

PWVIAG | **AIMHI** ACADEMY OF INTERNATIONAL MOBILE HEALTHCARE INTEGRATION
JOINT WEBINAR • LIVE & ONLINE

AMBULANCE ECONOMICS IN CRISIS:

Costs, Rates, and Reimbursement

Get the Insights You Need to Protect Revenue & Ensure Sustainability

- Recent National Reports on Ambulance Costs & Revenues
- The Perils of Underpricing Services
- Fee Considerations Under Patient Protection Legislation
- Navigating Medicaid Supplemental Payment Programs

DATE: April 30, 2026 | TIME: 9a CT | LIVE & ONLINE
FREE TO ATTEND

Presenters:

Ryan Stark | **Matt Zavadsky**

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THIS SESSION IS BEING RECORDED.

The archive will be emailed to all registrants tomorrow.

2



Submit questions through the Q&A function.

3

About AIMHI

AIMHI is the nation's leading advocate for *high-performance, high-value* EMS delivery.

We champion *innovative care models, integrated mobile healthcare, and alternative care pathways* that *improve outcomes* and *reduce system-wide costs*.

AIMHI member agencies represent the most nimble, innovative, transparent, and data-driven EMS systems in the world — setting the standard for what's next in mobile healthcare.

Our Mission
Leading the transformation of EMS to mobile integrated healthcare through the development of high-performance systems, and setting the standard for clinical excellence, accountability, public education, research and economic efficiency.

Our Vision
To improve patient health and experience of care by promoting excellence in mobile healthcare integration through evidence-based out of hospital healthcare system effectiveness and efficiency.

Learn More About Membership: www.aimhi.mobi

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About AIMHI

Membership Eligibility

- Externally reports performance measures; and
- Are authorized by local government; and
- Bills for services provided; and
- Should include, but not be limited to, the following system/agency attributes:
 - Tiered Deployment (BLS/ALS)
 - Flexible production strategy
 - Exhibits evidence-based clinical sophistication
 - Aligns with the mission and vision of AIMHI
- Any agency that operates an EMS-Based Mobile Integrated Healthcare program designed to improve patient outcomes, enhance the patient's experience of care, and reduce healthcare expenditures, defined as:
 - Uses specially trained personnel; and
 - Works as part of an organized delivery model, integrated with the local healthcare community; and
 - Are credentialed by a physician medical director; and
 - Augments the community's existing healthcare resources



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About AIMHI

Current Members

- Emergency Medical Services Authority (Tulsa and Oklahoma City, OK)
- Mecklenburg EMS Agency (MEDIC) (Charlotte, NC)
- Medic Ambulance of Scott County (Davenport, IA)
- Medic Ambulance of Solano (Solano, CA)
- Metropolitan EMS Authority (Little Rock, AR)
- Northwell Health Center for EMS (Syosset, NY)
- Novant Health Mobile Health (Wilmington, NC)
- Pinellas County EMS Authority (Sunstar) (Largo, FL)
- ProEMS (Cambridge, MA)
- Regional EMS Authority (Reno, NV)
- Richmond Ambulance Authority (Richmond, VA)
- Three Rivers Ambulance Authority (Ft. Wayne, IN)



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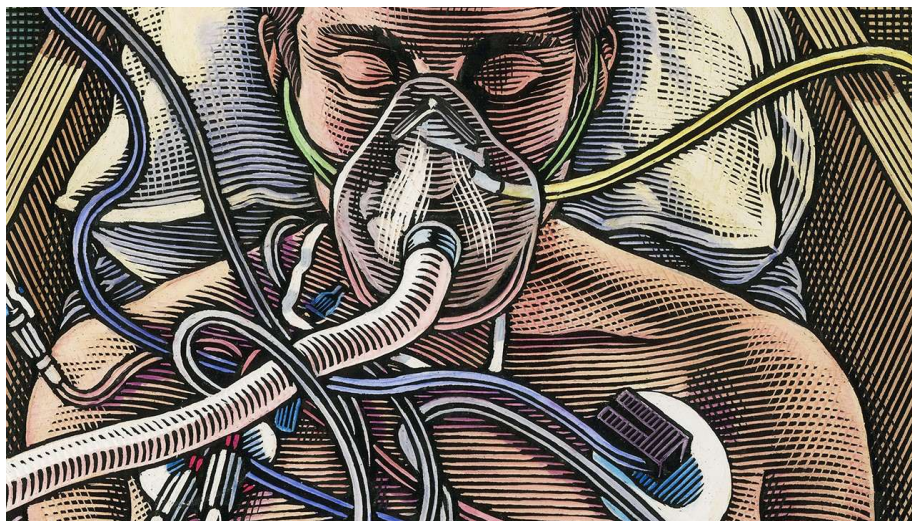
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Current State of EMS?



