

# CALIFORNIA GROUND EMERGENCY MEDICAL TRANSPORT AVERAGE COMMERCIAL RATE FAQ

## 1. Where can providers find the Ground Emergency Medical Transport (GEMT) Average Commercial Rate (ACR) Survey submission form and webinar presentation?

- a. The DHCS Form 25-0028 and GEMT ACR webinar presentation are available on the GEMT ACR website. Please visit <https://www.dhcs.ca.gov/Pages/GEMT-ACR-Survey.aspx>

## 2. What is the legal authority that mandates providers to submit commercial fee/rate information to DHCS?

- a. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, DHCS is authorized to implement the Public Provider Ground Emergency Medical Transportation (PP-GEMT) Intergovernmental Transfer (IGT) and GEMT Quality Assurance Fee (QAF) increases, without taking regulatory action pursuant to Welfare & Institutions (WIC) Code Sections 14105.94(h) and 14129.5. DHCS will issue a forthcoming policy letter mandating providers submission of commercial fee/rate information.

## 3. Will a provider's eligibility be impacted if they do not submit the ACR survey information?

- a. 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. The ACR survey data helps DHCS demonstrate to Centers for Medicare & Medicaid Services (CMS) that the GEMT supplemental payment programs operate efficiently and economically.
  - i. Under WIC Section 14129.7(b)(1), the GEMT QAF program may be discontinued if CMS no longer permits the collection or use of the emergency medical transport provider assessment.
  - ii. Under WIC Section 14105.945(j), the PP-GEMT IGT program may cease to operate if it is no longer financially or programmatically supportive of Medi-Cal.

**4. Which procedure codes should be included in the ACR survey?**

Provider must include the following five (5) procedure codes:

Procedure Code	Procedure Code Description
A0225	Neonatal Emergency Transport
A0427	ALS1-Emergency
A0429	BLS-Emergency
A0433	ALS 2
A0434	Specialty Care Transport

**5. Does a provider have to have claims for all five procedure codes to submit ACR?**

- a. No. Providers should report ACR information for as many of the five procedure codes as applicable.

**6. What if a provider has multiple NPIs? Does the provider submit data for only one NPI or all of the NPIs in their health system?**

- a. Each NPI must have its own ACR survey submission.

**7. What if a provider has more or less than five commercial payers?**

- a. If a provider has more than five commercial payers, the top five commercial payers by volume by procedure code for the 12-month period of July 1, 2024 through June 30, 2025 must be reported. If a provider has fewer than five commercial payers, please report all the available commercial payers.

**8. Do providers have to report ACR data for non-California transports?**

- a. No. Providers should only report transports occurring with California-regulated service lines.

**9. Should ACR data be reported for out-of-state insurers? How do providers determine if a claim is for an out-of-state insurer?**

- a. No. Out-of-state insurers are excluded from ACR reporting as they may be subject to another state’s authority.

If the insurer is California-based, and the service occurred within California-regulated state lines, then the data should be reported, even if the payment is ultimately processed or issued by an out-of-state payment center.

**10. If a provider operates in multiple areas/counties, is the ACR calculated separately or aggregated?**

- a. If a single NPI operates in multiple areas/counties with different rates, the provider must submit one ACR survey reflecting aggregate allowed amounts across all counties for each payer and procedure code. This ensures DHCS can accurately reflect geographic rate variations. Providers should only report commercial fee/rate information for the top five commercial payers based on volume by procedure code for the 12-month period of July 1, 2024 through June 30, 2025.

**11. Is supporting documentation required to be submitted with the ACR provider survey?**

- a. At this time, providers do not need to include supporting documentation with the ACR provider survey. However, in accordance with WIC Section 10853, federal regulations (including at 42 Code of Federal Regulations (CFR) section 431.107), the Medi-Cal Provider Manual, and each GEMT provider’s Medi-Cal Provider Agreement with DHCS, DHCS may request reports and records from GEMT providers to validate the accuracy, uniformity, and completeness of ACR submission.

**12. How should providers name commercial payers?**

- a. Providing commercial payer names is optional and may be included in the “Notes” section beginning on Line 60. If included, commercial payer names must match exactly as listed on the remittance advice (RA), explanation of benefits (EOB), or similar payment documentation that reflects the allowed payment amount.

