Medicaid Ambulance Supplemental Payment / Ground Emergency Medical Transport Programs

State-by-State GEMT Program Guide

Introduction

Medicaid supplemental payment programs have become an increasingly important source of revenue for ambulance service providers across the United States. As EMS agencies continue to face mounting financial pressures, including workforce shortages, rising operating costs, increasing readiness demands, and chronically inadequate Medicaid reimbursement, many states have developed innovative funding mechanisms designed to supplement traditional Medicaid payments and better support the delivery of emergency medical transportation services.

Today, these programs exist in a variety of forms, including Ground Emergency Medical Transportation (GEMT) programs, Ambulance Supplemental Payment Programs (ASPPs), managed care directed payment programs, provider assessment-funded reimbursement models, and other state-specific methodologies. While the structure of these programs varies significantly, they share a common objective: improving Medicaid reimbursement to help ensure access to emergency medical services for Medicaid beneficiaries and the communities they serve.

This matrix provides a comprehensive state-by-state overview of ambulance Medicaid supplemental payment programs across the nation. It is intended to serve as a practical reference tool for EMS leaders, policymakers, state associations, and other stakeholders seeking to better understand the current landscape of ambulance supplemental reimbursement programs.

Background

Historically, Medicaid reimbursement for ambulance services has frequently fallen well below the actual cost of providing care. For many EMS agencies, particularly governmental and safety-net providers, this reimbursement gap has contributed to ongoing financial challenges and increased reliance on local tax support, subsidies, and other funding sources.

In response, many states have pursued federal Medicaid financing opportunities to secure additional reimbursement for ambulance providers. Depending on the state, these programs may be funded through Certified Public Expenditures (CPEs), Intergovernmental Transfers (IGTs), provider assessments, managed care directed payments, or other financing arrangements approved by the Centers for Medicare & Medicaid Services (CMS).

As a result, the ambulance supplemental payment landscape has become increasingly complex. Some states operate mature, cost-based GEMT programs focused exclusively on governmental providers. Others have developed provider assessment models that include both public and private ambulance agencies. Still others have adopted managed care directed payment programs or hybrid reimbursement approaches that blend multiple funding mechanisms.

The importance of understanding these programs has grown substantially following CMS's May 2026 proposed rule addressing targeted Medicaid supplemental payments. The proposal would establish provider-specific payment limits for certain Medicaid supplemental payment arrangements and, for ambulance providers, could effectively limit supplemental reimbursement to Medicare Ambulance Fee Schedule-equivalent payment amounts. If finalized, the proposal could significantly affect the future design, funding, and sustainability of many existing ambulance supplemental payment programs beginning in 2029.

Given the potential implications of these federal policy changes, EMS agencies, state associations, and policymakers need a clear understanding of how their state's program is structured and how it compares to programs operating elsewhere in the country.

Purpose

The purpose of this matrix is to provide a concise and objective overview of ambulance Medicaid supplemental payment programs in all fifty states. The matrix is designed to help EMS stakeholders quickly identify and compare key characteristics of each state's program, including:

- Program type and financing methodology;
- Eligibility requirements;
- Basic program structure;
- Participation by public and/or private ambulance providers;
- Potential exposure to the 2026 CMS proposed rule; and
- Key source documents for additional research and verification.

PWW Advisory Group (PWW|AG) developed this resource to assist EMS agencies in evaluating reimbursement opportunities, understanding emerging policy risks, and supporting strategic planning efforts. By presenting information in a consistent state-by-state format, the matrix enables users to benchmark their state's approach against others and identify potential opportunities for program development, enhancement, or advocacy.

This resource is not intended to provide legal, regulatory, or financial advice. Medicaid programs continue to evolve, and many states are actively pursuing program modifications, State Plan Amendments, managed care directed payments, and other reimbursement initiatives. Rather, this matrix is intended to serve as an educational and informational resource that helps EMS leaders better understand the rapidly changing Medicaid reimbursement landscape.

The information in this guide is current as of the time of publication, and while the information is derived from numerous sources, we make no representation regarding the accuracy and completeness of the information provided.

