

Ground Ambulance Payment Landscape

Challenges and Policy Options

May 2026



EXECUTIVE SUMMARY

Ground ambulance transport is a critical piece of the US healthcare infrastructure and is currently facing several challenges, which may result in the loss of patient access to care. These life-saving services play a vital role in the patient care continuum and significantly impact acute care and long-term recovery. Often, at critical and tense moments before the patient is able to reach hospital care, ground ambulance paramedics and emergency medical technicians (EMTs) are the first point of healthcare contact for the patient. These medical professionals stabilize and treat patients to ensure they begin their care pathway smoothly and recover rapidly.

The ground ambulance industry touches many patient lives each year and serves patients regardless of—and often without—knowledge of the patients' insurance status. The roughly 15,000 ground ambulance organizations in the US provide approximately 41 million transports annually, slightly more than the number of annual hospital inpatient admissions (35 million).¹ This industry serves approximately 15 million Medicare and Medicaid patients per year.

Despite how critical pre-hospital care is to patient recovery, policymakers often overlook ground ambulance services. It is vital that policymakers understand and consider several current and emerging challenges, which will strain the financial condition of ground ambulance organizations in the next decade and may ultimately lead to gaps in access to care for patients. Recent research suggests that ground ambulance organization closures increased between 2019 and 2024, creating ambulance deserts, which are defined as areas where individuals live more than 25 minutes from an ambulance station.

Challenges facing the ground ambulance industry include:

- Inadequate payment for ground ambulance services from Medicare and Medicaid
- Low-volume ambulance organizations have higher costs per transport, augmenting concerns about payment inadequacy
- Unpaid patient cost-sharing liability for patients enrolled in Medicare Advantage (MA) and Commercial insurance plans
- Lack of payment and coverage for ground ambulance responses where medical assessment and care is provided at the patient scene, but the patient is not transported to a medical facility
- Payment that insufficiently captures evolving innovative pharmaceutical products, blood products, and other technologies and supplies
- Commercial insurers' unwillingness to negotiate in-network payment rates with ground ambulance organizations, resulting in higher out-of-pocket costs for patients

The ground ambulance industry will face several emerging challenges in the years ahead, which will build upon the current challenges identified above.

- Changes in payer mix resulting from impending reductions in Medicaid enrollment and individual Marketplace enrollment will lower Medicaid revenues and increase the number of uninsured patients.
- Medicaid revenue reductions are likely to result from changes in state-directed payments, provider taxes, and patient cost sharing originating in the 2025 budget reconciliation act (P.L. 119-21, OBBBA).
- Rural hospital closures will limit the availability of and distance to hospital emergency rooms.
- The aging of the population will increase demand for ground ambulance services.

To address the challenges that the ground ambulance industry is experiencing today and lessen the impact of the various emerging issues, we offer several recommendations for policymakers and stakeholders to consider.

Current Challenge	Policy Consideration
Inadequate payment for ground ambulance services from Medicare and Medicaid	<ol style="list-style-type: none"> 1) Continue to gather financial data from the ground ambulance industry in a streamlined manner to ensure payment systems are updated regularly and payment rates are adequate to maintain access to services. 2) Add variables to the ground ambulance cost collection process related to unpaid patient cost sharing liability, other unpaid payer liability, and response without transport. 3) Establish a nationwide standard for Medicaid ground ambulance payments rates to match or exceed Medicare payment rates.
Low-volume ambulance organizations have higher costs per transport, augmenting concerns about payment adequacy	<ol style="list-style-type: none"> 4) Implement a low-volume add-on payment within the Medicare fee-for-service (FFS) payment system.

Current Challenge	Policy Consideration
<p>Unpaid patient cost sharing liability associated with patients enrolled in Medicare Advantage (MA) and Commercial insurance plans</p>	<ul style="list-style-type: none"> 5) Add ground ambulance services to the list of services that the Centers for Medicare & Medicaid Services (CMS) has established cost sharing caps for under the MA program; 6) Establish federal copayment standards specific to ground ambulance services under MA that are aligned with copayments for emergency department services; 7) Strengthen provider protections for unpaid copayments, such as requiring plans and providers to share the financial risk related to unpaid copayments.
<p>Lack of payment under the Medicare FFS payment system for ground ambulance responses where medical assessment and care is provided on the patient scene, but the patient is not transported to a medical facility</p>	<ul style="list-style-type: none"> 8) Medicare should establish a separate payment to cover the costs of providing ambulance responses without transport.
<p>Insufficient payment for evolving innovative pharmaceutical products, blood products, and other technologies and supplies</p>	<ul style="list-style-type: none"> 9) Medicare payment should more accurately reflect the evolving costs associated with drug, blood, and other supplies and equipment through passthrough or outlier payments.
<p>Commercial insurers' unwillingness to negotiate in-network payment rates with ground ambulance organizations results in higher out-of-pocket costs for patients and lower revenues for ambulance organizations</p>	<ul style="list-style-type: none"> 10) Commercial payers must more accurately capture the cost of service on the community level.

BACKGROUND

Ground Ambulance Services Play an Integral Role in the US Healthcare System

Ambulance Industry Landscape

The ground ambulance industry is disaggregated and diverse, consisting of thousands of suppliers and providers serving millions of patients. Some estimates indicate that the number of organizations providing ground ambulance services to be as high as 15,000.² In 2023, approximately 11,000 organizations billed Medicare, and 14,000 billed Medicaid for the delivery of ground ambulance services.³

Organization Size: The industry reflects a mix of small and large organizations based on transport volume, but skews small. Of the approximately 7,400 ground ambulance organizations responding to the CMS Ground Ambulance Data Collection System (GADCS) survey, collected from 2022 to 2024, 68% had Medicare FFS transport volumes of 800 or fewer per year (37% were 200 or lower), and 32% had transport volumes above 800 transports per year (13% had transport volume of 2,500 or more).⁴ On average, the ambulance industry includes a large number of small businesses and organizations.

Scope and Public Impact: Although existing data do not enable exact counts on the number of patients served annually by the ground ambulance industry across all payers, using Medicare and Medicaid claims data, Health Management Associates (HMA) estimates that approximately 15 million patients with Medicare or Medicaid coverage receive a ground ambulance transport annually (see **Table 1**). In 2022, enrollees in Medicare and Medicaid received 47 million transports. In addition, roughly 37% of the Medicare transports (3.6 million transports) were associated with the 1.2 million low-income patients dually eligible for Medicare and Medicaid.⁵

Table 1. Count of Medicare and Medicaid Ground Ambulance Users, Transports and Transport Rates (2022)

Public Payer	Count of Unique Users of Ground Ambulance Transports (2022)	Count of Total Ground Ambulance Transports (2022)	Ground Ambulance Transports per User
Medicare FFS	4,000,000	11,000,000	2.8
MA	4,300,000	11,000,000	2.6
Medicaid FFS and Managed Care	6,300,000	25,000,000	4.0
Total	14,600,000	47,000,000	3.2

Source: HMA analysis of Medicare and Medicaid claims and encounter data, 2022

Geographic Location: In 2024, 78% of Medicare FFS transports nationally were in urban areas, 17% were rural, and 5% were super-rural. These proportions vary by state, with somewhat higher proportions of rural and super-rural transports in states such as Montana, Oklahoma, and West Virginia. These areas reflect the ZIP code location of where the patient received initial medical care before ambulance transport to a medical facility.

