HSJ 04: SUSTAINABLE REIMBURSEMENT FOR EMS
STAFF ANALYSIS

PROPOSAL INFORMATION			
SUBMITTING COUNTY:	Union County		
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FAC COMMITTEE:	Health, Safety, & Justice (HSJ)	**CROSS-CLAIMS:**	N/A
FAC STAFF:	T. Graham	**DATE:**	October 4, 2026

This staff analysis is based on the proposal as submitted and does not reflect an adopted position of the Florida Association of Counties.

POLICY PROPOSAL:

Union County supports legislation and administrative action to establish sustainable and equitable reimbursement for emergency medical services by:
1. Requiring Florida Medicaid reimbursement for emergency ground ambulance services to be no less than the applicable Medicare ambulance fee schedule amount, including reimbursement for loaded mileage.
2. Establishing Medicaid reimbursement for medically necessary EMS treatment provided without transport, modeled after successful treatment-without-transport reimbursement programs in other states.
3. Establishing a fair and enforceable reimbursement standard for emergency ground ambulance services provided to commercially insured patients, including appropriate protections for patients from excessive balance billing while ensuring that local taxpayers are not required to subsidize costs that should appropriately be borne by health insurers.

These reforms should recognize EMS as a healthcare provider delivering emergency assessment, treatment, stabilization, and medical decision-making rather than reimbursing EMS solely as a transportation supplier.

I. SUMMARY:

Union County requests FAC support for a Medicaid reimbursement floor equal to the applicable Medicare ambulance fee schedule, including loaded mileage; payment for medically necessary EMS treatment without transport; and a commercial insurance reimbursement standard with patient billing protections. Florida's Medicaid ground ambulance schedule has no separate loaded mileage payment, and the standard coverage policy centers on transport. Other states have obtained federal approval for treatment in place, and recent Florida bills offer statutory models for commercial payment and balance billing. The proposal would support county EMS funding and preserves home

rule if county operational authority is retained. It creates no unfunded mandate as submitted, although any new local duties and health plan costs would require review.

II. PRESENT SITUATION:

County EMS Authority and Provider Responsibilities

Florida regulates ambulance and advanced life support services under chapter 401, part III, F.S. Section 401.23, F.S., recognizes advanced life support as an emergency medical transport or nontransport service. Section 401.25, F.S., requires provider licensure and generally requires a certificate of public convenience and necessity from each county where a provider operates, subject to statutory exemptions. Counties may adopt reasonable certificate standards and must consider municipal recommendations. Rule 64J-1.004, F.A.C., governs medical direction. This framework recognizes clinical services beyond transportation but does not establish a payer reimbursement floor.

Union County reports an estimated cost of $1,100 for a 911 response and transport and average Medicaid reimbursement of $183. The proposal identifies staffing, equipment, medical direction, and readiness expenses that continue between calls, but it does not provide the transport volume, payer mix, or supplemental payment receipts needed to determine the county's annual net shortfall.

Florida Medicaid Coverage and Base Payments

AHCA administers Florida Medicaid. Section 409.905(12), F.S., requires appropriate transportation for eligible recipients who need access to medically necessary covered services, and s. 409.908, F.S., authorizes reimbursement methodologies subject to appropriations and federal law. Rule 59G-4.015, F.A.C., incorporates the Emergency Transportation Services Coverage Policy, which reimburses medically necessary transport to the nearest facility capable of providing appropriate care. Sections 4 and 8 of that policy do not establish a general, separately payable EMS treatment-without-transport benefit.

Rule 59G-4.002, F.A.C., incorporates provider fee schedules. The January 2025 transportation schedule, adopted in the final rule effective January 18, 2026, lists $152.73 for emergency basic life support, $213.37 for emergency advanced life support, and $371.20 for advanced life support level 2. It lists air mileage but no separate ground mileage code (A0425). These are fee schedule amounts, not every provider's actual collections.

Most Medicaid recipients receive services through managed care, and s. 409.973, F.S., includes emergency and transportation benefits. Section 409.9128(1), F.S., prohibits prior authorization for covered prehospital transport or treatment, and ss. 409.9128(5) and 409.967(2)(b), F.S., set a lesser payment standard for specified emergency services from noncontracted providers, including a Medicaid fee-for-service rate comparison. That framework does not establish Medicare parity or a separate treatment-without-transport

payment, so a reimbursement reform must address both fee-for-service and managed care.

Supplemental Payments and the Medicare Benchmark
Florida's Public Emergency Medical Transportation (PEMT) program, administered by AHCA, supplements payments to eligible public providers for allowable uncompensated Medicaid fee-for-service transportation costs. Providers certify public expenditures and submit cost reports, and the approved methodology offsets other Medicaid revenue and limits reimbursement to allowable costs. A higher base payment would reduce the remaining cost gap used to calculate the supplement, so the two increases cannot simply be added together when estimating net revenue.

