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This selection includes blogs I wrote and edited for Digitech. It's a mix of ghostwritten thought leadership for an executive and in-depth articles published under the "Marketing" byline. I led content strategy and execution: researching complex healthcare policy, interviewing EMS experts, and translating legislative shifts into actionable insights for municipal EMS leaders. The goal: build industry trust and position Digitech as a go-to authority on EMS billing.

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Checking the Numbers: How Federal and State Regulatory Changes Cause Subtle Shifts in EMS Reimbursement

September 3, 2025 // by Michael Brook

When you glance at your smartwatch at the end of a shift, the numbers often look fine. Heart rate steady, steps hit, oxygen levels normal. The real story is in the trends. A resting heart rate that inches upward week after week or a sleep score that keeps sliding may not set off alarms right away, but they are signals worth paying attention to before they turn into larger problems.

The same is true for the One Big Beautiful Bill Act (OBBBA) and recent Medicaid changes. They're not collapsing EMS budgets overnight, despite what the loudest headlines claim. Coverage and reimbursement patterns are shifting gradually, and the effects vary from state to state and community to community. For EMS leaders, the challenge is to keep an eye on those signals, track how they develop, and prepare for the direction they point to over time.

History Shows the Pace

Digitech believes that looking at historic changes in healthcare coverage offers a clearer picture of what OBBBA's impact might actually look like. Two examples stand out: the Medicaid unwinding process after COVID when states resumed normal eligibility requirements, and the enhanced subsidies that made Affordable Care Act (ACA) Marketplace plans more affordable. These show that changes are likely to occur relatively slowly, can shift direction over time, and impact states and communities in very different ways.

Medicaid Unwinding: A Patchy Drop in Coverage

Medicaid "unwinding" is the term for states returning to normal checks after the COVID-era continuous enrollment provision that let people stay enrolled without reapplying. That provision ended in March 2024, and ten months after that, only about half of those originally covered had been re-enrolled. Nationally, this resulted in a 10% drop in

Medicaid enrollees.[1] The decrease, however, was far from even: Texas saw enrollment fall by about 20%, while California's net enrollment decline was just 5.8%.

There was a correlation between the size of the drop and whether a state had expanded Medicaid coverage under the Affordable Care Act or not. Non-expanded states tended to be more aggressive in pursuing Medicaid unwinding, but even within those states, the approach varied. According to another Kaiser Family Foundation analysis, a year after unwinding began, 17% of people in non-expansion states were uninsured, compared to just 8% in expansion states.[2] In other words, where you live plays a major role in whether losing Medicaid means getting other coverage or going without coverage entirely.

By 2025, the Gaps Are Clear

By mid-2025, the trend lines are hard to miss. In just two years, Texas lost 29% of its Medicaid-covered population from March 2023 to April 2025. During that same period, California saw only a 7% decrease. For EMS providers, that gap represents how many of your patients show up with coverage and how much of your run volume gets reimbursed.[3]

Major Unknowns

That statewide drop in Medicaid coverage shows up clearly in local EMS billing data. Here's a snapshot from Digitech's client agencies[4]:

Texas – Medicaid

Municipality Type	Effective Change
Large metro city	-12%
Mid-size city	-22%
Mid-size city	-27%
Mid-size city	-26%
Rapid-growth suburb	-19%

Whether it's a large metro system or a fast-growing suburb, agencies in Texas saw noticeable declines in Medicaid-covered patients between 2023 and 2024.

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California – Medicaid

Municipality Type	Effective Change
Large city	-4%
Large county	-2%
Medium county	8%
Mid-size city	5%
Rapid-growth suburb	-7%
Mid-sized city	1%
Small town	-13%

In California, the results were more mixed based on locality. For this set of agencies, the combined total Medicaid transports were down 4.5%.

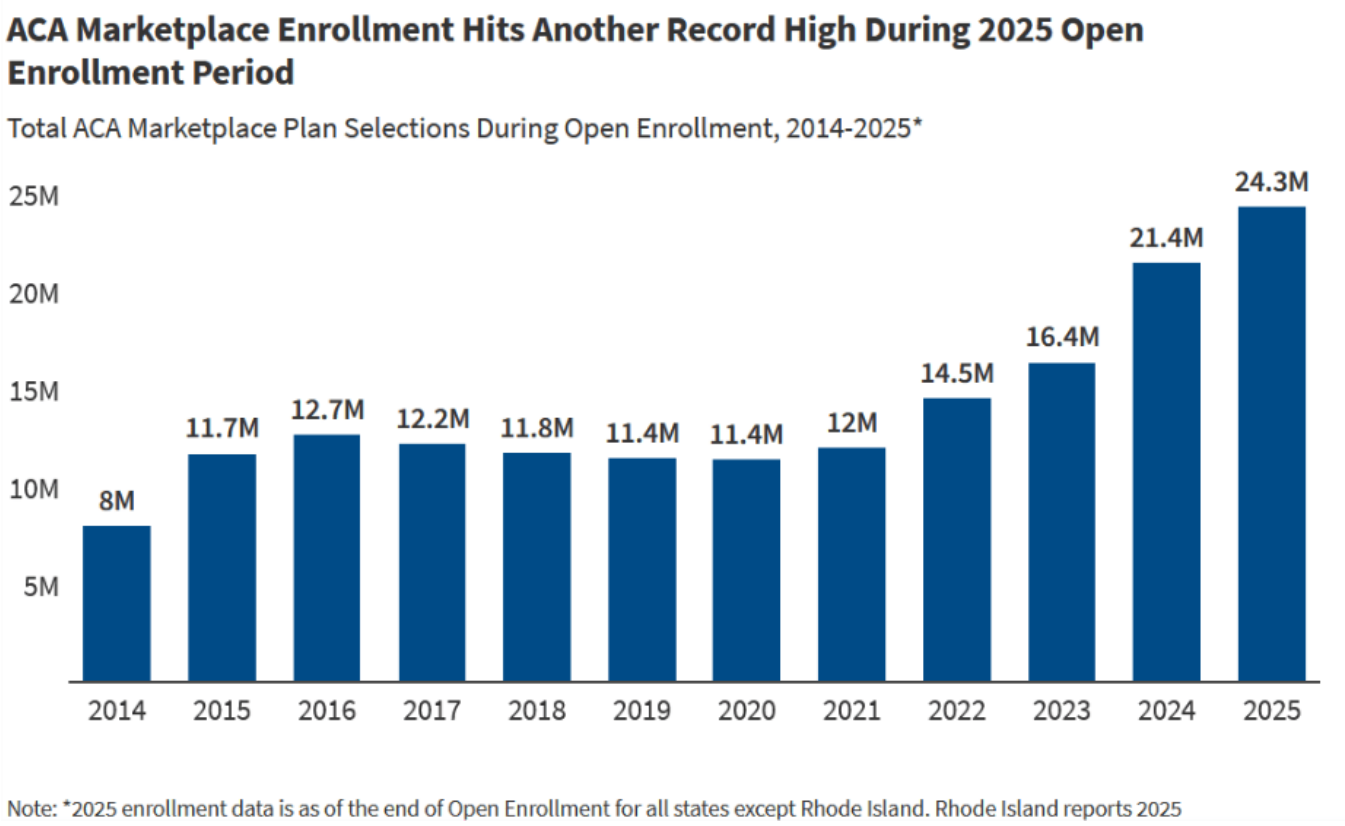
A small percentage of people who lost Medicaid nationwide did manage to get other coverage. About 4% obtained employer-sponsored insurance, 2% through the ACA Marketplace, and another 2% through Medicare[2].

Even so, Medicaid unwinding meant fewer patients with Medicaid in nearly every state, which put downward pressure on reimbursements for EMS agencies (and all healthcare providers). As the Texas-California comparison shows, the size of that drop, and the associated budget impact that follows, depends heavily on where your agency operates.

Enhanced Subsidies: Another Force in Play

At the same time Medicaid enrollment was dropping, another federal policy had a counterbalancing impact on the Medicaid reductions. The American Rescue Plan Act of 2021 (ARPA), later extended through the end of 2025 by the Inflation Reduction Act of 2022 (IRA), enhanced subsidies for ACA Marketplace plans, making them more affordable for millions of Americans.

The result was a substantial increase in Marketplace enrollments. Per Kaiser Family Foundation, enrollment doubled nationally from 2021 to 2025.[5] That growth helped offset some of the Medicaid losses, though the impact varied by state.



Just as we saw with Medicaid unwinding, the ACA enrollment surge did not hit every state the same way. From 2020 to 2025, Texas saw a huge jump with a 255% increase in Marketplace plan enrollment. California's enrollment growth was smaller at 29%.[4]

Digitech's client data again mostly validates this trend. In a sampling of Texas agencies, we saw strong growth rates in the commercially insured population as more residents moved onto ACA plans thanks to the expanded subsidies.

Texas – Commercial Insurance

Municipality Type	Effective Change
Large metro city	14%
Mid-size city	16%
Mid-size city	16%
Mid-size city	19%
Rapid-growth suburb	0%

California did not see the same uplift in insurance coverage per Digitech's agency-level data.

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California – Commercial Insurance

Municipality Type	Effective Change
Large city	5%
Large county	-2%
Medium county	-5%
Mid-size city	-6%
Rapid-growth suburb	-9%
Mid-sized city	-8%
Small town	-1%

Why was this the case? California had been aggressive in enrolling people within their state exchange, Covered California, prior to COVID and individuals who do not have healthcare coverage throughout the year are subject to a penalty on their tax return. The Texas gains for EMS agencies were strong, but not as much as the overall healthcare numbers. Digitech believes this is primarily due to the fact that EMS services skew toward the elderly and underinsured. That means macro changes in Commercial insurance coverage have a muted impact on EMS providers.

Enhanced subsidies are a good example of a federal policy change that took years to roll out and gradually but steadily increased the number of people with coverage. Additionally, it highlights just how differently the same policy can play out from state to state and locality to locality.

