NPIs that Entered Between 2017-2021

	2017–2021 Sample Characteristics	2017–2021 combined (% of entrances)	2017 (% of entrances)	2018 (% of entrances)	2019 (% of entrances)	2020 (% of entrances)	2021 (% of entrances)
Provider or supplier							
Supplier	94.4	90.3	88.6	88.7	91.5	89.9	92.7
Provider	5.6	9.7	11.4	11.3	8.5	10.1	7.3
Ownership							
For-profit	21.1	47.2	37.7	47.0	50.3	50.9	49.5
Government	50.6	31.5	38.3	28.6	31.3	27.2	32.5
Non-profit	28.3	21.3	24.0	24.4	18.4	21.9	17.9
Service area density							
Rural	28.2	26.2	20.7	26.6	30.8	28.5	23.4
Super rural	19.1	20.0	22.5	21.0	18.7	17.6	20.7
Urban	52.8	53.9	56.9	52.4	50.6	53.9	55.9
Volume							
Low	43.2	75.6	77.8	72.5	73.4	75.2	79.6
Medium	28.4	15.8	12.6	16.4	18.1	17.9	13.7
High	17.2	6.4	7.8	7.7	6.9	4.8	5.2
Very high	11.2	2.1	1.8	3.4	1.7	2.1	1.5
Total number of entrances		1,758	333	353	364	379	329

SOURCE: Authors' analysis of Medicare fee-for-service claims accessed via CMS' IDR (run date April 26, 2023, for 2017 data; April 27, 2023, for 2018 and 2019 data; March 21, 2022, for 2020 data; July 19, 2022, for 2021 data; and June 7, 2023, for 2022 data) and PECOS data (run date May 2, 2023).

NOTE: Percentages in the table may not add up to 100 due to rounding. Unit of analysis is an NPI within a year.

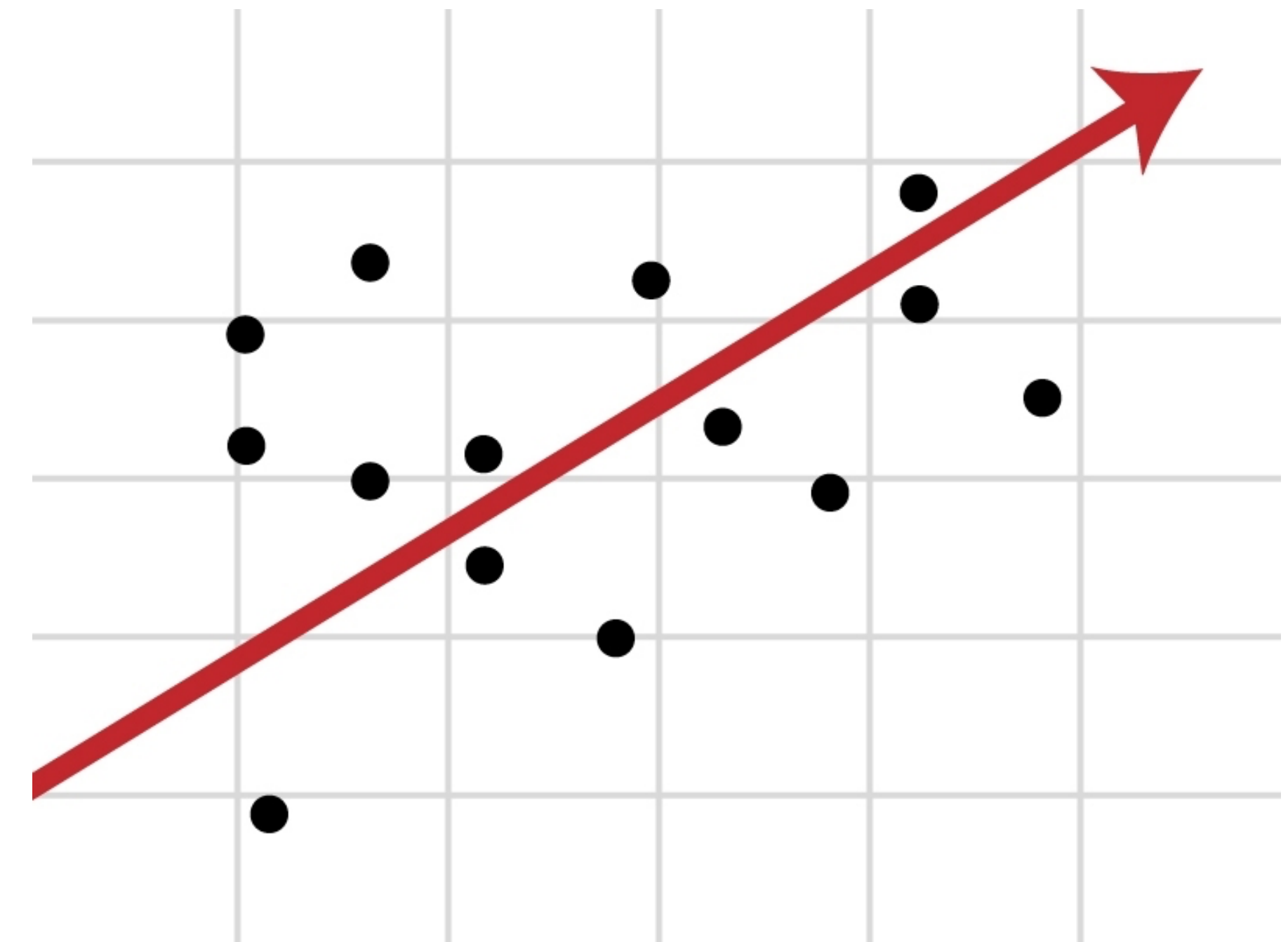
Key Findings:

- **Government agencies second most likely to enter**

REGRESSION ANALYSIS



1. Providers had greater odds of exiting and entering than suppliers.
2. Government and non-profit organizations less likely to enter compared to for-profits.
3. Government and non-profit organizations less likely to exit compared to for-profits.
4. Rural and super rural organizations less likely to enter compared to urban counterparts.
5. Super rural organizations less likely to exit compared to urban counterparts.



Key Point: As volume increased, less likelihood of an organization entering or exiting.



Ground Ambulance Industry
Trends, 2017–2022
Analysis of Medicare Fee-for-Service Claims
April 2024

Three Main Sources of Data:

1. Medicare FFS claims
 - Ground ambulance HCPCS Codes (Part A & B)
 - Revenue Codes 540-49 (Part A)
2. PECOS data

Used to classify ambulance ownership type, service area, linkage between enrollment records and NPIs
3. Medicare Enrollment Data

Used to capture Traditional Medicare enrollment and Medicare Advantage penetration rates

Data Elements Used in the Medicare FFS Claims File

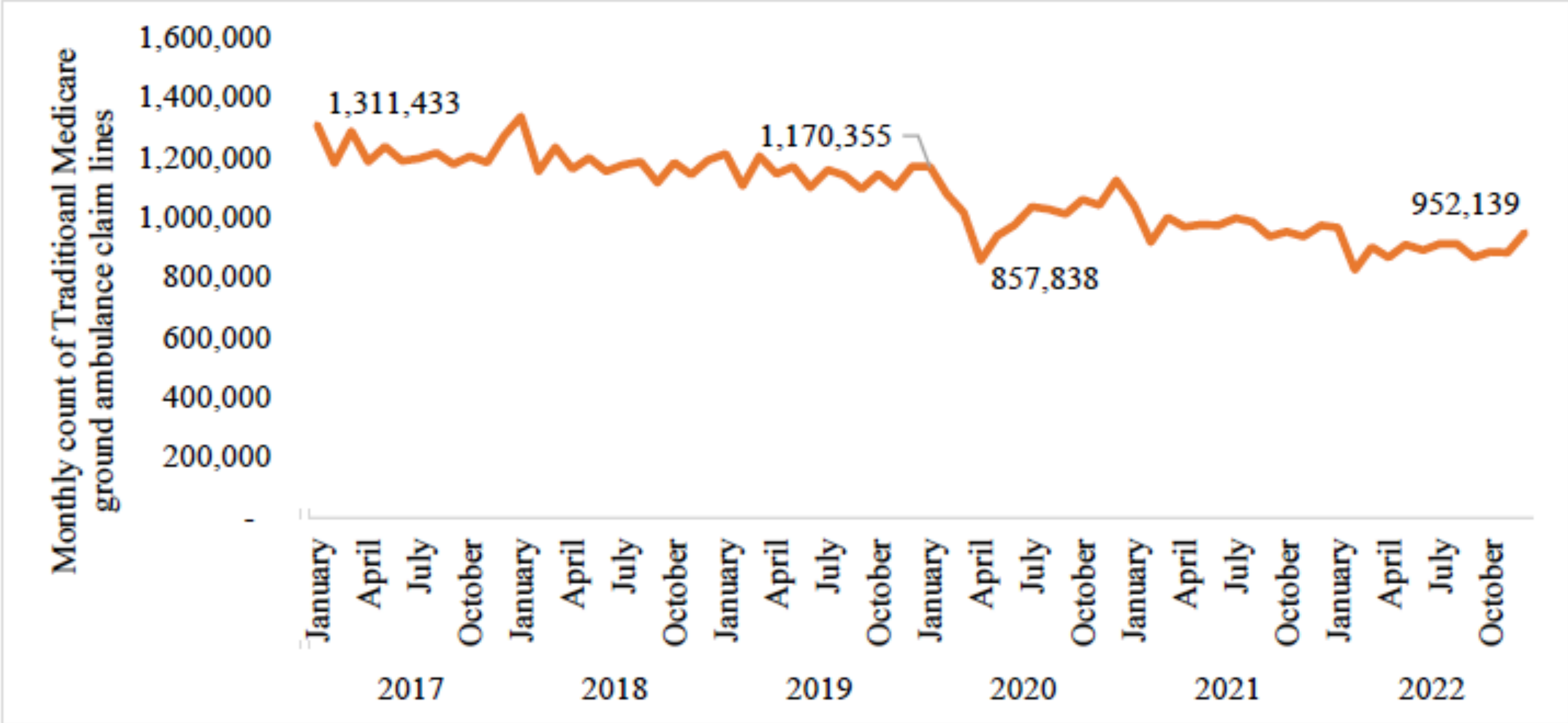
- National Provider Identification (NPI) number
- Service Date
- Paid Amount
- HCPCS code
- Origin and destination modifier codes
- ZIP code for point of ambulance pickup (professional claims)
- Provider ID linked to primary practice location ZIP code (facility claims)

