

March 26, 2026

Michael E. Chernew, PhD.
Chairman
Medicare Payment Advisory Commission
425 Eye Street, NW, Suite 701
Washington, DC 20001

Paul B. Masi, M.P.P.
Executive Director
Medicare Payment Advisory Commission
425 Eye Street, NW, Suite 701
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Dear Dr. Chernew and Executive Director Masi:

On behalf of the American Ambulance Association (AAA), I want to thank you, the Commissioners, and the staff for the thoughtful presentation and discussion of ground ambulance services 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.

Member 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 health care 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 which 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:

- The AAA strongly supports the chair's recommendation for the ongoing collection of ground ambulance cost, revenue, and demographic data and offers suggestions about the frequency of such reporting and modifications to the variables collected to balance the need for data with the burden of providing it.

- MedPAC's analysis aligns with the GADCS and HMA analyses which found that the average reimbursement rate per transport is lower than the average cost. HMA's analysis specifies that Medicare fee-for-service rates are not adequate to cover the cost of providing ground ambulance services.
 - To further avoid patient access problems,¹ the data support not only long-term payment system reform, but also immediate increases in the Medicare payment rates.
 - We also ask that the Chapter caveat the revenue-to-cost ratios because they rely in part on the geographic designation by ground ambulance organizations and that the analysis relies on all revenue which could skew the results.
 - We encourage the Commission to caveat its geographic categorizations of urban, rural, and super-rural as entity-level designations, rather than transport-level (point-of-pick-up) designations. Payment is based on the patient's location and not the entity location or the categorization distinctions you include. Therefore, the revenue-to-cost ratio findings presented for the three geographic categories actually include transports across a mix of urban, rural, and super-rural transports. Therefore, as HMA highlighted in its recent work, organizational level geographic designation fails to capture accurately the cost of providing services to patients located in these geographic areas.
 - These constructed designations of urban, rural, and super-rural ground applied to ambulance organizations should not be assumed to align with traditional Medicare payment system classifications of rural providers because those are based on the physical location of the provider rather than the location of the patient at the point of pick-up. The purpose of current permanent rural adjuster, which based on the distance an organization must travel (defined as the first 17 miles), differs from the purpose of other provider rural adjusters. It is not a proxy for volume. Thus, we urge the Commission not to reiterate the 2013 recommendation that would replace this mileage adjuster with a low-volume adjuster for the current geographic adjusters. While a low-volume adjuster may be appropriate, it is not necessarily appropriate to eliminate the rural mileage adjuster and replace it with a low-volume adjuster.

¹As described in Section II of this letter, we encourage MedPAC to refine how it assesses patient access in reference to ground ambulance services which involve the mobile delivery of health care services and creates different criteria related to evaluating patient access.

- Finally, we encourage the Commission to support greater data transparency by stating in the chapter that CMS should release the GADCS raw survey data in the same way it releases cost report files for other Medicare providers and suppliers. Further, CMS could consider releasing these data in a de-identified manner.

In addition, the AAA is working internally, as well as with other stakeholders, to develop data-driven recommendations for comprehensive payment system reform. While we recognize that such policies are outside the scope of the Commission's Congressional charge, we encourage the Commission to articulate in its report that the GADCS data identify significant challenges in the payment system that warrant a more comprehensive review of current policies to ensure adequate reimbursement, restore patient access, and promote the delivery of high-quality care. As the staff noted in its presentation in December, the system is outdated and stagnant. It needs to be reformed.

I. The AAA strongly supports the ongoing collection of ground ambulance data and initial suggestions as to how the data elements could be streamlined to balance the need for data with the burden of providing it.

As the AAA has noted in previous communications to the Commission, our members strongly support the ongoing collection of ground ambulance data. Our members are representative of many types of ground ambulance service organizations. They are large, medium, and small; provide services to patients located in urban, rural, and super-rural areas; and represent the various organizational models that deliver ground ambulance services. The AAA and its members, as well as other community stakeholders, view the goal of such data collection as two-fold. First, the ongoing data collection would support a data-driven approach to modernizing the ground ambulance fee schedule (AFS). Additionally, Medicare Advantage plans enroll more than 50 percent of Medicare beneficiaries, and their rates are linked to the AFS. Second, the ongoing data collection would permit the ongoing evaluation of the adequacy of payment rates over time and support their periodic adjustment.

