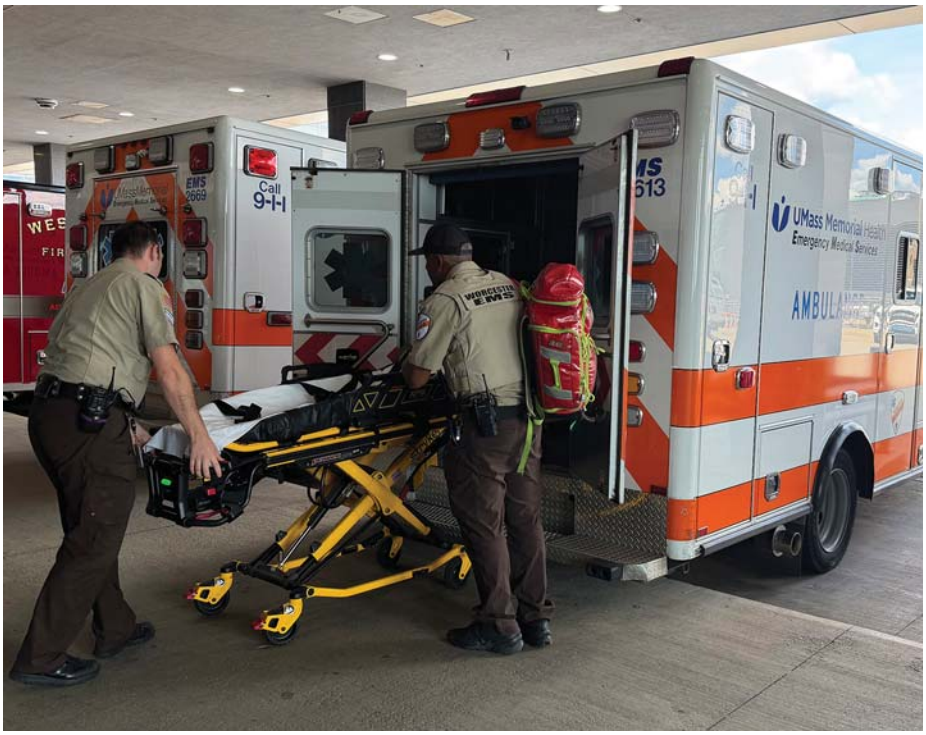


Serving patients: In central Massachusetts, Worcester Emergency Medical Services, operated by UMass Memorial Health, serves a sizable population of patients who rely on Medicaid.

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For Emergency Medical Services, An Old Threat Resurfaces: Medicaid Cuts

Local communities expect H.R. 1 and subsequent Centers for Medicare and Medicaid Services rules to place financial strain on a system already struggling with inadequate reimbursement.

BY MICHAEL S. GERBER

Sometime in the past year, Ken Shanahan created a folder on his computer just for Medicaid denials. Before that, he hadn't really needed one—it was pretty rare, he said, for MassHealth to question claims for patients taken to the hospital by an ambulance. Those claims had been filed by Worcester Emergency Medical Services (EMS), which is operated by UMass Memorial Health, where Shanahan was serving as senior director of emergency medicine and behavioral health when he spoke to *Health Affairs*. (He left the position in October.) He then he noticed an uptick in the number of times the state's Medicaid agency was questioning a bill before sending a payment. Most denials, he said, were associated with patients who had been transported back to the emergency department (ED) within twenty-four hours of discharge, and payment for the second (or sometimes third or fourth) trip was denied.

Maybe the state is just trying to confirm that multiple transports took place, or perhaps it is questioning the medical necessity of those transports; Shanahan isn't always sure. What is clear, he said, is that they're scrutinizing payments more than in the past, possibly in preparation for looming cuts to Medicaid across the country from the 2025 budget reconciliation bill, also known as H.R. 1.