Role in the Healthcare System: Ground ambulance services play a unique role in the broader healthcare system, addressing patient conditions before hospital care on an urgent basis. For patients, ambulances are often the first point of contact at the beginning of a longer episode of care, serving as a safety net, particularly in rural areas. Hospital emergency departments depend on emergency medical services (EMS) to identify high-acuity cases, initiate time-critical interventions, and transport patients who cannot self-present. Unlike hospitals or physician practices, EMS cannot limit services, close during low-volume periods, or opt out of unprofitable areas. They must respond to every call, regardless of the patient’s ability to pay or insurance type.

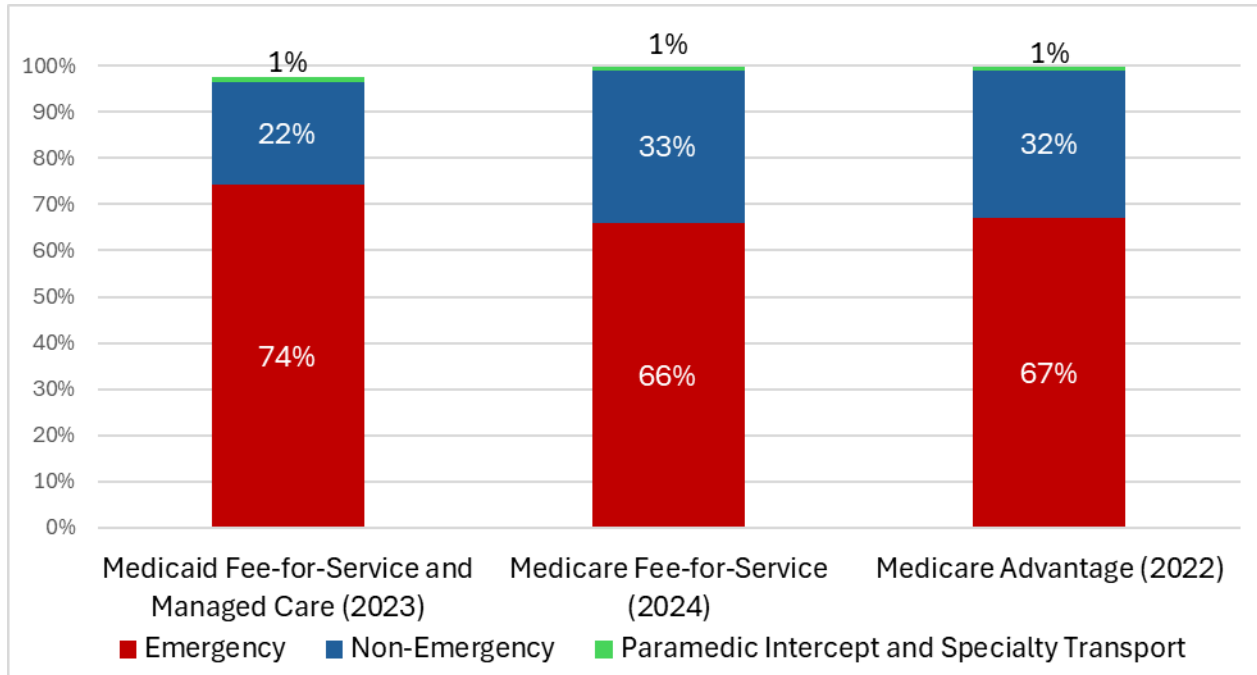
In rural areas, ground ambulances often serve an even more important function as the first point of care for patients because of gaps in primary care provider availability and hospital closures. In addition, ambulance deserts are often more common in rural counties. Of all individuals living in counties deemed ambulance deserts, 52% (2.3 million people) reside in rural counties.⁶

Clinicians: Ground ambulances are staffed by EMTs and paramedics, with medical oversight provided by physician medical directors. These clinicians receive different levels of training, with paramedics receiving the higher level of training. Paramedics staff ground ambulance transports for Advanced Life Support (ALS), while EMTs provide Basic Life Support (BLS). Both types of clinicians provide resuscitation and stabilization services, perform critical procedures, and administer various medications.

Services Provided and Service Mix: Ground ambulances provide vital pre-hospital care on an urgent basis, including by responding to accident scenes, reversing drug overdoses, and treating stroke and heart attack patients. Ground ambulances have a significant impact on the care journey of the patient—both in terms of reducing lengths of hospital stays and costs and quickening the recovery process. Studies have shown that timely EMS intervention can reduce patient morbidity and mortality across a variety of conditions, including cardiac arrest, trauma, stroke, and respiratory failure.⁷ With regard to stroke care specifically, more timely intervention resulting from ambulance transport reduces the time to treatment and length of hospital stay and, therefore, costs.⁸

Ground ambulances provide a range of services, including emergency and non-emergency services and interfacility transport. Nationally, 74% of Medicaid and 67% of Medicare ground transports are emergency, 20–30% are non-emergency, and another 1% are paramedic intercept and specialty care transports (**Figure 1** on next page).

Figure 1. Share of Ground Ambulance Transports by Service Type and Public Payer (Most Recent Year)



Source: HMA analysis of Medicare FFS, Medicare Advantage, and Medicaid 100% claims data.

Note: The years in Figure 1 reflect the most recent year of data available for this analysis. These proportions are relatively consistent year over year within each payer group.