PWW|AG hopes this matrix will support informed decision-making by EMS agencies, state associations, legislators, regulators, and other stakeholders as they work to strengthen the financial sustainability of EMS systems and preserve access to high-quality emergency medical services in communities across the country.

State	Program Type	Eligible Agencies	Structure / Notes	Potential Impact CMS Proposal	Sources
AL	ACR-based directed payments and cost-based supplemental payments	Public	Cost-based supplemental payment, based on Average Commercial Reimbursement (ACR).	**Potentially Significant**, state share appears to be funded through IGT.	https://www.medicaid.gov/medicaid/spa/downloads/AL-22-0003.pdf
AK	Cost-based Medicaid Supplemental Payment Program, CPE	Public	Interim payment followed by cost reconciliation and final settlement.	**Potentially Significant**. If finalized, CMS's proposed provider-specific payment limit could restrict future SEMT payments to Medicare Ambulance Fee Schedule-equivalent amounts beginning in 2029.	https://health.alaska.gov/en/services/supplemental-emergency-medical-transport-program-semt/
AR	Provider Assessment	Public and Private	Quarterly access payments.	**Potentially Significant**. Arkansas appears to use provider-specific supplemental payments designed to increase reimbursement above base Medicaid rates. The impact would depend on how CMS ultimately applies the proposed Medicare Ambulance Fee Schedule cap to existing UPL-based programs.	https://humanservices.arkansas.gov/wp-content/uploads/SPA2021-0008-Public-Ambulance-Supplemental-Payment-test2.pdf
AZ	No Program Found				
CA	PP-GEMT, Provider assessment (QAF) for private providers, IGT, CPE	Public and some private for QAF	Intergovernmental Transfers (IGTs) for public providers; Quality Assurance Fee (QAF) for private providers, add-on payment above base Medi-Cal reimbursement rates	**Potentially Significant**. Due to California's extensive provider-specific supplemental payment arrangements, provider tax and IGTs.	https://www.dhcs.ca.gov/providers-partners/medi-cal-ground-emergency-medical-transportation-supplemental-reimbursement-program/
CT	No Program Found				

State	Program Type	Eligible Agencies	Structure / Notes	Potential Impact CMS Proposal	Sources
CO	CPE, Cost-Based Medicaid Supplemental Payment Program	Public	Cost-Based Medicaid Supplemental Payment Program, payments generally made in September following the fiscal year being reconciled.	**Potentially Significant**. Colorado's program is a provider-specific supplemental payment program based on unreimbursed Medicaid costs. If finalized, CMS's proposed Medicare Ambulance Fee Schedule-based cap could reduce future supplemental payment opportunities beginning in 2029.	https://hcpf.colorado.gov/public-ems-supplemental-payment
DE	No Program Found				
FL	CPE	Public	Cost reporting, state review, reconciliation, and supplemental payment calculation.	**Potentially Insignificant**. Florida's program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS.	https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-program-finance/lip-dsh-gme-operations/public-emergency-medical-transportation-pemt-program
GA	ACR and Provider assessment (private providers)	Public and Private	ACR basis, No traditional GEMT cost report; providers submit ACR surveys and commercial payment data.	**Potentially Significant**. Georgia's ambulance UPL payments are targeted supplemental payments that may exceed Medicare Ambulance Fee Schedule levels today.	https://dch.georgia.gov/providers/provider-types/ground-ambulance-upl
HI	No Program Found				
ID	CPE-Based GEMT Program	Public	Supplemental Medicaid payments to eligible GEMT providers for qualifying Medicaid transports. Participating providers submit cost and expenditure information to document unreimbursed Medicaid costs. Supplemental payments are funded through the Certified Public Expenditure (CPE) methodology and federal matching funds.	**Potentially Insignificant**. Idaho's program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS.	https://www.medicaid.gov/medicaid/spa/downloads/ID-23-0014.pdf