A separate managed care supplement operates through public provider agreements and intergovernmental transfers (IGTs). Polk County's October 21, 2025, PEMT agreement documents participation in both the fee-for-service program and the managed care supplement, and its managed care return includes the county's transferred funds and additional federal funding. These arrangements are distinct from the fee-for-service certified expenditure methodology; provider eligibility, local contributions, and managed care payment terms must also be reconciled when estimating reform effects.

Medicare's ambulance fee schedule uses a service-level base amount and loaded mileage, with geographic and applicable rural adjustments. Loaded mileage means miles traveled with the patient aboard. The applicable amount therefore varies by service, pickup location, miles, and payment year. Using Medicare as a Medicaid benchmark would establish a payment reference but would not establish that every county's full readiness or transport costs are covered.

Treatment Without Transport and Commercial Insurance
Federal approval for Medicaid treatment in place is available. CMS approved Kentucky State Plan Amendment KY-23-0012 for emergency ambulance treatment without transport, effective January 1, 2024, and Maryland Amendment MD-23-0002 for treatment in place and mobile integrated health services under physician supervision. These approvals are legislative and administrative precedents, but they do not establish the savings or clinical results Florida would achieve. According to CMS, its Medicare Emergency Triage, Treat, and Transport (ET3) model ended December 31, 2023, after participation and interventions fell below expectations; it is not a continuing national payment authority.

Section 627.638, F.S., recognizes assignment and direct payment of insurance benefits to licensed ambulance providers but does not set a minimum reimbursement amount.

According to CMS, ground ambulance services generally remain outside the federal No Surprises Act's balance billing protections. A Florida commercial standard would need to

define the insured services, payer obligation, patient cost sharing, and enforcement. State insurance regulation reaches fully insured coverage but does not bind self-funded private employer plans governed by ERISA; *FMC Corp. v. Holliday*, 498 U.S. 52, 61 through 65 (1990), distinguishes insured plans from self-funded plans exempt from direct state insurance regulation.

III. EFFECT OF THE PROPOSAL:

The proposal can be implemented through changes to chapter 409, F.S., corresponding Medicaid rules and plan documents, and new ground ambulance insurance and HMO provisions in chapters 627 and 641, F.S. Appropriations and administrative action would accompany the statutory changes.

For the Medicaid payment floor, an amendment to s. 409.908, F.S., would establish the applicable Medicare ambulance fee schedule as the minimum payment benchmark for covered emergency ground ambulance services, including loaded mileage. Bill language would identify the full allowable fee schedule amount, rather than only Medicare's payment after beneficiary cost sharing, and specify annual updates, geography, covered service levels, and applicable rural adjustments. It would also reconcile the floor with existing billed-charge limits and permit higher authorized rates.

Conforming amendments to ss. 409.967 and 409.9128, F.S., would apply the requirement to managed care and reconcile the noncontracted emergency payment provisions. AHCA would revise Rule 59G-4.002, F.A.C., billing instructions, contracts, and capitation assumptions as necessary. The legislation would direct AHCA to seek required CMS approval and identify the effective date and funding for implementation. Maintaining supplemental eligibility would remain subject to federal cost and payment limits.

For treatment without transport, chapter 409 would expressly authorize a defined benefit for medically necessary emergency assessment and treatment without transport, with conforming managed care coverage under s. 409.973, F.S. AHCA would establish a payment methodology and revise Rule 59G-4.015, F.A.C., or adopt a separate coverage policy. Because the transport-based Medicare schedule does not supply a national treatment-without-transport rate, this component requires its own payment design.

Implementation would define eligible providers and services, medical necessity, documentation, clinical supervision, and criteria for safe disposition. It would distinguish treatment from a canceled dispatch or a refusal with no covered service, prevent duplicate claims, and preserve transport when clinically necessary. AHCA would seek required federal approval. Payment eligibility would not expand a provider's clinical scope under chapter 401 or replace medical direction.

For commercial coverage, new provisions in chapters 627 and 641 would set a reimbursement standard for covered emergency ground ambulance claims, define

application to insurers and HMOs, and establish prompt payment and dispute procedures. Because the proposal does not select a rate or formula, a bill would need to identify an objective benchmark, the treatment of locally established charges and negotiated contracts, and the regulator responsible for enforcement. Recent bills provide models, but their specific percentages are not part of Union County's proposal.

The patient protections would limit liability to permitted cost sharing and prohibit collection of covered balances beyond that amount, with provider payment coordinated so the patient is not responsible for resolving a payer dispute. Application to ERISA plans and other federal programs would require separate legal review, because statewide legislation does not reach every commercially covered patient. No change to county EMS certificate authority is requested.