For example, for procedure code A0225, providers may list payer names in the following format:

A0225 - RN1: Payer Name 1, RN2: Payer Name 2, RN3: Payer Name 3, RN4: Payer Name 4, and RN5: Payer Name 5.

**13. How should ACR be reported for transports bundled with ancillary services?**

- a. If a bundled payment includes ancillary services (including mileage) that cannot be separated from the transport code, the provider must report the total bundled amount and indicate that the ACR represents a bundled payment in the “Notes” section beginning on Line 60.

**14. Should Veteran Affairs (VA) and auto insurance claims be included in the ACR data?**

- a. No. Please exclude non-commercial payers such as VA and auto insurance claims from the ACR survey. For additional information, please refer to statement #1 on the Instruction tab of the provider survey.

**15. Do providers need to report billed charges? What rate should provider be reported?**

- a. Providers must report only the allowed amount before any deductions, reductions, patient cost sharing, third party payments, or other adjustments as stated on your remittance advice/EOBs. Do not report billed or collected amounts unless they are equal to the gross allowed amount for the service (prior to reduction in payment).

**16. How should sub-contracted services be reported?**

- a. GEMT providers should exclude subcontract arrangements from ACR reporting.

**17. Where do providers submit the data?**

- a. Please complete the DHCS form 25-0028 and attestation and submit via email to [GEMTACR@dhcs.ca.gov](mailto:GEMTACR@dhcs.ca.gov) with subject line “GEMT ACR <NPI>”.

**18. When is the provider survey due?**

- a. The provider survey is due June 19, 2026.

**19. Where can providers submit questions about the GEMT ACR survey and GEMT supplemental payment programs?**

- a. Questions may be submitted to the respective inbox:
  - i. GEMT ACR Survey: [GEMTACR@dhcs.ca.gov](mailto:GEMTACR@dhcs.ca.gov)
  - ii. GEMT QAF program: [GEMT@dhcs.ca.gov](mailto:GEMT@dhcs.ca.gov)
  - iii. PP-GEMT IGT program: [AB1705@dhcs.ca.gov](mailto:AB1705@dhcs.ca.gov)

**20. If our service is not contracted with any commercial payers, should we report the standard rate used for all commercial payers?**

- a. If your service is not contracted with any commercial payers, you should still report rates by payer. In this situation, please report the standard rate, the amount paid by the commercial payer, you use for your top five commercial payers by volume.

**21. Payor Fee/Rate - Do you want exact dollar amounts or rounded amounts?**

- a. Providers should report the exact dollar amounts for average commercial rates; do not round the values.

**22. Is the 12-month period of July 1, 2024 through June 30, 2025 based on service date or reimbursement date?**

- a. The 12 month period of July 1, 2024 through June 30, 2025 is based on service date. All units and commercial rates should be reported only for services rendered in this time period.

Examples:

- i. Example 1: If the date of service occurred on May 30, 2025 but payment was not received until July 5, 2025, the payment must be reported.
- ii. Example 2: If the date of service occurred on February 1, 2024 but payment was received on July 30, 2024, the payment may be excluded from the survey.

**23. How should providers report claims with a \$0 allowed amount or a denial? Should the volume for each HCPCS code include only reimbursed services while excluding unpaid base rates?**

- a. Providers should include only paid GEMT services. Please exclude claims where a payer assigned a \$0 allowed amount or denied the claim. Similarly, Healthcare Common Procedure Coding System (HCPC) volume should include only paid GEMT services. Unpaid base rates should be excluded.

**24. Most Emergency Medical Services (EMS) agency software captures only billed amount and payment amount – the allowed amount is viewable only on individual remit files and not readily reportable. How does the Department advise providers to complete the survey in that case?**

- a. Providers whose systems do not capture the allowed amount should use the allowed amount displayed on Remittance Advice (RA) or Explanation of Benefits (EOB) documents. Providers must report the allowed amount before any deductions, reductions, or other adjustments. If the allowed amount is the same as the payment amount, providers may report the payment amount in the rate field.

**25. Is the survey response requirement applicable only to providers who received GEMT payments during the reporting period?**

- a. All California GEMT providers are required to respond to this ACR survey. The lone exception is if a provider did not receive any commercial GEMT payment for dates of service during July 1, 2024 through June 30, 2025. In this instance, the provider does not need to complete an ACR survey.