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IL	CPE, limited use through IGAs, but not primarily IGT-funded	Public	Cost-Based GEMT Reconciliation, add-on payment on Medicaid reimbursement.	**Potentially Significant**. Illinois' GEMT program appears to fit squarely within the category of provider-specific Medicaid supplemental payment programs identified in CMS's May 2026 proposed rule. Because Illinois payments are based on unreimbursed costs rather than Medicare Ambulance Fee Schedule amounts, supplemental payments could be substantially reduced beginning in 2029 if CMS finalizes its proposal to cap GEMT payments at Medicare-equivalent reimbursement levels.	https://hfs.illinois.gov/medicalproviders/notices/notice.prn240729a.html
IN	Intergovernmental Transfer (IGT)-Based Supplemental Payment Program.	Public	Indiana's program is structured more like a UPL/IGT supplemental payment model than a traditional GEMT cost-settlement model. Supplemental payments are calculated based on the difference between Medicaid reimbursement and the provider's usual and customary charges (or another state-approved methodology).	**Potentially Significant.** Indiana's program appears to fit within the category of provider-specific ambulance supplemental payment arrangements targeted by CMS's May 2026 proposal.	https://law.justia.com/codes/indiana/2006/title12/ar15/ch14.5.html

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IA	Certified Public Expenditure (CPE)-Based GEMT Program.	Public	Cost-based reconciliation model. Iowa's program is a traditional governmental-provider GEMT model and is not funded through a provider assessment (tax). The program utilizes certified public expenditures and intergovernmental funding agreements to obtain federal matching funds.	**Potentially Significant.** Iowa's GEMT program is a provider-specific supplemental payment arrangement based on unreimbursed costs rather than Medicare Ambulance Fee Schedule amounts. Iowa providers could experience reduced supplemental reimbursement if CMS finalizes its proposal to cap GEMT payments at Medicare-equivalent rates beginning in 2029.	https://hhs.iowa.gov/medicaid/provider-services/programs-grants/ground-emergency-medical-transportation-reimbursements
KS	Certified Public Expenditure (CPE)-Based GEMT Program.	Public and Some Private	Government-owned or government-operated ambulance providers. Contracted private entities may qualify if operating on behalf of a governmental entity. Cost-based supplemental reimbursement designed to bring total Medicaid reimbursement up to allowable actual costs.	**Potentially Insignificant**. Kansas' program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS.	https://www.kslegislature.gov/b2023_24/laws/065_000_0000_chapter/065_061_0000_article/065_061_0059_section/065_061_0059_k/

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KY	Provider Assessment + IGT-Based Public Ambulance Program.	Public	Combines a provider assessment-funded supplemental payment program with a newer public-provider IGT supplemental payment structure. The public ambulance program allows governmental providers to transfer local funds (IGTs) to support enhanced Medicaid reimbursement, while the provider assessment program generates the non-federal share through assessments on participating ambulance providers.	**Potentially Significant**. Kentucky's provider-specific ambulance supplemental payments appear to fall within the category of targeted Medicaid payments addressed in CMS's May 2026 proposed rule. Because Kentucky's supplemental payments are designed to increase reimbursement beyond standard Medicaid ambulance rates, the proposal to cap targeted ambulance supplemental payments at Medicare Ambulance Fee Schedule-equivalent amounts could materially reduce future supplemental payment opportunities if finalized for implementation beginning in 2029.	https://apps.legislature.ky.gov/law/kar/titles/907/003/062/
LA	Upper Payment Limit (UPL) / Average Commercial Rate (ACR) Model.	Public and Private	Louisiana is not a traditional CPE-based GEMT program and is not funded through a provider assessment tax. The supplemental payment methodology is based on bringing Medicaid reimbursement toward an equivalent community (commercial) rate.	**Potentially Significant**. Louisiana's ambulance supplemental payment methodology is based on commercial-rate benchmarks that can substantially exceed Medicare Ambulance Fee Schedule amounts. Because the May 2026 CMS proposal would cap targeted ambulance supplemental payments at Medicare-equivalent levels, Louisiana's current UPL/ACR methodology could face meaningful downward pressure if finalized.	https://www.law.cornell.edu/regulations/louisiana/La-Admin-Code-tit-50-SS-XXVII-327