In Massachusetts alone, according to an analysis published by the Blue Cross Blue Shield of Massachusetts Foundation, the legislation's Medicaid work requirements and eligibility redeterminations will lead to 141,000–203,000 people losing coverage, with the vast majority of those remaining uninsured.[1]

Many of those people are likely to be in Worcester. Built atop a series of hills about forty miles west of Boston, Worcester saw its once robust industrial base fade in the second half of the twentieth century. Although the city—the second-largest in Massachusetts—and surrounding region have sought to boost investment in health care and technology, the transition has been inconsistent. An estimated 31.8 percent of Worcester's 213,000-plus residents were on Medicaid in 2024, with just under 4 percent being uninsured.[2] Shanahan said that Medicaid enrollees make up about 22 percent of Worcester EMS's transported patients.

Shanahan hopes that Worcester EMS, which is run by the hospital and is the primary provider of 911 ambulance response in the city and in the neighboring town of Shrewsbury, located across Lake Quinsigamond, will not be affected too negatively by the work requirements, other provisions of H.R. 1, and subsequent rules proposed by the Centers for Medicare and Medicaid Services (CMS). Worcester EMS currently receives no subsidy from the city and in fact pays

Photograph by UMass Memorial Health

Worcester a small stipend to cover the cost of an emergency telecommunicator to dispatch ambulances.

"[Worcester EMS doesn't] break even, but it's a community benefit," Shanahan said. Still, costs are going up: In just the last four to five years, according to Shanahan, the price of a fully equipped ambulance has skyrocketed by more than 10 percent to well over $400,000. At the same time, competition for emergency medical technicians (EMTs) and paramedics has increased, raising turnover and labor costs. Even before H.R. 1, the hospital and city were in negotiations to change their agreement, potentially putting more financial responsibility on the city, Shanahan said. Similar conversations are happening in communities across the country, and H.R. 1 has only increased the urgency.

Insurance Coverage And Emergency Care

With most of H.R. 1's provisions only now being implemented or set to take effect in 2027 or beyond, the law's full impact on emergency care is unclear. Yet stakeholders widely agree that the number of people with Medicaid will go down while the number of uninsured people rises—a reversal of trends that began with the 2010 passage of the Affordable Care Act (ACA) and the expansion of Medicaid in forty-one states (including Washington, D.C.) over the ensuing decade and a half.

Leading up to Medicaid expansion, some proponents argued that the policy would alleviate strain on EDs, thanks to increased access to primary care and other services. People with access to medical care, the thinking went, would no longer use the ED as a one-stop shop for all their medical needs; also, they would receive better preventive care, reducing acute flare-ups of chronic conditions requiring emergent treatment. Other experts suggested that ED use would increase, as people with coverage are more likely to seek care, especially costly services such as the ED.

What happened, in some ways, was both—or maybe neither. Some studies reported a slight decrease in overall ED use in expansion states compared with nonexpansion states. Along with that change came a predictable shift in payer mix: Higher proportions of ED patients had Medicaid coverage, and lower proportions were uninsured. Other studies, however, documented increased use of ED care among people who gained Medicaid coverage compared with those who didn't.[3]

Theodoros Giannouchos coauthored one of the papers finding a decrease in ED usage in two states that expanded Medicaid compared with two states that did not. In that study, the decrease was driven by fewer ED visits for reasons classified as nonemergent, treatable by primary care, and potentially preventable—perhaps a sign that newly eligible Medicaid enrollees were accessing primary care, urgent care, or other services.[4] Giannouchos, a professor at the University of Alabama at Birmingham, cautions that several factors could explain why some studies have not found similar results.

"Insurance is not access," Giannouchos said. "ED visits might go down in states where there is shortage of primary care providers or different levels of Medicaid patients. Or you could see an increase because once you get insurance, you pay less, so [there's] no reason why [you] wouldn't go now."

Even less is understood about the relationship between Medicaid coverage and use of EMS. It makes intuitive sense that in general, trends in ED use would be reflected in EMS use as well. In one of the few studies examining how EMS activations were affected by Medicaid expansion, Lauren Birmingham and coauthors found no change in EMS use for adult patients and a slight change in pediatric use that dissipated over time.[5] Acknowledging the limitations of that research, Birmingham, now a senior lead scientist at Booz Allen Hamilton, said that utilization was only a small piece of how changes in Medicaid enrollment could shape the emergency care system.