As described in our June 22, 2025, letter to the Chairman, we also agree with suggestions voiced by Commissioners that the fielding approach and data collection instrument could be modified to better balance the benefit and the burden on ground ambulance service organizations. We were pleased to hear Commissioners and the Chair recognize that annual data collection from every ground ambulance service organization is not necessary to achieve the desired goal. We reiterate our recommendation that the system be designed to collect a statistically representative sample of one quarter of all ground ambulance services so that any single ambulance service reports only once every four years. A statistically representative sample means that each year, a group of ground ambulance service providers/suppliers would be selected to represent the various types of ground ambulance organizational types, sizes, and locations. The sample would be statistically sound to support data-driven decision-making based on analyses of the data.

All data 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.

To reduce the burden on smaller suppliers and providers, the program should include an educational component to support ground ambulance services organizations that may need additional support for reporting. 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. Given that the vast majority of ground ambulance service organizations bill fewer than 3 claims each day, it is imperative that the data collection system ensure that their costs are incorporated into any analysis.

In terms of modifying the data collection instrument, we agree that the cost data do not need to be Medicare-specific; however, the revenue data do need to be stratified by payer type. We also agree that the data elements could be streamlined. However, some cost centers should remain detailed, especially to support payment reform efforts. For example, while we appreciate comments that the labor subcategories may not be necessary for a general MedPAC analysis at the aggregate level, they are very useful in assessing the different costs related to valuing the different service levels given that labor costs are the most significant cost input.² Further this information will become helpful to CMS in the future as the sources of labor costs change with the marketplace. For example, it is critical to maintain the collection of volunteer labor to allow these costs to be imputed into any analysis. Additional data elements are necessary to allow for such costs to be taken into account.

We support the collection of additional data elements outlined in the HMA June 2025 report. This includes the collection of information related to services provided when patients are not transported, . Maintaining the collection of data related to MA plan enrollees and rates paid by MA plans for these services is also important, given the significant percentage of beneficiaries enrolled in MA plans. Even though we support adding some new data elements, we agree with the Commissioners who noted the need for streamlining the current data collection instrument. We ask MedPAC to consider highlighting areas where less detail may be necessary and other areas where additional information would be useful for CMS. Specifically, the AAA recommends that the following variables by payer-level costs be added to the GADCS instrument:

- Uncompensated care and bad debt
- Services provided without transporting the patient

²According to the GADCS data, labor costs comprise 87.1 percent of total ground ambulance service costs. Clinical labor costs are 80.3 percent of those labor costs.

- More targeted data on medication supply costs categories by drugs, medical devices, and communications technology

We also support the collection of data that enable more accurate assessment of costs for urban, rural, and super-rural data. Ideally, data collected from ambulance entities will permit policymakers, including the Commission, to better assess payment adequacy based on patient-location, rather than ambulance entity location. This would better align with how mobile health care is delivered. This approach is preferable to one that tries to create a more standardized method for assigning individual ambulance entities to one of the three geographic service areas.

We encourage the Commission to call on CMS to work with stakeholders to undertake the revisions to the instrument. but leave the details to further stakeholder engagement with CMS. This approach would allow for flexibility to consider technological solutions that may evolve over time as well.

In sum, we appreciate the Chair’s draft recommendation and agree that data will help drive more accurate payments. While data elements can be streamlined, it is important to maintain data elements not only to support reform, but also to understand access and quality.

II. The GADCS data show that Medicare rates are not adequate to cover the cost of providing ground ambulance services; to further avoid patient access issues, the data support not only long-term data reform, but also immediate increases in the Medicare payment rates.

The AAA recognizes that the publicly available data released from the GADCS cannot be used to calculate Medicare margins without using additional claims and other data in such an analysis. Even with this limitation, which can and should be addressed as described below, the cost of providing ground ambulance services exceeds the current Medicare rates. As Slide 13 in the March MedPAC presentation shows, the costs per transport are significantly higher than current Medicare rates. The table shows the costs for the lowest quartile of transports being \$2,852 per transport and the highest quintile as \$914 per transport. These amounts are substantially higher than all but the SCT rates in the 2025 Ambulance Fee schedule.

Payment Category	RVU	CF	Total
BLS-NE	1	\$278.98	\$278.98
BLS-E	1.6	\$278.98	\$446.37
ALS-NE	1.2	\$278.98	\$334.78
ALS-E 1	1.9	\$278.98	\$530.06
ALS-E 2	2.75	\$278.98	\$767.20
SCT	3.25	\$278.98	\$906.69
PI	1.75	\$278.98	\$488.22

The costs continue to exceed Medicare rates for the most part even when the data are stratified by the type of ownership and the service-area location on Slide 14 of the March presentation (reproduced below). It is important to note that many governmental entities do not provide the interfacility transports that are essential to managing patient care when patients require health-related services as part of their transport between facilities. While these may be BLS or ALS services, the fact that some types of organizations provide them while others do not provide important context for the differences in the cost per transport by ownership as well.

