AMERICAN AMBULANCE ASSOCIATION

Caring for people—first.

June 22, 2025

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Chair
Medicare Payment Advisor Commission
425 I Street NW, Suite 701
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Dear Dr. Chernew,

On behalf of the American Ambulance Association (AAA), I want to thank you, the Commissioners, and the staff for the thoughtful presentation and discussion during the March meeting of the Medicare Payment Advisory Committee (MedPAC). In light of that discussion, the AAA would like to share some additional background and information that relates to many of the comments made by Commissioners and staff during that meeting. We also would like to provide our suggestions supporting the continuation of collecting data related to ground ambulance services.

Members companies of the AAA provide mobile health care services to more than 75 percent of Americans. These essential mobile health care services include the local operation of the 9-1-1 emergency/equivalent system, as well as both emergent and non-emergency interfacility care transition ambulance services and transportation. Often ground ambulance service organizations are the first medical professionals to interact with individuals in need of a health care encounter. These organizations also serve as the health care safety net for many individuals in small communities. This is especially the case in rural areas where other types of providers and suppliers have reduced their hours of operation or left the community altogether. As such, these organizations play a critical and unique role in the country's health care infrastructure. The role ambulances play as a safety net provider has never been more critical than now, as we await the implementation of Medicaid eligibility cuts and state and federal budget cuts.

In brief, this letter addresses the following topics.

- Clarifications about ground ambulance services details which arose during the March 2025 meeting;
- Background about the Medicare ambulance fee schedule;
- Suggestions for reviewing the CMS Ground Ambulance Data Collection System (GADCS);

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- Initial considerations for evaluating GADCS rounds 1 and 2 data; and
- The AAA's strong support to continue data collection for ground ambulance services

If the Commission has more questions or would like additional background, we would welcome the opportunity for further discussion.

I. Clarifications about Ground Ambulance Services Details which Arose during the Commissioner Meeting

While the AAA would welcome the opportunity to provide more detailed background of ground ambulance services, we recognize that the two CMS reports discussing the Ground Ambulance Data Collection System (GADCS) include a significant amount of information about ground ambulance services and the providers/suppliers that provide those services. While CMS' reports provided an important and expansive array of data for policymakers, in this section of our letter we highlight a few key points of clarification that are important in light of the Commissioner's discussion at the March 2025 MedPAC meeting. The topics below arose during the March 2025 MedPAC meeting and we offer these clarifications.

Question about the role of non-governmental/non-shared service entities in providing 9-1-1 services: GADCS data demonstrates that 57 percent of for-profit ground ambulance entities routinely respond to 9-1-1 calls.[1] As these data demonstrate, communities will often rely upon for-profit entities to operate their emergency medical response systems.

Question about the scope of "non-emergency" services: The term "non-emergency" services can be extremely misleading because these services often involved complex care. Some of the types of services that are commonly provided when ground ambulance services are billed as "non-emergency" include:

- Mental/behavioral health concerns that endanger the individual or those around him/her that requires medical management
- Oxygen administration requiring third party administration
- Special handling/positioning necessary to prevent negative health care outcome
- Morbidly obese requiring assistance to be safely transported
- Ventilation/advanced airway management
- Suctioning necessary to keep patient stable
- Isolation precautions necessary
- Intravenous fluid or drug administration necessary
- Specialized management during or after transport
- Extreme distances/duration of trip

[1]CMS. "Medicare Ground Ambulance Data Collection System (GADCS) Report Year 1 and Year 2 Cohort Analysis." Figure 4.2.2. (Dec. 2024).

Sometimes these are defined as scheduled interfacility transport. Some examples include:

- A patient in rural hospital needs specialized care and cannot safely be transported by other means to facility located substantial distance away;
- A patient requires isolation;
- A patient on ventilator requires transport from hospital to LTCH and cannot be transported safely by other means

In other instances "non-emergency" transports involve services provided during transports from an institutional setting to home, such as when a patient may require continuous oxygen upon release and State law may require ambulance to transport patient home.

Questions about the extreme challenges in rural areas. Access to ground ambulance services in rural America is threatened. While the problem of hospital deserts has gained significant attention, ambulance deserts are just as prevalent if not more so. When a rural area has no access to a hospital or other health care providers, it is often the ground ambulance services that steps in to provide the community with essential health care. However, the lack of sufficient reimbursement has led to the closure of many ground ambulance services in rural areas, leaving these communities without any immediate access to health care services, including EMS services. The Rural Health Research Gateway has identified "ambulance deserts" in every State in America.[2] It found that:

- 4.5 million people lived in an ambulance desert (AD); 2.3 million (52%) of them in rural counties.
- Four out of five counties (82%) had at least one AD.
- Rural counties were more likely to have ADs (84%) than urban counties (77%).
- Areas with the highest share and number of people living in ADs include the Appalachian region in the South; Western states with difficult mountainous terrain; coastal areas across the U.S.; and the rural mountainous areas of Maine, Vermont, Oregon, and Washington.
- Eight states had fewer than three ambulances covering every 1,000 square miles of land area (the Western states of Nevada, Wyoming, Montana, Utah, New Mexico, and Idaho; and the Midwestern states of North Dakota and South Dakota).[3]

As these findings demonstrate, access to ground ambulance services is at-risk with many Americans already having lost access to them.