Excluded all professional claims with a payment of zero dollars, billed without corresponding mileage code, and institutional claims billed under Part A.

Table 1. Categories of Traditional Medicare Ground Ambulance Transport Volume

Volume Category	Number of Annual Medicare Ground Ambulance Transports
Low Volume	200 or fewer
Medium Volume	201 to 800
High Volume	801 to 2,499
Very High Volume	2500 or more

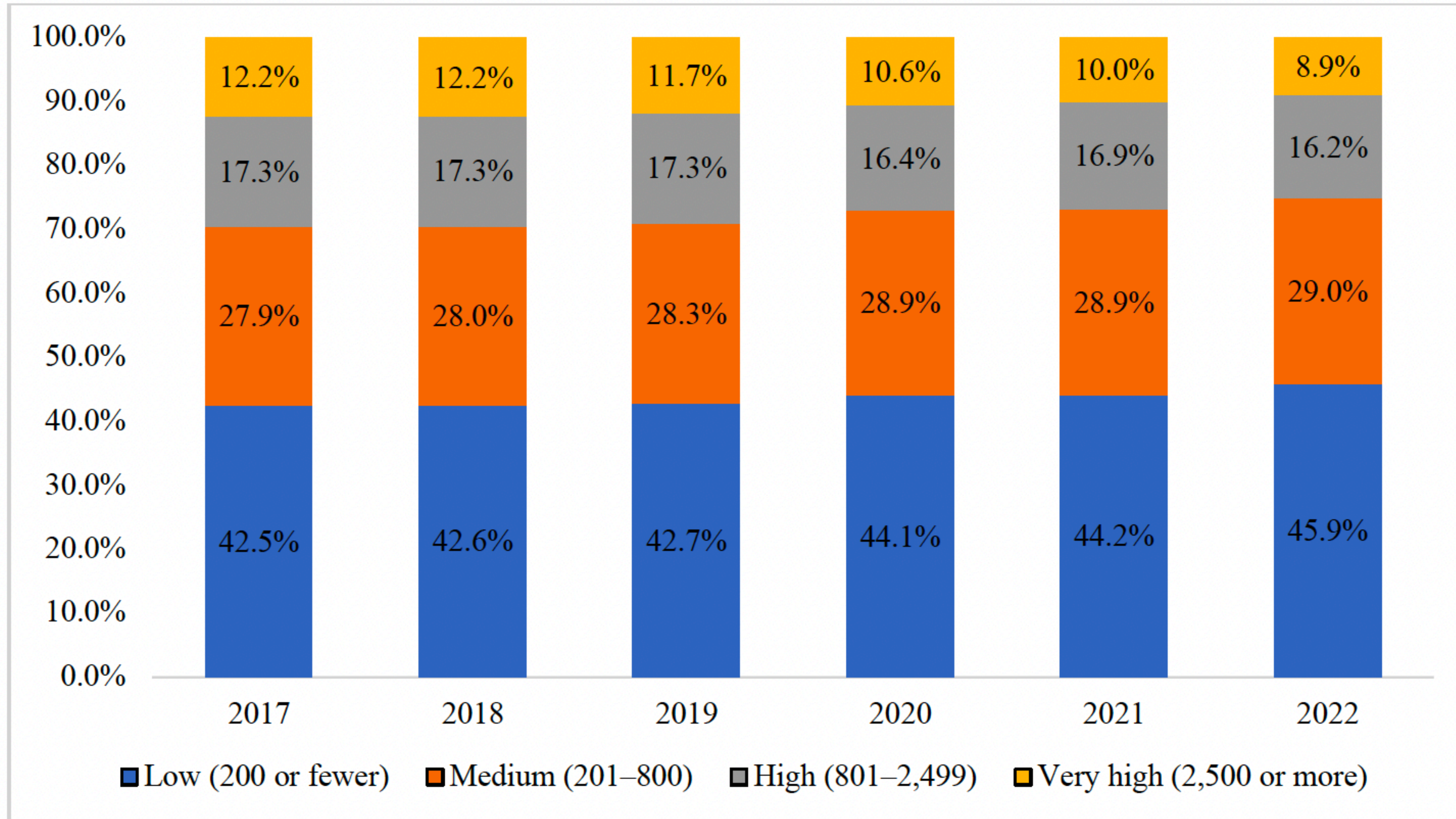
Figure 2. Monthly Traditional Medicare Ground Ambulance Transport Volume, 2017-2022



SOURCE: Authors' analysis of Medicare fee-for-service claims accessed via CMS' IDR (run dates March 21, 2022, to June 7, 2023).

