Study of the Feasibility and Desirability of Establishing a Delinquent Billing Reimbursement Grant System for Ambulance Service Providers

Survey Results & Overview

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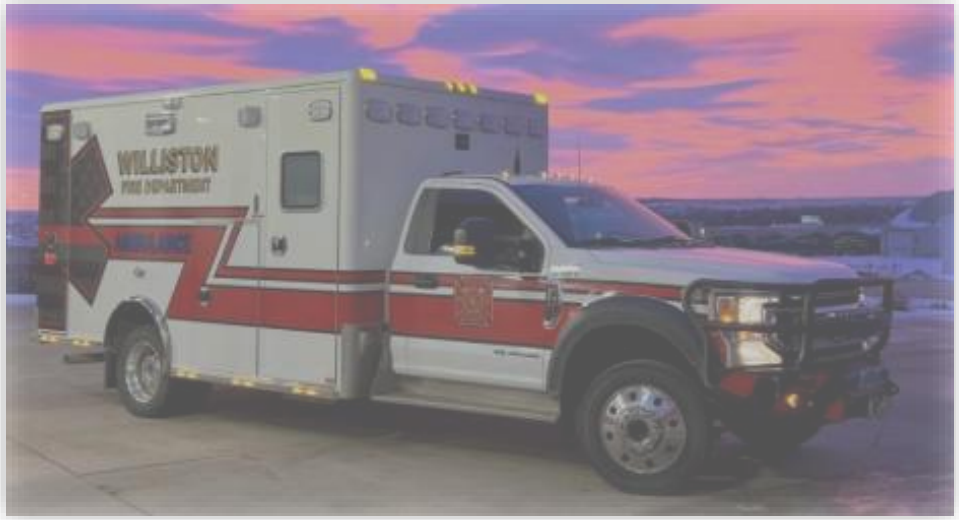
Agenda



- **A National Crisis**
- **Survey Response Statistics**
- **Overview of Survey Results**
- **Key Findings and Policy Implications**
- **Explanation of Variations in Costs and Revenues Based on**
  - Agency Type
  - Geographic and Demographic Differences
- **Considerations for the North Dakota Legislature**
  - Option 1: Create a ‘North Dakota Ambulance Delinquent Accounts Stabilization Grant Program’
  - Option 2: Create a More Stable, Statewide EMS Readiness & Workforce Funding Program Based on Funding Response and Readiness vs. Patient Transport
- **Q & A**

A National Crisis

- **EMS agencies across the country are facing unprecedented fiscal challenges.**
- **Skyrocketing costs, staffing challenges, and stagnant fee-for-service revenue are significantly impacting service delivery.**

EMS Related News Reports

Summary: Jan 11, 2021 -Jan 31, 2025
Article Count: 3,874

Keywords	**Tag Count**	**% of Total**
Staffing	1,336	34.5%
Funding, Tax Levy	1,700	43.9%
Total	**3,036**	**78.4%**

Other	**Tag Count**	**% of Total**
Closure/Takeover	353	9.1%
Response Time	544	14.0%
Staffing+Response Time	**1,880**	**48.5%**
Staffing+Funding+Response Time	**3,580**	**92.4%**

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Survey Response Statistics

- **Partnership with the North Dakota EMS Association**
  - Promoted participation from ambulance agencies across the state
  - Town hall meetings, co-branding, membership communications

- **North Dakota Health Response and Licensure Emergency Medical Systems Unit**
  - Contact info for agencies

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Respondent Summary

- **Overall participation was more limited than hoped**
  - Despite multiple communications from NDEMSA and PWW|AG
- **Results may not fully reflect the full diversity of agency structures, service areas, or funding conditions across the state**
- **Several agencies, particularly smaller or primarily volunteer-based services, reported challenges in assembling the requested information**
- **36 completed surveys**
  - Good diversity of system types

	Agency Type						
Respondent Characteristics	**City**	**3rd Service, County / City**	**District Owned**	**Hospital Based**	**Private, Non-Profit**	**Private, For Profit**	**Overall Snapshot**
Respondents	4	2	11	4	11	4	36
Response Volume	613	504	2,717	44,758	3,730	18,343	70,665
Responses resulting in no transport	107	No Data	563	No Data	472	1,400	2,542
No Transport %	17.5%		20.7%		12.7%		16.9%
Agencies that bill for non-transports	0	0	5	3	6	4	18
% of agencies that bill for non-transports	0.0%	0.0%	45.5%	75.0%	54.5%	100.0%	50.0%
Service Area Population	15,251	4,262	33,606	257,990	55,166	172,000	538,275
Service Area Sq Miles	2,345	2,080	8,195	2,733	12,038	5,829	33,220
Average Transport Miles	57	61	42	6	29	10	34
Number of Ambulances	13	8	30	34	31	25	141
Contracted Billing	4	2	11	1	9	3	30
In-House Billing	0	0	0	3	2	1	6

Overall Themes

- **Even with incomplete participation and reporting variability, the survey response data consistently highlights common themes:**
  - The structural gap between fee-for-service reimbursement and the cost of service delivery,
  - Increasing workforce pressures, and
  - The growing reliance on local subsidies to sustain essential EMS coverage

Key Observations:

- **36 agencies** responded to the survey, representing nearly **71,000 EMS responses**
- Of agencies reporting non-patient transport, **the average non-transport rate is 16.9%**
- Only half of the respondents reported billing for non-patient transport
- The average patient transport distance is 34 miles

Key Findings from the Data & Policy Implications

- **Fee-for-Service (FFS) Ambulance Billing Does Not Cover the Cost of Service**
  - Average fee-for-service **revenue** per patient transport: **$1,101**
  - Average **expense** per patient transport: **$1,584**
  - Net **loss** per patient transport: **$482**
    - This means that for many agencies, every additional patient transport increases financial losses rather than improving sustainability

Policy Implication

The ambulance system cannot be stabilized through billing reforms alone because the underlying payment model does not fund readiness and staffing.

Key Findings from the Data & Policy Implications

- **Local Tax Subsidy and Fundraising/Donations Have Become the Backbone of EMS Finance**
  - Total reported revenue across respondents is $55.8 million. The funding composition is shown below:

Source	Amount	Share
Fee-for-service billing	$39.3 million	**53.0%**
Local tax subsidy	$9.2 million	**26.2%**
State grants	$3.0 million	**9.4%**
Other/fundraising/etc.	Remaining	**~11%**

Policy Implication

The EMS system is being supported locally, but community capacity to subsidize varies widely, creating inequity across the state.

Key Findings from the Data & Policy Implications

- **Lack of Collections Is a Major System Stressor**
  - Agencies responding to the survey reported that **only 78.7%** of claims submitted for ambulance services **were paid**, representing **$2.7 million in unpaid ambulance claims**.

Key Observations:

- The average patient charge across all respondents is $1,756.85
- Of the respondents reporting, only 78.7% of ambulance claims were paid
- Private, For-Profit agencies have the highest claim payment rate of 91.8%, and Private, Non-Profit have the lowest paid claim rate at 64.0%
- The average claim amount sent to collections is $1,062.94

Key Findings from the Data & Policy Implications

- **Lack of Collections Is a Major System Stressor**

Respondent Characteristics	City	3rd Service, County / City	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
Number of Transports Billed	654	144	2,279	11,650	2,988	15,838	33,553
Gross Revenue Billed	$597,002	$285,428	$4,169,922	$57,111,005	$5,261,014	$36,408,661	$103,833,032
Average Patient Charge	$912.85	$1,982.14	$1,829.72	$4,902.23	$1,760.71	$2,298.82	$1,756.85
Total # of claims paid	468	129	1,740	381	1,912	14,537	19,167
% of claims paid	71.6%	89.6%	76.3%		64.0%	91.8%	78.7%
# of transports Unpaid after 90-days	45	11	66	1,909	325	1,378	3,734
$ value of claims unpaid after 90-days	$67,781	$15,222	$143,245	$2,300,257	$965,389	$2,403,931	$5,895,825
Average claim $ unpaid after 90-days	$1,506.24	$1,383.77	$2,170.38	$1,204.95	$2,970.43	$1,744.51	$1,601.97
# of claims sent to collections	**46**	**0**	**234**	**862**	**179**	**987**	**2,308**
$ value of claims sent to collections	**$72,570**	**$0**	**$305,952**	**$791,468**	**$233,066**	**$1,255,811**	**$2,658,867**
Average $ claim amount sent to collection	**$1,577.61**	**$0.00**	**$1,307.49**	**$918.18**	**$1,302.04**	**$1,272.35**	**$1,062.94**

Policy Implication

Ambulance agencies operate with fragile cash flow and high administrative burden, especially in rural areas with small billing offices. ***The burden of uncollected claims places a significant burden on the financial sustainability of essential ambulance service.***

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Key Findings from the Data & Policy Implications

- **Workforce Instability is a Growing Threat**
  - Agencies responding to the survey reported an overall attrition of 12.7%
  - The qualitative findings highlight major drivers of workforce attrition:
    - Inadequate pay
    - Limited benefits
    - Lack of retirement systems
    - Inability to compete with hospitals and larger systems

Policy Implication

Workforce challenges are not isolated; they are systemic and financial. Staffing shortages will translate directly into response delays and service gaps.

