LIFEFLIGHT OF MAINE

1 June 2026

Daniel Zabinski, PhD
Principal Analyst
MedPAC

Re: Mandated Report: Assessment of the Medicare Ground Ambulance Data Collection System

Dear Daniel:

We logged on to your presentation to the Commission last month and appreciate your work. We agree with your conclusions and recommendations that data collection should continue and focus on the adequacy of reimbursement balanced with access to care combined with perhaps some simplification of the current data set. As noted, the current data set is not the same as cost reporting.

While MedPAC has not yet weighed in with formal recommendations on the "accuracy and adequacy" of CMS reimbursement under the AFS we are concerned the data and analysis to date are missing critical implications in rural emergency medical care, which if remaining unaddressed significantly increase morbidity and mortality risk in rural communities.

Specifically, we highlight three concerns with the report:

i. We agree the current temporary add-on ambulance payments, now in place for over twenty years are not an effective measure of payment adequacy but are critical to the finances of rural agencies.
ii. We are concerned that the analysis misses critical elements and implications of rural coverage cost of service as the AFS exists within the larger emergency care system, which is challenged throughout the country but crumbling in rural America.
iii. We are concerned that the RAND analysis essentially glossed over A0434 Specialty Care Transport as it is only approximately two percent of ambulance transports volume. The SCT reimbursement code has been a huge problem from the implementation of the AFS. It is one of the three most significant factors in the rapid growth of air medical helicopters driven since the introduction of the AFS.

We, along with our colleagues from Boston MedFlight and Dartmouth Hitchcock (DHART) have previously met with MedPAC to discuss how the AFS led to rapid increase in helicopters and loss of ground critical care ambulance coverage dramatically increasing costs of care.

As background, LifeFlight of Maine is a non-profit charitably supported provider of critical care ground, helicopter, and fixed wing ambulance services in Maine. We are the only air medical provider in Maine serving every community and hospital along with providing mutual aid throughout northern New England. We care for all patient ages and disease types ranging from premature newborns to patients on full cardio-pulmonary bypass. (ECMO)

i. <u>Add on payments.</u>

From the outset of the AFS the actual costs of service versus reimbursement were under recognized leading to the

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add on payments which have been in place for more than two decades with uncertainty for the future. As recognized in your analysis, rurality based on zip code and mileage is a proxy at best for rural costs of service. Volume, as your findings note, is the critical variable and adjustments to the AFS should target low volume in isolated communities. As noted below, however, volume is only part of the equation.

We agree that volume rather than rurality is the single most important variable in costs noting our increasing rurality is tied to lower volumes. Your analysis mirrors work a 2022 legislatively directed EMS Blue Ribbon Commission in Maine. The study used a fully allocated cost model noting a significant portion of fully allocated costs are offset by volunteers and paid on call staffing. Actual ground ambulance total revenue in Maine average $491.99 per call.

Percentile	Volume	Net Income	Ambulances	FTEs	Net Income Per Call	Cost Per Transport
25th	191	$ (653,854.54)	1	9.8	$ (3,423.32)	$ 3,915.31
50th	399	$ (568,300.56)	1	9.8	$ (1,424.31)	$ 1,916.30
75th	1241	$ (805,613.47)	2	18.6	$ (649.16)	$ 1,141.15
Maximum	14795	$ (201,752.76)	9	83.2	$ (13.64)	$ 505.63

Percentile	Volume					Cost per Transport
Lowest	166					$ 2852.00
Q2	795					$ 1970.00
Q3	2600					$ 1485.00
Highest	15,271					$ 914.00

We are not sure your analysis fully recognizes the actual cost versus revenue picture:

- In Maine, consistent with an analysis of the GDAC report by the PWW Advisory group, the revenue to cost ratio is far less than the GDAC findings or your analysis of the GDAC for the lowest volume providers.
- Recognizing the impact of outliers, we are also not sure that 5% trimming either end of the respondent data for low and high provides the most accurate picture as the composition of this 10% of providers is not included in the report.
- It is not clear how the costs for non-transport (19.7%) or treatment without transport (11.4%) of responses are calculated into the revenue to cost per transport.

ii. Rural Coverage

It is also important to note the cost of an individual transport is only a piece of the puzzle. While the cost of rural transport may be partially covered by reimbursement, there is a not gathered or analyzed significant opportunity cost for the next patient in which EMS is not available due to lengthy response, transport times, distance, and turnover/ around. Often there is no actual timely availability of mutual aid for services with limited, often volunteer staffing and a single ambulance.

In addition, multi-hour time out of the community responses are particularly an issue for inter-hospital emergent transfers from critical access and community hospitals to distant major centers. The service

essentially must choose between maintaining 911 response and equally important interhospital transfer. This is a rapidly increasing problem exacerbated by the transition to Rural Emergency Hospitals. The policy disconnect is substantial. One recent REH conversion in Texas has the closest available (not full time staffed) ambulance located 75 miles distant unaligned with the actual transport trajectory. Consequently, the cost of an individual transport is not the same as total system costs to manage the individual patient.

iii. A0434 SCT

In any consolidation of multiple fees into a national schedule there will be relative winners and losers. The AFS "winners" were helicopters and ALS II. The "loser" was ground critical care transport which at any intervention beyond the national scope of a paramedic became "a paramedic with an IV pump." We believe that made a lot of sense as back in the early 1990's we had created a Paramedic Interfacility Transport Program to account for low acuity stable patients being transferred from community to major hospitals for schedule care. Due to the paramedic formulary a stable patient on a nitroglycerin and heparin drip being transferred for scheduled cardiac assessment and potential intervention required the community hospital to send a nurse on the transport affecting both costs as there was no compensation and staffing. The A0434 RVU essentially met this added cost for the EMS agency.

That same reimbursement however did not and even more so today does not represent the cost of ground critical care transport with specialized teams, equipment, medical oversight, and vehicles. Unless significantly subsidized, the AFS evaporated ground critical care, especially in rural areas and led to a more than threefold increase in helicopters replacing ground even for short distance transport at much higher costs. In urban areas, five-mile interhospital helicopter flights are not unusual as there is no reasonable ROI for and consequently no ground critical care.

The GDAC report scarcely mentions and lists ALS2 and SCT as "3% of transports," with a much higher rate for low volume providers consistent with the need to move high acuity patients from critical access hospitals to major centers. But as noted, A0434 reimbursement might be a single paramedic with a stable patient on infusions, and a critically unstable patient on ECMO with a three-four member highly specialized team with hundreds of thousands of dollars of specialized medical equipment.

Recognizing GDAC's is not the same as cost reporting, we strongly believe this is a policy area which needs attention and a more applicable actual critical care reimbursement code or modifier code. We sincerely hope the Commission takes up the next steps of addressing adequacy and accuracy in Medicare reimbursement and digs deeper into these reimbursement policy gaps. As noted earlier, we provide all modes of ground, helicopter, and fixed wing critical care transport and we are more than willing to share specific cost and use data as we have previously shared with the GAO in the constant effort to improve policy. I may be reached via email: tjudge@lifeflight.me or 207 576 3329.

Sincerely,

Thomas Judge
LifeFlight of Maine