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Challenges in Today's EMS Systems

- Financial sustainability
- Staffing shortages
- Equipment/supply challenges
- Unrealistic public understanding
- Unrealistic public expectations



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EMS Related News Reports

Summary: Jan 11, 2021 - Mar 31, 2026
 Article Count: **4,047**

Keywords	Tag Count	% of Total
Staffing	1,361	33.6%
Funding, Tax Levy	1,792	44.3%
Total	3,153	77.9%
Other	Tag Count	% of Total
Closure/Takeover	373	9.2%
Response Time	565	14.0%
Staffing+Response Time	1,926	47.6%
Staffing+Funding+Response Time	3,718	91.9%

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<https://aimhi.mobi/news/>



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News Items

Your Patients Are Getting Surprise Ambulance Bills. Federal Law Still Allows It.

Interesting editorial and perspective from an EMS clinician in a well-respected healthcare publication. State balance billing laws have been all over the map (literally and figuratively) and only apply to state-regulated [...]

Independent Dispute Resolution (IDR) Is Reshaping Air Ambulance Reimbursement

Over the past few years, IDR has shifted from a safeguard under the No Surprises Act to something much more central to how air ambulance reimbursement is being determined. This [...]

CMS considering automatic enrollment in a Medicare Advantage plan

Two news reports last week that could impact EMS reimbursement should catch the attention of EMS leaders. The first report signals that Medicare is considering making enrollment in Medicare Advantage (MA) [...]

(WV) House Approves Permanent EMS Funding

Excellent state-level advocacy by the West Virginia EMS folks. Interestingly, West Virginia is one of only FOUR states in the country that has a true 'Essential Service' designation statute for EMS, that is, requiring that jurisdictions [...]

Yakima considering \$3M EMS levy, raising concerns about compounding tax hikes

Yakima considering \$3M EMS levy, raising concerns about compounding tax hikes Thu, February 5, 2026 <https://www.everettpost.com/state-news/yakima-considering-3m-ems-levy-raising-concerns-about-compounding-tax-hikes/> The Yakima City Council is considering another tax proposal to keep a local fire [...]

EMTs push for reform amid insurance reimbursement crisis

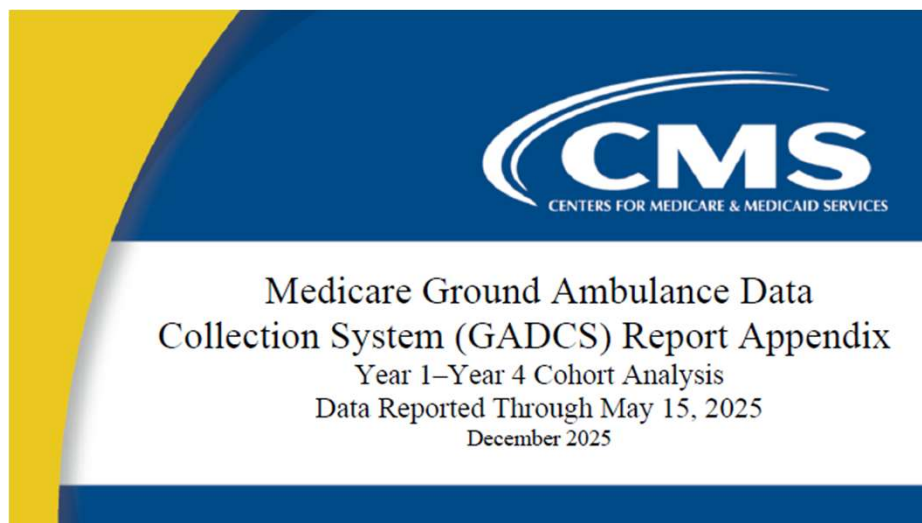
Great example of grass roots advocacy using DATA to drive decisions... Common response from the Kentucky Association of Health Plans. And, an example of what information the profession should provide [...]

