Emergency Medical Services (EMS) Suggested CMS SDP Proposed Rule Comment Letter Considerations and Message Points

CMS Proposed Rule (CMS-2449): Medicaid Managed Care State Directed Payments (SDP) and Medicaid Fee-For-Service (FFS) Targeted Medicaid Practitioner Payments

Considerations for State Leadership on Commenting on the Proposed Rule

Overview

The proposed rule represents a significant shift in Medicaid financing policy, with implications for states, providers, and the Medicaid populations they serve. Comments are due by July 21st, 2026. Ambulance providers may be significantly impacted by the proposed rule.

With the tremendous diversity of programs and impact among states and companies the American Ambulance Association will be focusing its' comments on the sole issue of inadequate reimbursement by Medicare and Medicaid. This will be highlighted as a critical issue impacting patient care and access. Medicare should not be viewed as a sufficient benchmark payment as it is inadequate.

We understand that individual companies and states will have specific comment they wish to make and are providing the following points for individual companies and state associations to consider when forming their comment letters to CMS.

We strongly encourage states to submit comments as you discern how the proposed rule will affect your individual program.

Overarching Policies to Consider

- Are you currently below the 100%/110% of Medicare that the rule caps payment to?
- Is your provider assessment/tax already at 3.5%?
- Is there a disproportionate advantage/disadvantage to different provider types in your state? For example, is supplemental payment for public entities much higher than for privately owned?
- Is the cliff of immediate implementation vs. phase down a critical issue for your operation?
- Is Medicare parity your goal as a state association, or when SDP is included are you above Medicare for Medicaid payment?

Talking Point 1 - Congressional Intent to Exempt Ground Ambulance Services

The foundational argument for those seeking exemption from the rule is that it goes beyond the scope of HR.1 and Congress intent:

The Proposed Rule Goes Beyond What Congress and The President Enacted in H.R. 1 and Beyond Congressional Intent: H.R. 1 established significant reductions to Medicaid and CHIP. However, the proposed rule introduces additional changes that expand both the scope and magnitude of these reductions.

- This is a significant reduction to Medicaid; it is a much deeper cut than what Congress legislated in H.R.1.
- This proposed rule extends those new rate caps to other services that HR1 did not cap, as well as fee-for-service programs which also were not included in HR1 caps.
- With regards to ambulance services, our congressmembers voted for H.R. 1 with the understanding that the Medicaid funding cuts would impact four provider classes, not including the ambulance class: inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers.
- The proposed rule views ambulance as a non-grandfathered class, thus imposing an immediate reduction to EMS SDPs to 110% of Medicare in 2029. As this was not delineated within H.R. 1, we view this as administrative overreach.

Talking Point 2 - Medicare Under reimburses Ground Ambulance Services

Medicare is Not an Appropriate Payment Benchmark: Medicare rates are not an appropriate benchmark because Medicare and Medicaid cover vastly different demographics with entirely different cost structures.

- Further, in ambulance services context, Medicare rates are often insufficient to cover the costs of providing services leading to significant reimbursement shortfalls. These are compounded at a time when services are experiencing significant fuel and workforce cost increases.

Talking Point 3 - Supplemental Payments are the only mechanism afforded ground ambulance services to increase woefully undercompensation for the underinsured.

Medicaid Supplemental Payments are Vital to Serving Medicaid Members:

Insert your state's Medicaid Shortfall—the actual cost of delivering care versus the state's baseline Medicaid fee-for-service reimbursement rate. Show that current SDPs are not "excessive windfall profit," but are mathematically required just to bring total reimbursement up to the actual cost of care.

Talking Point 4 - Ambulance services are subjected to a cliff and not the phase down afforded providers "grandfathered" by HR1 - lack of parity of impact of draw down

Provision: SDP Caps on services not included in H.R.1, specifically ambulance service

Under the proposed rule, these services would be subject to caps that converge to the Medicare payment limit without a transition period comparable to the phasedown provided for grandfathered programs.

- Unlike SDPs for grandfathered programs, SDPs for these services must comply with the prohibition on separate payment terms and the prohibition on uniform rate increases before reaching the Medicare payment limit, adding to the administrative burden of these programs.
- In the 2024 Medicaid Managed Care rule, CMS did not apply an SDP benchmark to EMS services. The application of a 100%/110% Medicare cap will have detrimental impacts on access to care, particularly in rural regions.
- The immediate decrease of these SDPs to Medicare in 2029 would not only put EMS providers under significant financial and administrative strain; it would likely cause increased closures of organizations and further limit access to care across the country.
- An alternative approach would extend the transition period applied to grandfathered SDPs to services not capped by H.R. 1. Similarly, restrictions on uniform rate increases and separate payment terms should align with those for grandfathered SDPs and take effect only once payments reach the Medicare limit.
- Alternatively, these services should not be capped at the Medicare equivalent. They were excluded from the H.R. 1 SDP caps and the Medicare or state plan equivalent is not always appropriate for these services. Additionally, these services have often been excluded from CMS's payment benchmark guidance including in the 2024 Medicaid Managed Care rule.

Talking Point 5 - Administrative Burden to small providers with little or no impact to fraud and abuse

Provision: The Medicare Equivalent Rate on a Per-Service Per-Provider Basis

- CMS proposes applying the Medicaid payment limit on a per-service, per-provider basis. For SDP implementation, this requires establishing a Medicare-equivalent payment limit for each service a provider delivers; once an SDP reaches that level, payments may not exceed the Medicare limit.
- This provision goes beyond both H.R. 1 and the President's memo on eliminating waste, fraud, and abuse in Medicaid by imposing highly specific caps at the individual provider and service level. The shift from aggregate ACR or UPL ceiling to service-specific Medicare limits is one of the most significant policy changes. Providers already at or near Medicare receive little/no additional benefit.

- The proposed caps are significantly more rigid than the Medicare upper payment limit (UPL) caps currently in place on certain Medicaid FFS payments.
- From an operational perspective, this approach would introduce substantial administrative burden for both states and providers, requiring the application of potentially hundreds of thousands of individual payment benchmarks and caps. There is no clear precedent for payment benchmark policy that is both broadly applied and structured at this level of specificity and rigidity.
- Medicare is not an appropriate benchmark for ensuring access to ambulance service for Medicaid patients.

Talking Point 6 - Overreach to FFS programs again imposing. cliff versus a phase in

Provision: Payment limits on targeted Fee-for-service payments

- Fee-for-service payments were not capped by H.R. 1. The H.R. 1 SDP provisions were focused on Medicaid Managed and did not include provisions that limited Medicaid FFS.
- The proposed rule includes no step-down in payments to the Medicare equivalent like the grandfathered SDPs enjoy. This creates a cliff that will heavily impact ambulance services.
- Targeted FFS payment limits should be excluded from the proposed rule as they were not contemplated in H.R. 1.

Conclusion

There could be even more nuanced points dependent upon your state's individual landscape as it relates to Medicaid Supplemental Payments. The core message points above are the most common issues with the proposed rule; however, depending upon your particular program, where it may be in its life cycle and other ground emergency medical transport programs within your state careful consideration should be given to how best to submit comments to address your particular programs' issues. Please reach out to sbaird@ambulance.com if you want to talk through any state specific concerns you may have.

Instructions to Submit Comments

DATES:

To be assured consideration, comments must be received at one of the addresses provided below, by July 21, 2026.

ADDRESSES:

In commenting, please refer to file code CMS-2449-P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *https://www.regulations.gov/docket/CMS-2026-1916*. Follow the "Submit a comment" instructions.

2. *By regular mail*. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2449-P, P.O. Box 8016, Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-2449-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850. For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.