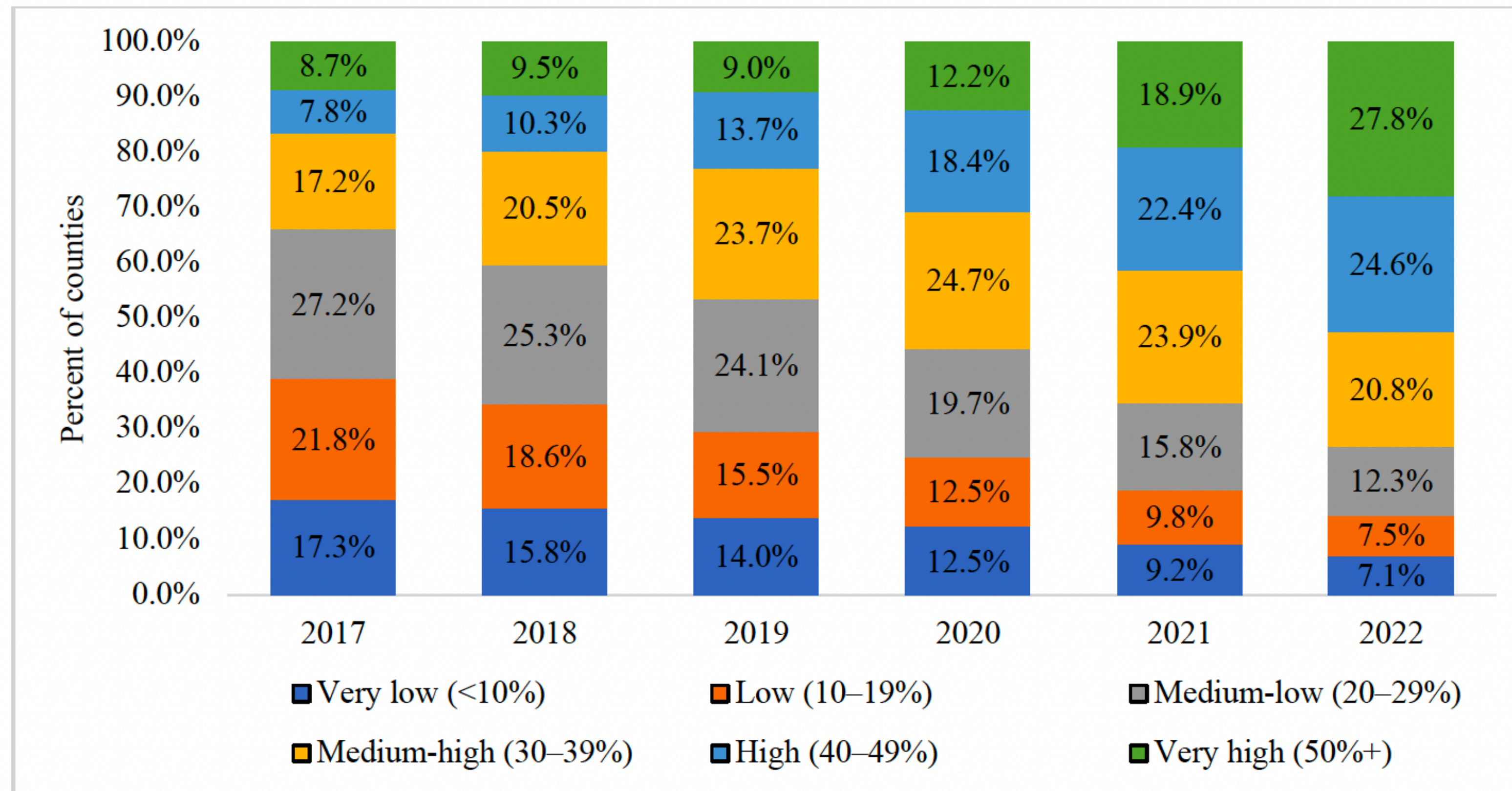


Figure 4. Distribution of Traditional Medicare Ground Ambulance Transport Volume per NPI, 2017-2022



SOURCE: Authors' analysis of Medicare fee-for-service claims accessed via CMS' IDR (run dates March 21, 2022, to June 7, 2023).

Figure 6. County-Level Medicare Advantage Penetration Rates, 2017-2022



- **Enrollment increases in large markets but decreases in small markets from 2017 - 2022**
- **Utilization of EMS services does not follow the same pattern of increase or decrease from Part B to Part C**

SOURCE: Authors' analysis of Medicare fee-for-service claims accessed via CMS' IDR (run date August 8, 2023) and MA penetration rates.