Characteristic	Ambulance transports per organization	Cost per transport
Ownership		
For profit	10,838	\$575
Nonprofit	3,500	849
Government	3,400	1,675
Service-area location		
Urban	7,402	1,046
Rural	2,448	1,021
Super rural	959	1,293

Note: GADCS (Ground Ambulance Data Collection System).
Source: MedPAC analysis of data from Ground Ambulance Data Collection System.

MedPAC’s revenue-to-cost analyses show a similar trend when using the entire dataset, but we acknowledge that the for-profit ownership type and the trimmed, weighted ratios suggest some type of margin for certain types of ground ambulance organizations as noted on Slides 20 and 21 of the March presentation. However, we caution against assuming these ratios indicate that Medicare payments are adequate or that the AFS does not require significant revisions/reform.

We encourage the Commission provide important context for its readers when presenting these ratios in the chapter. First, we hope MedPAC will highlight that the ratios include all payer types, not only Medicare. Based on what we have assessed of our own data, we believe Medicare-specific ratios would be lower. It would also be helpful to isolate the Medicare revenue to understand the stability specifically of the AFS. HMA’s analysis of the Amber data (discussed below) offers what a Medicare-specific analysis might reveal. In addition, we would ask that you include the caveat in your chapter that the revenues used for this analysis include Medicare’s statutory geographic add-ons which are intended to enhance revenues for the rural category of entities. This in part explains why the urban and rural ratios are similar. As MedPAC has noted previously, governmental organization also have several revenue streams that maybe underreported in the GADCS data. Moreover, these revenue streams provided higher overall levels of funding that may allow for greater spending, such as more expensive equipment, increased utilization of workers with higher salaries and benefits, and other similar costs that organizations with smaller revenues simply cannot afford to purchase. Thus, when comparing the ratios, one factor as to why governmental entities may have higher costs is because they spend at a higher level than those organizations that have lower revenue streams and work within more limited

budgets. It is also true that some organizations rely primarily on ALS level services. These entities may contract out their BLS services to other organizations, while some may provide ALS services regardless of the situation. Doing so can lead to higher costs, as well as higher revenues. It will be important to try to tease out what are true higher costs and what constitutes the efficient provider when evaluating the payment system. Finally, the use of artificially constructed geographic designations at the organizational level - rather than at the claims level as these adjusters are designed and implemented - make it difficult to tease out a firm conclusion about what those ratios represent.

While MedPAC's analysis focuses on the revenue-to-cost ratios, HMA undertook the additional analysis necessary to estimate overall margins for 2022. HMA found that the median Traditional Medicare margin was a **negative 6.3 percent**. The 2022 Median Traditional Medicare margins were lower for ground ambulance organizations serving a higher proportion of rural patients (**negative 12.7 percent**) and those serving a higher proportion of super rural patients (**negative 19.5 percent**). HMA also found that ground ambulance entities with fewer than 600 total transports per year had median Traditional Medicare margins of **negative 16 percent**. Directionally, these findings are consistent with our expectations. Further, we want to highlight for you that Medicare margins appear to have declined since GAO's 2010 assessment.

The analysis presented to the Commission in March is directionally similar to the HMA analysis, but as noted some of the difference may rest in the fact that MedPAC relies on all payer data while HMA compared the Medicare margins to an all-payer margin. We encourage MedPAC to consider the methodology HMA used with the larger data GADCS data set to evaluate Medicare-specific margins in contrast to an all-payer revenue to cost method. While we agree that the costs may not vary across payer type, the actual rates payers use does vary. The HMA analysis demonstrates this by finding a 6-percentage point difference between the -6.3% Medicare margin and the -0.3% all-payer margin.

We strongly assert that Medicare margins below zero are not sustainable for our industry. We were surprised by the suggestion that there are not patient access issues related to ground ambulance services. Several studies and recent media reports support the opposite conclusion. While considering NPI numbers to identify organizations that have closed is one data input that can help assess patient access, other factors should be taken into account given the unique mobile nature inherent in ground ambulance services. For example, time is a critical factor in determining patient outcomes. When patients do not have access to ground ambulance services, especially emergency services, within a 25-minute radius, it should not be assumed that they have adequate access to such services. Similarly, when patients lack 365-24-7 access to ground ambulance services, they do not have adequate access to these services. We encourage the Commission to re-evaluate the conclusion that there is no access issues related to ground ambulance services before it publishes this finding in its report.