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<https://aimhi.mobi/news/>



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Medicare Ground Ambulance Data Collection System (GADCS) Report Appendix Year 1–Year 4 Cohort Analysis Data Reported Through May 15, 2025 December 2025

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<https://www.cms.gov/medicare/payment/fee-schedules/ambulance/medicare-ground-ambulance-data-collection-system>



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Table X - Ground Ambulance Margins
Medicare Ground Ambulance Data Collection System (GADCS)
 Created by PWW Advisory Group, December 2025

Cohort 2 Years 1 - 4	N	Per Transport							
		Mean				Median			
		Revenue	Cost	\$ Shortfall	% Shortfall	Revenue	Cost	\$ Shortfall	% Shortfall
All NPIs	9,607	\$1,268	\$2,763	-\$1,495	-54.1%	\$613	\$1,335	-\$722	-54.1%
Provider vs. Supplier Status									
Suppliers	9,093	\$1,256	\$2,804	-\$1,548	-55.2%	\$607	\$1,378	-\$771	-56.0%
Providers	514	\$1,487	\$2,024	-\$537	-26.5%	\$876	\$1,301	-\$425	-32.7%
Medicare Transport Vol.									
Low	4,063	\$1,645	\$4,034	-\$2,389	-59.2%	\$987	\$2,055	-\$1,068	-52.0%
Medium	2,791	\$1,072	\$2,273	-\$1,201	-52.8%	\$635	\$1,349	-\$714	-52.9%
High	1,689	\$1,034	\$1,648	-\$614	-37.3%	\$665	\$1,024	-\$359	-35.1%
Very High	1,063	\$719	\$968	-\$249	-25.7%	\$477	\$651	-\$174	-26.7%
Ownership Category									
Non-Profit	2,612	\$1,136	\$2,578	-\$1,442	-55.9%	\$642	\$1,199	-\$557	-46.5%
For Profit/Unknown	1,869	\$1,135	\$1,912	-\$777	-40.6%	\$466	\$609	-\$143	-23.5%
Government	5,125	\$1,384	\$3,167	-\$1,783	-56.3%	\$680	\$1,884	-\$1,204	-63.9%
Service Area Pop. Density									
Urban	5,112	\$1,267	\$2,529	-\$1,262	-49.9%	\$539	\$1,196	-\$657	-54.9%
Rural	2,640	\$1,062	\$2,458	-\$1,396	-56.8%	\$618	\$1,246	-\$628	-50.4%
Super Rural	1,854	\$1,567	\$3,834	-\$2,267	-59.1%	\$909	\$2,339	-\$1,430	-61.1%
Public Safety									
Yes	4,447	\$1,460	\$3,545	-\$2,085	-58.8%	\$866	\$1,969	-\$1,103	-56.0%
No	5,160	\$1,104	\$2,088	-\$984	-47.1%	\$689	\$1,292	-\$603	-46.7%

All data sourced from Medicare Ground Ambulance Data Collection System (GADCS) Report, Year 1 through Year 4 Cohort Analysis, December 2025, Centers for Medicare and Medicaid Services
<https://www.cms.gov/files/document/medicare-ground-ambulance-data-collection-system-gadcs-report-appendix-year-1-year-4-cohort-analysis.pdf>

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Table Z - Medicare Ambulance Fee Schedule Insufficiency
Medicare Ground Ambulance Data Collection System (GADCS)
 Created by PWW Advisory Group, January 2025

Years 1 - 4 Cohort	Average Medicare Payment (2,3)	Per Transport					
		Mean (1)			Median (1)		
		Cost	\$ Medicare Shortfall	% Medicare Shortfall	Cost	\$ Medicare Shortfall	% Medicare Shortfall
All NPIs	\$328.89	\$2,763	-\$2,434	-88%	\$1,335	-\$1,006	-75%
Provider vs. Supplier Status							
Suppliers	\$328.89	\$2,804	-\$2,475	-88%	\$1,378	-\$1,049	-76%
Providers	\$328.89	\$2,024	-\$1,695	-84%	\$1,301	-\$972	-75%
Medicare Transport Vol.							
Low	\$328.89	\$4,034	-\$3,705	-92%	\$2,055	-\$1,726	-84%
Medium	\$328.89	\$2,273	-\$1,944	-86%	\$1,349	-\$1,020	-76%
High	\$328.89	\$1,648	-\$1,319	-80%	\$1,024	-\$695	-68%
Very High	\$328.89	\$968	-\$639	-66%	\$651	-\$322	-49%
Ownership Category							
Non-Profit	\$328.89	\$2,578	-\$2,249	-87%	\$1,199	-\$870	-73%
For Profit/Unknown	\$328.89	\$1,912	-\$1,583	-83%	\$609	-\$280	-46%
Government	\$328.89	\$3,167	-\$2,838	-90%	\$1,884	-\$1,555	-83%
Service Area Pop. Density							
Urban	\$328.89	\$2,529	-\$2,200	-87%	\$1,196	-\$867	-73%
Rural	\$328.89	\$2,458	-\$2,129	-87%	\$1,246	-\$917	-74%
Super Rural	\$328.89	\$3,834	-\$3,505	-91%	\$2,339	-\$2,010	-86%
Public Safety							
Yes	\$328.89	\$3,545	-\$3,216	-91%	\$1,969	-\$1,640	-83%
No	\$328.89	\$2,088	-\$1,759	-84%	\$1,292	-\$963	-75%

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But Wait – There’s More...