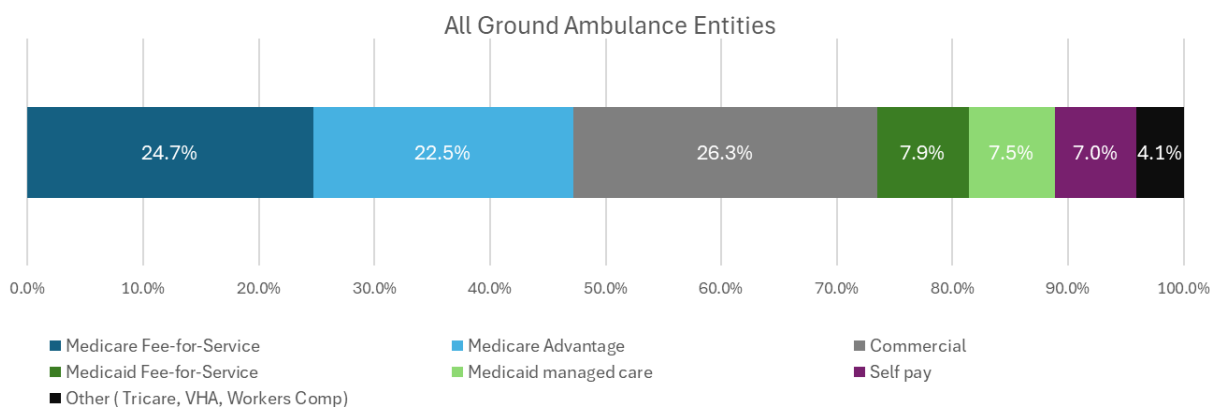
Ground ambulances also enable care transitions for complex patients transported between facilities; for example, from hospital to hospital or nursing home to hospital, also known as interfacility transports. Approximately one-quarter of all transports for patients covered by public payers are interfacility transports: Medicare = 27%; Medicaid = 13%. Among these interfacility transports, approximately 30% are emergency transports. These transports often are conducted outside of the traditional EMS 911 systems, and many are unscheduled and urgent.

Emergency Services: Most ground ambulance transports are emergency transports, and this is generally consistent across the public payers. Under Medicare, 66% of Medicare FFS transports were emergency and 67% of MA transports were emergency.⁹ Under Medicaid FFS and managed care, 74% of transports were emergency. Service type tends to vary by geographic location of the patient. In super-rural areas in 2024, 82% of all Medicare FFS transports were emergency transports, compared with 70% in rural areas and 65% in urban areas.

Payer Mix

Nearly 70% of the ambulance industry's annual revenue is associated with patients enrolled in Medicare, Medicaid, TRICARE, and the Veterans Health Administration,¹⁰ with nearly 47% of industry revenue stemming from Medicare patients and 15% from Medicaid patients. Commercial payer revenue accounts for 26% of industry revenue but is critical because commercial plans tend to pay higher rates than public payers (**Figure 2**). The ground ambulance payer mix is more reliant on public payers than hospitals, physicians, and other types of providers and suppliers. Comparatively, approximately 50% of hospital industry revenues associated with public payers, with Medicare and Medicaid accounting for 25% and 19% respectively. Commercial payers account for approximately 40% of hospital revenue. Rural hospitals have higher shares of public payer revenue, which is more consistent with the ambulance industry.¹¹

Figure 2. Ground Ambulance Industry Revenue by Payer



Source: CMS 2026 (Medicare Ground Ambulance Data Collection System survey report)

Ground Ambulance Payment Structure

The Medicare FFS payment system serves as the baseline for ambulance payment across payers nationwide. Managed care plans tend to pay for ground ambulance transports as a proportion of the Medicare FFS payment rates. Medicaid programs establish their own ambulance payment systems, but many follow the Medicare structure as a baseline with some variation.

Medicare: Medicare's payment system for ground ambulance services is called the Ambulance Fee Schedule (AFS). The AFS has two primary components—a base payment and a mileage payment. The base payment consists of three specific pieces: the relative value unit (RVU), a conversion factor, and a geographic adjustment factor, which establishes the standardized payment level for ground ambulance transport.¹² The AFS includes seven levels of ground ambulance service that reflect varying levels of clinical intensity and resource use. Each level is

assigned a distinct RVU, with most services set relative to the value of the lowest-intensity service category, BLS non-emergency transport, which serves as the benchmark with a RVU of 1.00.¹³ Emergency transports have RVUs higher than 1.00, reflecting higher relative case severity and resource use expectations. Under the AFS methodology, service level RVUs are multiplied by a conversion factor (\$279 in 2025), which is a specific dollar amount to determine the base payment amount for a given transport.¹⁴ In addition, Medicare provides a mileage payment intended to capture the operational costs of ground ambulance providers (i.e., cost of vehicle, price of fuel).¹⁵

The AFS also incorporates several add-on payments and policy adjustments intended to account for geographic and service-related cost differences. If the ZIP code where the patient originates is rural, the rural short-mileage ground ambulance add-on payment increases the standard mileage rate by 50% for the first 17 miles.¹⁶ The ground ambulance add-on payment increases the base payment and mileage rate for all ground transports by 3% when transports originate in rural ZIP codes and by 2% for transports that originate in urban ZIP codes. The super rural add-on payment increases the base payment by 22.6% for all ground ambulance transports when the ZIP code location where the patient is initially cared for by the ambulance team is designated as super rural. These three temporary geographic add-ons for urban, rural, and super rural transports are mandated to expire on December 31, 2027. The AFS also includes a targeted 23% reduction in payment for non-emergency BLS transports of an individual with end-stage renal disease (ESRD) traveling to renal dialysis services, reflecting policy efforts to manage costs associated with high-volume dialysis-related transports.¹⁷

The AFS conversion factors and mileage rates are updated annually by the ambulance inflation factor. This update is calculated as the annual percentage increase in the Consumer Price Index for All Urban Consumers (CPI-U), reduced by the 10-year moving average of multifactor productivity. The update was 2.4% for 2025 and 2.0% for 2026.¹⁸

Medicaid: While Medicaid programs tend to follow a similar payment method as Medicare, payments are structured differently. In general, Medicaid payments per transport tend to be lower than the Medicare payments per transport, as we demonstrate in a later section of this report. However, among the most important ways in which Medicaid payments differ from Medicare is the use of state-directed payments and provider taxes. These methodologies do not exist in all state Medicaid programs, but states where they are used pay select ground ambulance organizations supplemental payments beyond the established rates. In addition, several Medicaid programs cover types of service not covered by Medicare FFS, such as ground ambulance response without transport or treatment in place.

Ground Ambulance Cost Structure

The cost structure of the ground ambulance industry is unique relative to many other healthcare providers. Labor accounts for the majority of costs for ground ambulance organizations, reflecting 71% of total ground ambulance costs.¹⁹ While this is similar to the hospital industry, at 66%,²⁰ ground ambulance industry costs are heavily influenced by vehicle and fuel costs (9%), equipment and supply costs (5%), and facility costs (4%). These costs vary by type of organization, and organizations serving rural communities tend to have higher shares of equipment and vehicle costs.²¹ Within the labor cost category, in 2022, on average 80% of labor costs were associated with clinical staff.²² Among the remaining labor costs, nearly 14% was associated with administrative staff and 4% was associated with dispatch service staff. Volunteer labor is an important piece of the labor structure in many organizations, typically small and municipal entities.

Unlike most healthcare providers, the ground ambulance industry includes a range of organizational structures. In addition to traditional for-profit and nonprofit provider organizations, many ground ambulance organizations are organized, regulated, and in part financed at the municipal, county, or state level. CMS reported that approximately 60% of ground ambulance organizations are fire/public safety department-based or otherwise government owned, which results in substantial variations in cost structures, delivery models, operational requirements, and funding mechanisms. Regardless of ownership status, local governments often determine how ambulance services are provided while also regulating ground ambulance clinical and operational standards, coverage expectations, and staffing requirements. Locally determined requirements can necessitate significant administrative and operational costs regardless of federal payer reimbursements.