Key Findings from the Data & Policy Implications

- **Non-Patient Transport Responses Represent Unfunded Clinical Work**
  - Medicare, Medicaid and most insurers only reimburse ambulance agencies for patient ***transport*** to the hospital.
  - For agencies reporting non-patient transport rates, the average non-patient transport rate is **16.9%**
- **These calls still require:**
  - Ambulance response
  - Clinical assessment
  - Readiness and staffing
  - Documentation and oversight
  - Medical director involvement

Key Findings from the Data & Policy Implications

- **Non-Patient Transport Responses Represent Unfunded Clinical Work**

Policy implication

North Dakota agencies are delivering care and readiness costs without reimbursement, especially as EMS increasingly functions as mobile healthcare.

The legislature should enable a mechanism for state-regulated insurers, including Medicaid, to reimburse agencies for ambulance responses that result in treatment on scene without patient transport.

The survey data shows that North Dakota's ambulance agencies are operating in a structurally unsustainable financial environment. Patient billing alone does not cover the cost of readiness, staffing, and response.

Key Findings from the Data & Policy Implications

- **Capital Replacement Needs Are Significant, Unavoidable and Underfunded**
  - Agencies anticipate **$12.9 million** in vehicle and equipment replacement over **5 years**, for an average planned investment of **$357,667 per agency**.
  - Ambulances are life-safety infrastructure with replacement cycles that cannot be deferred indefinitely.

Policy implication

Without predictable capital support, agencies will face equipment failure, safety risk, and service interruption.

Key Findings from the Data & Policy Implications

Cost of Capital Components for Ambulance Agencies

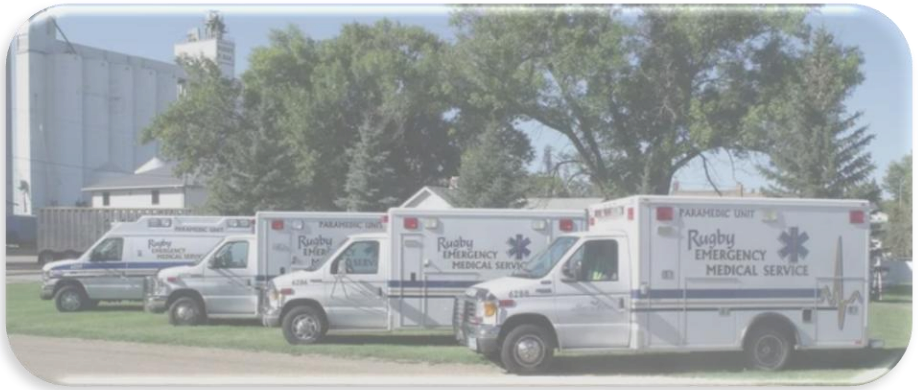
Component	Typical Cost
Ambulance vehicle	$180K – $300K
Power stretcher + auto loader	$40K – $70K per ambulance
ALS equipment package	$45K – $90K per ambulance
Radios + Mobile Data Terminals + AVL system	$10K – $20K per ambulance
Total per frontline ambulance	$275K – $480K per ambulance

Policy implication

Without predictable capital support, agencies will face equipment failure, safety risk, and service interruption.

Variations in Costs and Revenues Based on Agency Type, Geographic and Demographic Differences

- **Ambulance services all perform the same essential functions, respond, treat, and transport patients to the hospital (when clinically appropriate)**
- **The financial model underneath them is fundamentally different depending on who owns them and what role EMS plays in the broader system**
- **Variation is driven by five primary forces:**
  - Call volume and service mix
  - Payer mix and reimbursement leverage
  - Staffing model and labor costs
  - Subsidy access and public support
  - Cost allocation/accounting differences



Municipal Department Operated EMS

- **Typical characteristics**
  - EMS division within an existing department
  - Often blended with fire/public safety (e.g.: fire)
  - Generally lower patient transport volume
- **Cost drivers**
  - Shared overhead costs (HR, payroll, fleet, facilities) may not be fully allocated to EMS
  - Some agencies under-report “true cost” because other city departments absorb expenses
  - If unionized, wage/benefit costs may be higher
- **Revenue mix patterns**
  - Often less reliant on fee for service billing
  - More reliant on:
    - City general fund support
    - Property tax subsidy

***Key Point*: City service** *costs may be under-reported, and fee for service revenues may be lower than other service delivery models.*

Third-Service County/City EMS

- **Typical characteristics**
  - Dedicated EMS agency with full administrative structure
  - Heightened EMS focus due to single role function vs. dual role function (EMS/fire)
- **Cost drivers**
  - Full cost accounting (admin, QA/QI, training, supervision)
  - Higher staffing standards (career paramedics, benefits)
  - Broader geographic coverage responsibilities (countywide services, long patient transports)
- **Revenue mix patterns**
  - Balanced between:
    - Billing collections
    - County/city appropriations

***Key Point**: **Third services** often show the "truest" cost of readiness due to their stand-alone, single role focus.*

District-Owned EMS (Ambulance Districts)

- **Typical characteristics**
  - Independent taxing authority
  - Common in rural areas
  - Like County, 3rd service, single role focus
- **Cost drivers**
  - Higher fixed readiness cost due to coverage geography
  - Fleet replacement and capital investment may be stronger due to tax-based revenue
- **Revenue mix patterns**
  - Less dependent on patient transport revenue because of:
    - Dedicated property tax levy for funding
    - Predictable local funding

***Key Point*: Districts** *are built to finance readiness across multiple jurisdictions and large geography, not just patient transport.*

Hospital-Based EMS

- **Typical characteristics**
  - EMS operated as part of a hospital system
  - Often focused on interfacility patient transport or critical care
- **Cost drivers**
  - May have expanded clinical staffing (RN/Critical Care Paramedic models)
  - Higher equipment intensity (ventilators, IV pumps, specialty teams)
  - Hospital overhead allocation:
    - IT, compliance, admin, benefits, supply chain
- **Revenue mix patterns**
  - May include:
    - Medicare/insurance patient transports
    - Hospital cross-subsidy
    - Strategic value (*community relations and services to internal hospital/health system*)

***Key Point*: *Hospital EMS* is often a clinically and operationally integrated component of the hospital, not a standalone entity.**

Private, Non-Profit EMS

- **Typical characteristics**
  - Most often community-based, mission-driven
  - May operate both 911 and inter-facility patient transports (IFTs)
  - Sometimes rural or volunteer-supported
- **Cost drivers**
  - Limited economies of scale
  - Could have higher uncompensated care burden
  - May invest heavily in community readiness despite low revenue
- **Revenue mix patterns**
  - Combination of:
    - Billing
    - Donations/fundraising
    - Grants
    - Occasional municipal contracts