MEDPAC
Advising the Congress on Medicare Issues

Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System

Dan Zabinski
April 9, 2026

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<https://www.medpac.gov/meeting/april-9-10-2026/>



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MedPAC mandate under BBA of 2018

- BBA of 2018 directs MedPAC to assess:
 - the GADCS data,
 - the adequacy of AFS payments, and
 - geographic variations in the cost of furnishing ambulance services
- MedPAC required to produce a report (due June 15, 2026) that includes:
 - an analysis of the GADCS data,
 - an analysis of the burden on organizations associated with the data collection, and
 - a recommendation of whether the data collection should continue and whether it should be revised

Note: BBA (Bipartisan Budget Act), GADCS (Ground Ambulance Data Collection System), AFS (ambulance fee schedule).

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Preliminary and subject to change

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<https://www.medpac.gov/meeting/april-9-10-2026/>



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Among all service-area categories, reported revenues are higher than costs from weighted data

Characteristic	Revenue-to-cost ratio (trimmed, weighted by transports)	Revenue-to cost ratio (full dataset)
Service-area location		
Urban	1.11	1.01
Rural	1.02	0.91
Highest quartile	1.10	1.05

Note: Q (quartile). **These results exclude government-owned organizations.** The reported revenue-to-cost ratios are the median for each group. "Revenue" is revenue from all sources, and "cost" is cost from providing ground ambulance services to all patients. Results from the trimmed data were weighted by number of transports for each organization.

Source: MedPAC analysis of data from the Ground Ambulance Data Collection System, 2022-2023.

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Highest quartile	1.10	1.05
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Summary

- GADCS is a comprehensive dataset
- Stakeholders support continued collection of GADCS data
- GADCS could be streamlined to ease reporting burden
- **Difficult to evaluate adequacy of payments**
 - Substantial revenue from sources not related to billing for services
 - May be underreporting of revenue from some sources
 - First year of data collection; may include errors
 - Little information about access to care and quality
- Analysis suggests AFS adjustments not well targeted

Note: GADCS (Ground Ambulance Data Collection System), AFS (ambulance fee schedule).

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Draft recommendation

- The Congress should direct the Secretary to continue collecting cost and revenue data from suppliers and providers of ground ambulance services.
 - Data collection should focus on information essential to assessing both the accuracy of Medicare payments and Medicare beneficiaries' access to care; and
 - The Secretary should pursue opportunities to streamline data collection to minimize burden on suppliers and providers.

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EMS Financial Index
 Driving Change through Data and Best Practices
 March 2026

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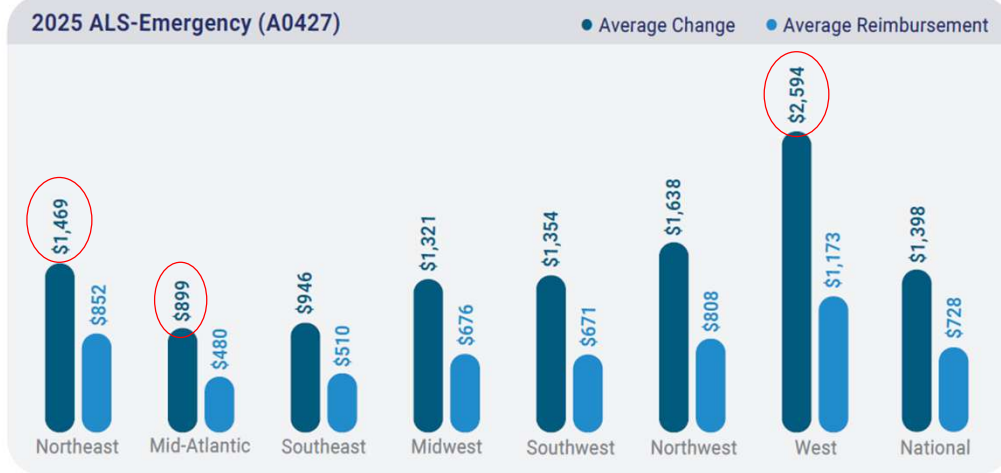
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	Per Transport	
	Mean (1)	Median (1)
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Index: 2025 Average Collections



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2025 vs. 2026 Percent Fee Change by HCPCS Code