What This Means for Your Agency

Federal and state policy changes have an impact on the number of insured patients in your community, but the effects usually play out over years, not months. Multiple initiatives, sometimes moving in opposite directions, make it difficult to isolate immediate impacts.

OBBBA's tighter Medicaid rules will push some off the program, mostly to the uninsured category. Because those changes are phased in over several years, the impact will be gradual and different in every state and every municipality. Meanwhile, the ACA subsidies are currently slated to lapse unless Congress takes action. If that occurs, enrollment in the marketplace exchanges is likely to drift downward, with more patients falling into the uninsured bucket.

It will take a decade for Medicaid cuts under OBBBA to fully take effect, with the steepest reductions coming in years 5-10. Immediately after the bill passed, some of the lawmakers who supported it were already exploring ways to soften the impact of those cuts. And over the next nine years, political shifts are inevitable, making it nearly impossible to predict the exact long-term outcome.

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For now, Digitech expects EMS agencies to experience a gradual decline in reimbursements over the next few years related to recent federal legislative action/inaction. It won't feel like a sudden budget crisis, but the trend is there and worth monitoring. The key is to treat these shifts the way you'd treat a patient's vitals or your own smartwatch readout. Day to day, everything may look steady, yet the numbers may drift in ways that matter down the road. If you track them early and plan for the direction they're heading, you'll stay in control. If you assume stability, you risk being caught off guard by shifts that could affect staffing, equipment, or service levels.

[1] Source: Kaiser Family Foundation. Three Questions About Medicaid Unwinding: What We Know and What to Expect by Robin Rudowitz, Jennifer Tolbert, and Larry Levitt. February 28, 2024

[2] Source: A state-by-state comparison can be found in this analysis: Kaiser Family Foundation. KFF Survey of Medicaid Unwinding by Lunna Lopes, Grace Sparks, Marley Presiado, Jennifer Tolbert, Robin Rudowitz, Amaya Diana, and Ashley Kirzinger. April 12, 2024

[3] Source: Kaiser Family Foundation. Medicaid Enrollment and Unwinding Tracker. July 28, 2025

[4] Data for both States represents more than 100,000 transports for agencies where comparable Digitech data existed for both 2023 and 2024. The Effective Change normalizes for changes in transport volume occurring at each agency.

[5] Source: Kaiser Family Foundation. Enrollment Growth in the ACA Marketplaces by Jared Ortaliza, Justin Lo, and Cynthia Cox. Apr 02, 2025

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ABCs of EMS Medicaid Funding: The New Rules After OBBBA

August 14, 2025 // by Michael Brook & David Mead

A clear-eyed look at CPE, IGT, and provider tax programs—and how to protect your agency's budget now.

There's no siren when a funding stream disappears. No alarm sounds when CMS quietly redefines which costs are reimbursable under Medicaid. But if you're relying on Medicaid supplemental payments, whether through CPE, IGT, or provider tax, you need to know what recent legislation means for your agency's budget and future.

A Small Slice of the Medicaid Pie, But a Big Impact

On July 4, 2025, the One Big Beautiful Bill Act (OBBBA) was signed into law, introducing sweeping changes to tax, energy, and entitlement policy. One major provision is a $1 trillion cut to Medicaid over the next decade, driven by new eligibility restrictions, work requirements for enrollees, and limits on Medicaid financing plans, also known as supplemental payment programs. These cuts raise concern for EMS providers in more than 30 states who rely on supplemental payments for critical revenue. While some impacts are obvious, others will vary depending on the type of program in use within each state.

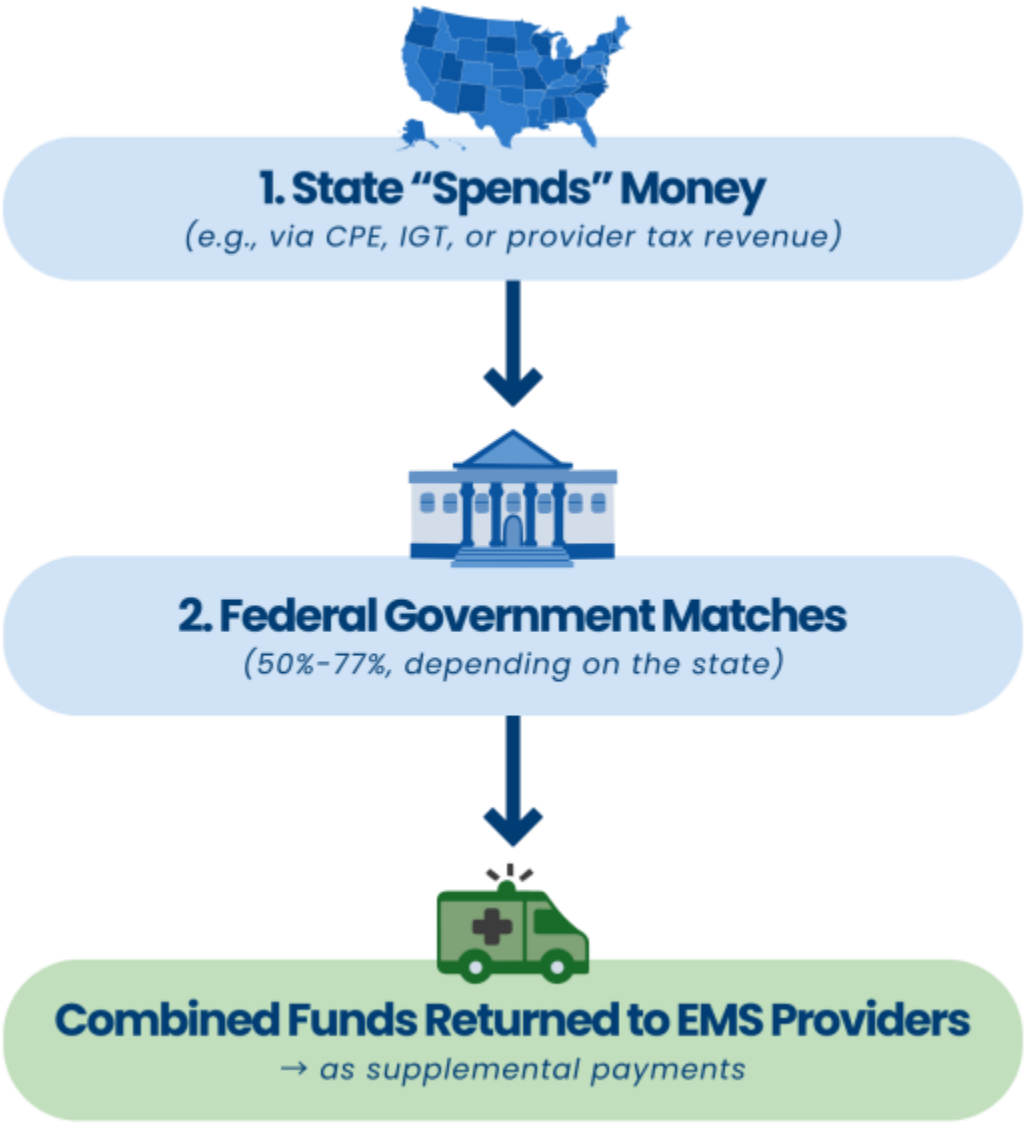
At Digitech, we've seen the confusion firsthand. EMS leaders across the country are trying to make sense of the patchwork of Medicaid supplemental payment programs in play. And we get it. The alphabet soup is dense, and the funding rules vary by state. But understanding how these programs work is important, especially now. EMS receives just a fraction of what hospitals take in through supplemental payments — less than $500 million annually, by our estimates (as no aggregated numbers exist for EMS), compared to $94 billion for hospitals in FY 2022.[1] The *impact* on EMS is outsized in relation to this small piece of the federal spending puzzle. For many overworked, chronically underfunded systems, these dollars aren't extra. They're critically important to the viability of EMS.

How State Dollars Unlock Federal EMS Funding

Despite their different names and acronyms, all EMS supplemental payment programs work in a similar way: they use state funds to pull down federal matching dollars. Because Medicaid is a joint state-federal program, for every dollar a state "spends," the federal government provides a matching percentage—anywhere from 50% to 77%, depending on the state's per capita income. (States with lower income levels get a higher federal match.[2]) This core funding structure is what

makes supplemental payments possible and why changes to the rules at either level can directly impact EMS budgets.

The Common Thread in All EMS Supplemental Programs



Similarly, Medicaid programs are jointly *administered* by the federal and state governments. Any changes provider payments or covered services at the state level needs federal approval. The OBBBA brings some of the most significant shifts we've seen in Medicaid financing in decades, and that includes the supplemental payment programs many EMS providers have depended on for a decade or more. If your agency relies on these dollars to keep units staffed and ready, expect changes ahead.

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Three Paths to Supplemental Medicaid Payment

Before we dive into the possible impact of restrictions or changes that the OBBBA may bring to Medicaid supplemental payments, it's important to understand the three main types of these programs commonly used by EMS agencies:

- **Certified Public Expenditure (CPE):** Used by government agencies**,** this model allows providers to report the actual cost of delivering Medicaid-covered ambulance transports. As allowed through a State Plan Amendment approved by CMS, an eligible EMS entity may voluntarily certify public funds spent to support the cost of providing a Medicaid-covered service (e.g., ambulance transport). CPE programs can go by many names, including Ambulance Services Supplemental Payment Program (ASSPP), Emergency Service Transporter Supplemental Payment Program (ESPP), Ground Emergency Medical Transport (GEMT), Public Emergency Medical Transport (PEMT), amongst others.
- **Intergovernmental Transfer (IGT*):*** In an IGT program, a local government entity (like a city or county EMS agency) transfers funds to the state Medicaid agency before a Medicaid payment is made. The state agency then uses this money to draw down federal match. The combined funds are returned to providers as supplemental payments. Each state makes its own decisions, within federal requirements, regarding how to finance its share of the Medicaid program. Generally speaking, these are often linked to State Directed Payments (SDPs) and used to support Medicaid Managed Care transports. The enhanced payments may be established at statewide average cost, Average Commercial Rate (ACR), or Medicare.
- **Provider Assessment (Tax):** Unlike CPE or IGT, this is a broad term for a program that funds State contributions toward Medicaid healthcare expenditures in order to secure matching federal funds. Provider taxes may benefit both governmental and private EMS agencies, depending on regulation and CMS approval. To qualify, the taxes must be broad-based and uniform – levied at the same rate across all providers in a class, and providers cannot be held harmless (direct/indirect guarantee that each provider will be repaid for the amount of taxes paid). There's a federal "safe harbor" if the tax stays below 6% of net patient revenue; the indirect guarantee does not apply if the tax rate falls at or below the safe harbor limit.