Questions about the effectiveness of services other than Basic Life Support. The AAA appreciates the discussion related to ALS services. While it is true that local governments

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[2]Yvonne Jonk, Carly Milkowski, Zachariah Croll, Karen Pearson. "Ambulance Deserts: Geographic Disparities in the Provision of Ambulance Services. (May 2023) *available at* https://www.ruralhealthresearch.org/publications/1596 (accessed August 25, 2023).
[3]*Id.*

determine the scope of services, the definitions of ALS and BLS are set by the federal Medicare program. If a ground ambulance supplier/provider submits an ALS claim, that claim must meet the definition outlined in the Medicare Benefits Policy Manual (See Appendix A for the complete definition). It is important to also keep in mind that ground ambulance service providers/suppliers must determine what type of response (*i.e.,* BLS or ALS) is required based on the information provided during the 9-1-1 or equivalent call. As a result, medical necessity for emergency ALS is determined at that point in the response, not at the scene or later after the patient has been assessed at the hospital. To do otherwise would create significant disincentives to provide ALS services and likely result in significant patient harm. In terms of the higher level ASL services (ALS-2), the paramedic's actions at the scene must align with the specific services outlined in the Medicare manual. We agree with Commissioners' comments that it is important that MedPAC avoid trying to make generalized clinical judgements about the appropriateness of ALS services in light of the current detailed regulations governing these services.

Questions about the medical appropriateness of ALS services. During the Commissioner discussion, there was a point about the appropriateness of providing prehospital services at the scene versus stabilizing a patient and taking him/her directly to a hospital. While there have been a few reports suggesting that the later approach might be favored, these have been debunked by other researchers. For example, a 2024 retrospective, propensity matched cohort study using a national sample of trauma patients published in the *Journal of Trauma and Acute Care Surgery* found that "attendance by ALS providers was associated with reduced mortality" and that the result "was observed in the entire cohort."[4] The study recognized the publication of earlier studies with other result and differentiated them from this and other work.

> Several previously published studies have observed either no survival benefit for trauma patients cared for by ALS versus BLS providers or increased mortality in the ALS cohorts.12–18 Our analysis suggests that these differences might be attributed to an inadequate adjustment for confounding variables such as injury severity, limited in part to smaller sample sizes. A strength of our study includes the relatively large sample size, as well as robust adjustment for prehospital variables related to both the patient and the EMS responding unit, allowing for propensity score matching for more rigorous analysis. The results may be more generalizable, as we included multiple hospital systems and regions of the country, mitigating the effect of a single region or system of care.[5]

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[4]Harrison, Julia MD; Bhardwaj, Akshay MS; Houck, Olivia MPH; Sather, Kristiana MD; Sekiya, Ayako MPH; Knack, Sarah MD; Saarunya Clarke, Geetha PhD; Puskarich, Michael A. MD, MSCR; Tignanelli, Chris MD, MSc; Rogers, Lisa MPH; Marmor, Schelomo PhD; Beilman, Greg MD. Emergency medical services level of training is associated with mortality in trauma patients: A combined prehospital and in hospital database analysis. Journal of Trauma and Acute Care Surgery 98(3):p 402-409, March 2025. | DOI: 10.1097/TA.0000000000004540
[5]*Id*.

Similarly, a 2023 study published in *Circulation* found ALS services are better than BLS care when it cardiac care outcomes.

> In contrast to previous literature, ALS care in the study was superior to BLS care. ALS care was associated with higher rates of Return of Spontaneous Circulation (ROSC) in Out-of-Hospital-Cardiac-Arrest (OHCA) patients regardless of rhythm. Further, ALS care was associated with higher rates of being discharged alive from the hospital and favorable neurological outcomes among patients with a shockable rhythm.[6]

Questions about reimbursement related to the terms "loaded" and "unloaded miles." Ground ambulances entities are not paid for unloaded miles, which are the miles driven when a patient is not on the vehicle. This means that for a ground ambulance service's response that only the last portion of miles for trip between the dispatch location, the scene, and the final destination are incorporated into the reimbursement rate. This reality creates a significant disconnect between the actual cost and what is reimbursed.

I. Background about the Medicare Ambulance Fee Schedule

During the March discussions, several Commissioners raised factual questions about the origins of the Ambulance Fee Schedule (AFS). Given the unique process used to establish the AFS, we thought it would be helpful to provide that background.