Table 3. Top Ten ICD-10-CM Diagnosis Codes Reported for Non-Emergency Ground Ambulance Transports, as a Share of All Transports and Non-Emergency Transports, 2017 and 2022

Top ICD-10-CM Diagnosis Codes	All Transports	Non-Emergency Transports
2017		
Total number of transports	14,652,995	5,805,197
<i>Share of transports (all and non-emergency)</i>		
ESRD (N18.6)	6.4%	16.2%
→ Unspecified lack of coordination (R27.9)	3.2%	8.1%
→ Weakness (R53.1)	1.5%	3.7%
Altered mental status, unspecified (R41.82)	1.5%	3.7%
Other lack of coordination (R27.8)	1.1%	2.8%
Bed confinement status (Z74.01)	1.0%	2.6%
→ Muscle weakness (generalized) (M62.81)	0.7%	1.8%
Delirium due to known physiological condition (F05)	0.7%	1.7%
Unspecified kidney failure (N19)	0.6%	1.6%
Chronic kidney disease, unspecified (N18.9)	0.6%	1.6%
2022		
Total number of transports	10,787,064	3,615,848
<i>Share of transports (all and non-emergency)</i>		
ESRD (N18.6)	4.3%	12.8%
→ Weakness (R53.1)	2.5%	7.5%
→ Unspecified lack of coordination (R27.9)	2.2%	6.6%
Altered mental status, unspecified (R41.82)	2.1%	6.3%
Other abnormalities of gait and mobility (R26.89)	1.0%	2.9%
Bed confinement status (Z74.01)	0.9%	2.8%
→ Muscle weakness (generalized) (M62.81)	0.8%	2.5%
Transient alteration of awareness (R40.4)	0.8%	2.4%
→ Other lack of coordination (R27.8)	0.6%	1.8%
COVID-19 (U07.1)	0.6%	1.8%

SOURCE: Authors' analysis of Medicare fee-for-service claims accessed via CMS' IDR (run date August 24, 2023).
 NOTE: The All Transports column uses transports with the HCPCS codes A0426, A0427, A0428, A0429, A0432, A0433, A0434, and A0999. The Non-Emergency Transports column uses transports with HCPCS codes A0426 and A0428.

YOUR ORGANIZATION & FUTURE REFORMS

- **Audits**
- **Emergency versus non-emergency public policy initiatives**
- **Patient-centered reforms**
- **Public/private synergies**
- **Market dynamics**
- **Out-of-pocket reforms**

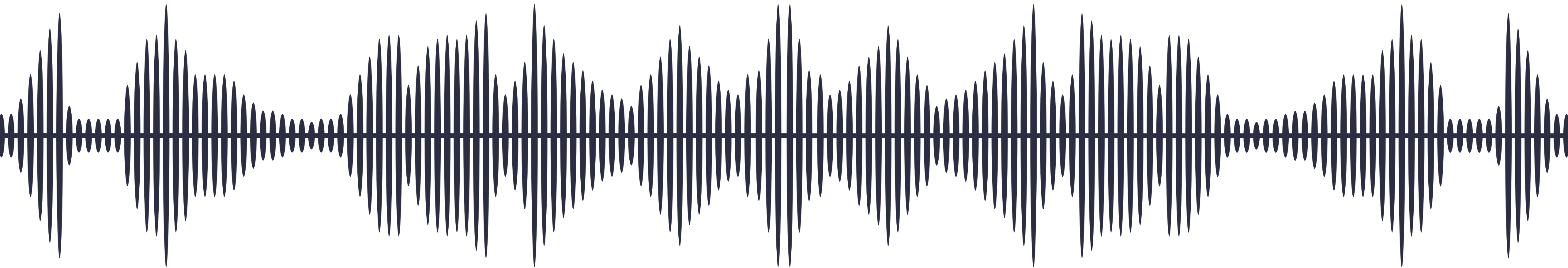
THE FUTURE OF EMS REIMBURSEMENT



Pigs get fat

Hogs get slaughtered

“Listen for what you need to hear, not what you want to hear.”



“

Let us never negotiate out of fear.
But let us never fear to negotiate.

John F. Kennedy

Future Reforms: An EMS Perspective



NEAT Prior Authorization Process



Prescriptive Physician Certification Statement



Inclusion in Emergency Medical Services definition to limit OOP variances (regulatory)