Medicaid Supplemental Payment Programs at a Glance

Type of Program	Certified Public Expenditure (CPE)	Intergovernmental Transfer (IGT)	Provider Assessment (Tax)
Entities Eligible	Governmental	Governmental	Governmental, nonprofit, and for-profit (private)
Reporting Requirements	Annual cost report	Cost report or average commercial rate survey	Net patient revenue report
Medicaid Payment Delivery Systems Covered	Typically, Medicaid FFS (in Texas, CPE is utilized for uninsured charity care reimbursement only)	Typically, Medicaid MCO but may also be utilized for Medicaid FFS	Medicaid FFS and Medicaid MCO
Approvals Needed	State Plan Amendment (SPA)	CMS preprint	Typically, state legislation and CMS preprint
Frequency of Approvals	Once approved, remains in effect until amended	Must be re-approved annually/biennially	Must be re-aproved annually/biennially
Audit/Desk Review Requirements	Yes	No	No

Now that we've defined the three programs, we move on to how these programs work.

CPE: How It Works and Where It Falls Short

In CPE programs, participating agencies submit detailed annual cost reports to document the true cost of providing ambulance transports to Medicaid patients.

How it works: If your agency calculates an average transport cost of $2000 and the Medicaid allowable (interim payment already received) is $200, the $1800 difference becomes eligible for reimbursement. Assuming a 50/50 state-federal match, you'd be eligible to receive $900 in federal funds. But there are three key limitations:

1. A CPE is only available for governmental providers.
2. Only Medicaid Fee-for-Service transports are eligible for reimbursement under a CPE. If your state has transitioned most enrollees to Medicaid Managed Care through a managed care organization (MCO), the funding opportunity through a CPE can be very limited.
3. Cost reporting introduces administrative overhead on the state and participating providers to maintain CMS compliance. This can be a significant burden.

Not sure how much of your Medicaid population is covered by FFS vs. MCO? Check with your billing vendor. You can also get a rough estimate at kff.org.[3] They estimate that the national average is around 75%.[4]

IGT: Filling in the Gaps in Managed Care States

While traditional CPE programs work well in states that have a majority of their claims covered by FFS, an IGT-based supplemental payment program may be layered on to cover costs related to Medicaid MCO transports.

In this scenario, a governmental EMS provider sends funds to the state Medicaid agency, which then uses those dollars to draw down federal matching funds. The combined funds (local and federal) are distributed back to the participating providers as supplemental payments. States may use IGT programs based on average statewide costs (which requires cost reporting) or Average Commercial Rates (ACR). But these programs require formalization and an annual CMS approval to remain in place, making them more vulnerable to policy shifts.

Provider Tax Programs: Broader Access, Different Rules

Unlike CPE and IGT, provider assessment (tax) programs are available to ALL EMS agencies, including governmental, nonprofit and private for-profit. Under this model, EMS agencies are taxed based on a formula tied to transport number or percentage of revenue. The state uses those funds to draw down federal matching funds, which are then redistributed to providers in the form of enhanced payments. Providers receive supplemental payments proportional to their Medicaid transport volume, making this a potentially meaningful funding stream for high-volume providers.

Policy Impact: What Does the OBBBA Mean for EMS Supplemental Payments?

CPE Under the Microscope

The OBBBA doesn't appear to *directly* target CPE programs, but they are under CMS scrutiny in terms of its interpretation of what counts as reimbursable costs for Medicaid patient transports. Historically, agencies could include readiness costs (staffing, ambulance maintenance, administrative support) in addition to the actual response cost and clearing the hospital. CMS is challenging that readiness piece. In some states like Texas, CMS audits have already excluded readiness costs, restricting the allowable cost to the time when the ambulance crew first comes

in contact with a patient to when the patient is dropped at the hospital. This shift ignores the 24/7 readiness that is essential to serving Medicaid patients, even if the clock doesn't start until patient contact. Without those substantial expenditures, the Medicaid patient could not call 911, receive immediate treatment, and be transported to the hospital. If readiness is excluded, local taxpayers will likely be left to fill the funding gap.

IGT: High Risk, Fast Changes

IGT programs are vulnerable to quick federal changes. CMS could decide to cap allowable costs (reimbursement) at the Medicare rate, which would lower supplemental payments, in many cases substantially. Because IGT programs require annual CMS approval, changes can happen fast with little time for agencies to adjust.

Provider Tax: Uncertain but Tightening

Nearly every state uses provider assessments for at least one provider class (49 out of 50, with only Alaska as the exception), whether that's hospitals, EMS, nursing facilities, or others. This is why any cuts to provider assessments are an important issue. The ripple effects go far beyond EMS, impacting multiple parts of the healthcare system.

The OBBBA's impact on provider tax programs is less clear and may vary by state, but CMS has already signaled that changes are coming. Most likely, we'll see freezes on assessment increases, limits on new programs, and tighter rules for existing ones.

From our work with EMS agencies across the country, we believe provider assessments are the most likely target for significant federal scrutiny. Not only has the OBBBA highlighted them, but CMS has also proposed new rules aimed at closing loopholes in how these programs operate (link to rule).

States that rely heavily on provider assessments to supplement Medicaid funding—particularly those with large Medicaid populations such as Kentucky, Missouri, and Tennessee—should prepare for possible revenue contraction. One lesson from recent experience is that regulatory changes often cause the most harm because of the uncertainty and lag time. You don't feel the impact right away; it can take months before reduced payments are reflected in your reports and budget. At that point, replacing the lost revenue becomes extremely difficult.

In Texas, for example, Digitech and our clients have had to navigate significant changes to the Ambulance Services Supplemental Payment Program (ASSPP) *after* cost reports were submitted. New cost allocation and data reporting requirements, likely tied to a federal OIG audit, were implemented midstream, creating delays, confusion, and making it impossible for providers to budget accurately.

We recommend running worst-case scenario models now and factoring in the possibility of delayed or reduced payments. For high-volume Medicaid providers in states that depend on

provider assessments, this is a “double whammy” risk. As Medicaid enrollment drops due to new eligibility restrictions, you may face both increased uncompensated care and reduced supplemental funding.

Act Now to Protect Your EMS Funding Future

Given federal spending changing substantially and Medicaid rules tightening, EMS agencies need a clear understanding of which supplemental payment programs they use and how each could be impacted as changes take effect. The exact impacts are still uncertain, as broad legislation like the OBBBA must be interpreted, implemented, and potentially altered over time.

Now is the time to review your funding streams, run scenarios, and start conversations with state partners and local decision-makers. These changes may roll out gradually, but agencies that understand their exposure and plan ahead will be in the strongest position to protect service levels and budgets.

Digitech encourages you to reach out to our Medicaid supplemental payment program experts if you want to discuss this situation in more detail. Talk to us now to understand the potential impact on your agency:

- Email Michael: mbrook@digitechcomputer.com
- Email David: dmead@digitechcomputer.com

Blog posts ghostwritten and edited by Rachel Wilson

EMS in Unprecedented Times: Federal Funding Uncertainty in 2025 and Beyond

April 9, 2025 // by Michael Brook

Widespread layoffs. Looming budget cuts. Federal funding freezes. Tariff uncertainty. Behind the attention-grabbing headlines are critical questions from EMS agencies that need answers:

- Will government payers continue to reimburse ambulance claims amid funding freezes?
- How will federal cuts to Medicaid affect reimbursement?
- Will Medicare payments take a hit?
- Are Medicaid Supplemental Payment programs like GEMT at risk?
- How can you navigate through tariffs?

The Rapidly Evolving Landscape

First, a Civics 101 lesson. Congress is the legislative branch of the federal government and holds the power of the purse, meaning it has authority over government spending. For substantial changes to occur, such as cuts in Medicaid or Medicare spending, Congress must pass legislation or budgets. Early signs in the current administration point to Congress creating a framework for sizeable spending cuts, but specifics are lacking at this point.

In the meantime, the Executive Branch has been issuing spending freezes through executive orders. There is no doubt that many government entities and individuals have been substantially impacted by those freezes, but major spending changes need to pass through Congress. Additionally, the courts have challenged many of these freezes, resulting in judicial orders for spending to continue.

At the time of this writing, the House budget resolution under consideration aims to cut at least $880 billion in costs over the next ten years. Experts say a substantial portion will need to come from Medicaid spending. Dissention is already rising; public sentiment indicates that not enough money is spent on Medicaid. According to a Kaiser Family Foundation Poll conducted February 14-19, only about 20% of respondents felt that too much was being spent on Medicaid and that it should be cut. Even among voters who supported Trump in the election, only 34% felt that too much was being spent on Medicaid. Around 19% of the U.S. population relies on Medicaid for health coverage[1], so Congresspersons' constituents would be undoubtedly affected by cuts.

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Medicaid is jointly funded by states and the federal government. Contributions vary state to state, but range from over 50% to 80%. What would happen if the federal government reduced its portion of the contribution? With roughly 19% of EMS patients covered by Medicaid in a time where Medicaid already under-reimburses providers for the costs of emergency ambulance transports, it's not a stretch to say that EMS providers would be impacted.

States Backed Into a Corner

If federal Medicaid funding was reduced, the states would be put in a difficult situation. In the short term, states could cover the shortfall, but most are not in a financial position to do this for very long. Other options include reducing the amount reimbursed for services (e.g., announcing a 50% cut in reimbursement rates, which are already very low to start with for most Medicaid programs) or reducing the number of covered individuals. These options could start a domino effect of negative consequences for EMS providers, as the number of uninsured individuals would grow while the Medicaid-insured population would decline. Uninsured patients rarely pay their EMS bills in full (or at all).