Prior to the implementation of the AFS, Medicare paid ground ambulance services on a reasonable cost basis when furnished by a provider and on a reasonable charge basis when furnished by a supplier. The Balanced Budget Act of 1997 required that CMS establish a fee schedule. The Health Care Financing Administration (HCFA) (the precursor to CMS) explained that in doing so, its goal was to:

- Establish mechanisms to control increases in expenditures for ambulance services under Part B of the Medicare program;
- Establish definitions for ambulance services that link payments to the type of services furnished;
- Consider appropriate regional and operational differences;
- Consider adjustments to payment rates to account for inflation and other relevant factors;
- Phase in the fee schedule in an efficient and fair manner; and,

[6]Ryan Silvagi, Ryan Reece, James Cranford, Shobi Mathew, Mitchell Byrd, John Pum, Damon Gorelick, Valerie H Mika, Robert B Dunne, and Brian O'Neil. "Abstract 417: Advanced vs. Basic Life Support Outcome Variation in the Treatment of Out-of-Hospital-Cardiac-Arrest in Detroit." 148 *Circulation* Supp.1 (2023). Available at: https://www.ahajournals.org/doi/10.1161/circ.148.suppl_1.417.

- Require payment for ambulance services be made only on an assignment related basis.[7]

In the Balanced Budget Refinement Act of 1999, Congress refined this charge emphasizing new policy for rural services.

In mandating the AFS, Congress also required that the agency rely upon "negotiated rulemaking." Negotiated Rulemaking was established by the Congress to change the way federal agencies developed certain rules. It required working through a committee of stakeholders in a consensus-building process to develop the proposed regulations. While it sought to create rules that were more acceptable to stakeholders, foster cooperation, and reducing the likelihood of post-publication challenges, the experience of the AFS negotiated rulemaking process demonstrated that it also did not result in the ideal analytical and data-driven processes. In the end, the AFS essentially created a new division of an existing pie that had little to do with the actual cost of providing the services. It began by identifying the existing amount of Medicare expenditures for ground and air ambulance. It then divided those dollars into the different service levels and created relative value units (RVUs) to measure the value of ambulance services relative to the value of a base level ambulance service. Based on notes from participants during the process, the decisions were not driven by rigorous data analysis, but the opinions of the selected participants. While the participants were well-meaning, it is fair to say that the resulting rates were not truly linked to the cost of providing services.

As a result, the AFS has not been successful at addressing the changing medical landscape over time. The GAO has documented these failures in two reports,[8] and the Congress has consistently passed legislation for more than a decade extending geographically defined add-ons to try to keep the system working, despite the add-ons themselves not being tied strictly to a cost-based analysis, but rather the funding available at the time of their passage.[9]

Given the growing gap between cost and reimbursement rates, the Congress developed the three add-ons. The first two – urban and rural – were set as percentages that reflect the available funding that Congress could spend. They did not (and still do not) represent the actual amount that would be needed to achieve even a break-even point for the vast majority of ground ambulance services. While authorized by Congress, the super-rural add-on was

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[7]HCFA." Fee Schedule for Payment of Ambulance Services and Revisions to the Physician Certification Requirements for Coverage of Nonemergency Ambulance Services." 65 *Fed. Reg.* 55078 (Sept. 12, 2000).
[8]GAO. "Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly." (May 2027). GAO. "Ambulance Providers: Costs and Medicare Margins Varied Widely; Transports of Beneficiaries Have Increased" (Oct. 2012).
[9]The GAO reports found vary margins and significant higher costs than the Medicare reimbursement rate. However, when Congress established the add-ons, they were set at an amount that would address pay-go and other budgetary concerns rather than at an amount to fill the gap between costs and rates. Thus, these add-on amounts should not be assumed to be the amount that would be required to align Medicare rates with provider/supplier costs incurred when providing ground ambulance services.

developed by CMS. CMS designed the super-rural add-on to provide additional financial assistance to ambulance service providers and suppliers in the most sparsely populated rural areas. The add-on applies to ground ambulance transports originating in a rural area designated as being in the lowest 25th percentile of all rural populations by population density.[10] The amount of add-on is based on the Secretary's estimate of the ratio of the average cost per trip for the rural areas comprised of the lowest quartile of population arrayed by density compared to the average cost per trip for the rural areas comprised of the highest quartile arrayed by density. In 2004, the Secretary used GAO data to determine the amount of this increase as 22.6 percent.[11] As a result, it was closer to actual costs, but it has remained static during the past 21 years. That is also essentially true for the urban and rural add-ons.

In addition, each loaded ambulance mile greater than 50 (that is, miles 51 and greater) for ambulance transports originating in either urban areas or in rural areas are paid based on a rate that is 25 percent higher than otherwise would be applicable under the AFS.

