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PWW | AG

Re: MedPAC Mandated Report – Assessment of the Medicare Ground Ambulance Data Collection System (April 2026)

Dear Commissioners:

We appreciate the opportunity to provide comments regarding the Medicare Payment Advisory Commission’s (MedPAC) ongoing analysis of the Ground Ambulance Data Collection System (GADCS) and the adequacy of the Medicare Ambulance Fee Schedule (AFS). These comments are being submitted jointly by the [Academy of International Mobile Healthcare Integration](#) (AIMHI), an association of high-performance EMS systems for over 16.3 million people and responding to more than 1.1 million EMS responses annually.

We commend MedPAC and its staff for undertaking the first comprehensive national evaluation of ambulance cost and revenue data. The development of GADCS represents an important milestone in understanding the economic realities of ambulance service delivery. At the same time, we respectfully offer the following concerns and recommendations to ensure that the Commission’s conclusions and policy recommendations accurately reflect the operational and financial realities of EMS systems across the United States.

Findings That Rural Costs Are Lower Than Urban Costs

We are concerned with MedPAC’s conclusion that rural ambulance organizations have lower costs per transport after controlling for other factors.

While regression analysis may isolate certain variables, this conclusion does not fully reflect the structural realities of rural EMS delivery.

Rural ambulance systems are characterized by:

- Low call volumes and limited economies of scale
- Significant fixed readiness costs (24/7 staffing and coverage of large geographic areas)
- Extended response and transport times
- Limited workforce availability and higher per-unit labor burden

These factors result in higher costs per unit of readiness, even if cost per transport appears lower in a statistical model. As MedPAC correctly notes elsewhere, transport volume is a primary driver of cost variation, with lower-volume agencies experiencing higher per-transport costs.

We are concerned that presenting rural services as “lower cost” risks creating policy conclusions that could undermine essential rural access by failing to account for standby capacity and readiness—core components of EMS that are not adequately captured in transport-based metrics.

Exclusion of Governmental Providers from “Trimmed” Analysis

We are particularly concerned that MedPAC’s “trimmed” dataset, used to evaluate revenue-to-cost ratios, excludes governmental ambulance providers, which MedPAC’s own analysis shows have the highest costs per transport.

Further, according to Table 1.2 of the GADCS Report Appendix (Year 1–Year 4 Cohort Analysis Data Reported Through May 15, 2025; December 2025 GADCS data report), more than half of the cost data submissions were from governmental agencies.

As noted in the Commission’s discussion, governmental agencies:

- Frequently operate 911 emergency response systems
- Maintain continuous readiness regardless of call volume
- Provide unfunded public health and safety services
- Rely on local tax subsidies to sustain operations

Excluding these providers from key analyses risks producing systematically biased conclusions about payment adequacy. Since governmental EMS agencies represent over 50% of GADCS respondents, their exclusion:

- Understates the true cost of providing 911 ambulance services
- Skews comparisons toward lower-cost, transport-focused models
- Limits the applicability of findings to real-world EMS system design

We strongly encourage MedPAC to include governmental providers in all primary analyses of payment adequacy.

Table 1.2. Summary of Unweighted and Weighted Samples

	All Sampled NPIs		NPIs That Completed the GADCS			
	Unweighted		Unweighted		Weighted	
	n	%	n	%	n	%
Total	10,581	100.0	7,387	100.0	9,608 ^a	100.0
Provider vs. supplier						
Supplier	9,978	94.3	6,982	94.5	9,094	94.7
Provider	603	5.7	405	5.5	514	5.3
Ownership type						
For-profit or unclassifiable	2,327	22.0	1,274	17.2*	1,869	19.5*
Government	5,298	50.1	4,177	56.5*	5,126	53.4*

Limitations of Revenue-to-Cost Comparisons

We recognize that MedPAC has stated that evaluating payment adequacy using GADCS data presents challenges, particularly due to the absence of data on revenue sources unrelated to ambulance billing, such as local tax subsidies.

It is our understanding that GADCS intentionally did not collect subsidy revenue, as one of its primary objectives was to assess the adequacy of fee-for-service reimbursement relative to service delivery costs. Additionally, local subsidy levels vary widely based on community service expectations, which could introduce inconsistencies in revenue reporting.