Similarly, with Medicare, reduced payments are unlikely to occur quickly. Medicare add-on payments were just extended through the end of the federal fiscal year, leaving long-term and higher levels of extension uncertain. The budget extension has not addressed the longer-term, substantial cuts that Congress and the Presidential administration are considering. The 4% PAYGO sequestration[2], deferred for several years as part of funding the Infrastructure Recovery Act, is also up in the air.

And then there's the Ground Data Ambulances Collection System (GADCS). The Medicare Payment Advisory Commission (MedPAC), tasked with advising Congress on Medicare issues, analyzed the initial dataset resulting from the GADCS that all EMS agencies were required to participate in. We were hopeful that the data and MedPAC's final report, due in June 2026, would result in a substantive increase in Medicare allowance amounts for ambulance transports. But given the various staffing cuts and focus on spending reductions, it would not be surprising to see a delay or end to the current efforts to seek increased/fair reimbursements from Medicare.

It's also unlikely that a consensus will be easily obtained on how to apply the recommendations that the Advisory Committee on Ground Ambulance and Patient Billing (GAPB) made regarding ground ambulance services vis-à-vis the federal No Surprises Act. With that said, addressing surprise medical bills is a topic that the current administration has said is a priority; hopefully that is not done without some thought and review of the GAPB report.

Major Unknowns

In addition to the various areas already covered, substantial changes to the global tariff structure appear to be likely. On the surface, EMS agencies are service providers and thus would not be substantially impacted by a change in the tariff structure. However, depending on how things play

out, supply costs could rise depending on from where required items (ambulances, equipment, supplies) are sourced. Additionally, there are concerns that new tariff structures will cause inflation to rise, which would put pressure on agencies to increase wages, the largest expense item for EMS systems by far.

At this point, there are many more questions than answers. One thing that appears to be certain: uncertainty.

In this industry, we react to the unexpected. From 9/11 to the opioid epidemic to Covid-19, emergency responders have adapted and moved forward during plenty of "unprecedented times." EMS providers will undoubtedly find ways to overcome any new challenge. But it shouldn't have to be this way. We encourage all involved in the EMS industry to get involved:

- Build relationships with local, state, and federal legislators. Regular meetings, phone calls, and emails can build strong working relationships, allowing EMS providers to educate them on the challenges faced by the EMS community and the need for improved funding. A good start is to write to your Congressional leaders and let them know how critical federal funds are for your organizations and communities.
- Join established organizations and advocacy groups. This list of EMS Associations hosted by NHTSA's Office of EMS (OEMS) shows organizations with which the OEMS collaborates most frequently, giving them a voice on the federal level. A unified voice has more impact when lobbying for legislative changes.
- Utilize digital and media outreach. EMS professionals can use social media platforms to raise awareness about funding issues, or even work with local news outlets highlight the challenges of EMS underfunding. Op-eds and opinion pieces for local newspapers or online publications can also have impact. Bringing public attention to the issues can pressure lawmakers to act.

Even small efforts and actions can make a big difference. EMS personnel and their supporters have the power to advocate for both preservation of and increases in reimbursement and funding, paving the way for more sustainable, efficient, and effective emergency medical services.

[1] Source: US Census Bureau, Health Insurance Coverage in the United States: 2023, September 2024.

[2] The 5% PAYGO sequestration refers to a mandatory spending reduction triggered by the PAYGO (Pay-As-You-Go) rules, which require offsets for new federal spending. For several years, this sequestration was deferred to support funding for the Infrastructure Recovery Act. For EMS, this sequestration could potentially reduce Medicare payments to providers, impacting their funding. However, the deferral allowed EMS services along with other federally funded services to avoid these reductions during the period when the infrastructure act was funded.

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Death and Taxes: Sustaining the Lifeline of EMS Services

February 12, 2025 // by Michael Brook

This article was originally published on EMS World in February 2025. You can check it out here.

In our previous article, *Behind the Sirens: The Hidden Costs of EMS Readiness*, we explored the costs involved in maintaining 911 EMS readiness with a midsize Midwestern agency called "Any Town Fire & Rescue Department" or ATFRD. In this follow-up, we'll examine the funding sources that support municipal EMS systems.

Introduction: The Life Behind the Lights

Late one stormy night in Some Town, a 9-1-1 dispatcher answers a call about a young mother struggling to breathe. Within minutes, EMTs from Some Town Fire & Rescue Department (STFRD) arrive, stabilize her condition, and rush her to the hospital. Behind this fraught moment lies a stark reality: EMS services depend on an intricate web of funding to ensure their readiness every day, every hour.

But who pays for this critical safety net?

This article delves into the urgent matter of EMS funding, illuminating the financial gaps that pose a threat to these life-saving services. It also presents potential solutions to bridge these gaps, underlining the need for immediate and concerted action.

The Costs of Readiness: Why It's So Expensive to Save Lives

Every EMS agency operates on two overlapping principles: readiness and response. Maintaining ambulances, equipment, medications, and staff requires funding, even when no emergencies occur. Yet readiness funding routinely falls short of covering its true costs.

In most municipal EMS systems, revenue comes from two primary sources:

1. **Direct Cost Recovery:** Revenue comes from billing insurers and patients for emergency transports.
2. **Tax-Based Funding:** Revenue comes from property taxes, municipal general funds, and special assessments.

However, these sources often do not sufficiently cover the needs. A staggering 80–90% of EMS transports involve uninsured patients or those covered by fixed-reimbursement government

payers, such as Medicare and Medicaid. The reimbursements tied to these transports often fall short of actual costs, leaving EMS agencies to fill the financial gap through taxpayer support.

Funding Breakdown: How Agencies Like STFRD Stay Afloat

Using publicly available data, we analyzed the funding mix for EMS agencies. Here's what we found:

- **Direct Billing Revenue:** Typically covers 20–35% of total costs.
- **Supplemental Medicaid Payments:** Provides additional funds in some states.
- **Tax-Based Revenue:** Fills the majority of funding gaps.

For example, at STFRD:

- 36% of EMS funding comes from property taxes.
- 22% comes from the municipal general fund.
- 11% comes from supplemental Medicaid payments.

Without the Medicaid program, funding gaps force STFRD to draw even more from property taxes, placing a heavier burden on the local community and forcing the municipality to make funding trade-offs.

Case Study: The Financial Gap at STFRD

Each ambulance transport at STFRD costs approximately $1,500, but they recoup just $490 per trip through billing. The remaining $1,010 must come from elsewhere—primarily from property taxes and supplemental funds.

This financial gap directly affects STFRD's operations, potentially leading to service cuts, increased tax burden, or the need for better reimbursement rates. Additionally, if state Medicaid programs aren't available, the same difficult decisions loom: raise taxes, cut services, or advocate for better reimbursement rates.

A Broken Model: Why EMS Funding Needs Advocacy

What if we viewed EMS funding like public utilities? Municipal water service requires an infrastructure (i.e., the storage, treatment facilities, pipes, and pipelines) to provide water to households and businesses at any moment; EMS readiness is an equally critical public service with infrastructure costs. Actual water usage fees apply to end-user usage. A household that consumes 1000 gallons of water pays a different amount on their water bill than those that use 100 gallons during the same period.

Following this analogy, taxes would cover the infrastructure of a 24/7 EMS service (like municipal water service infrastructure), and the cost of the actual ambulance transport would be covered by the patient receiving the service (like the water bill).

However, when reimbursements are insufficient, the burden shifts to taxpayers, stretching municipal budgets already allocated to schools, infrastructure, and public safety.

The question is: How do we ensure sustainability without breaking the system—or the community?

A Way Forward: Transparency, Advocacy, and Solutions

Sustainable EMS funding requires a multi-faceted approach:

- **Transparency with Taxpayers:** Agencies must communicate funding needs and the actual costs of EMS readiness.
- **Fair Reimbursement Rates:** A key pillar of sustainable EMS funding is the need for Medicare, Medicaid, and insurers to cover costs that truly reflect the actual expense of emergency transport. This fair reimbursement is essential to the financial sustainability of EMS services.
- **Community Engagement:** Residents must understand that EMS isn't just a service; it's a shared responsibility. Their active involvement and understanding play a significant role in sustaining EMS funding, empowering them to contribute to the safety of their community.

Conclusion: Beyond Death and Taxes

As STFRD prepares for its next budget meeting, its leaders must weigh impossible choices: service cuts, tax increases, or sustained advocacy. They—and every municipal EMS agency—face this truth: sustainable EMS funding is not an individual task but a collective effort that requires unity, collaboration, and the active participation of all stakeholders.

Behind the Sirens: The Hidden Costs of EMS Readiness

September 3, 2024 // by Michael Brook

This article was originally published on EMS World in August 2024. You can check it out here.

You are the EMS Chief of a midsize Midwestern agency called "Any Town Fire & Rescue Department" or ATFRD. It's 2 AM, and the call comes in — a 45-year-old male with chest pain. Your crew jumps into action, the ambulance's red lights flashing through the deserted streets. This scene, a lifeline in moments of crisis, is repeated countless times across the country daily. But what does it take to keep this service available around the clock? The costs are staggering and often hidden from view. Let's delve into the actual price of maintaining emergency ambulance services and our financial challenges.

The Hidden Infrastructure of EMS

As the crew responds, consider the intricate web of readiness behind this response. Maintaining an EMS system capable of responding to emergencies 24/7 involves substantial costs. While the spotlight is often on the staggering costs of ambulance services for patients, there's less focus on what each EMS incident costs the provider. These expenses extend far beyond the visible efforts of our paramedics and EMTs and include the readiness of staff, facilities, equipment, and supplies.

At Digitech, we process bills for over 5 million EMS incidents annually and assist clients in reporting cost data to CMS. To provide a clear picture of the true costs of readiness, we analyzed 2023 data from 11 diverse ambulance service providers across six states, including Fire-based and EMS-only services. This analysis reveals the extensive financial demands of maintaining an EMS operation.