***Key Point**: **Nonprofits** are often created/sustained in areas with limited revenue sources.*

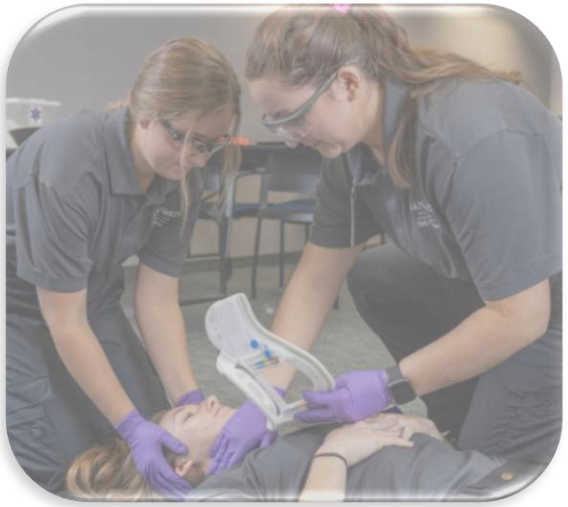
Private, For-Profit EMS

- **Typical characteristics**
  - Generally found in high-volume patient transport markets
  - Often concentrated in IFT or contracted 911 services
- **Cost drivers**
  - Lower cost per trip through scale and deployment efficiency
  - More aggressive revenue cycle management
  - Wages may be lower than public sector equivalents
- **Revenue mix patterns**
  - Heavy reliance on:
    - Medicare
    - Commercial insurance
    - Facility contracts
  - Less reliance on tax subsidy, unless contracted to provide 911 services

***Key Point**: **For-profits** typically operate where patient transport reimbursement is sufficient to support operations.*

Geographic and Demographic Differences

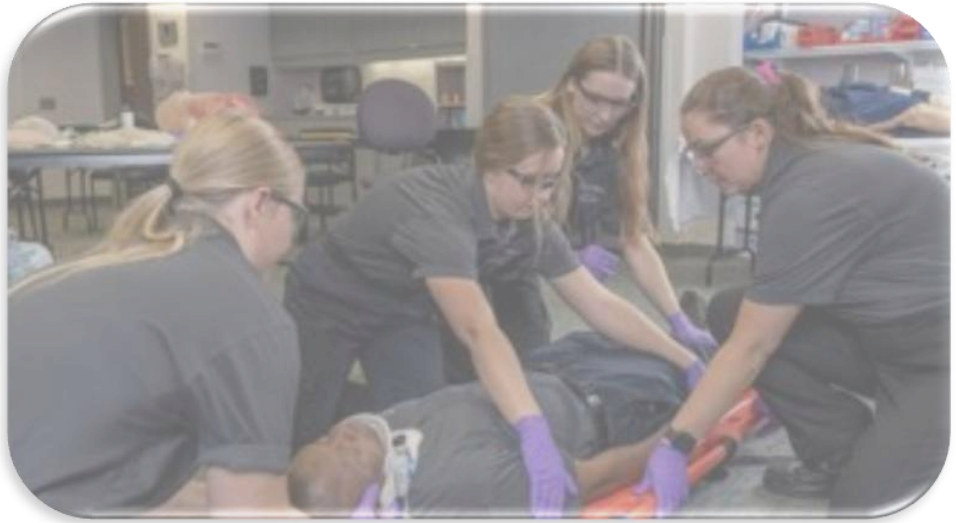
- **Rural agencies**
  - Must staff ambulances even when calls are sparse
  - Fixed cost remains high
  - Cost per response increases dramatically
- **Urban and suburban systems**
  - Benefit from a higher response volume
  - Spreading fixed costs over a higher response volume



- **Distances per response are also generally shorter in urban and suburban systems compared to rural or super rural systems**
  - Shorter vs. longer time on task

Geographic and Demographic Differences

- **Payer Mix**
  - Agency types serve different populations, and these populations variances can impact the insured status of patients
  - City/district EMS may serve more Medicaid/uninsured
    - This drives major revenue variation
- **Staffing Model Differences**
  - Volunteer, paid-on-call, and career models vary
    - Urban and suburban systems relying primarily on paid or career staffing models
    - Rural and super rural systems relying primarily on volunteers or paid on call staffing models



Geographic and Demographic Differences

- **Subsidy and Public Funding Availability**
  - Public, or governmental agencies can typically access property tax subsidies and general fund support
  - Private agencies may not, unless contracted to municipalities which may or may not provide a subsidy
- **Accounting and Cost Allocation Differences**
  - Reported cost is not always comparable
  - Cities and hospital-based agencies may exclude overhead, while private firms may carefully account for these expenses

Overall Fiscal Findings

	Agency Type						
	City	3rd Service, County / City	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
Overall Fiscal Analysis							
FFS Revenue per Patient Transport	$922.22	$2,976.44	$1,035.18	$1,820.15	$987.23	$742.50	$1,101.46
Expense (Reported) per Patient Transport	$1,501.48	$13,259.69	$2,285.03	$1,058.59	$2,270.43	$804.07	$1,583.92
Net FFS Revenue per Patient Transport	($579.27)	($10,283.26)	($1,249.85)	$693.60	($1,283.20)	($61.57)	**($482.47)**
Total Revenue per Patient Transport	$1,901.72	$21,341.25	$2,704.79	$2,109.18	$2,196.81	$897.99	**$1,962.10**
Expense per Patient Transport	$1,501.48	$13,259.69	$2,285.03	$1,126.55	$2,270.43	$804.07	**$1,597.51**
Net Revenue Per Patient Transport	$400.24	$8,081.56	$419.76	$982.63	($73.62)	$93.92	**$364.59**

Key Observations:

- Across all respondents, the financial gap between FFS revenue and cost per patient transport is $482.47
- This means that agencies lose money on every patient transport
- The only agency type reporting that FFS covers the cost of service delivery is Hospital-Based agencies

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Cost of Delinquent Accounts

	City	3rd Service, County / City	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
Delinquent Accounts							
The total number of accounts billed and not paid after 90-days.	45	11	66	1,909	325	1,378	**3,734**
% of claims not paid after 90-days	6.9%	7.6%	2.9%	16.4%	10.9%	8.7%	**11.1%**
The total dollar amount for accounts billed, but not paid after 90-days.	$67,781	$15,222	$434,245	$2,300,257	$965,389	$2,403,931	**$6,186,825**
Average $ per delinquent account	$1,506	$1,384	$6,579	$1,205	$2,970	$1,745	**$1,460**
The number of accounts your agency sent to a debt collection agency in the most recently completed fiscal year	46	0	234	862	179	987	**2,308**
% of claims not paid after 90-days	7.0%	0.0%	10.3%	7.4%	6.0%	6.2%	**6.9%**
The total dollar amount of accounts sent to a debt collection agency in the most recently completed fiscal year	$72,570	$0	$305,952	$791,468	$233,066	$1,255,811	**$2,658,867**
Average $ per uncollectible account	$1,577.60	$0.00	$1,307.49	$918.18	$1,302.04	$1,272.35	**$1,062.94**

Key Observations:

- Across all respondents, the **average value of claims not paid after 90 days is $1,460**
- **61.2%** of claims not paid after 90 days end up going to collections
- **6.9%** of ambulance claims are sent to collections as uncollectible
- The average value of each claim sent to collections is **$1,063**
- The total lost revenue across all respondents for claims sent to collections is **$2.5 million**.