Service Level	Region							National
	Northeast	Mid-Atlantic	Southeast	Midwest	Southwest	Northwest	West	
ALSE (A0427)	44.7%	14.1%	25.9%	51.0%	22.4%	73.3%	64.4%	42.0%
BLSE (A0429)	33.4%	21.8%	28.9%	56.2%	26.9%	92.2%	42.9%	49.6%
ALSNE (A0426)	-27.7%	58.5%	49.6%	84.8%	56.5%	86.8%	129.8%	86.4%
BLSNE (A0428)	10.4%	40.3%	31.2%	41.0%	84.0%	50.2%	-29.4%	15.8%
ALS 2 (A0433)	22.8%	6.5%	12.0%	13.9%	6.0%	35.6%	25.4%	17.6%
SCT (A0434)	118.0%	178.1%	169.6%	163.2%	190.0%	240.6%	279.9%	168.3%
TIP (A0998)	-5.4%	175.7%	174.8%	61.2%	29.6%	64.8%	21.4%	51.1%
Mileage (A0425)	33.4%	52.2%	5.6%	-8.5%	107.6%	162.7%	68.5%	31.1%

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Patient Protection/Balance Billing Impacts

Engaging with local regulators to enhance EMS economic sustainability

A new breed of state balance billing laws is tying commercial insurance reimbursement for noncontracted providers to locally established or approved rates.

Examples...



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Texas



- [A] health maintenance organization shall pay for a covered transport...by a non-network emergency medical services provider at:
- ...the rate set, controlled, or regulated by the political subdivision in which...the service originated

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<https://capitol.texas.gov/tlodocs/88R/analysis/html/SB02476H.htm>



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State	Does the state have balance billing protections for ground ambulance services?	Does the state require specific method for payment?	State specific method of payment	Do the protections apply to all private, state-regulated plans?	Do the protections apply to public and private ambulance services?	Do the protections cover non-emergency transport?
Arkansas	Yes	Yes	Minimum allowable reimbursement at: (1) Rate set by local government entity ; If no such rate exists, then the lesser of: (i) 325% of Medicare or (ii) the provider's billed charge	Yes	Both	Yes
California	Yes	Yes	The payment rate is based on (1) a rate established or approved by the local government with jurisdiction for the area or (2) if no local rate is available, a rate set under state regulations as the reasonable and customary value, considering various factors (e.g., provider training and qualifications, nature of services, usual charges, and prevailing provider rates in the local area)	Yes	Both	Yes
Colorado	Yes	Yes	The payment rate is based on (1) 325% of Medicare ; or if a private provider contracts with a government entity, then (2) a negotiated independent reimbursement rate	Yes	Private only	No
Delaware	Yes	Yes	In the absence of agreed upon or negotiated rates, the insurer and provider can seek arbitration. Prior to resolution, the insurer is required to pay the provider the highest allowable charge allowed by the insurer during the year before the date of service.	Yes	Both	No
Florida	Yes	Yes	The payment rate is based on the lesser of three : (1) The provider's billed charges ; (2) The usual and customary provider charges for similar services in the community where services were provided; or (3) The charge mutually agreed to by the insurer and provider within 60 days of claim submital	Only HMOs	Both	No
Illinois	Yes	Yes	Either (1) a locally-set rate if the provider is subjected to the jurisdiction of a local government, or, if a provider is not subject to a local government's jurisdiction, then (2) the lesser of (i) the negotiated rate between the provider and the insurer, (ii) 85% of the provider's billed charges , or (iii) the average gross charge rate for the service provided and a loaded mileage charge, if applicable	Yes	Both	No
Indiana	Yes	Yes	The payment rate is based on the lesser of the three: (1) At a rate not to exceed local rate set; (2) 400% of Medicare ; or (3) according to the out of network ambulance provider's billed charges	Yes	Both	Yes
Louisiana	Yes	Yes	Minimum allowable reimbursement rate to out-of-network provider at: (1) a rate set or approved by local government entity or; (2) if no such rate exists, then the lesser of 325% of Medicare or the provider's billed charge	Yes	Both	No
Maine	Yes	Yes	Carriers are required to reimburse out-of-pocket network providers at the lesser of the provider's rate or 180% of Medicare unless the ambulance service provider is in a rural or super rural area as determined by CMS. If based on being in a rural area the provider would be eligible for additional Medicare reimbursement for services that were provided to a Medicare enrollee, the carrier shall increase the reimbursement to that ambulance service provider in the same amount as the additional Medicare reimbursement.	Yes	Both	Yes
Maryland	Yes	Yes	Minimum allowable reimbursement rate is set to amount paid to an ambulance service provider under contract with the carrier for the same service in the same geographic region, as defined by CMS	Yes	Public only if the ambulance service accepts an assignment of benefits from PPO and EPO plans; Private and public for HMO plans	Yes
Mississippi	Yes	Yes	Minimum allowable reimbursement rate is a locally set rate , or, without that, the greater of (i) 325% of Medicare or (ii) the provider's billed charges	Yes	Both	Yes