Breaking Down the Costs: Where Your Budget Goes

Understanding the detailed cost breakdown is essential for managing an efficient EMS operation. Here's a comprehensive look at the categories involved:

Capital Costs – 2%

- Depreciation of buildings, vehicles, and operational equipment
- Leases, rental, and interest costs

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Salaries – 57%

- Regular, overtime, vacation, and holiday pay for all EMS staff, including EMTs, paramedics, chiefs, 911 call technicians, dispatchers, and support staff

Benefits – 25%

- Employer-paid health and life insurance, retirement plans, payroll taxes, and tuition assistance

NOTE: While salaries and benefits are over 80% of an EMS agency's costs, the industry still faces a staffing crisis; wages are simply not high enough to keep pace with the cost of living and pay in other competing fields. In New York City, EMT salaries start at $39,386 annually. That's less than the pay for an app delivery worker making the new city minimum wage of $19.56 plus tips while working 40 hours a week.

Medical Supplies – 1%

- Non-capital medical supplies such as medications, monitors, and consumables

Fleet Maintenance – 3%

- Maintenance parts, labor costs, and fuel for vehicle upkeep

Other Admin – 12%

- Professional services, contracted labor, medical director costs, training, utilities, and communications

Case Study: Any Town Fire & Rescue Department

Let's zoom out to understand the broader financial picture. The average cost for ATFRD to run one ambulance trip is nearly $2,000. Most ambulances make multiple trips daily, so the cost of keeping an ambulance operational and ready to respond is significant.

Cost Per Transport Breakdown

Using the example from above, here's how the cost from ATFRD breaks down:

Accounting	$24.98
Administrative	$15.24
Ambulance Salaries	$8.61
Contracts for Equipment Service	$6.07
Contracted Services – Ambulance	$1.39
Dispatch Service	$128.55
Dues and Subscriptions	$1.05
General Insurance	$43.42
Housekeeping	$4.58
Legal	$1.19
Medical Supplies	$30.07
Minor Equipment	$37.59
Minor Medical Equipment	$2.45
Other A&G	$4.39
Other A&G	$3.02
Salaries	$1,124.59
Salaries (Fringe Benefits)	$458.22
Supplies	$34.61
Training	$9.77
Utilities	$14.85
Total	**$1,954.60**

The Financial Gap: Charges vs. Costs

Your ATFRD crew stabilizes the patient and transports him to the hospital. This vital service comes at a significant cost. The disparity between the transport cost and the patient's charge is

substantial. In 2020, the average charge for an ALS emergency ground ambulance service was $758 (report), while the Medicare reimbursement for the same service was only $463. This leaves providers like ATFRD facing a significant shortfall for each transport unless they align fee schedules to costs, a decision with many downsides.

Moreover, for uninsured patients, ATFRD often recovers very little of the billed amount — not because the patients do not want to pay their bills but because they simply cannot. The collection rate for this "self-pay" group may be 5% or lower, meaning that if 1,000 uninsured patients are charged $1,000 each for an ALS transport, it would cost (ATFRD, for example) $1,955,000, and they may only recoup $50,000 on $1,000,000 invoiced.

Conclusion: Bridging the Financial Divide

As the patient receives definitive care at the hospital, your crew is already preparing for the next call. The cost of their service is the furthest thing from their minds — they are rightly focused on responding to that call and delivering high-quality pre-hospital medical care. However, for EMS leaders and administrators, understanding the true costs of EMS services is the first step towards bridging the financial divide. We must advocate for fair reimbursement rates that support our agencies and ensure sustainability. The math doesn't add up, and while the solution isn't simple, acknowledging and addressing these financial gaps is crucial for the future of EMS.

By shedding light on these hidden costs, we aim to foster a deeper understanding among our peers and drive the necessary changes to support our EMS providers. Together, we can work towards sustainable solutions that ensure our readiness and capability to serve our communities effectively.

The next call is just minutes away. Are we ready?

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What Will It Take to Get Fair Medicaid Reimbursement?

March 6, 2024 // by Michael Brook

Almost all Medicaid programs reimburse EMS providers for ambulance transports of Medicaid patients at a level *substantially below* the cost of providing the service.

That is a fundamental issue in the EMS reimbursement environment that needs to receive more attention, as it impacts the entire financial structure of the industry.

EMS isn't the only area of healthcare where Medicaid under-reimburses. For example, many doctors cap the number of Medicaid patients they will serve in their private practices because of the inability to subsidize service for those patients. In EMS, the payment levels for Medicaid patients transported by ambulance typically only cover a small fraction of the cost of providing emergency medical services.

Let's look at the four most populous states and what their respective state Medicaid programs pay for an advanced life support (ALS) ambulance transport:

California:

- Medicaid reimburses the provider **$119.20** for the ambulance transport. (This is the published rate, but these are subject to a mandatory 10% reduction, so the actual payment is **$106.38**.)

Texas:

- Medicaid reimburses the provider **$285.28** for the ambulance transport.

Florida:

- Medicaid reimburses the provider **$493.00 – $523.62** for the ambulance transport, depending on location.

New York:

- Medicaid reimburses the provider **$296.00** for the ambulance transport.

For most providers in these states, the average charge for an ambulance transport is more than $1000. We will explore the true cost of providing a 911 ambulance transport in a future article, but anyone can confidently conclude that an EMS provider transporting a Medicaid patient in the aforementioned states is not able to cover their costs with the amount that Medicaid reimburses.

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What are the impacts of Medicaid severely under-reimbursing providers for the costs of providing emergency ambulance transports?

First, states have had to pursue supplemental Medicaid payment programs to secure federal drawdowns to compensate for the shortfall in upfront payments. There are a wide variety of these supplemental payment programs. Some have not pursued these funds, so providers in those states will only receive the published Medicaid rate. Other states have taken a conservative approach on their supplemental Medicaid payment programs, resulting in modest additional payments. Still other states have taken aggressive approaches, resulting in more substantial supplemental funding.

This approach is analogous to rebate and special programs that pharmaceutical companies use to help patients pay for high-cost medications. Select, savvy consumers can obtain their medications for reasonable prices, but the average person ends up paying full price. This benefits fortunate providers that are in the right geography and able to take full advantage of supplemental reimbursement programs, versus providers unable to participate in a supplemental program or only in one that pays very little.

Ultimately, the result of these approaches is a hodgepodge of funding solutions which creates an unlevel playing field in the industry. Not to mention that in many cases, private EMS providers are excluded from state Medicaid supplemental payment programs. Consequently, we see private EMS services across the country struggling to staff their vehicles adequately or to deliver response times within mandated service level agreements. Some are closing up shop or pulling out of contracts that cannot support their workforce.

When prominent payers like Medicaid underpay, other payers have to subsidize the system. Within EMS, commercial insurance companies are covering a disproportionate amount compared to what government payers pay. The result: commercial insurance companies take advantage of this dynamic to argue that they should pay an amount less than the cost of providing the service, e.g., tying payments to a percentage of the Medicare reimbursement rate, or imposing a usual and customary amount.

In fairness, commercial insurance companies have a valid argument that they should not be picking up the tab that Medicaid and Medicare fail to cover. That said, EMS agencies are seldom charging more than the cost of providing the service; in some cases, they are not allowed to charge more than the cost of the service due to municipal statutes, meaning they always come up short.

The topic of fair reimbursement becomes more complicated when uninsured patients are part of the system. It is not unusual for 10-25% of an agency's patients to have no insurance. There is zero funding source for these patients who, for various reasons, are not covered by Medicaid – perhaps their income is above the threshold for qualifying for Medicaid, but they still cannot afford insurance, or they do qualify for Medicaid but are unwilling or unable to enroll. Who should pay for

these patients if they cannot afford to pay the bill? Currently, this payment burden falls to taxpayers.

Unfortunately, addressing the issue of inadequate Medicaid reimbursement requires legislative action in 40+ states to address severe underpayments for EMS. The current use of supplemental payment programs is a bandage, but it fails to stop the bleeding. A better approach would be to remove the bandage, assess the extent of the wound, and develop a fresh treatment plan with the goal of supporting a healthy and vibrant EMS transportation system. As an industry, we must start chipping away at the root causes that leave so many agencies struggling financially.

Resources

- CMS – Comparing Reimbursement Rates
- Medicaid.gov – State Overviews
- Kaiser Family Foundation – Medicaid Financing: The Basics

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How Does EMS Get Truly Integrated Into Mobile Integrated Health?

September 15, 2023 // by Michael Brook

With the early end to the Emergency Triage, Treat, and Transport (ET3) pilot program by the Centers for Medicare and Medicaid Innovation, a new conversation has emerged about how EMS agencies can be reimbursed for the services they provide other than transporting patients to hospitals.

The general sentiment is that agencies should not give up on the search for systemic solutions and should seek one-off funding sources by negotiating with individual payers. The question, however, comes down to whether this is practical and results in any sort of reasonable reimbursement.

There is a more fundamental reset needed in healthcare related to the importance of the full range of services provided by EMS. Rather than being truly "integrated," EMS is generally regarded as a mobility service – "you call, we haul." This is far from the truth, as any basic EMT could tell you. Here are some factors that counter a "keep at it" approach.

1. Funding Mobile Integrated Health (MIH) Programs Overall

Running alternative programs (Mobile Integrated Health, Community Paramedicine, treatment in place, transport to alternative destinations such as urgent care or mental health facilities – collectively referred to as MIH) is expensive. These programs require additional training, protocols, medical oversight, and sometimes additional vehicles and personnel.

Digitech has numerous clients that have some form of MIH in place, some with extensive programs and others with narrowly focused programs. In all circumstances, funding is challenging. Typically grants are the core funding source, sometimes supplemented by direct arrangements with select private insurance companies, hospitals, or physicians' groups. As noted by Dr. Allen Yee, medical director for Chesterfield County Fire and EMS's award-winning MIH program, other agencies have employed a cost savings model to direct resources toward preventing future needs for service expansion, thus preserving the agencies' finances.