Because all ambulances must be able to respond to any type of emergency call, the cost of individual ground ambulance responses is largely consistent across all payer types and service types. This is referred to as ambulance readiness cost.

Cost Data Collection

To comply with Section 1834(l)(17) of the Social Security Act, CMS developed the GADCS to incrementally collect data from ground ambulance organizations in 2022 to 2024.²³ The GADCS data collection tool includes questions for ambulance organizations about their organizational characteristics, service area, emergency response time, mix of ground ambulance services, cost structure, and revenues (e.g., payments from payers). CMS's contractor, RAND Health Care, completed its first report in December 2024, analyzing the first two years of GADCS data. The Medicare Payment Advisory Commission (MedPAC) is also statutorily required to analyze these

data and report to Congress on the adequacy of Medicare ground ambulance payments, the administrative burden data reporting requirements place on ambulance organizations, and the recommendations the Commission may have on these topics.

Given the potential of GADCS data to improve the accuracy of Medicare FFS reimbursement rates, the American Ambulance Association (AAA) developed a data collection device, known as Amber, to develop a mirror of the GADCS data from its membership of ground ambulance organizations. Amber is designed to test cost collection within the ground ambulance industry, educate ambulance organizations on accurate cost reporting, identify challenges ambulance organizations may have with data reporting, and identify potential improvements for future reporting. In addition, Amber is intended to enhance AAA's capacity to engage policymakers in developing recommendations that will ensure the sustainability of the Medicare ground ambulance benefit and protect beneficiary access to these services.

On April 9, 2026, MedPAC voted to recommend to Congress direct CMS to continue collecting cost and revenue data from ground ambulance service suppliers and providers. MedPAC called for data collection that focuses on information essential to assessing Medicare payment adequacy, patient access, and methods for streamlining data collection.

CHALLENGES OF THE GROUND AMBULANCE INDUSTRY: CURRENT AND EMERGING

The ground ambulance industry is experiencing financial insecurity, in part due to six core challenges that will be compounded in the future by five systemic emerging challenges. These six challenges represent gaps in existing payment systems, which policymakers can address directly. Individually and collectively, the current payment challenges lead to payment inaccuracy and, if not addressed, have potential to harm quality of care and access to services for patients. These challenges have resulted in the closure of ground ambulance organizations and organizations—reducing their geographic service footprint, scope of service types, or hours of operation.

For example, between 2021 and 2024 the number of organizations billing Medicare for ground ambulance services declined 6% and the number of organizations billing Medicaid declined 5%, which has resulted in ambulance deserts in several parts of the country. Further, a University of Pittsburgh assessment of ground ambulance organization closures and ambulance deserts suggested that closures between 2019 and 2024 have led to ambulance deserts in several states.²⁴

Beyond the long-standing payment challenges, new financial headwinds are emerging for the ground ambulance industry. This includes unprecedented shifts in payer mix driven by reductions in Medicaid enrollment and Marketplace plan enrollment, reductions in Medicaid revenues stemming from changes to the existing state-level, state-directed payment, provider tax mechanisms, and payment systems not built to adapt to innovations in the marketplaces, making payments antiquated and inconsistent with the cost of providing care. When there are stable and predictable payments, ground ambulance organizations can align staffing capital investment and operational capacity to predicted and anticipated demands. Hospital closures will also add pressure to the ground ambulance industry because of driving distance between a patient's pickup location and hospital emergency rooms. Finally, the aging of the population will increase the utilization of ambulance services and put greater pressure on ground ambulance capacity.

Current Challenges

Inadequate payment for ground ambulance services from Medicare and Medicaid.

Low-volume ground ambulance organizations have higher costs per transport, augmenting concerns about payment inadequacy.

Unpaid patient cost-sharing liability associated with patients enrolled in Medicare Advantage and Commercial insurance plans.

Lack of Medicare reimbursement for ground ambulance responses in which medical assessment and care are provided on scene, but the patient is not transported to a medical facility.

Payment does not adequately capture current and evolving innovative pharmaceutical products, blood products, and technologies/supplies, to ensure payment is keeping pace with the practice of medicine.

Commercial insurers' unwillingness to negotiate in-network payment rates with ground ambulance organizations, resulting in higher out-of-pocket costs for patients.

Emerging Challenges

Changes in payer mix resulting from impending reductions in Medicaid enrollment and Marketplace plan enrollment will lower Medicaid revenues and increase the number of uninsured patients.

Medicaid revenue reductions are likely to result from changes in state-directed payments, provider taxes, and patient cost sharing originating in the OBBBA.

Payment system is not built to adapt to site of service evolution.

Hospital closures limit the availability of and distance to hospital emergency rooms.

Aging of the population will increase demand for ground ambulance services.

Current Challenge: Inadequate Payment from Medicare and Medicaid

Ground ambulance organizations face payment inadequacy challenges for Medicare and Medicaid transports. Payment varies by payer type, creating a dynamic in the ambulance industry that is common for other healthcare industries where commercial payers with higher relative payments are used to subsidize lower paying public payers, such as Medicare and Medicaid. As described above, the ground ambulance industry is more reliant on public payers. A 2023 analysis of the relationship of commercial managed care payments to Medicare FFS payments for ambulance services concluded that the median commercial payments for the most common emergency ambulance transport type and the most common non-emergency transport type were 187% and 273% higher than Medicare FFS payments, respectively.

Margins

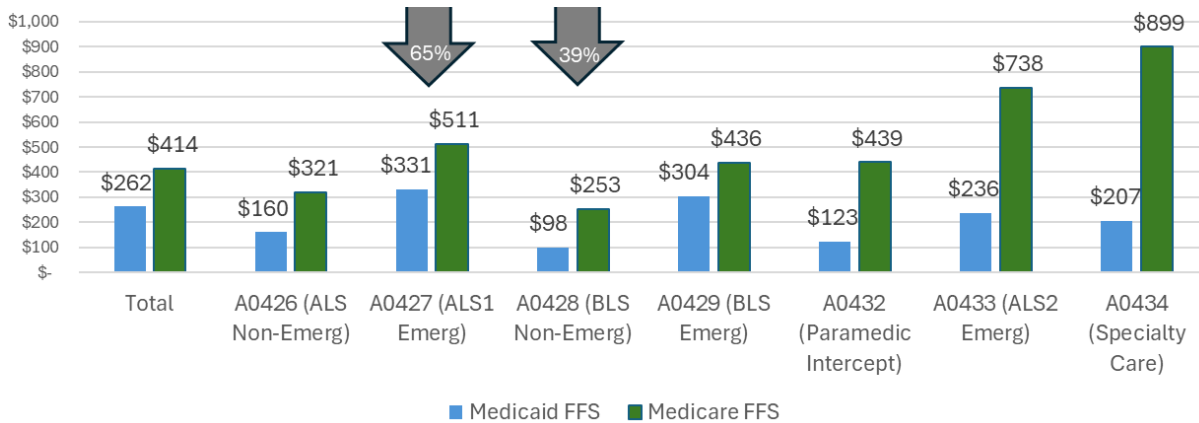
Medicare FFS margins were -6 % in 2022, down from what the GAO estimated a decade earlier.