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ME	Provider Assessment / Supplemental Payment Program	Public and Private	Provider-funded assessment. Mandatory assessment with supplemental distributions (subject to program rules). predominantly fee-for-service for ambulance services.	**Potentially Significant.** If supplemental payments qualify as targeted Medicaid payments subject to the proposed Medicare cap.	https://legislature.maine.gov/doc/9179
MD	Emergency Services Provider Supplemental Payment Program (ESPP)/ Certified Public Expenditure (CPE)-Based GEMT Program.	Public	To use a CPE, a local government entity needs to certify that they have uncompensated costs that are used to support the full cost of providing Medicaid-covered services.	**Potentially Insignificant**. Maryland's program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS.	https://health.maryland.gov/mmcp/Documents/JCRs/2024/EMSreimbursementrateJCRfinal11-24.pdf
MA	Hybrid Model: CPE for Public Providers and Provider Assessment for Nonpublic Providers	Public and Private	Massachusetts uses a dual-track supplemental payment system. Governmental providers submit cost reports and receive supplemental Medicaid payments based on allowable costs and certified public expenditures. Non-public providers contribute through a provider assessment mechanism that funds enhanced Medicaid reimbursement. The overall objective is to increase Medicaid reimbursement toward provider costs and improve EMS financial sustainability.	**Potentially Significant**. Both the public-provider CPE program and the non-public provider assessment-funded supplemental payments are provider-specific Medicaid supplemental payment arrangements. Because Massachusetts supplemental payments are designed to increase reimbursement beyond standard Medicaid ambulance fee schedule levels, the proposed CMS cap tying supplemental payments to Medicare Ambulance Fee Schedule amounts could materially reduce future supplemental payment opportunities if finalized beginning in 2029.	https://www.medicaid.gov/medicaid/spa/downloads/MA-21-0024.pdf https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter118E/Section67A

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MI	[Pending SPA approval] MDHHS Public Notice explicitly identifies the program as a Certified Public Expenditure Supplemental Payment Program.	Public	The SPA submission states supplemental payments are based on actual costs and total reimbursement is capped at 100% of actual costs, which is characteristic of a traditional cost-based GEMT model.	**Potentially Insignificant**. Michigan's program is a CPE model, with caps already set at the Medicare allowable, and cost reporting structures that limit allowable cost to only ambulance time with Medicaid beneficiaries, as described in the SPA and MDHHS materials.	https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Budget-and-Finance/State-Plan-Amendments/SPA_25-0023_Submission.pdf?hash=B498656515508B620A45FC095FB3D479&rev=6c1e00bd5dc04158978840db32748243
MN	Governmental Supplemental Payment Program.	Public	Payments are limited by the provider's costs or the difference between the Average Commercial Rate (ACR) and the Medicaid payments already made.	**Potentially Significant**. Minnesota's ambulance supplemental payment methodology is based on commercial-rate benchmarks that can substantially exceed Medicare Ambulance Fee Schedule amounts. Because the May 2026 CMS proposal would cap targeted ambulance supplemental payments at Medicare-equivalent levels, Minnesota's current UPL/ACR methodology could face meaningful downward pressure if finalized.	https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-316407
MS	Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Provider Assessment program.	Public and Private	A mandatory assessment is used to collect funds from eligible providers to fund the non-federal share of program payments. ACR is calculated for each applicable ambulance service corresponding to the Medicaid-covered procedure codes. To calculate the payment limit, the ACR for each procedure code is multiplied by the volume of Medicaid paid ambulance service units for the applicable period.	**Potentially Significant**. Mississippi's ambulance supplemental payment methodology is based on commercial-rate benchmarks that can substantially exceed Medicare Ambulance Fee Schedule amounts. Because the May 2026 CMS proposal would cap targeted ambulance supplemental payments at Medicare-equivalent levels, Mississippi's current ACR methodology could face meaningful downward pressure if finalized.	https://medicaid.ms.gov/transforming-reimbursement-for-emergency-ambulance-transportation-treat/