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State	Does the state have balance billing protections for ground ambulance services?	Does the state require specific method for payment?	State specific method of payment	Do the protections apply to all private, state-regulated plans?	Do the protections apply to public and private ambulance services?	Do the protections cover non-emergency transport?
New Hampshire	Yes	Yes	The payment rate is differentiated between a provider's status as enrolling/participating and nonparticipating. (1) For enrolling/participating providers: (i) from 2026-2027, the rate is temporarily set at 3.25 times the Medicare rate , then (ii) beginning in 2028, the rate will be a state-wide rate established by the commissioner, based on recommendations from an independent study conducted by an independent consulting expert; and (2) for nonparticipating providers, the rate is the greater of: (i) the out-of-network rate, or (ii) the Medicare rate.	Yes	Both	Yes
New York	Yes	Yes	In the absence of agreed upon rates, the usual and customary rate, which cannot be excessive or unreasonable	Yes	Both	No
North Dakota	Yes	Yes	The minimum allowable reimbursement rate is the lesser of (i) 250% of Medicare or (ii) the provider's billed charges	Yes	Yes	Yes
Ohio	Yes	Yes	The payment rate is based on the greater of: (a) In-network rate, or if more than one amount, the median rate; if no per-service amount exists, then this option is disregarded; (b) the same amount the health benefit plan generally uses to determine the payments for out of network health care services, such as the usual, customary, and reasonable amount; or, (c) the amount that would be paid under Medicare. If disagreement on rate, the disputing parties can enter arbitration	Yes	Both	No
Oklahoma	Yes	Yes	Minimum allowable reimbursement rate is a locally set rate , or, without that, the lesser of (i) 325% of Medicare, or (ii) the provider's billed charges	Yes	Both	Yes
Oregon	Yes	Yes	Either (1) the established local rate , or (2) 325% of the Medicare rate in the absence of a local rate.	Yes	Both	Yes
Texas	Yes	Yes	The payment rate is based on (1) an amount set by a political subdivision and filed with the state or; (2) the lesser of: (i) 325% of Medicare or (ii) the provider's billed charge	Yes	Both	No
Utah	Yes	Yes	The payment rate is based on a base rate corresponding to the type of ambulance provider. The bureau of insurance will establish a mileage rate for ground ambulance providers and paramedic providers that is just and reasonable.	Yes	Both	Yes
Washington	Yes	Yes	The payment rate is based on (1) Either (a) a rate set by a local government entity for public-sector organizations; or (b) a contracted rate for private-sector organizations; (2) If (1) is not established, then the lesser of (a) 325% of Medicare, or (b) the ground ambulance services organization's billed charges	Yes	Both	Yes
West Virginia	Yes	Yes	The payment rate is based on provider's normal charges	Only HMOs	Both	No

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S.B. No. 916

Relating to consumer protections against certain medical and health care billing by emergency medical services providers.

(c) A political subdivision may annually adjust a rate submitted under Section 38.006 by not more than the **lesser** of:

- (1) the Medicare Ambulance Inflation Factor; or
- (2) 10 percent of the provider's previous calendar year rates.

Texas



<https://legiscan.com/TX/text/SB916/id/3078170>

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SB269 ENROLLED

(c)(1) Beginning January 1, 2027, the minimum reimbursement amount from a health care insurer to an emergency medical service provider that is out-of-network for covered services shall be **180 percent of the Medicare Ambulance Fee Schedule rate as published by CMS.**



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<https://legiscan.com/AL/bill/SB269/2026>



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SB269 ENROLLED

(2)a. Beginning January 1, 2027, the minimum reimbursement from a health insurer to an emergency medical service provider that is in-network for **treat in place** shall be **200 percent** of the Medicare Ambulance Fee Schedule rate for basic life support as published by CMS which is in effect on January 1, 2027.

(2) The minimum reimbursement rate for **treat in place** provided in paragraph (b)(2)a. **shall not apply to an out-of-network emergency medical service provider.**



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<https://legiscan.com/AL/bill/SB269/2026>



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Explaining Fee Increases to Local Stakeholders

	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30
Cost per Transport	\$1,215.49	\$1,255.56	\$1,295.50	\$1,337.46	\$1,380.08	\$1,423.47
Tax/Benefit Revenue per Transport	\$594.93	\$610.99	\$627.76	\$645.28	\$663.57	\$682.68
Fee For Service (FFS) Revenue Required to Cover Cost of Service Delivery	\$620.56	\$644.57	\$667.73	\$692.19	\$716.51	\$740.79
Projected FFS Revenue per Transport	\$479.05	\$478.88	\$478.71	\$478.54	\$478.37	\$478.20
Current FFS Revenue Gap	(\$141.52)	(\$165.69)	(\$189.03)	(\$213.65)	(\$238.14)	(\$262.59)