- **Medicare FFS Margins:** Based on survey data collected by AAA, HMA found that ground ambulance organizations had a median Medicare FFS margin of -6% in 2022. This margin varied by the geographic service area and the size of the ground ambulance organization. Organizations serving largely urban areas had a median

Medicare FFS margin of 4%, rural had a median Medicare FFS margin of nearly -13%, and super-rural had a median margin of nearly -20%.²⁵ Organizations with fewer than 600 total transports per year had median Medicare FFS margins of -16%, whereas the largest organizations (more than 25,000 total transports per year) had a median margin of -4%. In a separate survey limited to New York ambulance organizations in 2025, HMA found that the 17 ambulance organizations surveyed had a median Medicare FFS margin of -7%.²⁶

- **Medicaid Margin:** Based on AAA survey data, HMA found that ground ambulance organizations had a median Medicaid margin of -27%. Medicaid margins are lower than Medicare margins in part because of lower Medicaid payment rates and the complex structure of Medicaid payment, which sometimes involve the use of supplemental state-directed payments and provider tax payments per transport.²⁷ These additional revenues can be difficult for ambulance organizations to reconcile in revenue reporting and are therefore inconsistently reported by ambulance organizations. Similar to Medicare FFS margins, however, Medicaid margins tend to be lower for organizations serving primarily rural and super-rural service areas, and lower for organizations with fewer transports. In addition, in 2025 HMA separately surveyed 17 ambulance organizations in New York State and found that their median Medicaid margin was -31%.²⁸
- **Medicaid Compared to Medicare:** Medicaid margins are generally lower than Medicare FFS margins, in part because Medicaid payment rates are lower on average than Medicare payments for each of the seven individual ground ambulance services. For example, in 2023, Medicaid FFS payments per transport were 65% of Medicare payments per transport for ALS emergency services (A0427 Medicaid = \$331 v. A0427 Medicare = \$511) and 39% of Medicare payments per transport for BLS non-emergency services (A0428 Medicaid = \$98 v. A0428 Medicare = \$253) (**Figure 3**).

Figure 3. National Average Medicaid and Medicare Payments per Service (2023)



Source: HMA analysis of Medicare FFS and Medicaid FFS 100% claims data.

- All Payer Margins:** Based on survey data collected by the AAA, HMA found that ground ambulance organizations had a median margin across all payers of -0.3%, including transport for Medicare, Medicaid, commercial insurers, and others. Similar to Medicare and Medicaid margins, all payer margins tend to be lower for organizations serving primarily rural and super rural service areas, and lower for organizations with fewer transports.
- Alternative Payment Models:** Unlike many other types of providers that receive Medicare and Medicaid reimbursement, ambulance organizations do not have access to alternative payment models that can compensate for the lower reimbursement rates of Medicare and Medicaid. In the past CMS operated the Emergency Triage, Treat, and Transport (ET3) model, which was a voluntary, five-year payment framework that provided greater flexibility to ambulance care teams to address emergency healthcare needs of FFS beneficiaries following a 911 call. ET3 paid ambulance organizations to 1) transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center (or 2) initiate and facilitate treatment in place with a qualified healthcare partner, either at the scene of the 911 emergency response or via telehealth.²⁹ This model ended in 2023, but CMS currently does not offer the ambulance industry other alternative models of reimbursement. In contrast, CMS's Center for Medicare and Medicaid Innovation creates a variety of alternative payment models for hospitals, physicians, and other providers.³⁰

Policy Considerations to Address This Challenge

Several options exist for policymakers to address the challenges of Medicare and Medicaid payment inadequacy. First, and most importantly, to ensure payment adequacy over the long-term policymakers should consider continuing to gather industry financial data through a cost collection mechanism that occurs semi-regularly, such as every three years. This process will enable policymakers and collaborative stakeholders to assess industry margins by payer and to assess the accuracy of the RVUs of each type of ambulance service, which have not been adjusted since their creation more than 20 years ago. These data will also enable policymakers to assess the evolving financial complexities of this industry and to design or refine payment adjustments to the base rates that can address the wide variability in ambulance costs, such as geographic or volume-based variation, and generally better target the gaps in the base payment rates.

In addition, policymakers should consider streamlining the existing version of the GADCS because it includes more variables than necessary to assess payment, and it also fails to capture certain variables essential to assessing payment adequacy, such as details about unpaid patient cost sharing liability, uncompensated care, and responses without transport. Strengthening the ground ambulance payment system in these ways may require Congress to provide additional funding for CMS.

Policymakers should consider establishing nationwide standards for Medicaid ground ambulance payments that match or exceed Medicare rates and share common payment adjustments to base rates, which can reduce the complexity of payment systems across payers.

In addition, to improve Medicare FFS payment adequacy, in particular, and to fund future modifications to ground ambulance geographic payment adjustments (urban 2.0%, rural = 3%, super rural = 22.6%) policymakers might consider leveraging the funding that was removed from the industry through the congressionally mandated total factor productivity adjustments that occur each year. We estimate that these productivity adjustments have amounted to roughly a 0.6% reduction in the Ambulance Inflation Factor payment update each year over the last 15 years (2011–2025), and a total of nearly \$500 million in lost Medicare FFS revenue. If these funds were to be returned to the industry through the geographic adjustments over a five-year period it would increase the individual adjustments by 1–4 percentage point(s) each (urban = 3.3%, rural = 4.3%, super rural 26.6%).

Current Challenge: Low-Volume Organizations Have Higher Costs per Transport, Augmenting Payment Inequities

Approximately 43% of the ground ambulance industry is regarded as providing a low volume of transports, and research has demonstrated that these organizations generally have higher costs per transport than other ambulance organizations due to economies of scale. Low-volume ambulance organizations exist across urban, rural and super-rural ambulance regions and include nonprofit, for-profit, and government organizations.³¹ CMS reported that costs per transports for low-volume organizations can be as much as \$1,700 higher, \$2,200 higher, and \$2,600 higher than the medium, high, and very high groups, respectively.³²

In a more recent analysis, MedPAC specified that the average cost per transport for low-volume organizations was \$2,852 and that these organizations had on average of 166 transports annually. In contrast, the high-volume organizations have average costs per transport of \$914 and had on average 15,721 transports annually (**Table 2**). Because payment rates from Medicare and Medicaid are fixed regardless of the volume of transports that organizations provide, low-volume organizations may be at a greater financial disadvantage than high-volume organizations when payment rates are inadequate.