In relation to this background, the geographic designations in the AFS take on significant meaning. They are closely aligned with the definition of "rural" in the hospital setting, but include a unique "super-rural" designation. Statute refers to "super-rural" as "a qualified rural area". It states:

> (B) Identification of qualified rural areas
>
> (i) Determination of population density in area. Based upon data from the United States decennial census for the year 2000, the Secretary shall determine, for each rural area, the population density for that area.
>
> (ii) Ranking of areas. The Secretary shall rank each such area based on such population density.
>
> (iii) Identification of qualified rural areas. The Secretary shall identify those areas (in subparagraph (A) referred to as "qualified rural areas") with the lowest population densities that represent, if each such area were weighted by the population of such area (as used in computing such population densities), an aggregate total of 25 percent of the total of the population of all such areas.
>
> (iv) Rural area. For purposes of this paragraph, the term "rural area" has the meaning given such term in section 1395ww(d)(2)(D) of this title. If feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification,

[10] *See*, CMS. "Medicare Ambulance MMA Temporary Rate Increases Beginning July 1, 2004." 69 *Fed. Reg.* 40288 (July 9, 2004).
[11] *Id*.

> originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as a rural area for purposes of this paragraph.[12]

While it might seem easier to apply the geographic designations developed for hospitals or other brick-and-mortar providers, Congress understood that ground ambulance services are mobile health care where the provider/supplier goes to the patient rather than the patient coming to the provider. This creates geographic variation within a single entity that is not the experience of hospitals or similar static providers. At a practical level, for CMS to determine mileage, it needed to have a point of pick and point of drop off. ZIP codes are as small a geographical unit as could be realistically used.

Moreover, the concept of "super-rural" recognizes the higher costs these mobile providers and suppliers incur in extremely rural areas. As noted elsewhere in this letter, in some of these super-rural locations, ground ambulances may be the only provider or supplier to which beneficiaries have access within a relatively "close" distance. We believe it is important for the Commission to acknowledge these unique attributes of ground ambulance providers and suppliers by not assuming that the geographic designations of other providers should be applied to them by default. Doing so would undermine a critical aspect of ground ambulance services that the Congress sought to protect. While we welcome the opportunity to think about low-volume and similar concepts, we encourage MedPAC to avoid trying to fit ground ambulance services into other provider payment definitions because the Commission may be more familiar with the other definitions.

As several Commissioners noted, another unique aspect of ground ambulance services reimbursement system is that CMS has interpreted the Social Security Act (SSA) to reimburse only for services when a patient is taken to one of the regulatorily designated locations. They are a hospital, a skilled nursing facility, a critical access hospital, dialysis facility, or a patient's home. Taking a patient to another location even if it would be more clinically appropriate, such as a behavioral or mental health facility or a substance abuse facility, cannot be reimbursed.[13] As a result, a significant number of ground ambulance responses are not reimbursed. Many state Medicaid programs and commercial insurers follow Medicare's practice as well. We appreciate the Commissioner's statements that ground ambulance service entities should be paid for the services they provide.

We would like to dispel the notion that the decision not to pay for the services was based on a concern about incentivizing overutilization. That is simply not true. At the time Congress added ground ambulance services to Medicare in 1965, pre-hospital health care was in its infancy so the standard of care was to load the patient onto the ambulance with minimal services and to transport him/her to the hospital as quickly as possible. In its 2007 report, the then-Institute of Medicine (IOM) described the evolution of ground ambulance services from

[12]42 U.S.C. § 1395m(l)(12)(B).
[13]CMS. "Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services" § 10.3.

primarily transporting patients to providing substantial health care services.[14] While some MA plans and some state Medicaid programs, such as New Hampshire, recognize this evolution and currently reimburse for these services, the Medicare program has not kept pace with advances in pre-hospital medicine.

It is also not possible for ground ambulance services to "cherry-pick" their responses. While calls may be "held" when the system is overwhelmed, ground ambulance service entities are required by law and/or contract to responded to in order of priority based on Information provided to the dispatcher or emergency medical dispatch (EMD) protocols.. They do not have the ability to refuse 911 (or equivalent) calls.

We do agree, however, that considering reimbursement for pre-hospital services when no transport is provided will require evaluating incentives and establishing appropriate guardrails to ensure balanced approach. There is no evidence that patients are systemically being transported when such transport is unnecessary under current laws. All transports must meet Medicare's medical necessity requirements. However, we recognize that if the policy were to change all incentives would need to be evaluated to ensure an appropriate approach. We also recognize that there may be abuse of every payment system to some degree. Medicare currently controls for such behavior across many payment systems using audits and claim reviews. We anticipate CMS would need to do the same for these services. We have no reason to believe abuse of reimbursement for ground ambulance services provided when there is no transport would be any different than other types of services. The AAA has convened a diverse group of industry experts – including several individuals from other stakeholder organizations to develop specific recommendations as part of more comprehensive ground ambulance payment system reform. We would welcome the opportunity to provide updates and recommendations from this group during the next few months.