Expand coverage requirements in Part B



Ambulance response without transport



Specialty Care Transport Definition Changes

YOUR ORGANIZATION & FUTURE REFORMS



Audits



Emergency versus non-emergency public policy initiatives



Patient-centered reforms



Public/private synergies



Market dynamics



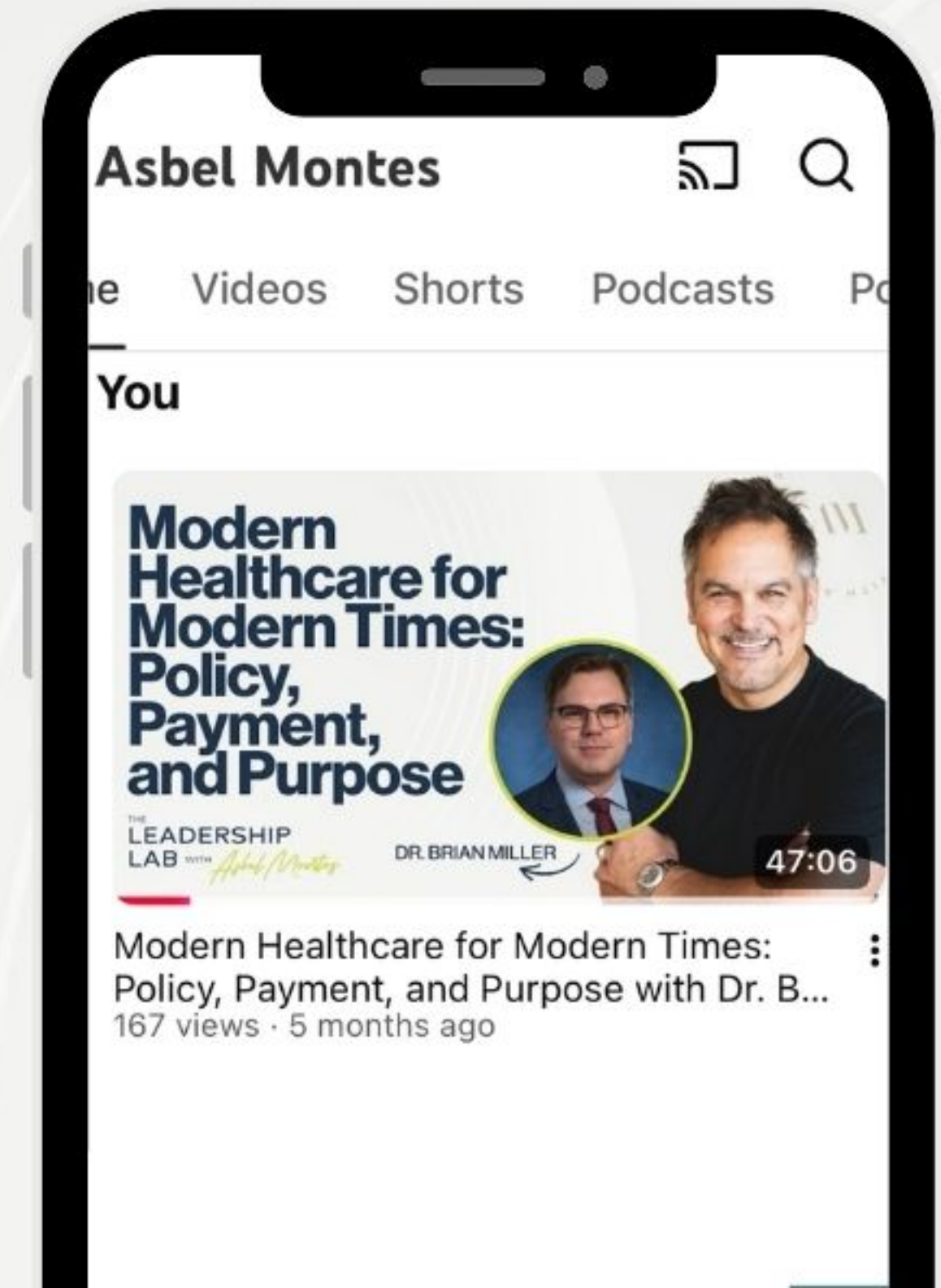
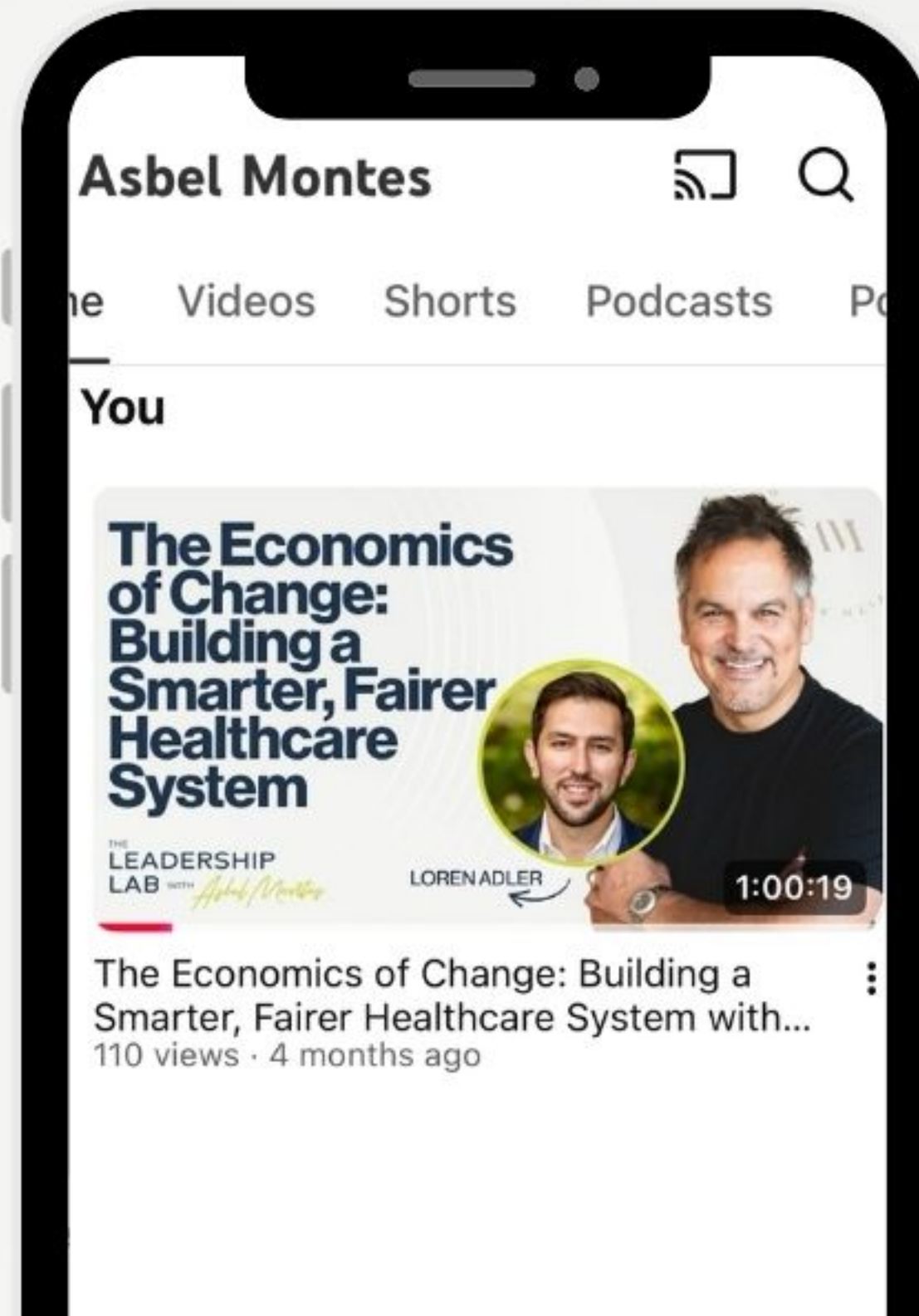
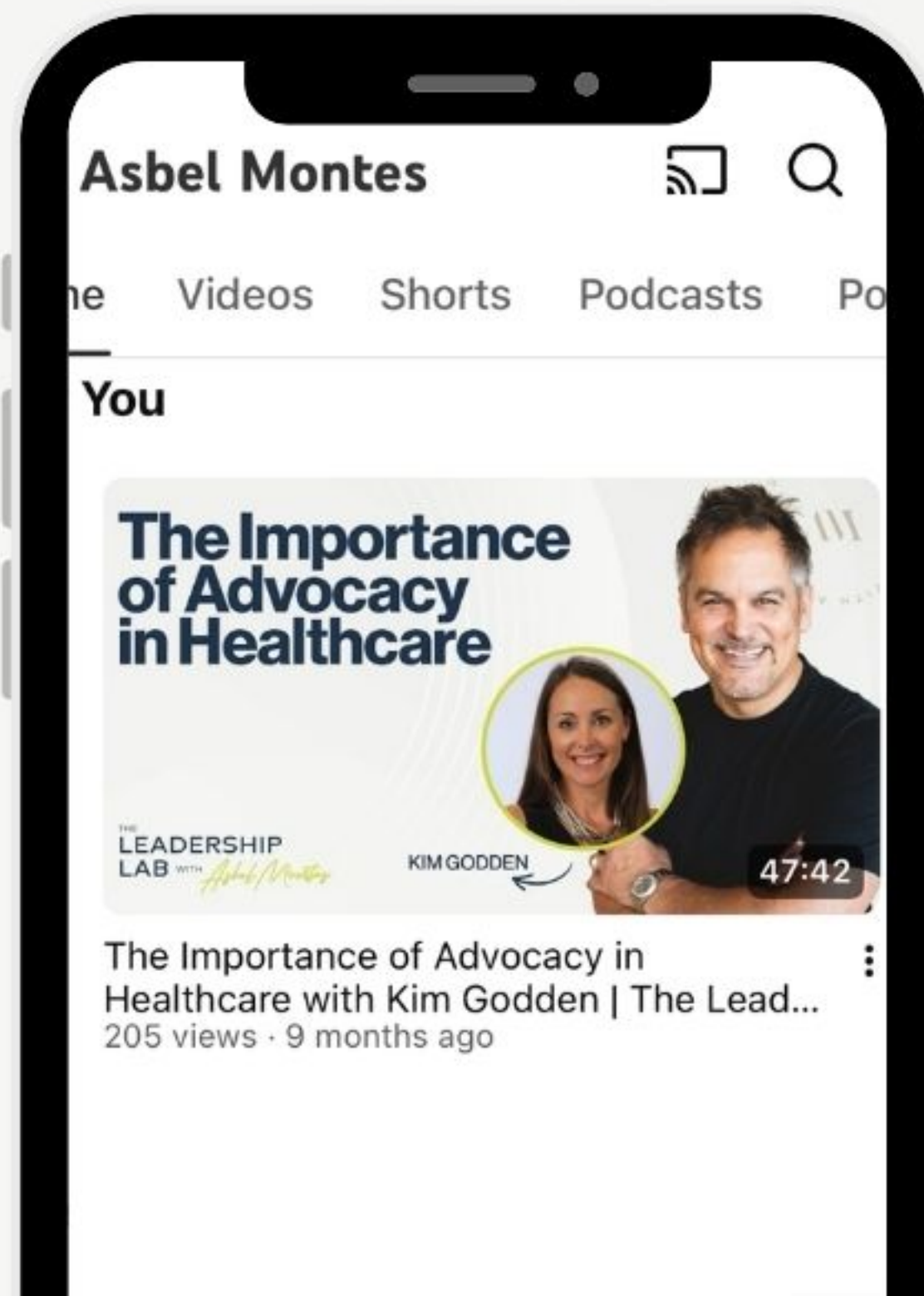
Out-of-pocket reforms