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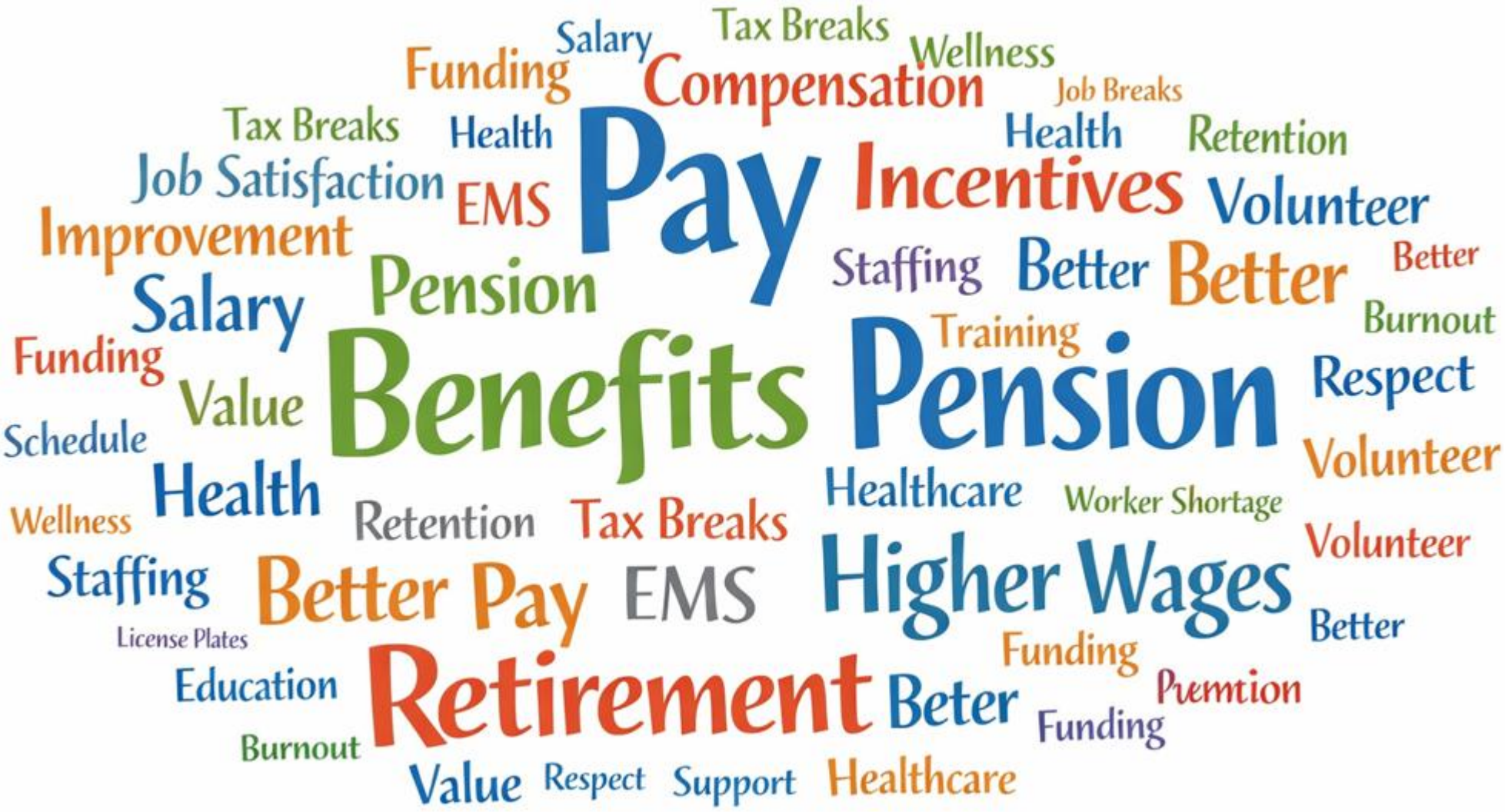
Employee Attrition

	City	County, 3rd Service	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
# of employees/volunteers who left last year	8	3	27	32	21	27	**118**
Personnel/Staffing Type							
Non-Certified Driver	19	19	34	7	51	7	**137**
Emergency Medical Responder	11	7	24	2	28	5	**77**
EMT	37	35	77	77	117	84	**427**
Advanced EMT	0	11	6	5	16	1	**39**
Paramedic	3	14	19	131	36	47	**250**
Total Staff	70	86	160	222	248	144	**930**
Attrition Rate	**11.4%**	**3.5%**	**16.9%**	**14.4%**	**8.5%**	**18.8%**	**12.7%**
% Full Time Paid	4.7%	10.0%	12.0%	28.8%	7.4%	28.0%	**15.1%**
% Part Time Paid	0.0%	0.0%	1.0%	18.5%	5.8%	27.0%	**8.7%**
% Paid on Call	70.7%	10.0%	19.0%	3.0%	42.6%	6.0%	**25.2%**
% Volunteer	8.7%	58.0%	14.0%	0.0%	11.9%	0.0%	**15.4%**

Most Common Reasons for Leaving

City/County 3rd Service	District Owned	Hospital-Based	Private, Non-Profit	Private, For-Profit
Retirement	Wages & Benefits	Relocation	Wages & Benefits	Wages & Benefits
	New career, compensation	Retirement	Retirement	Educational Benefits
	Better Pay/Hours	Wages & Benefits	Burnout	
	Burnout	Pension		

Incentives for Personnel Recruitment & Retention



Best Ways the Legislature Could Help

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Next Steps

- **Example Options for the North Dakota Legislature**
  - **Option 1**: Create a ‘North Dakota Ambulance Delinquent Accounts Stabilization Grant Program’
    - To provide temporary financial relief to licensed ambulance agencies experiencing significant unpaid or delinquent patient accounts, in order to:
      - Stabilize rural EMS cash flow
      - Reduce reliance on local subsidies
      - Prevent service degradation due to delayed reimbursement
      - Support continued statewide readiness and response capability

Option 1: Create a ‘North Dakota Ambulance Delinquent Accounts Stabilization Grant Program’

2024 Statewide Ambulance Responses*	95,617
Average transport % across survey respondents	83.1%
Estimate of billable ambulance transports	**79,416**
% of Delinquent Accounts Across Agencies Surveyed	6.9%
Estimate of Statewide Claims sent to Collections	5,463
Average $ value of claims sent to collections	$1,062.94
Total cost of unpaid ambulance claims	**$5,806,614**
<u>Average Medicaid reimbursement for an ambulance claim</u>	
BLS Emergency Base Reimbursement	$517.24
Mileage Reimbursement	$10.37
Average transport miles	34
Average mileage reimbursement	$352.75
Average Total Reimbursement	**$869.99**
Total Medicaid expenditure if all uncollectible claims were reimbursed at the Medicaid reimbursement rate	**$4,752,570**
% of uncollectible revenue reimbursed by Medicaid	**81.8%**

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*https://ndlegis.gov/sites/default/files/pdf/committees/69-2025/27.5022.02000_1015.pdf

Option 2: Create a More Stable, Statewide EMS Readiness & Workforce Funding Program Based on Funding Response and Readiness vs. Patient Transport

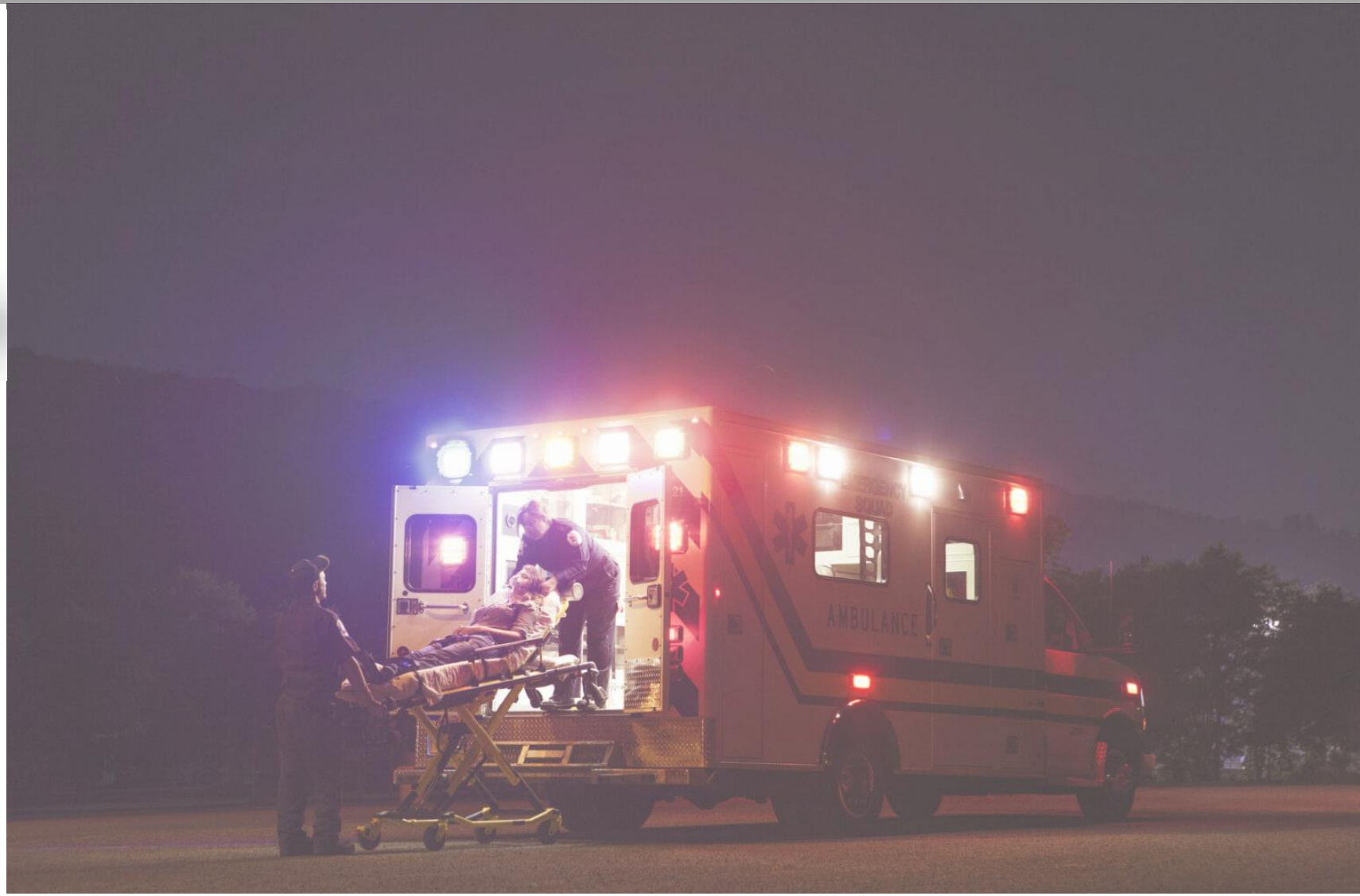
- **What the program could include:**
  - Allow/require reimbursement for treatment-in-place and clinically appropriate non-patient transport responses (so agencies are paid for care delivered even when transport isn't needed), paired with a simple documentation standard.
  - Base "readiness" payments to licensed ambulance agencies tied to coverage obligations (hours of coverage, response capability, service area, and call demand), not just patient transports.
  - Workforce support is built into the base funding (e.g., on-call stipends, minimum staffing grants, and/or a statewide benefits/insurance pool option to lower benefit costs and improve retention).