II. Suggestions for Reviewing the CMS Ground Ambulance Data Collection System (GADCS)

The AAA appreciates the careful review and analysis MedPAC has undertaken in regard to the GADCS data. During the presentation and Commissioner discussion that referenced the trimming decisions MedPAC staff made which resulted in less than 40 percent (1710 of the 4500 organizations) of the ground ambulance service organizations that reported data being included in the MedPAC analysis. While we support the concept of trimming data using standard practices (such as eliminating organizations with cost levels that are more than three standard deviations from the mean), it is not appropriate to drop <u>all</u> organizations that share costs and revenues with fire departments, police departments, or hospitals. These shared-service organizational models are prominent within this industry and provide a significant percentage of

[14] IOM. "Emergency Medical Services: At the Crossroads" (2007).

all ambulance transports under Medicare. Excluding them all share-service entities will inappropriately skew the data on the actual cost of services.

The AAA recognizes the challenges that addressing data from different organization types, sizes, and location may create. This is a complex industry, but it is critically important that the various types of ground ambulance entities are included in this analysis in order to provide as complete and accurate a picture of the costs of providing ground ambulance services as possible. Recognizing these data in the analysis would acknowledges the flexibility and independence that state and local governments have in contracting with these organizations to provide emergency services. It is important to include shared-service providers/suppliers. It is also critically important to ensure that organizations with low volumes of service are also represented appropriately in the sample. As noted below, approximately three-quarters of ground ambulance service organizations provide two or fewer claims each day.[15] Just as it is inappropriate to exclude all shared-service organizations (especially if part of the problem is that their costs seem higher than the costs of other organizational types), it would also be inappropriate to exclude all smaller providers from the data analysis. We agree that responses/data that appear significantly inconsistent (such as data that are 3 or more standard deviations from the average shared-service provider) should be removed; however it is essential to include usable responses/data from share service providers. Excluding all shared services is a would skews the reality of cost data.

We also encourage MedPAC to retain the costs associated with volunteer labor to the extent possible by using the imputed volunteer cost data provided through the GADCS dataset. Eliminating responses based solely on the fact that volunteer labor is present skews the data. The multi-decade trend shows a reduction in volunteer labor, so we urge MedPAC not to assume that the level of volunteer labor existing today will remain steady during even the next decade. As more than one Commissioner noted, people do want to be paid for the work they provide. As gracious and selfless as volunteer EMTs and paramedics are, the economic reality may not allow them to continue working unpaid in the near future. Thus, assessments of future rounds of data collection, as well as the evaluation of ground ambulance service rates should treated these individuals as being paid for their work.

Concerns about inconsistencies between claims data and GADCS revenue data. Differences between revenues reported by ambulance entities in GADCS and payments reported on claims data do not come as a surprise and is likely due to survey reporting error. This error could be caused by respondents misunderstanding the instructions which define revenues. For example, the respondents could be including unpaid claims under appeal in their revenues or they could be including Medicare Advantage revenues within their Medicare revenues. These differences could also result from fiscal year (survey) versus calendar year (claims) reporting.

[15]CMS. “Ground ambulance industry Trends, 2017-2022” (April 2024); all other data come from CMS. “Medicare Ground Ambulance Data Collection System (GADCS) Report: Year 1 and Year 2 Cohort Analysis (Dec. 2024).

Based on its analysis of the Amber data, HMA recommends the following trimming rules we thought it would be helpful to share.

- Given the newness of the cost surveying process for this industry and the common presence of outlier responses within individual survey variables, develop a trimming methodology that enables the inclusion of survey data for individual variables within a response when data for that variable is usable
- Focus trimming rules on the count of reported transports and responses, total revenue, total costs, and both revenue per transport and cost per transport.
- Given the variability within the industry and the sample, it will be difficult to apply a single concrete rule of eliminating responses that are 2 or 3 standard deviations above the mean, therefore, it may be more realistic to trim these data on a case by case basis or to establish different trimming rules based on entity type or size.

In addition, we wanted to share their methodology for calculating margins using Amber data.