IV. COUNTY IMPACT:

The policy would affect EMS systems in all 67 counties, including county, municipal, special district, and private providers serving covered patients. Revenue effects would vary by payer mix, service levels, distance, and current contracts.

- Existing licensure, clinical, and emergency response requirements continue to apply. The proposal does not require counties or municipalities to create a new EMS service or treatment program.
- County providers would receive higher Medicaid base payments and new payments for eligible treatment without transport. Counties can adjust budgets and provider contracts as collections change; private provider gains would benefit county budgets only where contracts or subsidy obligations reflect them.
- Providers would need to adapt to revised coding, mileage records, clinical documentation, and any patient billing limits enacted. Treatment without transport would require appropriate medical direction, protocols, staff training, and quality review before eligible claims could be submitted.
- County providers could no longer collect covered commercial balances barred by a new patient protection. Additional considerations for counties include the payment formula, claim disputes, supplemental offsets, federal approval, and effects on their employee health plans.

Protective of Home Rule: Yes, as a funding policy that retains existing county EMS authority.

V. FISCAL IMPACT:

Indeterminate. No proposal-specific Revenue Estimating Conference or EDR estimate was identified.

State Government
Higher Medicaid payments and a new benefit would increase program spending before any offsetting reductions in transport or hospital use. Federal participation would depend on approval, allowable expenditures, and the applicable matching rate, and the nonfederal share would require identified funding. AHCA would incur implementation and oversight costs, managed care capitation would need adjustment, and insurance regulators would administer new payment and billing requirements. State employee health plan costs would rise where the final policy applies.

Local Government
Using Union County's estimates, $1,100 less $183 produces a $917 difference per Medicaid transport, and $183 divided by $1,100 equals approximately 16.6 percent cost recovery. This is the reported comparison before supplemental receipts and allowable costs are reconciled. It does not establish a $917 taxpayer subsidy after all revenues or the savings produced by a Medicare floor, and Medicare parity may still leave a gap below actual cost.

Net county revenue would depend on additional base and treatment payments, changes to commercial collections, lost prohibited patient collections, supplemental offsets, and implementation costs. Under PEMT's cost-gap methodology, increased base payments would reduce supplemental payments while improving payment timing, and managed care supplemental receipts must be evaluated net of the county's IGT contribution. A statewide increase therefore cannot be multiplied by Union County's reported shortfall; annual estimates require provider-level claims and payment records. Treatment without transport may reduce some avoidable transports and hospital visits, but savings depend on appropriate clinical selection and actual subsequent use.

Private Sector and Patients
Private EMS providers would receive additional covered revenue, while insurers and applicable employer health plans would face higher claims and administrative costs, potentially affecting premiums or benefits. Patients would receive stronger protection against unexpected balances. The commercial formula must be evaluated against both existing payer payments and patient collections, since a payment cap paired with a billing ban could reduce some providers' total receipts. The Legislature's 2025 HB 425 fiscal analysis (pp. 1 and 2) described indeterminate provider and state health plan effects rather than guaranteed savings.

Unfunded Mandate (Art. VII, s. 18, Fla. Const.): No.

VI. LEGISLATIVE & FAC HISTORY:

Enacted Law and Administrative History
Chapter 2020-177, Laws of Florida, created ss. 627.42397 and 641.514, F.S., addressing air ambulance reimbursement and patient liability, but did not create a ground ambulance

payment standard. Florida's PEMT State Plan Amendment 2015-014 took effect October 1, 2015, and its approved cost-gap methodology remains an administrative precedent for public EMS financing.

Recent Florida Legislation
2025: HB 425, Coverage for Out-of-network Ground Ambulance Emergency Services, and SB 704, Coverage for Ground Ambulance Emergency Services, proposed commercial payment and patient billing protections. The House analysis (pp. 1 and 2) described payment at the lowest of a locally established rate, 325 percent of the applicable Medicare rate, or billed charges. HB 425 died in Commerce Committee, and SB 704 died in Banking and Insurance on June 16, 2025.

2026: SB 1086 and HB 1185, Health Care Services Jurisdiction and Reimbursement, addressed nonparticipating emergency providers, including ambulances. The Senate bill proposed restricting patient collections and allowing recovery from insurers or HMOs through a reasonable-value claim. SB 1086 died in Banking and Insurance, and HB 1185 died in Health Care Facilities & Systems Subcommittee on March 13, 2026.

FAC Policy and Guiding Principles
Guiding Principle HSJ 33 addresses coordinated countywide EMS through the certificate process and preservation of ambulance providers' ability to receive reimbursement.

BoCC Action
The Union County BoCC has approved this proposal.