Option 2: Create a More Stable, Statewide EMS Readiness & Workforce Funding Program Based on Funding Response and Readiness vs. Patient Transport

- **What the program could include:**
  - Dedicated capital replacement matching grants (ambulances/major equipment) to address the documented $12.9 million 5-year need without forcing ambulance fee spikes or service cuts.
  - Accountability that is easy to comply with, but meaningful: basic reporting on response performance, staffing levels, and financials—focused on sustainability and access, not punishment.

Option 2: Create a More Stable, Statewide EMS Readiness & Workforce Funding Program Based on Funding Response and Readiness vs. Patient Transport

- **Potential benefit This approach directly addresses the two biggest threats surfaced by the survey data:**
  - Structural underpayment under FFS and workforce instability
  - Reduces pressure on local property taxes
  - Help ensure consistent EMS access statewide



The information and suggestions in this report should not be relied on as legal, financial or accounting advice.

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FINAL REPORT

Study of the Feasibility and Desirability of a Delinquent Billing Reimbursement Grant System for Ambulance Providers

February 17, 2026

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North Dakota Legislative Council
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PWW Advisory Group (PWW|AG) was honored to assist the State of North Dakota Legislative Management Committee to study the feasibility and desirability of a delinquent billing reimbursement grant system for ambulance service providers RFP. We recognize the significance of this engagement for the state, its ambulance services, and the communities they serve.

We wish to thank the ***North Dakota EMS Association*** *and the* ***North Dakota Health Response and Licensure Emergency Medical Systems Unit*** *for their assistance with the development and distribution of the survey.*

The information and suggestions in this report should not be relied on as legal, financial or accounting advice.

A National Crisis

EMS agencies across the country are facing unprecedented fiscal challenges. Skyrocketing costs, staffing challenges, and stagnant fee-for-service revenue are significantly impacting service delivery. We commend the North Dakota Legislative Management Committee for undertaking an innovative and ambitious approach to quantifying the current and future economic challenges for the state's ambulance providers by embarking on a study of the feasibility and desirability of establishing a delinquent billing reimbursement grant system for ambulance service providers.

This report summarizes the findings of a statewide survey of ambulance agencies across North Dakota designed to assess the overall financial sustainability of essential ambulance services, with a specific focus on the cost of service delivery and the impact of uncollectible claims for services provided.

Survey Response Statistics

There were 36 respondents to the survey, with 4 being city services, 2 county-based, 11 district owned agencies, 4 hospital-based, 11 private, non-profit and 4 private, for-profit ambulance agencies.

The survey conducted in support of this project gathered information, including:

- Annual Revenue
- Annual Expenses
- Anticipated vehicle or equipment asset purchases
- Number of delinquent accounts
    - The dollar value of delinquent accounts
- The total number of responses
    - Responses that did not result in patient transport
- Number of employees and/or volunteers who left the ambulance service in the most recently completed fiscal year
    - The reasons given for leaving
- Ambulance agency input on potential options to improve ambulance service sustainability in North Dakota.

A copy of the survey instrument is included in this report as 'Attachment A'.

Survey Response and Data Limitations

While the survey provides valuable insight into the financial and operational realities facing North Dakota ambulance agencies, it is important to acknowledge several limitations in the dataset.

First, overall participation was more limited than hoped. A number of ambulance services did not respond to the survey, which means the results may not fully reflect the full diversity of agency structures, service areas, or funding conditions across the state.

Second, several agencies, particularly smaller or primarily volunteer-based services, reported challenges in assembling the requested information. Many rural EMS organizations operate with limited administrative capacity, part-time staffing, or decentralized recordkeeping systems. As a result, collecting detailed financial, billing, staffing, and response metrics required significant effort and, in some cases, may not have been feasible within the survey timeframe.

Finally, because the survey relied on self-reported data, there are indications that some responses may contain inconsistencies or potential inaccuracies. Variations in accounting practices, differences in how agencies track responses versus patient transport, and differing interpretations of certain questions may have affected data quality in isolated cases.

Despite these limitations, the survey findings remain directionally important. Even with incomplete participation and reporting variability, the survey response data consistently highlights common themes:

- **The structural gap between fee-for-service reimbursement and the cost of service delivery,**
- **Increasing workforce pressures, and**
- **The growing reliance on local subsidies to sustain essential EMS coverage.**

The information summarized in this report is based on survey responses voluntarily submitted by a subset of licensed ambulance service providers in North Dakota. Participation in the survey was not universal, and therefore the findings may not represent the full range of operational, financial, and staffing conditions experienced by all ambulance agencies statewide.

In addition, some responding agencies, particularly smaller or primarily volunteer-based organizations, may have had difficulty in compiling certain requested data elements. Many such agencies operate with limited administrative staffing, variable documentation practices, or decentralized financial systems, which may constrain the ability to collect and report detailed service, billing, and cost information in a consistent manner.

Because the survey relied on self-reported data, the results are subject to potential reporting error, differences in accounting methodology, and variation in interpretation of survey questions. In some instances, submitted data may reflect estimates or incomplete records rather than audited financial statements.

Accordingly, the findings presented should be interpreted as preliminary and directional in nature. While the survey provides meaningful insight into common challenges facing ambulance providers in North Dakota, additional data collection, validation, and broader participation would strengthen future assessments and support more precise statewide planning.

These results should be viewed as an initial baseline that underscores the need for continued data development and a more durable statewide framework to support ambulance services across North Dakota.

Key Findings and Policy Implications

Key Findings from the Data

The survey data shows that North Dakota's ambulance agencies are operating in a structurally unsustainable financial environment. Patient billing alone does not cover the cost of readiness, staffing, and response. Agencies remain viable only because of local tax subsidies, fundraising, and temporary support mechanisms. Without a stable statewide strategy, North Dakota risks service degradation, workforce loss, and uneven access to emergency medical care, especially in rural and frontier communities.

Fee-for-Service (FFS) Ambulance Billing Does Not Cover the Cost of Service

Ambulance reimbursement in North Dakota is fundamentally misaligned with the actual cost of delivering emergency medical care.

- Average fee-for-service revenue per patient transport: **$1,101**
- Average expense per patient transport: **$1,584**
- Net ***loss*** per patient transport: **$482**

This means that for many agencies, every additional patient transport increases financial losses rather than improving sustainability.

Policy implication

The ambulance system cannot be stabilized through billing reforms alone because the underlying payment model does not fund readiness and staffing.

Local Tax Subsidy and Fundraising/Donations Have Become the Backbone of EMS Finance

Total reported revenue across respondents is **$**55.75 million. The funding composition is shown below.

Source	Amount	Share
Fee-for-service billing	$39.3 million	53.0%
Local tax subsidy	$9.2 million	26.2%
State grants	$3.0 million	9.4%
Other/fundraising/etc.	Remaining	~11%

North Dakota communities are essentially paying for EMS twice, once through insurance and Medicare / Medicaid billing and again through local property taxes and subsidies.