> HMA's data analysis assessed the ground ambulance industry's cost structure, revenue structure, and margins stratified by type of ambulance entity. Margins were calculated using a formula of revenues minus costs over costs. We calculated three types of ambulance margins: all payer margins, Medicare fee-for-service margins, and Medicaid margins. To calculate Medicare FFS and Medicaid margins, HMA gathered ground transport utilization data from CMS's 100 percent Medicare FFS claims data for 2022 and CMS's 100 percent Medicaid claims data for 2022. To calculate the three types of margins we used payer revenues as specified by entities on their survey responses and adjusted costs as specified by entities by the share of transports attributed to Medicare FFS and Medicaid. In addition, HMA created several categorical variables to stratify costs, revenues, and margins by ambulance type. This included: geographic service area, size (annual transport volume), share of emergency transports, ownership structure, and fire and non-fire entities. To identify the geographic service areas of respondent entities, HMA relied on 2022 Medicare FFS claims data to assign each respondent entity to one of the three CMS ground ambulance service areas (urban, rural, super rural) based on the majority of transports each entity provided. The transport size categories used for this analysis were selected in an effort to be consistent with MedPAC and GAO reports.[16]

[16]Health Management Associates. "Amber ground ambulance dataset reflects complexity and challenges of the industry, highlights the need to improve and continue cost data collection" (April 2025). Available at: https://www.healthmanagement.com/insights/briefs-reports/amber-ground-ambulance-dataset-reflects-complexity-and-challenges-of-the-industry-highlights-the-need-to-improve-and-continue-cost-data-collection/.

III. Initial Considerations for Evaluating GADCS Rounds 1 and 2 Data

The AAA is pleased that CMS has provided a summary of the data collected during the first phase of the GADCS. It comes as no surprise that the report demonstrates that ground ambulance Medicare payments are substantially lower than the cost of providing ground ambulance services. We also recognize that the data collection effort was less than perfect, which is to be expected from the first round of any new data collection systems. The Congress has originally mandated a four-year process that would have allowed CMS and stakeholders to address problems that would have been identified in the early years. Unfortunately, yet somewhat understandably, CMS truncated the four years into two in order to suspend data collection during the years of the COVID-19 pandemic.

The data obtained during the first round illuminate some critically important points about ground ambulance services, including:

- The ground ambulance service organizations are significantly more diverse in terms of size and organizational structure than many other types of health care providers and suppliers. This variation is not only driven by the organization providing the services, but also by the state and local governments contracting with these organizations to provide emergency services, such as 9-1-1 or equivalent responses. The locations where the services are provider also impact the type of organization providing them.

- The diversity of ground ambulance organization size has a meaningful impact on the cost of the services provided. With 75 percent of ground ambulance services providing 800 or fewer transports each year (which translates into roughly 2 claims a day),[17] more traditional policy practices, such as excluding smaller providers would be inappropriate to apply in this situation. It is critically important to ensure the integrity and accuracy of the data that all types, sizes, and locations of ground ambulance service organizations submit data and that these data are taken into account when assessing payment amounts and considering payment reform options.

- Labor costs are particularly challenging. Sixty-one percent of non-profit organizations rely on volunteer labor,[18] but it would be inappropriate to zero out or otherwise reduce the cost of labor because of this unique, often community-driven organizational type. Similarly, while nearly 70% of total ground ambulance costs are

[17]CMS. "Ground ambulance industry Trends, 2017-2022" (April 2024); all other data come from CMS. "Medicare Ground Ambulance Data Collection System (GADCS) Report: Year 1 and Year 2 Cohort Analysis (Dec. 2024).
[18]*Id.*

for labor, it is somewhat unique that more than 90 percent of those costs relate to direct patient-care personnel costs.[19]

- Medicare comprises a substantially higher percentage of overall revenue (42 percent) than it is for most other providers.[20] For example, Medicare comprises only 19 percent of the average hospital's payer mix.[21] Yet, for those hospitals that serve a large number of low-income patients, including those on Medicaid and the uninsured, the Congress has provided a policy-based adjustment to recognize that such a significant percentage of federal payers requires additional consideration in the rate setting process.
- While margins cannot be easily calculated from the GADCS data, the percent difference between the mean costs and revenues for ground ambulance services are directionally and significantly negative, based on the data aggregated in Tables 6.1 and 6.2 summarizing the unadjusted costs and unadjusted revenue per service.[22]

The data also highlight some areas that might benefit from additional analyses particularly related to better understanding the differences in costs among shared-services entities and non-shared-savings entities. HMA has also begun work on stratifying the costs across the different payment categories, which we plan on sharing with MedPAC in the coming weeks.

IV. The AAA strongly supports continued data collection for ground ambulance services.

The AAA strongly supports ongoing data collection related to the costs and revenues for ground ambulance services, particularly in relation to Medicare and Medicaid. The ground ambulance providers/supplies have lived through the problems that a lack of data have created during the last 30 years. While we appreciate the concerns some Commissioners' expressed about the cost of submitting data, it is important that we do not repeat the mistakes of the past. Without data about the cost of ground ambulance services that reflects the unique aspects of all types, sizes, and geographic locations of these providers/suppliers, it will be impossible for the Congress and other federal policy-makers and advisors to accurately assess the impact of payment and quality improvement policies.