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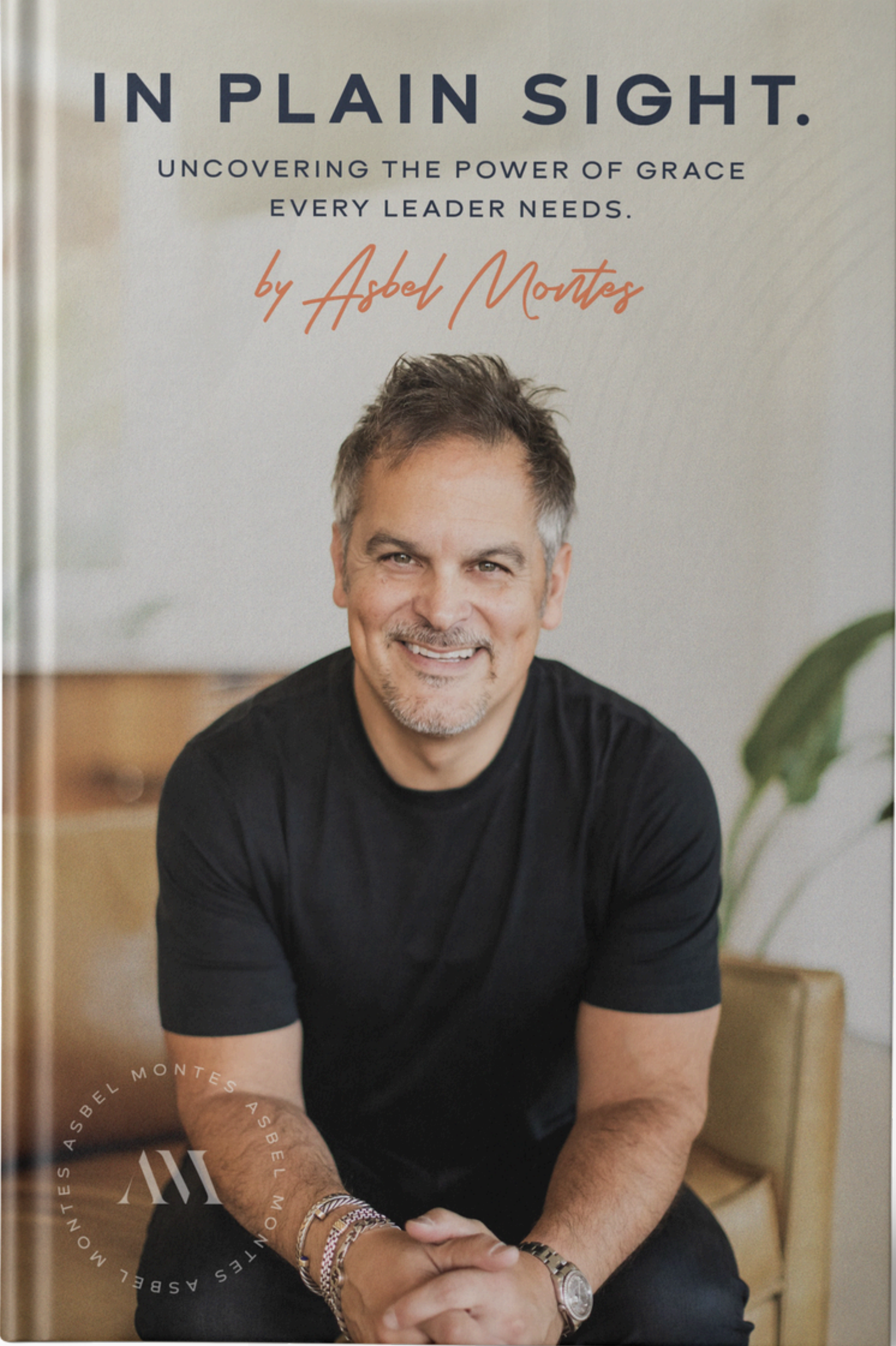
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