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MO	Hybrid CPE / IGT Cost-Based GEMT Program. Missouri is generally classified as a GEMT cost-reimbursement program for governmental providers.	Public	Providers certify costs through annual cost reports and make an Intergovernmental Transfer (IGT) equal to the non-federal share of uncompensated Medicaid costs before receiving the supplemental payment.	**Potentially Significant**. Missouri's GEMT program is based on unreimbursed costs rather than Medicare Ambulance Fee Schedule amounts. In addition, Missouri has expanded supplemental payment methodologies involving Medicaid managed care governmental providers. Because the May 2026 CMS proposal targets provider-specific supplemental payments in both FFS and managed care arrangements, Missouri could face meaningful reductions in future GEMT funding if the Medicare-based cap is finalized.	https://mydss.mo.gov/mhd/gemt
MT	[*Pending*] Provider Assessment Model	Primarily non-governmental ambulance providers (for-profit, nonprofit, volunteer).	The State will impose an assessment on private non-governmental providers. Ambulance services will pay the state a 5% fee on their revenue.	**Uncertain**. Montana's program was only recently authorized by the legislature and still requires CMS implementation steps.	https://legiscan.com/MT/text/HB56/id/3213603 https://maa3.wildapricot.org/medicaid

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NE	IGT-Based GEMT Program (Newly Authorized) funded through a provider tax from Intergovernmental Transfers (IGTs).	Public	Program is designed as a cost-based supplemental payment model for governmental providers. Participating agencies submit an IGT equal to the non-federal share of the supplemental payment, allowing Nebraska Medicaid to draw down federal matching funds. The legislation also authorizes a Medicaid managed care directed payment approach so participating providers may receive reimbursement up to their allowable costs.	**Potentially Significant.** Nebraska's newly authorized GEMT structure appears to fit squarely within the provider-specific supplemental payment arrangements identified in CMS's May 2026 proposed rule. Because the Nebraska model is designed to reimburse providers up to cost and relies on IGT financing and managed care directed payments, it could be materially affected if CMS finalizes its proposal to cap ambulance supplemental payments at Medicare Ambulance Fee Schedule-equivalent amounts beginning in 2029.	https://nebraskalegislature.gov/FloorDocs/109/PDF/FN/LB610_20250225-113447.pdf
NV	Certified Public Expenditure (CPE)-based GEMT supplemental payment program.	Public	Cost reconciliation methodology comparing allowable Medicaid costs to Medicaid reimbursement received. Primarily Fee-for-Service Medicaid GEMT; Nevada Medicaid also operates managed care programs, which may affect reimbursement dynamics.	**Potentially Insignificant**. Nevada's program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS	https://www.medicaid.gov/Medicaid/spa/downloads/NV-21-0015
NH	No Program Found				
NJ	No Program Found				

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NM	IGT-Funded Ambulance Supplemental Payment Program (ASPP).	Public	New Mexico's ASPP is structured as a Medicaid managed care state-directed payment program. Participating governmental ambulance providers transfer the non-federal share through an IGT to the state, allowing New Mexico Medicaid to draw down federal matching funds. The managed care organizations then make directed supplemental payments to participating governmental ambulance providers.	**Potentially Significant.** New Mexico's ASPP appears to fit squarely within the category of Medicaid managed care directed payment programs targeted by CMS's May 2026 proposed rule. Because the program uses provider-specific supplemental payments to governmental ambulance providers that may exceed Medicare Ambulance Fee Schedule reimbursement levels, the proposal could materially reduce future ASPP funding if finalized beginning in 2029. The managed care directed payment component places New Mexico among the states most directly affected by the managed care portions of the proposal.	https://www.medicaid.gov/medicaid/managed-care/downloads/NM_Fee_Oth_Renewal_20260101-20261231.pdf
NY	No Program Currently Found – application pending.		In 2024, the New York Legislature enacted provisions directing the state to pursue increased federal Medicaid reimbursement opportunities for ambulance providers, including governmental ambulance services. The legislation authorized the state to explore and seek federal approval for supplemental Medicaid reimbursement mechanisms for emergency medical transportation providers. However, no evidence exists of a SPA being submitted.		