These limitations are particularly important when interpreting findings suggesting that revenues exceed costs in certain segments. As MedPAC notes, revenue-to-cost ratios vary significantly by ownership type, with governmental providers showing lower ratios than for-profit and nonprofit entities.

We support the exclusion of subsidy revenue from GADCS and believe that payment adequacy should be evaluated based on fee-for-service revenue—not on the level of local subsidies required to sustain operations when reimbursement is insufficient.

Concern Regarding Shifting Payment Adjustments from Rurality to Low-Volume Metrics

We are concerned about the potential policy direction implied in MedPAC’s analysis suggesting that payment adjustments could be more effectively targeted based on transport volume rather than geographic rurality.

While we acknowledge that call volume is a meaningful driver of cost variation, we caution against replacing or diminishing rural-based adjustments in favor of a solely volume-driven reimbursement framework.

Rurality is not simply a proxy for low volume; it reflects a broader set of structural challenges that directly impact the cost and sustainability of ambulance service delivery, including:

- Large geographic coverage areas and extended response times
- Limited availability of mutual aid and system redundancy
- Workforce recruitment and retention challenges
- Increased reliance on cross-trained or multi-role personnel
- Higher readiness costs relative to demand

A payment model that prioritizes volume alone risks creating unintended consequences, including:

- Underfunding rural and frontier EMS systems that must maintain constant readiness despite unpredictable demand
- Disincentivizing service availability in sparsely populated areas
- Failing to recognize the public safety role of EMS, which requires capacity independent of utilization

Additionally, not all low-volume systems are rural, and not all rural systems are accurately captured through transport-based metrics. A purely volume-based adjustment risks misclassifying agencies and misaligning reimbursement with actual service obligations.

We strongly encourage MedPAC to maintain rurality as a core component of payment policy while exploring complementary refinements that account for low-volume challenges. Specifically, we recommend:

- Preserving existing rural and super-rural payment adjustments
- Incorporating low-volume considerations as a supplemental—not replacement—adjustment
- Ensuring any revised framework explicitly accounts for readiness costs and geographic isolation

A balanced approach that recognizes both where services are delivered (rurality) and how often they are utilized (volume) will better reflect the true cost structure of EMS and protect access to care in vulnerable communities.

Strong Support for Medicare Reimbursement of Treatment in Place (TIP)

We strongly support MedPAC Commissioner Dr. Brian Miller’s statement that Medicare should reimburse ambulance providers for Treatment in Place (TIP) services.

The current Medicare payment structure requires transport to qualify for reimbursement, which:

- Incentivizes transport to emergency departments to receive payment
- Limits patient-centered care options
- Forces EMS agencies to provide clinically appropriate care without compensation

TIP services are:

- Clinically appropriate for many low-acuity patients
- Aligned with broader healthcare goals of reducing avoidable utilization
- Consistent with value-based care principles

As Dr. Miller noted, providers should not be expected to deliver medically necessary care without reimbursement.

We respectfully urge MedPAC to include in its final recommendations:

- Recognition of TIP as a reimbursable Medicare service
- Development of a payment framework that supports non-transport care
- Consideration of TIP as a mechanism to improve system efficiency and patient outcomes

Recommendation for a More Nuanced Payment Framework

We agree with comments from several Commissioners regarding the diversity of ambulance service models, including:

- Urban 911 fire-based systems
- Private non-emergency transport providers
- Rural “all-risk” providers serving multiple roles

A single, transport-based payment system may not adequately account for these fundamentally different operational models. As such, we encourage MedPAC to explore:

- Payment structures that recognize readiness and standby capacity
- Adjustments for low-volume and high-readiness systems
- Differentiated approaches based on service type and community need

Conclusion

We support MedPAC’s efforts to improve data-driven policymaking. However, we urge the Commission to ensure that its analysis:

- Fully accounts for the role of governmental providers
- Reflects the realities of rural and low-volume EMS systems
- Recognizes the limitations of early-stage data
- Advances modernization of Medicare reimbursement, including Treatment in Place

We appreciate your consideration of these comments and look forward to continued collaboration to ensure sustainable, patient-centered ambulance services for Medicare beneficiaries.

Respectfully submitted,



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