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[19] *Id.*

[20] One exception to this statement are the End Stage Renal Disease (ESRD) facilities, which has more than 75 percent of patients being Medicare beneficiaries. US Renal Data System (USRDS). "Healthcare Expenditures for Persons with ESRD." (2025). Available at: https://usrds-adr.niddk.nih.gov/2024/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd#:~:text=Non%2DMedicare-,A%20larger%20percentage%20of%20point%20prevalent%20patients%20with%20ESRD%20was,kidney%20transplant%20recipients%20(17.3%25).

[21] Definitive Healthcare. "Breaking down U.S. hospital payor mixes" (2024). Available at: https://www.definitivehc.com/resources/healthcare-insights/breaking-down-us-hospital-payor-mixes#:~:text=What%20is%20the%20payor%20mix,Medicaid:%209.3%25

[22] *Supra* note 1.

The AAA continues to support a balanced approach that the Senate initially recommended and that ultimately became the underpinning for GADCS. Specifically, we ask that MedPAC recommend that data on ground ambulance services be collected annually; but instead of implementing a cost reporting system (such as that is used by other provider groups and that is based in antiquated payment system policies), the GADCS should be designed as follows:

- It should be a statistically representative sample of one quarter of all ground ambulance services so that any single ambulance services reports only once every four years.
- A statistically representative sample means that each year, a group of ground ambulance service providers/suppliers are selected to represent the various types of ground ambulance organizational types, sizes, and locations. The sample should be statistically sound to support data-driven decision-making based on analyses of the data.
- The 10 percent penalty for not reporting is appropriate to incentivize data collection.
- Ideally, ground ambulance services that demonstrate excessive hardship or financial constraints in being able to meet the requirements, should be able to access grant funding to support their efforts to be able to provide the data. This could be similar to the HITECH Act grants Congress established for hospitals to come into compliance with electronic health record mandates.
- All data that are reported should be publicly available without disclosing specific ground ambulance service organizations. CMS could follow the models it uses for other provider cost report data files that are publicly released annually.
- The program should include an educational component to support ground ambulance services that may need additional support for reporting.

We appreciate that concern that about 700 (or 14 percent) of selected ground ambulance organizations opted out of the first phase of GADCS reporting, an 86 percent response rate is exceptionally good. While there are many reasons this could have happened (and we do not know of any systematic effort to determine the exact reasons why some organization chose not to report data), the AAA believes based on our extensive nationwide educational programs that the novelty of the new system presented challenges that would be address if a permanent data collection system were put in place. Moreover, any concerns about cost or compliance challenges could be address through the grant funds and education programs we recommend be added to the collection system.

These recommendations align with those included in a March 2025 white paper produced by Health Management Associates (HMA) based on its analysis of the GADCS data and the Amber data set.[23]

> Based on our assessment of the Amber dataset and its 2022 financial data, we offer several recommendations to policymakers and stakeholders. These recommendations are intended to improve future cost collection efforts that may inform payment reforms to enhance the payment accuracy of the Medicare FFS payment system for ground ambulance services.
>
> - Provide additional educational support to respondents to improve consistency of data reporting
> - Streamline and modify data collection devices to adhere to industry trends and challenges
> - Develop a standardized method for assigning ground ambulance entities to geographic service area for research purposes
> - Collect data on ground ambulance uncompensated care and bad debt
> - Collect payer level data for cases involving treatment without transport
> - Collect targeted data on top 10 medications by cost to accurately reflect costs in payment rates
> - CMS should consider collecting ground ambulance cost data on a semi-regular basis
> - CMS should consider phasing in the use of GADCS data to ensure that the data reflect the diversity of ambulance entities and consistent reporting of key financial variable.[24]

While we strongly support the continuation of the GADCS, we recognize that there are several improvements that could be made to the system. These include providing clarity in three areas:

- General allocation methods for shared service models. Having additional structure here would reduce potential inconsistent interpretations by these organizations and make data more consistent and usable.

- Dispatch costs, particularly related to areas that rely on county dispatch centers which provide services to multiple agencies, municipalities, and agency types. It would help to provide more specificity as to how they should allocate costs.

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[23]The Amber data set is a data collection device similar to GADCS and developed by the American Ambulance Association. An overview of Amber is available at the AAA's website. American Ambulance Association. Ambulance Cost Collection. (2023). Available at: https://ambulance.org/advocacy/cost-reporting/.
[24]*Supra* note 16.

Given that there is no monetary exchange, many organizations found it difficult to identify data for this category.

- The dual role requirement for submitting data. Some organizations truly have only one person on staff. The amount of effort it took for one person to hold dual roles in the portal was arduous for many.

In addition to these initial thoughts, the AAA is in the process of surveying our members and others in the ground ambulance community to identify ways that data could be streamlined and specific modifications to the data elements to improve the data collection and ease the burden on providers/suppliers. We will provide our findings and recommendations to the Commission as soon as this process is finished, which we expect to be this fall.