State	Program Type	Eligible Agencies	Structure / Notes	Potential Impact CMS Proposal	Sources
NC	Hybrid CPE / IGT model. For fee-for-service, Public Ambulance Providers certify public expenditures through annual Medicaid cost reports; under managed care, additional utilization-based payments are financed through IGTs.	Public	Public ambulance providers receive normal service payments plus supplemental/cost-settlement replacement payments. Under managed care, PHPs make Additional Utilization-Based Payments (AUBPs) to approximate prior cost-settlement payments; PAPs make IGTs equal to the non-federal share.	**Potentially significant**. North Carolina's public ambulance payments appear to be provider-specific supplemental/directed payments, including IGT-financed managed care payments. If CMS finalizes the proposed Medicare Ambulance Fee Schedule cap for targeted GEMT-type payments beginning in 2029, NC's supplemental payment capacity could be reduced.	https://medicaid.ncdhhs.gov/mct-102-webinar-04112019/open
ND	Certified Public Expenditure (CPE)-Based GEMT Program.	Public	Participating governmental providers submit annual cost reports documenting allowable Medicaid ambulance costs. Supplemental payments are based on the difference between Medicaid reimbursement received and allowable costs incurred for Medicaid transports. The state uses certified public expenditures to draw down additional federal Medicaid matching funds and make supplemental payments to participating governmental providers.	**Potentially Insignificant**. North Dakota's program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS.	https://ndlegis.gov/assembly/68-2023/regular/bill-overview/bo1322.html

State	Program Type	Eligible Agencies	Structure / Notes	Potential Impact CMS Proposal	Sources
OH	CPE-Based Ambulance Supplemental Payment Program (ASPP). It is not a provider assessment program.	Public	Participating providers submit Medicaid ambulance cost reports documenting actual costs of providing services. Supplemental payments are intended to offset the difference between Medicaid reimbursement and actual allowable costs.	**Potentially Insignificant**. Ohio's program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS.	https://codes.ohio.gov/ohio-administrative-code/rule-5160-15-30
OK	Certified Public Expenditure (CPE)-Based GEMT Program. Oklahoma operates a traditional GEMT supplemental payment program for governmental ambulance providers. The program is not funded through a provider assessment tax and does not primarily rely on IGT financing.	Public	Participating governmental providers submit annual GEMT cost reports documenting allowable Medicaid ambulance costs. Supplemental payments are calculated based on unreimbursed Medicaid costs. Providers certify public expenditures, allowing Oklahoma to draw down additional federal Medicaid matching funds and distribute supplemental payments. Payments are generally limited to the provider's actual allowable costs.	**Potentially Insignificant**. Oklahoma's program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS.	https://oklahoma.gov/ohca/policies-and-rules/xpolicy/medical-providers-fee-for-service/individual-providers-and-specialties/transportation-by-ambulance/ground-emergency-medical-transportation-gemt-supplemental-payment-program.html

State	Program Type	Eligible Agencies	Structure / Notes	Potential Impact CMS Proposal	Sources
OR	**Hybrid:** public-provider GEMT plus private-provider Quality Assurance Fee.	Public and Private	Public FFS GEMT: voluntary enhanced payments for qualifying GEMT services to OHP FFS members. CCO GEMT: CMS-approved directed payment to CCOs, passed through to eligible government-owned GEMT providers. Private GEMT: OHA collects a quality assurance fee and uses it to fund supplemental payments.	**Potentially Insignificant**. Oregon has provider-specific GEMT supplemental payments, including managed care directed payments and QAF-funded private-provider payments. A Medicare Ambulance Fee Schedule cap could reduce payment room if current add-on/supplemental amounts exceed Medicare-equivalent limits.	https://www.oregon.gov/oha/hsd/ohp/pages/policy-ground-emergency-transportation.aspx
PA	No Program Found				
RI	No Program Found				
SC	Managed care state directed payment, with provider assessment legislation also enacted/proposed.	Public and Private	CMS approved a uniform increase for emergency medical transport services provided by all ambulance providers for the July 1, 2024–June 30, 2025 rating period. The state assessment law authorizes SCDHHS to charge each ambulance service a fee based on its share of statewide net ambulance revenue. The program is designed to close the gap between Medicaid rates and **average commercial rates**.	**Potentially Significant.** South Carolina has a provider-specific Medicaid managed care directed payment for all ambulance providers, it appears to fall within the type of targeted ambulance supplemental payment arrangement CMS proposed to limit to Medicare Ambulance Fee Schedule-equivalent amounts. Provider assessment-funded expansion, if implemented broadly, could also be affected.	https://www.medicaid.gov/medicaid/managed-care/downloads/SC_Fee_Oth2_New_20240701-20250630.pd https://www.scstatehouse.gov/sess125_2023-2024/bills/4113.htm