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Explaining Fee Increases to Local Stakeholders

Payer Source	Payer Mix	
Medicare	38.1%	} Fixed "Allowed" Reimbursement Amount • Patient only responsible for deductible and co-insurance (required) • No other 'balance billing'
Medicare HMO	25.8%	
Medi/Medi	0.8%	} Fixed Reimbursement Amount • No other 'balance billing'
Medicaid	1.2%	
Medicaid HMO	7.2%	
Insurance	20.6%	
Self-Pay	5.8%	
Auto	0.2%	
Other	0.2%	
Total	100%	



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Explaining Fee Increases to Local Stakeholders

Change fees to XXXXX Structure

- Maximize 3rd party reimbursement
 - Will Not Impact 73.1% of residents
 - Will Not Impact 55.9% of non-residents

Implement a 'no balance billing' policy for residents

- Accept what commercial insurance reimburses
 - Minimize impact to residents who subsidize system with taxes and benefit fees

Implement a 'Charity Care' policy

- Help those who are not able to pay their ambulance bill
- Refer to collections those who are able, but unwilling to pay their ambulance bill

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Actual (Budgeted) [Projected]	[FY 2024-25]	[FY 2025-26]	[FY 2026-27]	[FY 2027-28]	[FY 2028-29]	[FY 2029-30]
Revenue						
FY Collected FFS Ambulance Revenue	\$3,638,447	\$6,152,880	\$6,464,904	\$6,719,972	\$7,009,522	\$7,412,684
Revenue per Transport	\$533.53	\$873.84	\$889.24	\$895.19	\$904.32	\$926.14
Collection %	62.8%	22.7%	22.0%	21.1%	20.3%	19.8%
Other Revenue						
Total Other Revenue	\$4,066,000	\$4,175,916	\$4,289,327	\$4,375,697	\$4,464,236	\$4,555,003
Total Revenue	\$7,704,447	\$10,328,796	\$10,754,230	\$11,095,669	\$11,473,758	\$11,967,688
Total Expenses	\$8,015,789	\$8,414,150	\$8,752,563	\$9,111,093	\$9,480,785	\$9,862,638
Fully Allocated Retained Earnings (Total Revenue - Expenses)	(\$311,342)	\$1,914,646	\$2,001,668	\$1,984,577	\$1,992,972	\$2,105,050

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Medicaid Ambulance Supplemental Payment Programs

- Many public & private agencies participate in Ground Emergency Medical Transport (GEMT) supplemental payment programs
 - Medicaid program to reimburse public ambulance providers for **Medicaid under-payments**
 - Compensate for Certified Public Expenditures
 - **Reimburse taxpayers for State underpayments**
 - **State Directed Payments**
 - Provider tax/Inter-Government Transfers (IGT)



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§ 414.610 Basis of payment.

(a) **Method of payment.** Medicare payment for ambulance services is based on the lesser of the actual charge or the applicable fee schedule amount. The fee schedule payment for ambulance services equals a base rate for the level of service plus payment for mileage and applicable adjustment factors. Except for services furnished by certain critical access hospitals or entities owned and operated by them, as described in [§ 413.70\(b\) of this chapter](#), all ambulance services are paid under the fee schedule specified in this subpart (regardless of the vehicle furnishing the service).

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<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-H/section-414.610>



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Ambulance agencies that bill below their reported GEMT costs face significant potential compliance risks

- May be subject to claw-backs, as Medicaid regulations prohibit reimbursement amounts from exceeding a provider's publicly billed charge.
- If the cost report indicates a higher amount reimbursements than what was billed, the state may be required to recover the overpayment.
- Billing inconsistencies create audit exposure.
- Agencies whose billed fees do not align with their cost reports are more likely to be flagged for audit.

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DATE: [Date]
TO: ALL GROUND EMERGENCY MEDICAL TRANSPORTATION PROVIDERS
SUBJECT: CALIFORNIA GEMT AVERAGE COMMERCIAL RATE PROVIDER SURVEY
PURPOSE:
The Department of Health Care Services (DHCS) is mandating all public and private California Ground Emergency Medical Transportation (GEMT) providers to complete an Average Commercial Rate (ACR) Survey for the 12-month period of July 1, 2024, through June 30, 2025, in order to comply with new federal requirements set forth by the Centers for Medicare & Medicaid Services (CMS). Provider responses are due no later than [insert due date]. Failure to complete and submit this survey by the due date may impact future eligibility for payments under the Public Provider GEMT Intergovernmental Transfer (PP-GEMT IGT) program and GEMT Quality Assurance Fee (QAF) program payment increases.