"The central question isn't whether ambulance utilization rises or falls," she said. "It's more about how the shifts in coverage can shift overall demand, system capacity, and resource availability. When you call 911, you want somebody to be able to come and get you in a timely manner.…Utilization is a component of that, but not the whole story."

Charles Courtemanche, a researcher at the University of Kentucky, agrees. He has authored two papers looking at how changes in insurance coverage may have affected EMS. Using national data from the Fatality Analysis Reporting System, one study in 2019 found that ambulance response times to motor vehicle crashes increased in Medicaid expansion states compared with nonexpansion states—a possible adverse effect of increased demand on the system.[6] Another 2019 paper reported that EMS use for "minor" complaints increased in New York City after the passage of the ACA, while calls for more serious illnesses or injuries remained stable.[7]

"When you're introducing people to health insurance…they are used to showing up at the [ED] when something goes wrong," Courtemanche explained. "Continuing to use the [ED] as the primary care doc—now they don't have to worry."

State Of Emergency

"For years now, EMS as a whole has been underfunded," said John Peterson, executive director of Medic, the EMS agency for Mecklenburg County, North Carolina. "EMS is the backstop of health care: When people don't have access to or can't afford [care] or they're sick and they need help, we're the ones that they call."

Medic is governed by a board of commissioners made up of members representing two Charlotte-area hospital systems and the county government. But it operates similarly to a government-run county EMS agency. According to Peterson, the agency operates at a loss, with a portion of its budget coming from county subsidies, but about 75 percent of its revenue comes from billing for EMS services, and more than 20 percent of those bills are for Medicaid patients. Medic recently added ten ambulances to its fleet in response to increased call volume, and other costs are going up. Meanwhile, the state hasn't increased its Medicaid fee schedule in more than a decade. Pressure to keep the subsidy down while continuing the same level of service led Medic to increase its overall billing rates in 2022. Now, rising costs mean that it is considering another increase.

"From my perspective, [H.R. 1] is one of the reasons we're looking to do a rate increase," Peterson said. "If we lose

funding on the one side, we've got to recover it somewhere."

But even before all of H.R. 1's provisions have taken effect, Medic's leaders have reported an increase in the number of uninsured patients in 2026. North Carolina was one of the states hit hardest when Congress allowed the COVID-19 subsidies for ACA Marketplace insurance to expire last year.[8] In Mecklenburg County alone, enrollment in ACA plans dropped by more than 17 percent.[9] Because of its close relationship with the local hospital systems, Medic generally follows their financial assistance policies and will not pursue unpaid bills from patients whom the hospitals deem eligible for charity care. But for the remaining uninsured or underinsured patients, Medic will send bills and sometimes rely on state programs that allow the agency to garnish tax refunds from residents with outstanding balances.

As EMS organizations lobby at the state and national level for higher Medicare and Medicaid reimbursement rates, agencies look for other ways to provide effective service with diminishing resources amid increasing call volumes. Medic, for one, has been at the forefront of EMS systems trying to better triage calls in the emergency communications center. After all, not every 911 call requires the same response. A few years ago, Medic began staffing more basic life support ambulances—meaning those with EMTs instead of paramedics with higher levels of training.

The agency also stopped guaranteeing immediate response. Instead, Medic might tell a caller with a low-acuity complaint to expect an ambulance in thirty minutes. These changes enable Medic to "send the right resource to the right patient at the right time" and ensure faster response times for time-critical emergencies while also improving efficiency, Peterson explained. But with labor, equipment, and fuel costs continuing to outpace inflation, operational improvements can only help so much.

One way to improve EMS financing, Peterson and other EMS leaders said, is to allow EMS agencies to bill for treatment without transport. At this time, most payers, including Medicare and Medicaid in the majority of states, only reimburse for calls that result in a transport to the hospital.[10] But a significant

Even before all of H.R. 1's provisions have taken effect, Medic's leaders have reported an increase in the number of uninsured patients in 2026.

percentage of ambulance responses—around 20 percent in many communities—do not result in a trip to the hospital.[11,12] Some of those calls are for minor illnesses; car accidents with no injuries; or false alarms, such as someone sleeping in public who is mistaken by a bystander to be unconscious. Other calls are for serious and even life-threatening conditions, such as a person with critically low blood sugar that is reversed by paramedics administering intravenous dextrose or an overdose victim receiving naloxone but not necessarily requiring—or wanting—subsequent immediate care in an ED.