State	Program Type	Eligible Agencies	Structure / Notes	Potential Impact CMS Proposal	Sources
SD	Certified Public Expenditure (CPE)-Based GEMT Program. It is not a provider assessment program and is not primarily structured as an IGT-funded directed payment model.	Public	Participating governmental ambulance providers submit cost reports documenting allowable Medicaid ambulance costs. Supplemental payments are calculated based on the difference between Medicaid reimbursement already received and allowable costs associated with Medicaid transports. Providers certify public expenditures to draw federal Medicaid matching funds.	**Potentially Insignificant**. South Dakota's program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS.	https://sdlegislature.gov/Session/Bill/25015
TN	Provider Assessment + Managed Care Directed Payment. Tennessee operates a Ground Ambulance Assessment Program funded through ambulance assessment fees.	Public and Private	Tennessee uses a provider assessment to fund supplemental payments for qualifying emergency ground ambulance claims.	**Potentially Significant.** Tennessee's program is a targeted ambulance supplemental payment/directed payment program funded by a provider assessment. A Tennessee fiscal note already flags risk if base reimbursement plus supplemental payments exceed allowable federal limits.	https://publications.tnsosfiles.com/acts/110/pub/pc0258.pdf

State	Program Type	Eligible Agencies	Structure / Notes	Potential Impact CMS Proposal	Sources
TX	Hybrid CPE / IGT. CPE-Based Supplemental Payment Program with ACR Enhancement. Texas uses a Certified Public Expenditure (CPE) methodology for governmental ambulance providers. Certain Medicaid Managed Care Directed Payment Components Utilize IGTs from governmental entities.	Public	Participating governmental providers submit annual cost reports and certify public expenditures. Texas operates two supplemental payment components: (1) an uncompensated-cost payment methodology and (2) an enhanced supplemental payment based on Average Commercial Rates (ACR) for eligible fee-for-service ground ambulance services. Enhanced payments may reimburse up to 100% of the calculated ACR differential.	**Potentially Significant.** Texas may be one of the most affected states nationally because its enhanced ambulance supplemental payments are tied to Average Commercial Rates, which frequently exceed Medicare Ambulance Fee Schedule amounts. The proposed CMS cap limiting targeted ambulance supplemental payments to Medicare-equivalent levels could substantially reduce future supplemental payment opportunities for participating governmental ambulance providers.	https://pfd.hhs.texas.gov/acute-care/ambulance-services/ambulance-services-supplemental-payment-program-cost-report-information
UT	Provider Assessment Program. Utah utilizes a Medicaid ambulance assessment mechanism and enhanced reimbursement methodology rather than a traditional CPE- or IGT-based GEMT cost reconciliation program.	Public and Private	Utah Medicaid reimburses ground ambulance providers at an enhanced rate for emergency medical transports and mileage, subject to CMS approval and state rate limits. The state maintains an ambulance assessment program and enhanced reimbursement methodology rather than requiring annual GEMT cost reports and CPE reconciliation.	**Potentially Significant.** Utah's enhanced ambulance payments are provider-specific Medicaid payments that exceed standard fee-for-service reimbursement, the state could be affected by CMS's proposal to limit targeted ambulance supplemental payments. However, Utah's exposure may be less severe than states whose programs are entirely dependent on cost-based GEMT reconciliations.	https://ems.utah.gov/wp-content/uploads/sites/34/2023/07/Medicaid-assessment-FAQ-8819.pdf