Table 2. Cost per Transport for Ground Ambulance Organizations by Volume Category

Quartile of Transport Volume	Ambulance Transports per Organization	Cost per Transport
Lowest Quartile (Low-Volume)	166	\$2,852
Second Quartile	795	\$1,970
Third Quartile	2,600	\$1,485
Highest Quartile (High-Volume)	15,721	\$914

Source: Medicare Payment Advisory Commission, 2026³³

Policy Considerations to Address This Challenge:

To address the variation in organization-level costs per transport policymakers should consider a low-volume adjustment for the Medicare FFS ground ambulance payment system which provides additional payments to ambulance organizations with low volumes. A low-volume payment adjustment precedent exists within the Medicare FFS Inpatient Prospective Payment System, but a low-volume adjustment within the ambulance payment system may need to function differently given the mobile nature of ambulance services. With this in mind, policymakers might consider attaching a low-volume adjustment to either the organization or to the area in which the patient care originates. In addition, policymakers will need to consider the threshold at which costs increase for ambulance organizations, which the Government Accountability Office (GAO) identified as 600 transports per year in 2012, which noted that “after 600 transports, each increase of 10 transports results in a decrease in cost per transport of less than 0.10 percent.” This threshold may be different today.³⁴

Current Challenge: Unpaid Patient Cost Sharing Liability Associated with Medicare Advantage and Commercial Plans

As the share of Medicare beneficiaries enrolled in MA plans now exceeds 54% of all Medicare beneficiaries, differences between MA cost sharing and traditional Medicare FFS cost sharing are having a pronounced impact on Medicare beneficiaries and providers.³⁵ Traditional Medicare includes a standard 20% coinsurance consistent with other Medicare Part B services, and therefore for ground ambulance services. In contrast, under MA, health plans can choose to assign a coinsurance percentage for each service or they can specify copayments with a fixed dollar amount.

The flexibility permitted to MA plans to establish beneficiary cost-sharing levels for ground ambulance services has resulted in variation in MA plan copayments and significantly higher cost sharing for ground ambulance services for MA beneficiaries than those enrolled in traditional Medicare. This policy decision negatively impacts patients enrolled in MA plans by exposing them to higher out-of-pocket costs and potentially additional medical debt. Ground ambulance organizations are also negatively impacted by the flexibility policymakers have provided to MA plans in the form of unpaid beneficiary cost sharing liability.

UNPAID PATIENT COST SHARING LIABILITY

Average ground ambulance cost sharing under MA plans was \$273 in 2024, exceeding cost sharing for Medicare FFS and MA cost sharing for emergency department services; 30% of ground ambulance transports have unpaid patient cost sharing.

HMA's 2025 analysis of MA plan copayment amounts for ground ambulance transports demonstrated that MA copayment amounts were consistently higher than the estimated dollar amount of beneficiary cost sharing for the same services under traditional Medicare.³⁶ In 2024, the national average MA plan copayment across all MA plans requiring a copayment was \$273, more than two-and-a-half times higher than the estimated equivalent under traditional Medicare (\$100). This \$273 reflects a significant share of the average payment ground ambulance organizations received under traditional Medicare for these services in 2024. For example, under traditional Medicare in 2024, CMS paid an average of \$525 for ALS emergency transports and \$261 for BLS non-emergency transports. Therefore, the average MA plan copayment for 2025 reflects more than 50% of the payment for ALS emergency transports and 105% of the payment for BLS non-emergency transports. While it is unlikely MA plans pay ambulance organizations exactly the same rates as traditional Medicare, anecdotal information suggests MA plan rates are comparable.

HMA's 2025 analysis also concluded that:

- Across all states, the average MA plan copayment for ground ambulance services was higher than the traditional Medicare cost sharing equivalent, but levels varied across states.
- In five states (Vermont, Iowa, Montana, South Dakota, and Maine), average MA plan copayments exceeded \$300 per transport.
- Between 2021 and 2025, the national average copayment for ground ambulance transports across all MA plans increased 7%, from \$255 to \$273.
- Copayments from ground ambulance services are higher than copayments for emergency department services. In 2025, average MA plan copayment amounts for ground ambulance services (\$273) were 229% higher than for emergency department services (\$119).

To understand the impact of higher MA plan copayments, in 2025 HMA separately surveyed a small but geographically diverse sample of ground ambulance organizations to assess the extent to which MA plan enrollees pay their copayments to ground ambulance organizations. We found that approximately 30% of ground ambulance transports have copayments that are unpaid to some degree and MA plan copayments were completely unpaid by the enrollee for 15% of MA plan transports.

Policy Considerations to Address This Challenge

To mitigate the financial risks posed by high and often unpaid copayments, policymakers could consider several policy proposals to reduce state-level variation with ground ambulance cost sharing and promote greater consistency with traditional Medicare. Options include:

1. Add ground ambulance services to the list of services CMS has established cost sharing caps for under the MA program. Beginning in 2023, MA plans using coinsurance must not exceed the coinsurance charged within traditional Medicare, and for MA plans using copayments they must not exceed an actuarially equivalent value of the benefit provided for the following services: chemotherapy administration, renal dialysis, skilled nursing care, home health, durable medical equipment, and Medicare Part B drugs (42 C.F.R. § 422.100(j)). The Secretary of the US Department of Health and Human Services has the authority to expand this list of services if the Secretary determines the service “requires a high level of predictability and transparency for beneficiaries,” per SSA § 1852(a)(1)(B)(iii) & (iv).
2. Establish federal copayment standards specific to ground ambulance services under MA that are aligned with copayments for emergency department services.
3. Strengthen provider protections for unpaid copayments, such as requiring plans and providers to share the financial risk related to unpaid copayments.

As enrollment in MA continues to grow, ensuring that ground ambulance services remain financially sustainable and accessible will require thoughtful policy action. Addressing high and frequently unpaid copayments is critical to protecting beneficiaries from excessive financial burden and safeguarding the financial stability of ambulance providers.

Current Challenge: Lack of Reimbursement for Treatment Without Transport

Response without transport is common within the ground ambulance industry and has grown. In these cases, ambulance organizations incur the cost of responding to a medical scene but often do not receive reimbursement. Estimates of the volume of these cases vary from 2% to 10% of all ground ambulance responses. Research also suggests instances of treatment without transport have increased in recent years, and vary by type of payer and patient age.^{37, 38} More definitively, CMS reported in 2026 that among the 7,400 ground ambulance organizations responding to the GADCS that 11% of all ground ambulance responses result in treatment without transport and therefore, without payment.³⁹ This amounted to at least 7 million cases of treatment without transport.