BACKGROUND:
In accordance with [Assembly Bill \(AB\) 1705](#) (Chapter 544, Statutes of 2019), DHCS established the PP-GEMT IGT Program to provide supplemental Medi-Cal payments to eligible public GEMT providers. Similarly, under [Senate Bill \(SB\) 523](#) (Chapter 773, Statutes of 2017), DHCS established the GEMT QAF program to provide supplemental Medi-Cal payments to eligible private GEMT providers. Proposition 35 (November 5, 2024, General Election) allocated funding to DHCS to implement additional GEMT payment increase.


[Section 1902\(a\)\(30\)\(A\) of the Social Security Act \(the Act\)](#) requires Medicaid payments to be "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

As part of the CMS review of pending GEMT State Plan Amendments (SPAs) [25-0002](#), [25-0003-A](#) and [25-0030](#) in 2025, CMS issued Requests for Additional Information (RAI) requiring DHCS to demonstrate that proposed GEMT supplemental payments comply with the requirements in Section 1902(a)(30)(A) of the Act for efficiency and economy.

POLICY:
To comply with CMS requirements, DHCS is mandating all GEMT providers, including public and private entities, to submit commercial fee/rate information for the top five commercial payers based on volume for GEMT procedure codes A0427, A0429, A0433, A0225, and A0434 during the 12-month period of July 1, 2024, through June 30, 2025. Responses are due no later than [insert due date]. Failure to complete this survey by the due date may impact future eligibility for payments under the PP-GEMT IGT program and GEMT QAF program payment increases.

Provider Rates Division
1501 Capitol Avenue, MS 4600, P.O. Box 997417
Sacramento, CA 95899-7417
Phone (916) 552-9600 | www.dhcs.ca.gov

State of California
Gavin Newsom, Governor



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Date of Service	Average Charge	Avg Medi-Cal Collection	Gross Col %
2022-10	\$967.54	\$335.59	34.69%
2022-11	\$869.18	\$341.77	39.32%
2022-12	\$900.27	\$344.36	38.25%
2023-01	\$889.23	\$863.93	97.16%
2023-02	\$869.07	\$895.70	103.06%
2023-03	\$795.15	\$838.40	105.44%
2023-04	\$873.40	\$725.87	83.11%
2023-05	\$730.26	\$776.95	106.39%
2023-07	\$741.30	\$834.84	112.62%
2023-09	\$807.14	\$836.77	103.67%
2024-01	\$772.37	\$1,023.14	132.47%
2024-02	\$756.80	\$990.15	130.83%
2024-03	\$829.95	\$971.52	117.06%
2024-04	\$786.39	\$1,021.46	129.89%
2024-05	\$927.50	\$1,023.64	110.37%
2024-06	\$846.34	\$928.64	109.72%
2024-07	\$864.22	\$1,056.84	122.29%
2024-08	\$724.62	\$985.35	135.98%

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Key Takeaways:

- EMS and ambulance agencies are facing unprecedented financial pressures
- So are the communities they serve!
- Being good public servants means being good fiscal stewards.
- Calculate and justify your fees using **reliable cost** data
- There may be significant compliance risks of **arbitrary, outdated, or inflated** fees
- Need help? Phone a friend!

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JOINT WEBINAR • LIVE & ONLINE

AMBULANCE ECONOMICS IN CRISIS:

Costs, Rates, and Reimbursement

Get the Insights You Need to Protect Revenue & Ensure Sustainability

- Recent **National Reports** on Ambulance Costs & Revenues
- The Perils of **Underpricing** Services
- Fee Considerations Under **Patient Protection Legislation**
- Navigating **Medicaid Supplemental Payment Programs**

DATE: **April 30, 2026** | TIME: **9a CT** | **LIVE & ONLINE**
FREE TO ATTEND

Presenters:

Ryan Stark | **Matt Zavadsky**

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this

Certificate of Completion

is presented as evidence of completion, by the CAC, CACO, CAFO whose signature and Certification Number appear below, of the NAAC ® approved Continuing Education course entitled

PWW|AG - 2026 - Ambulance Economics in Crisis: Costs, Rates, and Reimbursement

CEU Code: XZeLHKd9

CEU Units: 1.00

I hereby certify that I have completed the continuing education training as represented on this certificate.

Signed: _____

NAAC ® ID: _____

Britanie Holubik

04/30/26

Program Coordinator

Date of Training

Certificate is invalid without the signature and certification number of the attendee.