Policy implication

The EMS system is being supported locally, but community capacity to subsidize varies widely, creating inequity across the state.

Lack of Collections Is a Major System Stressor

Agencies responding to the survey reported that only **78.7%** of claims submitted for ambulance services were paid, representing **$2.7 million** in unpaid ambulance claims.

Policy implication

Ambulance agencies operate with fragile cash flow and high administrative burden, especially in rural areas with small billing offices. The burden of uncollected claims places a significant burden on the financial sustainability of essential ambulance service.

Workforce Instability is a Growing Threat

Agencies responding to the survey reported an overall attrition of 12.7%. The qualitative findings highlight inadequate pay, limited benefits, lack of retirement systems and the inability to compete with hospitals and larger systems as major drivers of workforce attrition.

Policy implication

Workforce challenges are not isolated; they are systemic and financial. Staffing shortages will translate directly into response delays and service gaps.

Non-Patient Transport Responses Represent Unfunded Clinical Work

Medicare, Medicaid and most insurers only reimburse ambulance agencies for patient transport to the hospital. For agencies reporting non-patient transport rates, **the average non-patient transport rate is 16.9%** This means that agencies are generally providing essential ambulance service with limited to no ability for reimbursement for those services. Only half of responding agencies reported billing for non-patient transport responses, indicating a substantial volume of unreimbursed clinical work. These calls still require:

- Ambulance response
- Clinical assessment
- Readiness and staffing
- Documentation and oversight
- Medical director involvement

Policy implication

North Dakota agencies are delivering care and readiness costs without reimbursement, especially as EMS increasingly functions as mobile healthcare. The legislature should enable a mechanism for state-regulated insurers, including Medicaid, to reimburse agencies for ambulance responses that result in treatment on scene without patient transport.

The survey data shows that North Dakota's ambulance agencies are operating in a structurally unsustainable financial environment. Patient billing alone does not cover the cost of readiness, staffing, and response.

Capital Replacement Needs Are Significant, Unavoidable and Underfunded

Agencies anticipate **$12.9 million** in vehicle and equipment replacement over 5 years, for an average planned investment of **$357,667 per agency**. Ambulances are life-safety infrastructure with replacement cycles that cannot be deferred indefinitely.

Policy implication

Without predictable capital support, agencies will face equipment failure, safety risk, and service interruption.

Explanation of Variations in Costs and Revenues Based on Agency Type, Geographic and Demographic Differences

Responses to the PWW|AG survey reveals significant cost and revenue differences across various agency models (City-based, 3rd Service Governmental, District Owned, Hospital-Based, Private, Nonprofit, and Private, For-Profit), as well as demographic and geographic differences (urban vs. rural, vs. super-rural). These differences are not random. They likely reflect structural realities in mission, service environment, payer mix, subsidy availability, staffing model, call profile, and accounting practices.

Ambulance services all perform the same essential functions, respond, treat, and transport patients to the hospital (when clinically appropriate). However, the financial model underneath them is fundamentally different depending on who owns them and what role EMS plays in the broader system.

Variation is driven by five primary forces:

- Call volume and service mix
- Payer mix and reimbursement leverage
- Staffing model and labor costs
- Subsidy access and public support
- Cost allocation/accounting differences

City-Operated EMS

Typical characteristics

- Municipal department, or EMS division within an existing department
- Often blended with fire/public safety
- Typically lower patient transport volume

Cost drivers

- Shared overhead costs (HR, payroll, fleet, facilities) may not be fully allocated to EMS
- Some agencies under-report “true cost” because other city departments absorb expenses
- If unionized, wage/benefit costs may be higher

Revenue mix patterns

- Often less reliant on fee for service billing
- More reliant on:
    - City general fund support
    - Property tax subsidy

***Key Point**: **City service** costs may be under-reported, and fee for service revenues may be lower than other service delivery models.*

3rd Service County/City EMS

Typical characteristics

- Dedicated EMS agency with full administrative structure
- Heightened EMS focus due to single role function vs. dual role function (EMS/fire)

Cost drivers

- Full cost accounting (admin, QA/QI, training, supervision)
- Higher staffing standards (career paramedics, benefits)
- Broader geographic coverage responsibilities (countywide services, long patient transports)

Revenue mix

- Balanced between:
  - Billing collections
  - County/city appropriations

> ***Key Point**: **Third services** often show the "truest" cost of readiness due to their stand-alone, single role focus.*

District-Owned EMS (Ambulance Districts)

Typical characteristics

- Independent taxing authority
- Common in rural areas
- Like County, 3rd service, single role focus

Cost drivers

- Higher fixed readiness cost due to coverage geography
- Fleet replacement and capital investment may be stronger due to tax-based revenue

Revenue mix patterns

- Less dependent on patient transport revenue because of:
  - Dedicated property tax levy for funding
  - Predictable local funding

> ***Key Point**: **Districts** are built to finance readiness across multiple jurisdictions and large geography, not just patient transport.*

Hospital-Based EMS

Typical characteristics

- EMS operated as part of a hospital system
- Often focused on interfacility patient transport or critical care

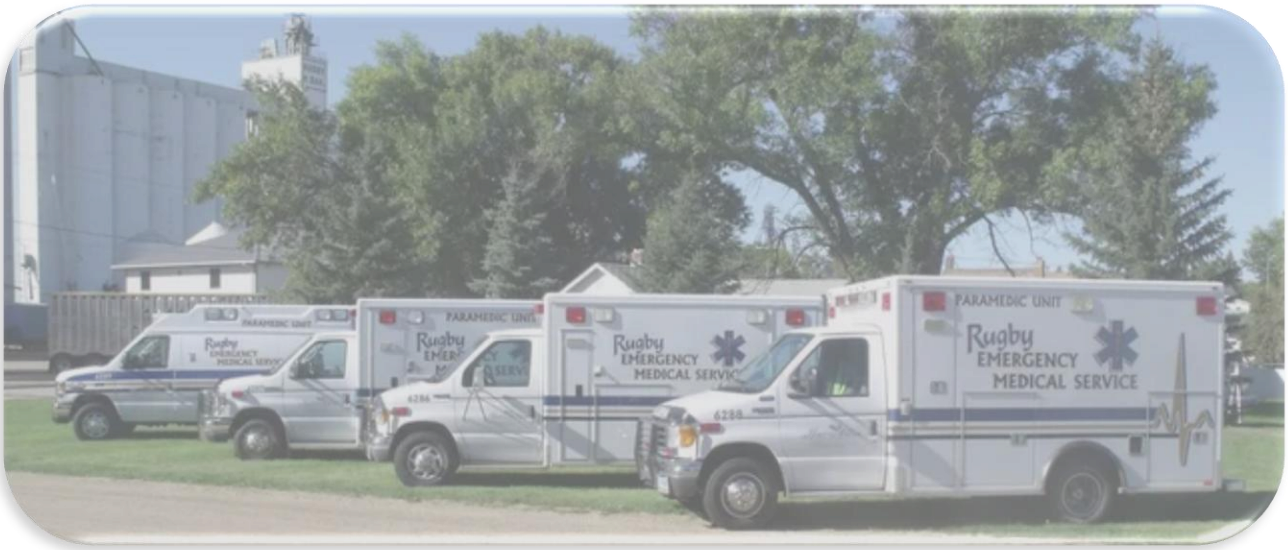
Cost drivers

- May have expanded clinical staffing (RN/Critical Care Paramedic models)
- Higher equipment intensity (ventilators, IV pumps, specialty teams)
- Hospital overhead allocation:
    - IT, compliance, admin, benefits, supply chain

Revenue mix patterns

- May include:
    - Medicare/insurance patient transports
    - Hospital cross-subsidy
    - Strategic value (*community relations and services to internal hospital/health system*)

> ***Key Point**: **Hospital EMS** is often a clinically and operationally integrated component of the hospital, not a standalone entity.*



Private, Non-Profit EMS

Typical characteristics

- Most often community-based, mission-driven
- May operate both 911 and inter-facility patient transports (IFTs)
- Sometimes rural or volunteer-supported