"That's a whole lot of people that we send an ambulance to that I can't bill," Peterson said.

Supplemental Payments At Risk

At a roundtable discussion earlier this year, Rep. Brad Schneider (D-IL) heard similar comments from fire chiefs in his district. Schneider represents Illinois's Tenth Congressional District, comprising Chicago's most northern suburbs as well as more rural areas along the Wisconsin border. The sentiment wasn't new, Schneider said—he's heard complaints about Medicare and Medicaid reimbursement before—but this time, the urgency seemed greater.

"When you talk to people in your district, …one person tells you something, it's a concern; two people tell you something, and it's an issue. When all of your fire chiefs in the district are saying, 'Hey, we have this concern,' and your mayors are talking about it, police chiefs are talking about it, it's something altogether different," Schneider said.

The officials were not just worried about an increased number of uninsured patients, they also worried about a potential reduction in Medicaid reimbursement for people who still had coverage. Through legislation enacted in 2018, Illinois's Medicaid system reimburses agencies that participate in its ground emergency medical transport (GEMT) program at rates approaching ten times the scheduled Medicaid fee-for-service rate for an ambulance transport. More than a dozen states have GEMT programs, which typically only pay the higher rates to public municipal or county-run EMS organizations, whereas some states use other methods to increase Medicaid rates, including state-directed payments funded by provider taxes.[13] The programs vary in how they fund the state's portion, how they determine payment rates, and which EMS agencies are eligible.

When Congress passed H.R. 1 in 2025, it included cuts to Medicaid managed care state-directed payments to four provider types: inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at academic medical centers. Then, in May 2026, CMS issued a proposed rule that took the limits even further, to all provider types and other supplemental payments outside of state-directed payments. According to the rule, not yet finalized at the time this article was written, supplemental Medicaid payments would be limited to no more than the Medicare payment rate in Medicaid expansion states and 110 percent of the Medicare rate in non-expansion states, possibly drastically reducing reimbursement under GEMT laws such as Illinois's.[14]

Schneider raised these concerns at a recent House Ways and Means Committee markup, calling the GEMT program "critical for fire departments to keep their ambulance[s] ready to respond when emergencies happen, when citizens call."[15]

"Fire chiefs in my district are trying to build multiyear budgets around a policy that is not at all clear or provide any certainty," he continued. "If [this is] finalized without clear guidance, we won't be talking about a rounding error, we'll be talking about ambulance [services] that can't afford to be fully staffed, response times that are increasingly longer, and already-bootstrapped public safety agencies having to make up the cost difference."

Erik Christensen, a lieutenant with the Wauconda Fire District northwest of Chicago, just outside of Schneider's congressional district, has overseen EMS operations for the agency for almost a decade. In his time in the role, the department has seen its call volume grow by about 25 percent. In 2025, the department responded to 4,898 calls, more than 3,500 of which were medical incidents.[16]

"The type of calls that we're running has changed quite a bit," Christensen said. "We're seeing a greater majority of patients who are just chronically ill, who don't have access to services, who don't have primary care physicians."

The region is dotted with a dense forest preserve, scenic lakes, multiple boat repair and storage services, and a quaint Midwest downtown village. Although the majority of the agency's patients are Medicare beneficiaries, Christensen said, the second-biggest payer is Medicaid, which covers about a fifth of the people the agency's paramedics and EMTs treat. Before the GEMT program, the department would receive around $200 each time it cared for a Medicaid enrollee and transported them to the hospital. Now, that payment is significantly greater, finally aligned with the department's true costs, he said.