2. Percentage of Medicaid/Medicare Patients Receiving MIH Services

At least two-thirds of patients receiving alternative services and treatments from EMS are covered by Medicare or Medicaid. Because Medicare has now withdrawn the ET3 program, there are no current avenues for reimbursement for the largest group of users of alternative EMS services.

Even when ET3 was in place, the requirements were so restrictive that very few EMS provider agencies were able to take advantage. For example, most municipal departments did not have the

ability, in a cost-effective way, to ensure an advanced level practitioner was involved in every treatment in place. Dr. Yee also reminds us that medical necessity was still a required component of that program.

With rare exceptions, Medicaid programs do not cover alternative services by EMS. This is unlikely to change quickly or easily, especially when it is up to individual EMS agencies to band together to lobby their State Medicaid and State legislatures to expand Medicaid coverage. Medicaid programs are notoriously slow to make changes.

3. The Challenge of Engaging Commercial Payers

A piecemeal approach to engaging commercial payers creates uneven results and favors the savviest payers. EMS providers are not typically experienced in negotiating contracted rates for services, particularly services they have never provided before. Municipal providers are not equipped to navigate multiple payers to negotiate rates for alternative services. Municipal agencies are also disadvantaged in negotiations, as commercial payers can push providers to the lowest negotiated level since they have full transparency into their numerous contracts (e.g., if one agency agrees to be reimbursed for a particular service at $100 that really costs $200, other agencies are unlikely to get the payers to negotiate above $100).

What would be a preferred approach?

First, there needs to be an acknowledgement that MIH benefits *all* participants in the healthcare system – patients, payers, and downstream providers.

The benefits need to be quantified, and the downstream providers need to pass along a substantial portion of their savings. Some of those savings include:

- Insurance companies save thousands of dollars per emergency encounter when a patient does not end up in the Emergency Room or the hospital.
- Hospitals avoid overcrowding ERs with low-acuity patients. This allows hospitals to focus on high acuity patients, as well as avoiding long wait times and poor patient experiences – today, low acuity patients often end up with long waits as higher acuity patients are triaged ahead of them.
- Other providers (urgent care, physicians, etc.) improve their utilization by seeing patients they can treat.
- Patients get the *right care* at the *right time* and the *right place*, all of which saves substantial money for all parties and improves the overall quality of the healthcare experience.

Second, there needs to be a concerted effort to engage Medicare and Medicaid about the benefits of MIH to their programs and to patients. Judging by the setup of ET3, which required an advanced level practitioner to "see" the patient prior to allowing them to be released without a transport, there is a clear concern about patient safety; however, this overlooks the fact that EMS already operates under medical direction and oversight.

Stakeholder concerns need to be identified and addressed prior to setting up these reimbursement models. There needs to be true stakeholder buy-in that MIH programs can and will provide safe and effective clinical treatments to individuals. After that is achieved, reimbursement levels should be established that appropriately compensate EMS for their services. Downstream providers and patients' payers should share a large portion of savings derived from delivering cost-effective treatment back to EMS, which will encourage agencies to enter the space.

Over time, as upfront investments are paid for and efficiencies are developed, there will be an opportunity to lower reimbursement levels. CMS and other payers should promote ways to optimize this space, not entrench the status quo. Additionally, downstream providers – hospitals, physicians' groups, urgent care facilities, mental health treatment centers, skilled nursing facilities – need to invest real dollars into MIH reflective of the substantial savings and benefits that MIH services deliver.

> *The EMS industry is experiencing a fundamental shift in how out-of-hospital care is delivered in our country. EMS providers play an important role in the health and safety of their communities and many EMS agencies have built innovative programs to better meet the needs of those they serve. Just as EMS has evolved, the reimbursement model must also evolve.*
>
> *-Kevin Spratlin, Division Chief of EMS Administration at the Memphis Fire Department*

A holistic approach that incorporates how timely and vital MIH services fit into the broader healthcare spectrum is needed, an approach that breaks the status quo and jump-starts investments. This is how we will provide superior patient care to our communities. This is how we get more than just the sum of Mobile + Healthcare and, instead, evolve toward true Mobile Integrated Healthcare (in its many forms) as a critical healthcare service.

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Pros and Cons of Aligning Ambulance Fee Schedules to Costs

July 20, 2023 // by Michael Brook

Setting ambulance fee schedules can be challenging and complex.

On one hand, governing bodies and EMS providers do not want to place an undue burden on patients who require an ambulance for an emergency medical need. On the other hand, providers need to try to optimize revenues for their agency to maintain operations and provide the highest level of care.

Another complexity of ambulance fee rate setting is that transport fees are considered a healthcare service; because of this, the amount a provider charges for transports is completely disconnected from the amount payers will pay.

Governmental payers – Medicare and Medicaid primarily – pay based on a set fee schedule which is not connected to the actual cost of the individual entity providing the service. Medicare and Medicaid transports typically represent two-thirds to three-quarters of an EMS agency's transport volume, which results in a substantial gap between the cost of providing the service and the reimbursement they receive.

Only with commercial payers – insurance carriers – do EMS providers get close to what they charge in payment.

So, especially for municipal providers with relatively high cost structures, there is *no* amount that could be charged that would result in full cost recovery. An agency would need to charge some astronomical amount, such as $10,000 per transport, and be able to recover 75% of those charges from the 10-20% of the patients that have commercial insurance coverage, to come close to recovering their costs. Of course, charging $10,000 per transport is unlikely to get either governing body approval or community support!

Here are some of the pros and cons of aligning ambulance transport fees to costs in 911 systems:

Pros

- Accurately reflects the cost of providing the service
- Can objectively be measured and adjusted periodically
- Promotes awareness within the community of the cost of providing 24/7, immediate response services

- Creates awareness for the various involved service providers (labor, management, governing bodies) of the contributors towards overall costs
- Likely is the best-case scenario for maximizing revenue and offsetting a substantial portion of the cost of providing the service

Cons

- Charging the cost of the service, especially for municipal providers, may result in a charge level that exceeds what the governing body and the community feel comfortable supporting
- Places an undue burden on uninsured or underinsured patients
- Creates a subsidization scenario in which commercial insurance providers are "subsidizing" the system since governmental payers do not adjust their payments based on costs or charges
- Increases the patient responsibility for patients with commercial insurance because co-pays are often tied to a percentage of charges (e.g., 20% is typical)

There are substantial and significant cons. But from an industry perspective, agencies are doing a disservice to their fellow providers by not charging at least equal to costs.

Undercharging reinforces the insurance practice of paying at a usual and customary level that is completely detached from the cost. The case needs to continue to be made through available avenues to Medicare and Medicaid that providers deserve to recover their cost of providing the service. For patients, agencies can establish hardship policies to mitigate some of the excess burden put on uninsured and underinsured individuals. As for patients with commercial insurance who get hit with high co-pays, the burden can be lessened by making sure hardship policies provide relief for people who truly cannot afford the payments.

In the end, the EMS community cannot "fix" the growing burden on patients. Patients do have protection once they reach a total out-of-pocket amount, but there is no doubt the financial burden is heavy when a patient experiences a medical emergency – of which the costs related to ambulance services is only a small piece.

The Surprise Factor: Why EMS Deserves to be Reimbursed for Costs in the Midst of Balance Billing Regulations

April 10, 2023 // by Michael Brook

The recent federal budget proposed by the Biden Administration for FY 2024 had an unwelcome surprise in it for the EMS industry. The proposed budget extends the No Surprises Act (NSA) to cover ground ambulance services, a category that was previously left out, starting in 2025. Let's look at where we are right now and how we got here.

No Surprises Act Overview & How Ambulance Services Fit In

The NSA was passed in 2021 with the stated goal to end surprise medical bills for patients. The Act applied regulations to emergency services in hospitals and air ambulance, but Congress kept ground ambulance services as an area that a separate committee (Ground Ambulance Patient Billing Advisory Committee) would review to determine how the NSA should be applied.

Specifically, the NSA prohibits *providers* from balance billing patients, which occurs when the *payer* (insurance companies) refuses to allow the charge from the *provider* (hospital, doctor, air ambulance). For patients, this usually occurs when there is no knowledge or choice of care options and the patient receives care from an out-of-network *provider*, leading to a surprise bill. The situation forces the *provider* to file a case with an arbitrator (federal independent dispute resolution process) if it feels the payment made by the *payer* is insufficient. The arbitration is "baseball style arbitration," in which the arbitrator chooses one side or the other; there is no settlement in between. The idea behind this is that both *provider* and *payer* are more likely to submit a realistic number to avoid the other party being deemed to have provided a more reasonable amount. Additionally, the arbitrator is supposed to consider the good faith efforts each party has made to reach a fair reimbursement through a negotiation and contracting process as part of the determination. For example, if a *provider* shows multiple attempts to negotiate a reasonable reimbursement through contractual outreaches, only to have the *payer* reject all efforts, that would benefit the *provider.*

Unfortunately, the NSA is off to a bumpy start. When the legislation was passed, it was estimated that there would be 17,000 cases of arbitration in the nine-month period for which it was in effect during 2022. That period actually produced 275,000 cases. The U.S. Administration weighed into the arbitration process with guidance that when in doubt, the arbitrator would consider the

amount of payment made by the payer as the presumed correct amount. Many feel this was tipping the scale too far in favor of payers.

In 2022, a judge ruled that the overweight consideration of the payer's "qualifying payment amount" was unfair. The Biden Administration revised the rule in September, and it was immediately challenged again by the Texas Medical Association (TMA) as being overly partial to payers. In February, a judge agreed with the TMA that the guidelines around the arbitration were unfairly biased towards payers. The arbitration process is on hold.

Another awkward aspect of the proposed FY 2024 budget is that the Ground Ambulance Patient Billing Advisory Committee Congress formed to make recommendations on how to apply the NSA to ground ambulances had already been formed and is pending its first meeting. The proposed extension of the NSA to ground ambulance undermines the process that Congress established to provide thoughtful consideration of what is fair to all parties.

Putting aside the growing drama around this topic, what does this mean and where do ambulance providers go from here?