Although Medicare does not reimburse for ambulance response and treatment with no transport, some state Medicaid programs do. In states covering these services, often referred to as “treatment without transport,” payment rates for these services vary by state Medicaid program. For example, New Hampshire Medicaid pays \$94 per case for ambulance treatment without transport (code A0998), whereas Michigan’s Medicaid program reimburses \$266 per case for the same service in 2026.^{40, 41}

The Medicare program temporarily tested a similar model of care in 2021–2023 called the Emergency Triage, Treat, and Transport Model (ET3 Model), which demonstrated some success.⁴² Under the ET3 model, treatment in place interventions were associated with relatively low follow-up emergency department (ED) utilization. In addition, this model demonstrated savings to the Medicare program of roughly \$500 per beneficiary when a patient was treated in place instead of being transported to the hospital ED.

[Policy Considerations to Address This Challenge](#)

To address this challenge, policymakers should consider expanding Medicare coverage of ground ambulance responses without transport and identify an accurate amount to pay ground ambulance organizations for these services. Amounting to approximately 7 million occurrences each year, these medically necessary responses contribute significantly to the cost of providing ground ambulance services to Medicare and other patients. Although Medicare does not reimburse these non-transport responses, some Medicaid programs do provide payment. Reimbursing ground ambulance organizations for these occurrences could fill gaps between costs and revenues for the industry.

Current Challenge: Inadequate Payment for Drugs, Blood Products, and Supplies

Ground ambulance organizations also carry several additional costs that are not directly reimbursed and have increased rapidly in recent years, including the costs of drugs, blood products, and supplies. Readiness costs include the costs associated with having an ambulance and crew readily available to respond to an emergency. In addition to readiness costs related to labor and vehicles, this also includes medical supplies and equipment such as cardiac monitors, splints, medications, and IV supplies. Medicare and other payers bundle payment for drugs, blood products, and supplies into the base payment rates, which have lagged behind the rising cost of pharmaceuticals and medical equipment, widening the gap between transport costs and payments for the ground ambulance industry.

Pre-hospital blood programs—which help stem blood loss as patients are transported to the hospital rather than waiting for this care at the hospital—have demonstrated positive outcomes, such as reducing mortality by 37%.⁴³ Given the potential for these programs to improve quality, policymakers have begun funding these programs. For example, The National Highway Traffic Safety Administration (NHTSA) recently awarded \$50 million for ambulance services to implement pre-hospital blood programs. Importantly, these programs come with additional costs for ambulance organizations, which are insufficiently captured within existing payments rates. The implementation grants support these programs temporarily, but do not sustain these programs in the long term.

These programs highlight the need for payment rates to more accurately keep pace with innovations in practice and technology. Within other Medicare payment systems, CMS and Congress have used mechanisms such as passthrough payments and outlier payments.

[Policy Considerations to Address This Challenge](#)

To address this challenge, policymakers should consider adding passthrough or outlier payments that account for the cases involving high-cost drugs, blood supplies, and other equipment. Precedent exists for these types of payment adjustments throughout the various Medicare FFS payment systems, but the hospital outpatient system provides the most appropriate model which could be replicated within the ambulance payment system. Currently the costs of maintaining access to these important clinical items have been built into the base payments of the ground ambulance payment system and the industry has absorbed price increases for these items faster than the ambulance payment system has adjusted to these price increases. Policymakers should consider adjustments that account for these innovations in order to ensure patients have access to contemporary clinical standards which can reduce the length of hospital stays and speed recovery and reduce patients' episodic costs to payers.

Current Challenge: Commercial Insurers' Unwillingness to Negotiate In-Network Ground Ambulance Payment Rates with Ambulance Organizations Results in Higher Out-of-Pocket Costs for Patients

Commercial insurers generally do not negotiate payment rates with ambulance companies. As a result, ambulance services are regarded as out-of-network providers. A 2024 study published in the *Journal of the American Medical Association* () showed that nearly 55% of a sample of 2 million ground ambulance transports were covered as out-of-network services.⁴⁴ Many organizations providing services in the ground ambulance industry are relatively small and do not maintain the administrative capacity to negotiate payments rates with insurers. The balance of power lies with the insurer in many markets, and enabled insurers to set rather than negotiate rates. The practice

of not negotiating in-network rates is inconsistent with how commercial insurers approach establishing payment rates with hospitals, physicians, and other providers.⁴⁵ The absence of negotiation often results in higher out-of-pocket costs for patients receiving ambulance transports, and subsequently higher levels of unpaid patient liability for ground ambulance organizations. In addition, the lack of negotiated rates also often results in payment rates that inadequately cover the costs of ground ambulance organizations providing transports.

[Policy Considerations to Address This Challenge](#)

To address this challenge, policymakers should consider requiring commercial payers to negotiate payment rates with ground ambulance organizations on a regular basis to ensure they more accurately capture the cost of service at the community level.

This challenge was publicly debated in 2023 and 2024 as a part of CMS advisory panel, which issued recommendations that are still relevant today as a reference point for policymakers. The recommendations in CMS's March 2024 report, *Ground Ambulance & Patient Billing Advisory Committee: Report on Prevention of Out-of-Network Ground Ambulance Emergency Service Balance Billing*, have been cited as a key influence for balance billing laws enacted in more than a dozen states.⁴⁶ The recommendation most applicable to this challenge is number 12, which states that commercial insurers must make a minimum payment for ground ambulance EMS defined as either the amount specified in a state balance billing law, the state or local regulated rate, or a rate negotiated by the insurers and the ground ambulance organization. However, if none of these exist, the CMS advisory panel recommended that the minimum payment be defined either through a congressionally mandated percentage of Medicare if the service is covered by Medicare or, if the service is not covered by Medicare, it should be defined via congressional mandate as a fixed amount or percentage.

Emerging Challenge: Changes in Payer Mix Resulting from Impending Reductions in Medicaid Enrollment and Marketplace Plan Enrollment Will Lower Medicaid Revenues and Increase the Number of Uninsured Patients

Among the most significant emerging challenges for the ground ambulance industry are the inter-related challenges associated with passage of OBBBA, which will cause payer mix to change, reduce Medicaid revenues, and yield higher numbers of uninsured patients. We anticipate that the increase in the uninsured population will stem from losses in the number of individuals insured by Medicaid programs and losses in the number of individuals insured by Marketplace plans.

The Congressional Budget Office (CBO) projects that the number of uninsured nationally will increase by 10 million by 2034. The estimated increase will occur gradually, increasing the number of uninsured by 1.3 million in 2026, 8.6 million in 2029, and grow to 10 million by 2034. For ground ambulance providers, an increase in the uninsured population could translate into greater uncompensated care and reduced revenue stability, given ground ambulance providers must respond to calls regardless of patients' insurance status.

The Medicaid enrollment loss component of this challenge will have a significant impact on the ground ambulance industry. Stemming from the insertion of state-level work requirements into the Medicaid program, we estimate that Medicaid enrollment loss nationally may range from between 8% to 16%, and will vary significantly by state. Based on current levels of Medicaid transport use, we also estimate that this will translate into a loss of Medicaid revenue of between \$288 million and \$580 million for the ground ambulance industry. Further, we estimate using Medicaid claims data that more than 90% of these revenue losses will come from emergency transports for individuals that are no longer covered by Medicaid.