In defining beneficiary access to ground ambulance services, we ask the Commission to consider the Rural Health Research Gateway analysis, which has identified “ambulance deserts” in every State in America.³ A ground ambulance desert is defined as a populated area where residents live more than 25 minutes away from the nearest ambulance station. These areas indicate significant geographic disparities in emergency medical services (EMS), where ambulance coverage is sparse or nonexistent, leading to longer response times and increased risks for patients. According to the report, 4.5 million people lived in an ambulance desert (AD); 2.3 million (52 percent) of them in rural counties. Four out of five counties (82 percent) had at least one AD in 2021-22. 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).⁴ As these findings demonstrate, access to ground ambulance services is at-risk with many Americans already having lost access to them. We encourage MedPAC to expand its definition of patient access to account for the unique nature of patient access needs when it comes to ground ambulance services.

While the AAA remains committed to long-term reform, immediate action is needed to bridge the gap between the current unsustainable Medicare rates and the time it will take to implement more comprehensive reform. Considering the Commission’s charge to assess the adequacy of Medicare rates, we encourage MedPAC to recommend that Congress consider bridge funding to address the gaps between costs and revenues to restore beneficiary access to 24-7 ground ambulance services with a medically appropriate response time.

III. Do not replace the current Medicare geographic adjusters with a low volume adjustment based on the location and volume of the provider. We prefer adjusters based on the location of the patient.

Even though Congress did not ask MedPAC for recommendations on comprehensive reform policies for the ambulance fee schedule, the Commission may be considering reiterating a previous recommendation to replace the rural adjuster with an isolated, low-volume adjuster. We strongly encourage the Commission not to repeat this recommendation because the premise on which it is based is not true for ground ambulance services.

An isolated, low-volume adjuster is generally based on the idea that entities with fewer claims have higher per-claim fixed costs because there are simply fewer claims over which to spread these costs. When these providers are isolated, their loss to a community would create patient access problems. Generally speaking, these adjusters are more

³Yvonne 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).

⁴*Id.*

targeted than geographic adjusters because they can pinpoint more precisely those providers with higher fixed costs and that are essential to their communities.

While there could be a place for an isolated, low-volume adjuster in the ground ambulance fee schedule, it is not a replacement for the permanent 0-17 mile rural adjuster. The application of the rural adjuster (and the rural and super-rural add-ons) is based on the patient's location, not the location of the facility. This adjuster was not designed to address the fixed costs of rural providers; rather it was created to address the longer distances these services must travel to patients. Moreover, ground ambulance service organizations located in urban areas often respond to patients located in rural or super-rural areas as well. This situation has become more prevalent with the increase of ambulance deserts. The primary costs being offset by the geographic adjusters relate to the added cost of traveling to the patient, which includes fuel costs, vehicle costs, greater number of unloaded miles, and additional labor costs (as well as the opportunity cost of not being able to use that ambulance or crew for other patients during the longer transportation periods). An isolated, low-volume adjuster would not capture such costs, but the permanent rural adjuster (as well as the rural and super-rural add-ons) for ground ambulance services seek to achieve that goal. The geographic adjusters provide the appropriate incentives for ground ambulance services to respond to patients in rural (and super-rural) areas. The ground ambulance geographic adjusters are not the same as the rural adjusters used in other provider payment systems. Thus, the AAA believes that it would not be appropriate to replace the rural adjuster (or the current rural and super-rural add-ons) with an isolated, low-volume adjuster. We urge the Commission to pause and review the appropriateness of a low-volume adjuster more thoroughly before reiterating its previous recommendation.

IV. The need for greater transparency supports releasing de-identified raw GADCS data.

In addition, we encourage the Commission to support greater data transparency by call on CMS to release the GADCS raw data in the same way it releases cost report files for other Medicare providers and suppliers. Having such data would allow for a more meaningful dialogue especially given the unique nature of mobile health care and structure of the AFS.

V. Conclusion

In addition to these initial thoughts, the AAA is in the process of developing comprehensive reform recommendations in coordination with other stakeholders to identify ways the payment system could better address the cost of providing services and protect beneficiary access. We would welcome the opportunity to share our work with the Commission as well.

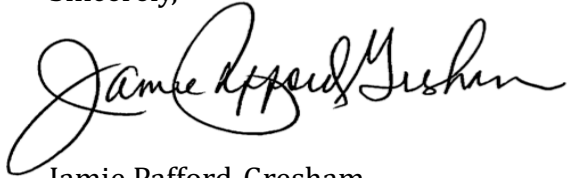
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Thank you for reviewing this letter. If you have any questions, please do not hesitate to reach out to Tristan North, AAA Senior Vice President of Government Affairs at 202-486-4888 or tnorth@ambulance.org or Kathy Lester, our counsel in Washington,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

Sincerely,

A handwritten signature in black ink that reads "Jamie Pafford-Gresham". The signature is written in a cursive style with a large, looping initial "J".

Jamie Pafford-Gresham

President

American Ambulance Association