Where Ambulance Providers Go From Here

In addition, messaging to the public on this topic is an area where there is an uneven playing field. Insurance payers have the deep pockets and can influence the message. Payers have hammered on messaging that the issue is about greedy providers, and that the providers are solely driving up healthcare costs. Compared to the insurance industry, ambulance providers are numerous, less financially endowed, and relatively unorganized.

What do we need to push for? The EMS industry needs to continue to make the case that ambulance providers must be allowed to get reimbursement for the costs of providing the services. On the municipal side, cutting insurance payments just means that tax subsidies will need to increase to cover the cost of the services. For private providers, companies will have to charge their public constituents more – and typically that burden will fall back on the municipality that has contracted for the services – or exit the market. This is just a shell game of placing the burden elsewhere.

Where insurance companies do have a fair argument is that they are subsidizing an unfair payment system in which governmental payers are not paying their fair share of the costs. Medicare should be addressing this through the CMS cost reporting process that is underway via the Ground Ambulance Data Collection System. But we are still several years away from the results that consider potentially increasing what Medicare pays for an ambulance transport. In most states, what Medicaid pays for an ambulance transport is a small fraction of the cost. There really needs to be a coordinated effort across *all* payers. Forcing a change favoring the commercial insurance payers starting in 2025 is not the answer.

The more fact-based we can be, and the stronger we can appeal to the sensibility of the general public about the value of EMS, the better the outcome will be for the industry. We cannot let ourselves be placed in a situation that will force tremendous infusions of money from municipalities' general funds that are already stretched thin. We cannot allow private providers to be forced out of the industry because the financial model is stacked against them.

The lifesaving EMS providers in our community deserve to receive reasonable reimbursement to sustain a vital part of the United States health system.

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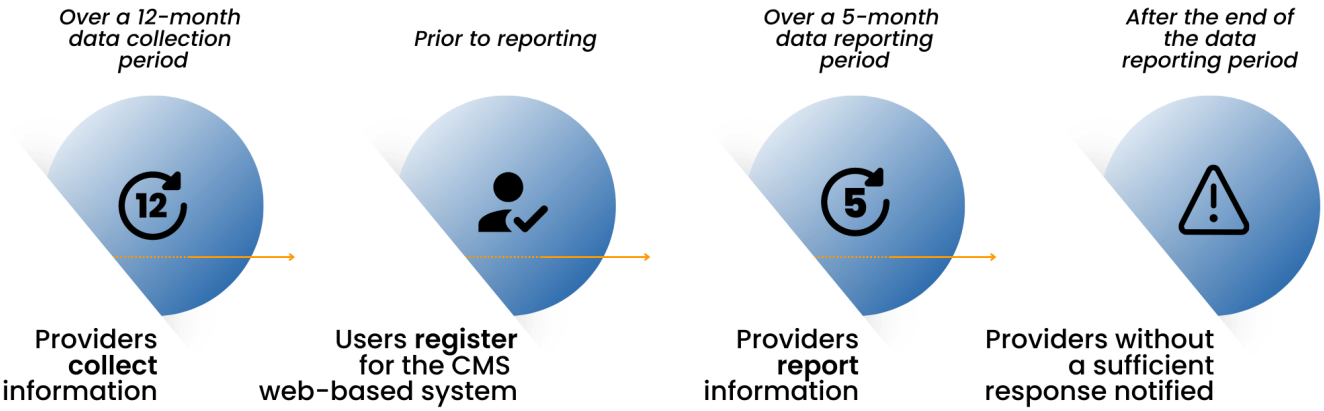
CMS Cost Reporting in 2023 and the Impact on EMS & Ambulance Medicare Reimbursement: Where Are We Now?

February 28, 2023 // by Marketing

Check out our webinar on this topic: Best Practices for EMS Providers Now That Mandatory Cost Reporting is Underway

Mandatory CMS cost reporting was announced in earnest several years ago, only to be interrupted and delayed (like many things in our lives) by the COVID Public Health Emergency. Now, ground ambulance providers are focused on reporting under the Medicare Ground Ambulance Data Collection System (GADCS), with approximately half of all EMS agencies well into or even having newly completed their mandatory data capture. The other half of EMS agencies are at the beginning stages of collecting the required data. The process of data submission to CMS has just begun, depending on the reporting period for each agency.

Now is a good time to take a look at some of the context around mandatory CMS cost reporting and examine the impacts on Medicare reimbursements in the medium-term as a result of these efforts.



GADCS Key Milestones for EMS Providers

First, let's review the history of ambulance reimbursements and how the structure for ambulance reimbursements differs from the reimbursement allowables that Medicare sets for other healthcare services.

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In 2002, Medicare implemented a phased-in national fee schedule for ambulance services. The goal was to address the high variability in the amounts being reimbursed depending on whether an EMS provider was hospital-based or independent. In 2005, the Government Accountability Office (GAO) conducted a cost study. Interestingly, of the responses received in the cost study, 1/3 were omitted because the responding services were Fire-based and did not have a clean carveout of only ambulance costs versus other costs. The GAO report estimated that in 2010, excluding most Fire based agencies, 39-56% of providers would receive average Medicare reimbursement payments that would exceed their costs – which means, conversely, that half or more of the providers would not be able to cover their costs with Medicare's reimbursements (Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly, 2007). Additionally, the GAO report identified super rural providers as being at the highest risk of having Medicare payments well below their costs.

In an attempt to address the perceived shortfall in Medicare reimbursement, Congress included temporary Medicare ambulance bonus payments in the Medicare Modernization Act that paid an additional 2% (urban), 3% (rural), and 22.6% (super rural), starting in 2004. Those temporary bonus payments have been extended, with much debate, every few years since then.

Elsewhere in healthcare services – hospitals, physicians, clinics, labs – Medicare payments are established via an annual collection of cost data from all providers. CMS uses the collected data to update the allowable amount continually to cover costs for the provider, plus a reasonable margin. Ambulance services have been the exception, and the industry has been vocal about the existing allowables not being sufficient to cover the costs of providing the service. Outside of the 2005 GAO study, which excluded a large number of fire-based municipal ambulance providers, there is little factual data that ties current reimbursements to current ambulance rates. The amounts set in 2002 are adjusted by an annual inflation factor. The "temporary" Medicare add-on bonus payments are a modest recognition that the current Medicare rates are insufficient.

As you likely have inferred, the ambulance cost reporting initiative by CMS is intended to put ambulance providers on par with other healthcare service providers in terms of assessing costs and delivering fair reimbursement. EMS providers have received a concession, at least initially, by not being required to submit cost data annually, but rather every four years.

The collected and reported data is going to the Medicare Payment Advisory Commission (MedPAC); MedPAC will then be required to submit a report to Congress on the adequacy of Medicare payment rates for ground ambulance services and geographic variations in the cost of furnishing such services. The timing of that report is not specified. The idea is that, at some point in the future, the data would be used for resetting the amounts Medicare will pay to ground ambulance providers.

There has been speculation by some providers that the Medicare allowable amounts will go up significantly as a result of the cost reporting submissions, while others believe the amounts could

drop. This difference in perspective likely depends on what type of agency you are. Fully integrated providers under municipal structures typically have costs substantially higher than the current allowables, but private ambulance services that provide a large percentage of 911 services nationwide typically have a much lower cost structure. Also, agencies running all-ALS services have a higher cost structure than those that have a mix of ALS and BLS vehicles in their system.

No matter what, over the next several years, we expect to see changes to Medicare reimbursements in ground ambulance as a result of the cost reporting efforts. Generally the sentiment is that, at minimum, the cost of providing 24/7 911 services has increased faster than the current inflation factor accounts for. Time will tell, but there is a reasonable chance that reimbursements will be enhanced to better align with today's costs of providing this critical service.

Digitech hopes that you find this context about the substantial Medicare GADCS cost reporting effort useful to understand the system more deeply or to explain the reasons to your key stakeholders. Please reach out to CMSDataCollection@digitechcomputer.com if you would like more information about Digitech's data collection software, which assists agencies in organizing the required data elements, or if you would like assistance in data collection via our cost reporting consulting services.

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Check out our webinar on this topic: Best Practices for EMS Providers Now That Mandatory Cost Reporting is Underway

Blog posts ghostwritten and edited by Rachel Wilson

Why Should You Outsource EMS Billing?

August 25, 2022 // by Marketing

EMS billing isn't for the faint of heart. While patient care is the core mission of any EMS organization, it's impossible to provide adequate care without resources provided by a healthy revenue stream.

Billing Isn't Just Paperwork

Agencies that handle their billing in-house, rather than outsourcing EMS billing to a third-party vendor, are in fact running two business. Ambulance transport and EMS billing are different enterprises with different requirements for staffing, IT infrastructure, compliance, operational costs, analytics, and more.

This leads many EMS agencies to outsource their billing. Smart decision. The fee that a billing service will charge will certainly be less than the cost of running a second internal business. Let a specialized company handle the specialized work of billing so that the EMS agency can focus on patient care and other operational priorities.

Here are five main reasons why EMS agencies have made the switch to outsourcing.

1. Reduced Costs

An established third-party billing company has a head start on infrastructure that an in-house department may never catch up with. Staffing, workspace, IT, hardware, training, software licenses, maintenance, even office supplies and equipment – these essential elements create burdensome ongoing fixed costs. Letting the billing provider handle these costs allows the EMS organization to direct resources to other essential budget items. Meanwhile, if the billing company invests in scaling their operation, building technology, and attracting top-tier staff, those benefits will be passed along to clients.

2. Industry Expertise

Billing companies deal with hundreds of providers, payers, and facilities – far more than a single EMS organization with an in-house billing department ever will. You may transport to a few different hospitals, but a billing firm may have connections to hospitals across an entire region

and access to databases of patient data that your in-house billing team will not have. Outsourcing EMS billing allows you to take advantage of these economies of scale and collect every dollar.

Billing vendors also have the benefit of a broader range of resources and staff who can engage with industry associations, attend events, and stay abreast of trends in the changing healthcare environment. A good partner will keep you informed of new developments when necessary and will make sure that changes are incorporated into technology and policy as needed.