The Marketplace plan component of this challenge will also significantly affect the ground ambulance industry but in a more nuanced manner. Stemming from the expiration of the enhanced premium tax credits, CBO estimates that 4.2 million people with a Marketplace plan may become uninsured by 2034.

OBBBA: MEDICAID REVENUE

Medicaid enrollment may decline by between 6 million and 13 million enrollees.

The ground ambulance industry will experience annual Medicaid revenue losses of between \$288 million and \$580 million due to Medicaid enrollment losses.

OBBBA: THE UNINSURED

Uninsured population may increase by 10 million.

Increases in the uninsured population will result in more uncompensated care.

Emerging Challenge: Medicaid Payment Reductions

At the same time Medicaid enrollment will be declining, changes in Medicaid financing policies which are likely to shrink state government budgets and add financial pressure to the ambulance industry. Although most state Medicaid spending is financed through state general funds, states also often rely on other sources of non-federal funding, including provider taxes and intergovernmental transfers. The OBBBA made significant changes to provider taxes and state-directed payments (SDPs).⁴⁷ These changes will result in reductions to the supplemental payments states make to ambulance organizations under Medicaid and are also likely to result in states lowering Medicaid payment rates. State budgets will become tighter, and providers are likely to feel this financial tightening in the years ahead.

The Medicaid provisions in OBBBA, including new provider tax restrictions, are estimated to reduce federal Medicaid spending by \$911 billion (or by 14%) over a decade, with wide variation in how the effects will be felt across the states. Out of this estimated impact, the changes to the provider taxes in expansion states is expected to account for \$191 billion and the changes to SDPs is expected to account for \$149 billion.

In addition, OBBBA requires states to impose cost sharing for Medicaid expansion enrollees with incomes between 100% and 138% of the federal poverty level. HMA estimates that this will affect approximately 14% of Medicaid enrollees nationally, or 2.2 million individuals. Under this provision, these individuals will be exposed to cost sharing for certain services of an amount between \$1 and \$35 per service. We anticipate that this may lead to additional bad debt for providers and lower use of services in general which may lead to sicker patients and eventually additional ambulance transports.

Emerging Challenge: Aging of the Population Will Increase Demand for Ambulance Services

Coupled with the changing fiscal environment, the ambulance industry must also contend with a changing demographic population and the resulting increase in demand. The US is facing an impending “silver tsunami”—the demographic shift as a larger portion of the US population ages. In 2024, 18% of the US population was age 65 or older. The US Census Bureau projects that by 2040 23% of the US population will be 65 years or older.⁴⁸ This age group, from 2024 to 2040, is projected to increase from approximately 61 million individuals to 80 million individuals.

SILVER TSUNAMI
Share of Americans over the age of 65 will increase from 18% in 2024 to 23% in 2040

This demographic shift will be particularly impactful to ground ambulance organizations. Individuals aged 65 and older are currently the largest age group for ground ambulance services, accounting for 30.6% of ALS claims and 40.9% of BLS claims.⁴⁹ As this age group continues to grow, the ground ambulance industry will need to increase capacity to keep pace with increasing demand. However, current payment inadequacies make it difficult for ground ambulance providers to build this capacity.

The changing policy and demographic landscape results in several challenges that policymakers may not be able to resolve through payment changes. Providers across the country are experiencing financial stressors associated with changing payer mix and state budgets tightening. These pressures are not isolated to a specific provider type. Hospitals, physician groups, and EMS agencies are all experiencing the cumulative effects of workforce shortages.

Emerging Challenge: Rural Hospital Closures Limit the Availability of and Distance to Hospital Emergency Rooms

Rural hospital closures in the past, and the potential for more to occur in the future, pose significant challenges for the ground ambulance industry because closures increase the distance and cost of transports. Between 2010 and 2026, 152 rural hospitals closed. Roughly two-thirds of these closed completely, while the remaining third closed inpatient and often ED capacity.⁵⁰ Medicaid enrollment reductions and Medicaid budget cuts are likely to put rural hospitals at great risk, because these facilities tend to have higher shares of Medicaid patients.⁵¹ In recent months, reports have projected that more than 400 additional hospitals may be at risk of closure, particularly in the Deep South, due to Medicaid enrollment losses.⁵²

SUMMARY OF POLICYMAKING CONSIDERATIONS

The ground ambulance industry has been collectively working to identify solutions to the various challenges it faces in 2026. Based on the work AAA has commissioned HMA to do, we offer several considerations for policymakers that would address many of the challenges noted herein. Solutions to the emerging challenges will require different policy solutions, but by resolving the current policy challenges, the emerging issues may have a less significant impact on the industry and its patients.

Current Challenge	Policy Consideration
<p>Inadequate payment for ground ambulance services from Medicare and Medicaid</p>	<p>Continue to gather financial data from the ground ambulance industry in a streamlined manner to ensure payment systems are updated regularly and payment rates are adequate to maintain access to services.</p> <p>Add variables to the ground ambulance cost collection process related to unpaid patient cost-sharing liability, other unpaid payer liability, and response without transport.</p> <p>Establish a nationwide standard for Medicaid ground ambulance payments rates to match or exceed Medicare payment rates.</p>
<p>Low-volume ambulance organizations have higher costs per transport, augmenting concerns about payment adequacy</p>	<p>Implement a low-volume add-on payment within the Medicare FFS payment system</p>

Current Challenge	Policy Consideration
<p>Unpaid patient cost sharing liability associated with patients enrolled in MA and Commercial insurance plans</p>	<p>Add ground ambulance services to the list of services CMS has established cost-sharing caps for under the MA program, establish federal copayment standards specific to ground ambulance services under MA that are aligned with copayments for ED services, and strengthen provider protections for unpaid copayments, such as requiring plans and providers to share the financial risk related to unpaid copayments.</p>
<p>Lack of payment under the Medicare FFS payment system for ground ambulance responses where medical assessment and care is provided on the patient scene by the ground ambulance organization but the patient is not transported to a medical facility</p>	<p>Medicare should establish a separate payment to ambulance organizations to cover the costs of providing ambulance responses without transport.</p>
<p>Payment does not adequately capture evolving innovative pharmaceutical products, blood products, and other technologies and supplies.;</p>	<p>Medicare payment should more accurately reflect the evolving costs associated with drug, blood, and other supplies and equipment through passthrough or outlier payments.</p>
<p>Commercial insurers' unwillingness to negotiate in-network payment rates with ground ambulance organizations results in higher out-of-pocket costs for patients and lower revenues for ambulance organizations</p>	<p>Commercial payers must more accurately capture the cost of service on the community level.</p>

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