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VT	Provider Assessment Program.	Public and Private	Annual assessment for each ambulance agency is 3.3% of the ambulance agency's annual net patient revenues for services delivered to patients in Vermont during the most recent annual fiscal period.	**Potentially Significant.** Vermont's program is a targeted ambulance supplemental payment/directed payment program funded by a provider assessment. Because the May 2026 CMS proposal targets provider-specific supplemental payments in both FFS and managed care arrangements, Vermont could face meaningful reductions in future GEMT funding if the Medicare-based cap is finalized.	https://legislature.vermont.gov/statutes/section/33/019/01959
VA	CPE-Based GEMT Program (Newly Authorized/Implementing). The budget language describes a traditional GEMT structure utilizing CPE rather than a provider assessment model.	Public	The program is described as a voluntary supplemental payment program that makes payments to eligible GEMT providers furnishing qualifying Medicaid ambulance services. Participating providers will submit documentation supporting allowable costs and public expenditures, allowing Virginia Medicaid to draw federal matching funds and provide supplemental payments beyond the regular Medicaid fee schedule.	**Potentially Significant.** Virginia's newly authorized GEMT program is structured as a provider-specific supplemental payment program for governmental ambulance providers, it appears to fit squarely within the category of programs targeted by CMS's May 2026 proposed rule. If finalized, the proposed Medicare Ambulance Fee Schedule cap could substantially limit the growth and future reimbursement potential of Virginia's GEMT program.	https://budget.lis.virginia.gov/amendment/2025/1/HB1600/Introduced/MR/288/17h

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WA	CPE-based GEMT program, with a managed care IGT component for certain managed care transports. Washington's Medicaid State Plan says GEMT supplemental payments are funded using the Certified Public Expenditures (CPE) method.	Public	Cost-based supplemental payment program covering the gap between actual allowable GEMT costs and Medicaid/other reimbursement. HCA makes supplemental payments for uncompensated allowable costs for Medicaid fee-for-service clients; managed care GEMT payments have also used an IGT process.	**Potentially Significant.** Washington's program is provider-specific and cost-based, so a Medicare Ambulance Fee Schedule cap could reduce payments where allowable costs exceed Medicare-equivalent reimbursement.	https://www.hca.wa.gov/assets/program/SP_Att_4_Payment_for_Services.pdf https://www.hca.wa.gov/assets/billers-and-providers/gemt-bg-20260101.pdf
WV	[Pending] Certified Public Expenditure (CPE)-Based GEMT Program. It is not a provider assessment program and is not primarily structured as an IGT-funded directed payment model.	Public and Private (when contracted to jurisdictions).	Participating governmental providers, or providers contracted to a jurisdiction, would submit annual cost reports and certify public expenditures.	**Uncertain**. West Virginia's program was only recently authorized by the legislature and still requires CMS implementation steps.	https://code.wvlegislature.gov/9-5-26/

State	Program Type	Eligible Agencies	Structure / Notes	Potential Impact CMS Proposal	Sources
WI	Hybrid CPE + Provider Assessment Program. Wisconsin operates a CPE program for public EMS providers and a separate Provider Assessment Program for private and nonprofit EMS providers.	Public and Private	Public Providers: Submit annual cost reports under the CPE program and receive supplemental Medicaid reimbursement based on reported allowable costs associated with Medicaid transports. Private/Nonprofit Providers: Pay a quarterly provider assessment; Wisconsin uses those assessment funds to draw federal matching funds and redistribute supplemental payments based on Medicaid transport volume.	CPE Program – **Potentially Insignificant**. Wisconsin's public program appears to be a CPE program and therefore may not be considered provider tax or state directed payment by CMS. Provider Assessment – **Potentially Significant.** The private-provider assessment program could face scrutiny because it provides provider-specific ambulance supplemental payments funded through assessments and federal matching funds.	https://www.dhs.wisconsin.gov/ems/wi-gemt-program.htm
WY	Supplemental Payment Program (*Neither Traditional CPE nor Provider Assessment* rather than a provider assessment tax. The program uses negotiated commercial payment rates as a benchmark.	Public and Private	Participating ambulance providers submit negotiated commercial payment rates. Wyoming Medicaid calculates supplemental payments based on the difference between Medicaid reimbursement and commercial payment benchmarks, subject to federal limits and available funding. The program became effective in 2023 following SPA approval.	**Potentially Significant**. Because Wyoming's supplemental payments are tied to commercial payment benchmarks rather than Medicare Ambulance Fee Schedule amounts, the state's program could face substantial reductions if CMS finalizes its proposal to cap targeted ambulance supplemental payments at Medicare-equivalent levels beginning in 2029.	https://www.medicaid.gov/medicaid/spa/downloads/WY-23-0013.pdf