Thank you for reviewing this letter. If you have any questions, please do not hesitate to reach out to Tristan North, AAA Vice President of Government Affairs at 202-486-4888 or tnorth@ambulance.org or Kathy Lester, our counsel in Washington, at 202-534-1773 or klester@lesterhealthlaw.com.

Sincerely,

Jamie Pafford-Gresham
President
American Ambulance Association

Appendix A: Medicare Benefits Policy Manual § 30.1.1
Definition of ALS Services

Advanced Life Support Intervention

Definition: An ALS intervention is a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic.

Application: An ALS intervention must be medically necessary to qualify as an intervention for payment for an ALS level of service. An ALS intervention applies only to ground transports.

Advanced Life Support, Level 1 (ALS1) - Emergency

Definition: When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response, as defined below.

Advanced Life Support, Level 2 (ALS2)

Definition: Advanced life support, level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three **separate administrations** of one or more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

a. Manual defibrillation/cardioversion;
b. Endotracheal intubation;
c. Central venous line;
d. Cardiac pacing;
e. Chest decompression;
f. Surgical airway; or
g. Intraosseous line.

Application: Crystalloid fluids include but are not necessarily limited to 5 percent Dextrose in water (often referred to as D5W), Saline and Lactated Ringer's. To qualify for the ALS2 level of payment, medications must be administered intravenously. Medications that are administered by other means, for example: intramuscularly, subcutaneously, orally, sublingually, or nebulized do not support payment at the ALS2 level rate.

The IV medications are administered in standard doses as directed by local protocol or online medical direction. It is not appropriate to administer a medication in divided doses in order to meet the ALS2 level of payment. For example, if the local protocol for the treatment of supraventricular tachycardia (SVT) calls for a 6 mg dose of adenosine, the administration of three 2 mg doses in order to qualify for the ALS 2 level is not acceptable.

The administration of an intravenous drug by infusion qualifies as one intravenous dose. For example, if a patient is being treated for atrial fibrillation in order to slow the ventricular rate with diltiazem and the patient requires two boluses of the drug followed by an infusion of diltiazem, then the infusion would be counted as the third intravenous administration and the transport would be billed as an ALS 2 level of service.
The fractional administration of a single dose (for this purpose, meaning a "standard" or "protocol" dose) of a medication on three separate occasions does not qualify for ALS2 payment. In other words, the administering 1/3 of a qualifying dose 3 times does not equate to three qualifying doses to support claiming ALS2-level care. For example, administering one-third of a dose of X medication 3 times might = Y (where Y is a standard/protocol drug amount), but the same sequence does not equal 3 times Y. Thus, if 3 administrations of the same drug are required to claim ALS2 level care, each administration must be in accordance with local protocols; the run will not qualify at the ALS2 level on the basis of drug administration if that administration was not according to local protocol. The criterion of multiple administrations of the same drug requires that a suitable quantity of the drug be administered and that there be a suitable amount of time between administrations, and that both are in accordance with standard medical practice guidelines.

An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate is the administration of a single 1 mg dose of IV Epinephrine in partial increments to treat an adult pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) patient. The American Heart Association (AHA), Advanced Cardiac Life Support (ACLS) protocol calls for Epinephrine to be administered in 1 mg increments every 3 to 5 minutes. Therefore, administering IV Epinephrine in separate increments of 0.25 mg, 0.25 mg, and 0.50 mg (for a total of 1 mg) over the course of a single 3 to 5 minute episode would not qualify for the ALS2 level of payment. Conversely, administering three separate 1 mg doses of IV Epinephrine over the requisite protocol-based time period to a patient with unresolvedVF/VT would qualify for an ALS2 level of service. **NOTE:** refer to and abide by your authorized protocols; AHA's ACLS protocols are referenced here only by way of widely recognized example.

Another example that **would not qualify** for the ALS2 payment level is administering Adenosine in three 2 mg increments (for a total of 6 mg) in treating an adult patient with

Paroxysmal Supraventricular Tachycardia (PSVT). ACLS guidelines dictate treating PSVT with 6 mg of Adenosine by rapid intravenous push (IVP) over 1 to 2 seconds. Should the initial 6 mg dose not eliminate the PSVT within 1 to 2 minutes, guidelines dictate that another 12 mg of Adenosine IVP should be administered where the PSVT persists, followed by another 12 mg dose 1 to 2 minutes later; for a total of 30 mg of Adenosine. Administering a total of 30 mg of Adenosine, involving three episodes of administration in a complete cycle of treatment as outlined above, **would** qualify for ALS2 payment.

Endotracheal (ET) intubation (which includes intubating and/or monitoring/maintaining an ET tube inserted prior to transport) is a service that qualifies for the ALS2 level of payment. Therefore, it is not necessary to consider medications administered by ET tube to determine whether the ALS2 rate is payable.