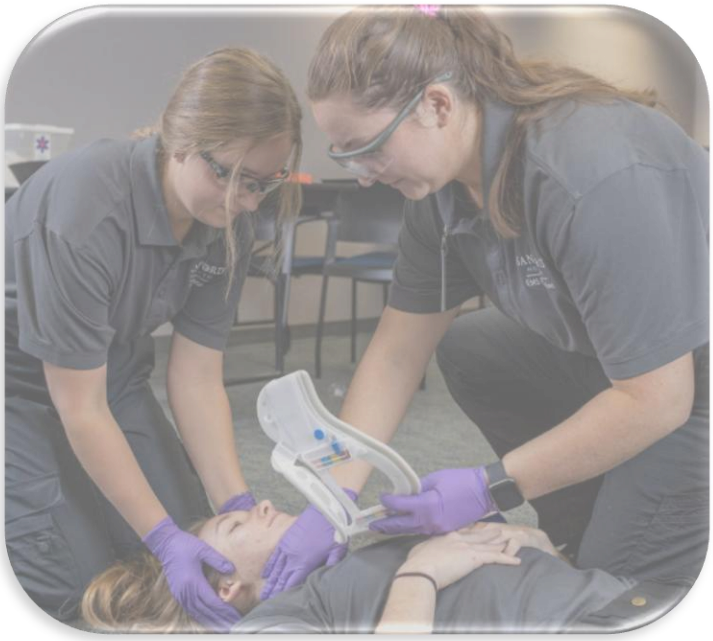
Cost drivers

- Limited economies of scale
- Could have higher uncompensated care burden
- May invest heavily in community readiness despite low revenue

Revenue mix

- Combination of:
    - Billing
    - Donations/fundraising
    - Grants
    - Occasional municipal contracts

***Key Point**: **Nonprofits** are often created/sustained in areas with limited revenue sources.*



Private, For-Profit EMS

Typical characteristics

- Generally found in high-volume patient transport markets
- Often concentrated in IFT or contracted 911 services

Cost drivers

- Lower cost per trip through scale and deployment efficiency
- More aggressive revenue cycle management
- Wages may be lower than public sector equivalents

Revenue mix patterns

- Heavy reliance on:
    - Medicare
    - Commercial insurance
    - Facility contracts
- Less reliance on tax subsidy, unless contracted to provide 911 services

> ***Key Point**: **For-profits** typically operate where patient transport reimbursement is sufficient to support operations.*

Geography / Demography

Rural agencies must staff ambulances even when calls are sparse, fixed cost remains high, therefore, cost per response increases dramatically. Urban and suburban systems benefit from a higher response volume, therefore spreading fixed costs over a higher response volume. Distances per response are also generally shorter in urban and suburban systems compared to rural or super rural systems.

Payer Mix

Agency types serve different populations, and these populations variances can impact the insured status of patients. City/district EMS may serve more Medicaid/uninsured. This drives major revenue variation.

Staffing Model Differences

Volunteer, paid-on-call, and career models vary, with urban and suburban systems relying primarily on paid or career staffing models, with rural and super rural systems relying primarily on volunteers or paid on call staffing models.

Subsidy and Public Funding Availability

Public, or governmental agencies can typically access property tax subsidies and general fund support, where private agencies may not, unless contracted to municipalities which may or may not provide a subsidy.

Accounting and Cost Allocation Differences

Reported cost is not always comparable. Cities and hospital-based agencies may exclude overhead, while private firms may carefully account for these expenses.

Consequently, variation may reflect accounting structure, not operational inefficiency. The dataset shows that EMS is not a uniform business model. Differences in cost and revenue mix reflect readiness vs patient transport emphasis, access to tax subsidy, payer mix realities, rural geography, or organizational accounting. No single model is inherently more efficient, each finances the same mission under different constraints.

Overview of Survey Results

Variable Call Volume, with Meaningful "Non-Patient Transport" Workload

70,665 responses were reported, including 2,542 responses with no patient transport. Only 18 agencies (50%) report billing for non-patient transports, suggesting a significant amount of unreimbursed clinical/readiness work.

Fee for Service Reimbursement Performance is a Material Financial Strain

Respondents billed **33,553** patient transports and reported **$103.8 million** in gross charges. **Only 78.7% of claims were paid**, meaning that 23.3% of responses are provided without reimbursement. After 90 days, 3,734 patient transports were unpaid (about **$5.90 million**). **2,308 claims** (about **$2.66 million**) were sent to collections.

Fees for Service Do Not Cover the Cost of Providing Service

On average, respondents reported FFS revenue of per patient transport of **$1,101**, while expense per patient transport were **$1,584**. Meaning, a structural FFS **loss per patient transport of $482**. In other words, patient-billing revenue alone is underwater; therefore, agencies must rely on local tax subsidies, donations and other revenue sources to remain economically viable.

Local Subsidy Is Foundational, Not Optional

Total reported revenue across all respondents was **$55.7 million**, with an overall revenue mix of:

- Fee for service: $39.3 million (53.0%)
- Local tax subsidy: $9.2 million (26.2%)
- State grants: $3.0 million (9.4%)

Other sources and fundraising make up most of the remainder, indicating that local taxpayers and other funders are already backfilling the structural financial gap.

Personnel Expense Dominates Costs and Workforce Stability is a Challenge

Reported expenses total $40.0 million, with personnel costs representing $29.5 million, or 73.8% of the cost of service delivery (the largest single cost driver). This mirrors findings from the recently published Medicare Ground Ambulance Data Collection System survey[1] which revealed that 71% of ambulance service delivery expenses are related to personnel costs.

Agencies reported **118 separations** last year across **930 total staff** (overall **attrition ~12.7%**). Qualitative comments repeatedly cite **pay, benefits, retirement/pension, and burnout** as drivers.

Capital Replacement Needs are Significant

Agencies anticipate about **$12.88 million** in capital expenditures (CAPEX) for vehicle/equipment purchases over the next 5 years (about **$357,667 average** planned per agency over that period).

Average costs of the most common capital assets for ambulance service delivery are noted below:

[1] https://www.cms.gov/medicare/payment/fee-schedules/ambulance/medicare-ground-ambulance-data-collection-system

Table 1: Cost of Capital Components for Ambulance Agencies

Component	Typical Cost
Ambulance vehicle	$180K – $300K
Power stretcher + auto loader	$40K – $70K per ambulance
ALS equipment package	$45K – $90K per ambulance
Radios + Mobile Data Terminals + AVL system	$10K – $20K per ambulance
Total per frontline ambulance	$275K – $480K per ambulance

Data Analysis

The tables that follow detail the specific survey responses broken into major categories by agency type:

- Respondent Characteristics
- Service Statistics
- Revenues
- Expenses
- Overall Fiscal Analysis
- Special Focus: Costs of Delinquent Accounts

In each table, data elements highlighted in orange represent potential outliers or data-entry inconsistencies due to potential errata in the data submitted by one or more respondents. For clarity, potential errata data were omitted from the overall snapshots.

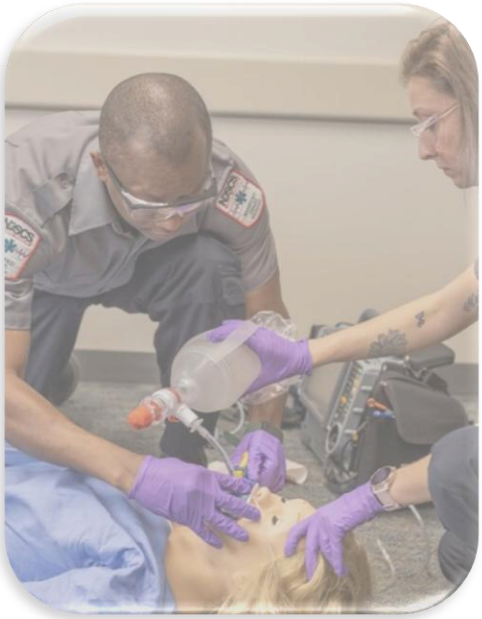


Table 2: Survey Respondent Characteristics

	Agency Type						
Respondent Characteristics	City	3rd Service, County / City	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
Respondents	4	2	11	4	11	4	**36**
Response Volume	613	504	2,717	44,758	3,730	18,343	**70,665**
Responses Resulting in no Patient Transport	107	No Data	563	No Data	472	1,400	**2,542**
Non-Patient Transport %	17.5%		20.7%		12.7%		**16.9%**
Agencies That Bill for Non-Patient Transports	0	0	5	3	6	4	**18**
% of Agencies That Bill for Non-Patient Transports	0.0%	0.0%	45.5%	75.0%	54.5%	100.0%	**50.0%**
Service Area Population	15,251	4,262	33,606	257,990	55,166	172,000	**538,275**
Service Area Sq Miles	2,345	2,080	8,195	2,733	12,038	5,829	**33,220**
Average Transport Miles	57	61	42	6	29	10	**34**
Number of Ambulances	13	8	30	34	31	25	**141**