**i. Do recently approved providers currently participating in the Medi-Cal program that were not approved Medi-Cal providers for the period of July 1, 2024 through June 30, 2025 need to respond to this survey?**

- a. Yes. All California GEMT providers are required to respond to this ACR survey.

The GEMT commercial rate data for July 1, 2024 - June 30, 2025 will be used to demonstrate that proposed GEMT supplemental payments comply with the requirements in Section 1902(a)(30)(A) of the Social Security Act related to efficiency and economy for current and future GEMT supplemental payment add-on amounts.

**ii. Will providers approved for the Medi-Cal program after the survey's deadline who would potentially not have responded to the survey be subject to having future eligibility for payment under the GEMT program impacted?**

Failure to complete and submit the ACR survey by the required deadline may impact future eligibility for payments under the PP-GEMT IGT program and the QAF program payment increases.

DHCS is continuing to engage with CMS regarding how non-submission may affect provider eligibility for GEMT supplemental payment programs. DHCS intends to work collaboratively with providers to obtain necessary ACR information and support compliance with federal requirements.

Please refer to our FAQ response #3.

**26. Is this something we have done previously? Or is this new?**

- a. This is a new process. DHCS is collecting commercial payment data from all California GEMT providers to meet new federal requirements. During CMS’s review of State Plan Amendments (SPAs) 25-0002, 25-0003-A, and 25-0030, CMS issued Requests for Additional Information (RAIs) requiring DHCS to demonstrate that the proposed supplemental payments meet the efficiency and economy standards outlined in Section 1902(a)(30)(A) of the Social Security Act. CMS specifically requested an ACR calculated using provider-specific commercial payment data with supporting documentation.

**27. For the Commercial Payer Fee/Rate - What if the fee/rate changed over the period from July 2024 and June 2025 what fee/rate should be recorded?**

- a. If the commercial fee/rate changed between July 1, 2024 and June 30, 2025, providers should report the rate as of June 30, 2025 (or last known if June 30 is not available).

**28. Are providers supposed to only report data for contracted payers or all payers?**

- a. DHCS is requesting all commercial payment data. Providers should report data for all commercial payers, not just those with whom they have contracts. If your service does not have contracts with any commercial payers, you must still report rates by payer. In that case, please report the standard rate or allowed amount you receive from your commercial

payers, using the rates for at most your top five commercial payers by trip volume.

Please exclude all non-commercial payers such as Medicaid/CHIP (Managed Care or State FFS), Medicare (Traditional or Medicare Advantage), TRICARE, workers' compensation programs, or any other payer or code not subject to commercial market forces.

**29. Are the Fee/Rate amounts just the fee for the specific procedure code or the total of all charges for those transports?**

- a. Where possible, the fee/rate amounts should reflect only the commercial fee or allowed amount for the specific GEMT procedure code (A0427, A0429, A0433, A0225, and A0434). Providers should not report the total charges for the entire transport or include any ancillary services, such as mileage.

The only exception to this is if bundled payments include ancillary services that cannot be separated from the transport code. This is addressed in Q13 above and these instances should be noted within the "Notes" section beginning on line 60

**30. What if a provider does not have payer contracts but bills the LEMSA-approved charges?**

- a. If a provider does not have payer contracts and instead bills the LEMSA-approved charges, providers should report the allowed amount (the amount before any deductions, patient cost sharing, or other adjustments). If the payer's allowed amount is equivalent to the LEMSA-approved charge, providers should report that amount as the allowed amount.

**31. What should providers report if they have multiple rates for the same procedure code with a single commercial payer (for example, different rates for residents and non-residents)?**

- a. If a provider has multiple rates for the same procedure code with a single commercial payer (for example, different rates for residents and non-residents), providers should report one aggregated (average) allowed amount for that payer and procedure code.

**32. Do commercial payors include private healthcare facilities such as hospitals and urgent care centers? Should entities like state prisons or other correctional facilities be included or excluded?**

- a. Yes, commercial payors include private healthcare facilities such as hospitals and urgent care centers when they operate as commercial entities subject to market forces. Commercial payors do not include state prisons or other correctional facilities. These are non-commercial entities and must be excluded from reporting.