"Prior to GEMT, [we had] a million dollars in ambulance revenue. Right now, we're at 2.2 million [dollars], and GEMT has been a big part of that," Christensen said. The 2026–27 budget adopted by the fire district's board estimates $2.8 million in ambulance fee revenue, accounting for about 12 percent of the district's total budget.[17] The rest of the budget is funded largely through property taxes, and GEMT is one of the reasons the district hasn't had to raise those taxes to cover the rising costs of vehicles, fuel, and equipment.

"If GEMT goes away, …it would be fairly dramatic," Christensen said. Communities such as Wauconda would be forced to make a choice: raise taxes to continue the same level of service they've come to expect or find ways to reduce expenses, including reductions in personnel, salary freezes, or eliminating programs. "There would be a delay in capital purchases," he explained. "Ultimately, vehicles would be older [and] buildings wouldn't get renovated."

Most EMS providers, regardless of who owns them or how they operate, agree that Medicare rates do not come close to covering the cost of service.

Cuts to Medicaid could also threaten the sustainability of the region's mobile integrated health care program—a partnership between Wauconda Fire District, neighboring fire and EMS departments, community organizations, and regional hospitals. The program sends specially trained paramedics to work with people with complex health needs and reduce their need for emergency services. In 2024, Illinois enacted a law requiring insurers to cover medically necessary services provided by programs such as these, beginning in 2026.[18]

Although neither ambulances nor GEMT payments were mentioned in H.R. 1, they have been targeted in the past by some administration allies as examples of wasteful Medicaid spending, and the CMS proposed rule calls them out specifically as "targeted payments" that "present clear oversight risks to Federal taxpayer dollars for which CMS is a financial steward."[14]

According to CMS, states reported making nearly $79 million in GEMT payments in fiscal year 2024,[14] with the programs designed to have the state share largely covered by the recipients of the payments themselves through intergovernmental transfers or certified public expenditures. In Illinois, for example, agencies such as the Wauconda Fire District send estimated payments to the state equal to about 50 percent of the total reimbursement they expect to receive from Medicaid reimbursements the following quarter. This process, which increases total state payments without requiring a greater outlay from the state itself, serves to pull in more funding from the federal government by taking advantage of Medicaid's matching formula.

Critics of these programs call it a form of money laundering: "These payments result in federal matching funds, producing windfalls for the states and government providers. The losers from this financial scam are federal taxpayers and private providers that are excluded from these arrangements and paid far lower rates for the same services," wrote Brian Blase, a former Trump administration official who serves as president of Paragon Health Institute, a conservative think tank.[19] CMS itself echoed similar sentiments in its proposed rule: "Moreover, we have not identified information indicating that these payments broadly improve access to care, quality, or other relevant programmatic outcomes, as they are typically targeted only to providers, or practitioners employed by or affiliated with such providers, that have the means and ability to fund the non-Federal share of the payments."[14]

GEMT programs have clearly led to wide differences for reimbursement rates in states where some communities are served by public EMS agencies and others by private agencies. Evanston, Illinois, for example, just north of Chicago, recently raised its ambulance fees from $2,000 to the amount in its annual GEMT cost report, which is closer to $3,000.[20] The published private ambulance transport rate for Cook County, meanwhile, is just over $550 for an advanced life support emergency.[21]

When Evanston raised its rates to match the GEMT cost-reporting data, it raised its rates for every ambulance transport, not just those for Medicaid beneficiaries. Similar to many communities, Evanston's policy is to waive any additional fees beyond what a resident's insurance covers.[20] Nonresidents transported while visiting Evanston might be subject to balance billing, however, and some other jurisdictions do bill their residents for the difference.

In California, GEMT led to some creative alliances formed by private and public entities. In several communities where 911 EMS response is delivered by a contracted private ambulance provider, agreements were altered to make the fire department the official provider of ambulance services, even if those services continued to be contracted out to the private entity.[22] This allowed the public fire agency to bill at GEMT rates and reimburse the private contractor at negotiated levels.

Defenders of public agencies argue that the extra reimbursement is deserved. Scott Clough is a former firefighter and paramedic who, as a consultant at AP Triton, helped set up GEMT programs in several states and assists agencies wanting to participate in those programs. He said that fire departments and other public entities typically have stations and equipment deployed throughout a community and often perform unreimbursed services, such as first response.