3. Top-Tier Technology

All billing companies rely on claims processing software to manage their operations. Good billing companies develop their own claims processing software to manage their operations with efficiency, opportunities for customization, and automated processes balanced with manual oversight.

Simply put, it would be impossible for an in-house billing department to develop and scale the technological expertise needed to maximize the potential of technology for billing.

4. Customer Service for Patients

After a traumatic 911 event, the best customer service may be no customer service at all. In other words, the best thing for a patient is not to have to worry about how to pay for their emergency transport.

Often, individuals are confused about their insurance coverage for EMS services. Third-party billing companies have advanced technology solutions designed to identify patient insurance information quickly and efficiently – more so than an in-house billing department could do alone, even armed with the best software. If your billing company processes millions of claims annually, they have established manual and automated processes to uncover patients' insurance information through clearinghouses, demographic databases, admitting hospital data access, and sheer manpower.

Patient inquiries and other sensitive customer service touchpoints will inevitably still arise, so it's important to look for a third-party vendor with high levels of professionalism and sensitivity to your organization's reputation.

5. Increased Collections

The results of the combination of cost reduction, industry expertise, targeted technology, and great customer service? Increased collections for your organization. A billing company has one goal: maximizing the return on every claim submitted. To keep the business viable long-term, they must do so compliantly and direct resources toward infrastructure and technological innovation. This results in increased collections for clients.

Third-party billing companies should also have the capability to perform sophisticated analysis by looking at the right metrics to measure performance. Your billing partner should help you understand the right data at the right time for the right reasons. Then, you'll be able to monitor and assess your billing company as well as project revenues.

Deciding how to handle your agency's EMS billing takes analysis and careful consideration, with plenty of pros and cons to weigh. We've provided a handful of good reasons to outsource EMS billing. What are your reasons to keep doing your own billing?

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50 Questions to Ask on Your EMS Billing RFP

January 27, 2022 // by Marketing

Issuing an EMS billing RFP this year? Selecting the right partner for EMS billing is a crucial decision for every EMS organization that outsources billing services.

Determining the best fit can be daunting. Choose wrong, and it could have devastating consequences to revenue and reputation. Choose right, and you could develop a mutually beneficial relationship with a vendor that helps your agency flourish for decades to come.

Many agencies go through a request for proposal process to find a billing partner, either for convenience and assistance with the search or because they are required by their governing body. Our team here at Digitech is highly experienced in creating proposal responses to these RFPs; we've read more than we care to admit over the years. In doing so, we've identified a standard set of questions that we believe should be in your next EMS billing RFP, whether you're considering outsourcing for the first time, you know your department needs a change, or you are seeking to determine if your current provider is still the best fit.

This list arms you with 50 questions in six major areas to include in your EMS billing RFP. Answers to these questions will give you a deep understanding of the proposing vendors so you can make an informed choice.

Want a printable checklist? —> **click here**

Company Overview

1. How many years has your company been in business?
2. How many years has your company provided third-party EMS billing services?
3. Disclose any key business partners, subsidiaries, and/or contractor relationships.
4. How many EMS billing clients do you have and what type are they (e.g. municipal, hospital-based, private)?
5. How many EMS claims does your company bill annually?
6. How many employees to you have dedicated to EMS billing services?
7. Provide an organizational chart providing the roles and responsibilities of the employees who will manage and/or be assigned to perform services.

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8. How many offices do you have dedicated to providing EMS billing services? Where are these offices located?
9. Provide information about your customer service policies and procedures, including escalation and issue resolution processes.
10. Describe how your company is notified of changes in legislation and how that information will be incorporated into your systems and processes in a timely fashion.
11. List any professional EMS associations that your company belongs to.
12. Provide a list of all award protests that your company has filed in the last five years, including the reason for the protest and the outcome.
13. Provide contact information, start date, annual transports, and a brief narrative covering implementation and services provided for three current EMS clients of similar size, complexity, and scope.

Compliance and Regulatory

1. Does your company have a compliance plan that is updated regularly?
2. Is a copy of your compliance plan available for inspection upon request?
3. Has your company, its parent, or a subsidiary ever been investigated for suspected fraud and abuse by any department or agency within the federal or state government such as OIG, Medicare, Medicaid, CMS, or Recovery Audit Contractor?
4. Has your company, its parent, or a subsidiary ever been required by a department or agency of the federal or any state government to follow a Corporate Integrity Agreement?
5. Has there been an investigation where the final determination resulted in a client paying a fine or penalty due to coding and billing actions that were related in any way to your provision of services?
6. Are you able to furnish evidence upon request that all current employees are not excluded from participation in state and federal healthcare programs?
7. Please provide a brief description of your company's quality or audit process.
8. Is any auditing process provided by an external vendor or source? If yes, briefly describe these audits.

Technology and Security

1. Is the EMS claims processing and billing system you use proprietary to your company or is it software developed by a third party?

2. Provide a general overview of the billing and records management solution. Describe the billing software used, who owns it, who supports it, how many clients use it, and describe the process by which required programming changes are made.
3. List any additional licenses that are necessary to fully operate all available aspects of the proposed billing software, including reporting software.
4. What level of access will be provided into the billing system? Will it include full visibility into all actions, notes, documents, etc.?
5. Does your system provide logging of all activities on a patient account for all dates of service, and do you provide access to these logs?
6. How is patient information stored, and for how long is this data retained? Are these records retrievable by the client?
7. Please provide a brief description of your business continuity plan or disaster recovery plan.
8. Provide a detailed listing of all data breaches including volume of patients affected and current status.
9. Provide evidence of at least three years of annual SOC 1 Type 2 audits.

Coding and Billing Process

1. What is your preferred method for receiving ePCR information?
2. Explain the format that the ePCR data will be uploaded into the billing software, and what fields will be included, e.g. patient demographics, insurance, guarantor, medical procedures performed, chief complaint, dispatched as, and found to be.
3. Briefly describe the training process for a new coder that starts with your company.
4. How are coding personnel audited?
5. How are claims assigned to coders? Are specific coders or groups of coders assigned to certain clients?
6. If there is not enough information to code the claim, what is the process for obtaining the necessary information?
7. Please describe the circumstances in which a claim would be returned to a client.
8. What is the typical length of time required to bill a claim once the necessary information is received?
9. What is your standard invoicing process and timeline?

10. Describe the appeals and review processes for denied claims and the process for limiting denied claims.
11. Describe the cash posting process.
12. Describe the refund process.
13. Please describe your process, including the frequency, for providing documentation feedback to providers.

Implementation and Onboarding

1. Describe the initial phases of this project, including a proposed implementation plan.
2. Describe how you ensure that implementation and the transition to your system does not negatively impact the billing and collections processes for our organization.
3. What resources will we need to provide during onboarding and implementation?
4. Describe the support and training you provide during the onboarding process, and describe the ongoing support and training for our administrative personnel that you will provide once onboarding is complete.

Reporting

1. Please provide sample of weekly or monthly client reports that are part of your standard client reporting process.
2. How are requests for non-standard reports handled? Is there a cost for these types of reports? If so, how is pricing determined?
3. Please include any additional information regarding your reports and the data analysis tools provided to your clients.

We hope this list helps you get started in your endeavor to create or revise an RFP related to your organization's EMS billing and coding process.

Embracing Change: Writing the Next Page of Digitech's Story

October 30, 2020 // by Marketing

Today marks a milestone for Digitech. We've finalized the merger between the R1 EMS business and Digitech that was announced earlier this year, and we are now moving forward with operations as a combined business under the Digitech name.

As a 36-year-old company, we've seen a lot of changes that have impacted our organization in one way or another: the shift from paper dispatch systems to CAD. The creation of NEMSIS. Changing EMS education standards and compliance requirements. Revisions to Medicare's national ambulance fee schedules. The Affordable Care Act. Advancements in mobile integrated healthcare. The still-evolving response to the COVID-19 pandemic. While some of these occurrences have been more challenging to deal with than others, Digitech thrives on these kinds of changes. Constant adaptation to the continuously changing environment of EMS is at the heart of our success.

Now we embark on a unique milestone for Digitech. Throughout our history, we have added clients and even employees carefully and selectively. Our growth can be attributed largely to strong references and referrals, and we are proud of that strong reputation. Moving forward, we will continue to build upon the mission and vision that R1's EMS division (formerly ADPI/Intermedix) and Digitech share: compliantly maximizing collections for customers through time-tested processes and powerful technology, keeping revenue flowing so EMS providers can focus on keeping their communities safe and healthy.

This shared dedication brings together two companies that have been competitors for a decade. As we continue under one metaphorical roof, we have a great opportunity to bring the best, most trustworthy ambulance billing services to even more Fire and EMS agencies across the country.

As one business, we bring a deep level of expertise to the marketplace. At Digitech, EMS billing is all we do. We are not part of a larger revenue cycle management company, and we do not have other divisions that focus on different lines of business such as physician billing. This allows us to specialize like no other company can. Our staff is made up of former Fire chiefs, EMS directors, paramedics, EMTs, and other first responders and public safety professionals. We know EMS.

We've also always been a technology company. Ambulance Commander will remain the same efficient processing platform that has powered our EMS billing services for years. We've always invested heavily in this area, directing our time and resources to improving our proprietary platform's speed, availability, and transparency. Our in-house teams have spent countless hours

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on research and development. Digitech's developers not only continuously incorporate client feedback and fine-tune processes with client goals and needs in mind, but also react instantly to the unexpected, like legislative mandates, reimbursement changes, and public health emergencies. Now, we will be able to dedicate even more of our efforts to Ambulance Commander. We'll be rolling out more user-friendly features, careful automations, and informative reports.

As we launch into the first merger or acquisition in Digitech's history, we more than double our staff and customer base. We have a tremendous opportunity ahead of us to expand our reach in the EMS community, to innovate more, to continue our tireless dedication to our mission. Among the many compelling strategic reasons for this transition, we pledge to maintain the same goal we've had since 1984: make every client feel like they're our only client.

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