"If you think about it, the fire service, the governmental entities…we have infrastructure," Clough said. "The reality is, fire agencies can do this job cheaper than the private sector. We own the infrastructure."

Now, CMS's rule cracking down on state-directed payments threatens those funding streams. Complicating matters is the variation in how the rule will affect different types of EMS agencies in different states. Public comments criticizing the inclusion of GEMT programs in the rule poured in from fire agencies and communities in GEMT states.[23] In contrast, the president and CEO of Global Medical Response—the private equity–backed owner of American Medical Response that recently went public—submitted a letter endorsing the rule, specifically noting that payments directed solely to public entities "promote waste and provide a conduit for fraud and abuse."[24]

"Differences in service levels may exist among communities, but those differences reflect local policy choices on the level of 911 EMS resources they make available, not the ownership of the provider delivering the services," wrote Edward Van Horne, president and CEO of Global Medical Response.[24]

At the same time, Priority Ambulance, a competitor that operates in fifteen states, commented that the limits on state-directed payments would "reduce our overall Medicaid supplemental payments by more than half and result in below-cost reimbursement on average for Medicaid transports" in six of those states.[25]

The Role Of Medicare

Despite disagreements on supplemental payments, most EMS providers, regardless of who owns them or how they operate, agree that Medicare rates do not come close to covering the cost of service. That's an issue not only because Medicare beneficiaries make up a significant portion of EMS patients but also in the case when Medicare rates become the ceiling against which Medicaid supplemental payments are measured, as CMS has proposed.

This past summer, Schneider and a bipartisan group introduced legislation in the House that would change how the Medicare ambulance fee schedule is set. The Reimbursing Emergency Services for Critical Urgent Encounters (RESCUE) Act would tie fees to cost data reported to CMS by EMS agencies around the country.[26]

Medicare payment for ambulance services, Schneider said, has been "increasing at a comparatively slow rate—much slower than the cost of providing services has grown—and departments are struggling." As a consequence, he continued, "municipalities are struggling."

"What we'd like to see," he said, "is that the rates are determined based on actual cost data coming from across the country, coming from departments—that the process…for applying for and getting that reimbursement is straightforward, and that this is done on a regular basis, not willy-nilly."

Schneider and others also point out that hospital finances have a direct impact on EMS operations. When EDs decrease staffing or rural hospitals close, they say, ambulance transport and patient turnover times only increase, putting further demand on EMS systems. Several EMS leaders also note that unlike hospitals, EMS services have no specific programs to rely on to help make up for uncompensated care. Medicare does provide temporary percentage add-ons to the ambulance fee schedule based on whether transports originate in urban, rural, or certain super-rural areas. But these adjustments are not enough, EMS officials argue.

"Two things are almost certain to happen as the years go by and the parts of [H.R. 1] actually get implemented, assuming Congress doesn't change it," said Matt Zavadsky, an EMS consultant who works with agencies around the country. "It is almost certain that call volume is going to increase. And it's almost certain that reimbursement for Medicaid is going to decrease.

"And when you look at the ripple effects of every one of those provisions—work requirements, eligibility refresh, look back periods, hospital impacts… all of those are going to lead to reduced ability for people to get health care," Zavadsky added. "And when there's a reduced ability for people to get health care, they use 911 as their safety net, either appropriately or inappropriately."

The full scope and specific details of CMS's final rule remain to be seen, as does the agency's approach to implementation. In Worcester, Shanahan said hospital officials told him they don't think the CMS proposed rules will affect the supplemental Medicaid payments they receive from the state. But who will be affected and by how much is still unclear. In a state-by-state analysis, Zavadsky and his colleagues at PWW Advisory Group, an EMS consulting firm, said that the rule "could materially reduce future supplemental payment opportunities" for public and private EMS agencies in Massachusetts starting in 2029.[27] That could mean millions of dollars in lost reimbursement, Shanahan said, leaving the residents of Worcester—similar to those in Wauconda, Mecklenburg County, and communities across the country—searching for new sources of funding for EMS or facing tough choices about cutting services. ■

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