Key Observations:

- **36 agencies** responded to the survey, representing nearly **71,000 EMS responses**
- Of agencies reporting non-patient transport, **the average non-transport rate is 16.9%**
- Only half of the respondents reported billing for non-patient transport
- The average patient transport distance is 34 miles

Table 3: Service Statistics

	Agency Type						
	City	3rd Service, County / City	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
Service Statistics							
Number of Patient Transports Billed	654	144	2,279	11,650	2,988	15,838	**33,553**
Gross Revenue Billed	$597,002	$285,428	$4,169,922	$57,111,005	$5,261,014	$36,408,661	**$103,833,032**
Average Patient Charge	$912.85	$1,982.14	$1,829.72	$4,902.23	$1,760.71	$2,298.82	**$1,756.85**
Total # of Claims Paid	468	129	1,740	381	1,912	14,537	**19,167**
% of Claims Paid	71.6%	89.6%	76.3%		64.0%	91.8%	**78.7%**
# of Claims Unpaid After 90-Days	45	11	66	1,909	325	1,378	**3,734**
$ Value of Claims Unpaid After 90-Days	$67,781	$15,222	$143,245	$2,300,257	$965,389	$2,403,931	**$5,895,825**
Average Claim $ Unpaid After 90-Days	$1,506.24	$1,383.77	$2,170.38	$1,204.95	$2,970.43	$1,744.51	**$1,601.97**
# of Claims Sent to Collections	46	0	234	862	179	987	**2,308**
$ Value of Claims Sent to Collections	$72,570	$0	$305,952	$791,468	$233,066	$1,255,811	**$2,658,867**
Average $ Claim Amount Sent to Collection	$1,577.61	$0.00	$1,307.49	$918.18	$1,302.04	$1,272.35	**$1,062.94**

Key Observations:

- The average patient charge across all respondents is $1,756.85
- Of the respondents reporting, only 78.7% of ambulance claims were paid
- Private, For-Profit agencies have the highest claim payment rate of 91.8%, and Private, Non-Profit have the lowest paid claim rate at 64.0%
- The average claim amount sent to collections is $1,062.94

Table 4: Agency Revenues

	Agency Type						
	City	3rd Service, County / City	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
Revenues							
Fee For Service Revenue Collected	$603,129	$428,607	$2,359,172	$21,204,749	$2,949,839	$11,759,752	**$39,305,248**
Revenue from Fund Raisers/Donations	$137,637	$4,679	$134,903	$0	$257,640	$700	**$535,560**
Local Tax Subsidy	$291,355	$1,611,609	$2,494,799	$2,785,222	$1,648,687	$393,513	**$9,225,185**
Revenue from Other Sources	$33,005	$567,384	$195,290	$74,718	$966,548	$305,592	**$2,142,538**
Revenue from State Grants	$100,631	$435,655	$1,052,309	$373,511	$891,400	$182,065	**$3,035,571**
Revenue from Federal Grants	$0	$0	$0	$138,420	$0	$0	**$138,420**
Total Revenue from All Sources (Calculated)	$1,165,757	$3,047,934	$6,236,473	$24,576,621	$6,714,114	$12,641,622	**$54,382,521**
Total Revenue from All Sources (Reported)	$1,157,622	$3,073,140	$6,164,207	$24,571,902	$6,564,079	$14,222,352	**$55,753,302**
As a % of Total Revenue Reported							
Fee For Service Revenue	52.1%	13.9%	38.3%	86.3%	44.9%	82.7%	**53.0%**
Revenue from Fund Raisers/Donations	11.9%	0.2%	2.2%	0.0%	3.9%	0.0%	**3.0%**
Local Tax Subsidy	25.2%	52.4%	40.5%	11.3%	25.1%	2.8%	**26.2%**
Revenue from Other Sources	2.9%	18.5%	3.2%	0.3%	14.7%	2.1%	**6.9%**
Revenue from State Grants	8.7%	14.2%	17.1%	1.5%	13.6%	1.3%	**9.4%**
Revenue from Federal Grants	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	**0.1%**

Key Observations:

- **Local tax subsidy** revenue as a percentage of overall revenue across all respondents represents **26.2% of total revenue**
- This percentage is **highest** for **County/City 3rd service agencies (52.4%)** and **lowest** for **Private, For-Profit agencies** (**2.8%**)
- **Fee For Service (FFS) revenue** represents **53.0%** of total revenue for respondents, with the highest for Hospital-Based agencies (86.3%) and City/County 3rd service reporting the lowest percentage of total revenue from FFS (13.9%)

Table 5: Agency Expenses

	Agency Type						
	City	3rd Service, County / City	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
Expenses							
Personnel	$722,837	$1,567,111	$3,519,292	$10,472,545	$4,506,411	$8,710,158	**$29,498,354**
Equipment	$22,777	$62,757	$107,307	$973,763	$305,084	$568,473	**$2,040,161**
Supplies	$65,392	$45,524	$259,320	$440,426	$288,845	$372,779	**$1,472,286**
Maintenance	$11,107	$81,088	$101,987	$208,972	$139,276	$367,178	**$909,609**
Fuel	$18,955	$27,259	$135,233	$304,461	$96,062	$275,473	**$857,444**
Training/Education	$19,578	$43,318	$80,444	$4,815	$33,103	$79,985	**$261,242**
Stations	$16,449	$7,239	$94,818	$240,976	$25,950	$430,986	**$816,418**
Professional Fees	$10,806	$12,588	$179,083	$23,606	$88,150	$141,040	**$455,272**
Software	$541	$0	$17,457	$103,396	$16,615	$68,728	**$206,738**
Information Technology	$6,629	$29,630	$61,970	$74,138	$47,072	$113,357	**$332,796**
Other	$86,856	$27,837	$711,259	$277,192	$786,170	$663,989	**$2,553,303**
Total Expenses (Calculated)	$981,926	$1,904,351	$5,268,170	$13,124,290	$6,332,738	$11,792,146	**$39,403,622**
Total Expenses (Reported)	**$981,969**	**$1,909,396**	**$5,207,578**	**$12,332,602**	**$6,784,049**	**$12,734,839**	**$39,950,433**

***Key Observations**:*

- Personnel expenses represent 73.8% of total reported expenses across all respondents

Table 6: Overall Fiscal Analysis

	Agency Type						
	City	3rd Service, County / City	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
Overall Fiscal Analysis							
FFS Revenue per Patient Transport	$922.22	$2,976.44	$1,035.18	$1,820.15	$987.23	$742.50	$1,101.46
Expense (Reported) per Patient Transport	$1,501.48	$13,259.69	$2,285.03	$1,058.59	$2,270.43	$804.07	$1,583.92
Net FFS Revenue per Patient Transport	($579.27)	($10,283.26)	($1,249.85)	$693.60	($1,283.20)	($61.57)	**($482.47)**
Total Revenue per Patient Transport	$1,901.72	$21,341.25	$2,704.79	$2,109.18	$2,196.81	$897.99	**$1,962.10**
Expense per Patient Transport	$1,501.48	$13,259.69	$2,285.03	$1,126.55	$2,270.43	$804.07	**$1,597.51**
Net Revenue Per Patient Transport	$400.24	$8,081.56	$419.76	$982.63	($73.62)	$93.92	**$364.59**

Key Observations:

- Across all respondents, the financial gap between FFS revenue and cost per patient transport is $482.47
- This means that agencies lose money on every patient transport
- The only agency type reporting that FFS covers the cost of service delivery is Hospital-Based agencies

Specific Focus – Costs of Delinquent Accounts

Table 7: Cost of Delinquent Accounts

	City	3rd Service, County / City	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
Delinquent Accounts							
The total number of accounts billed and not paid after 90-days.	45	11	66	1,909	325	1,378	**3,734**
% of claims not paid after 90-days	6.9%	7.6%	2.9%	16.4%	10.9%	8.7%	**11.1%**
The total dollar amount for accounts billed, but not paid after 90-days.	$67,781	$15,222	$434,245	$2,300,257	$965,389	$2,403,931	**$6,186,825**
Average $ per delinquent account	$1,506	$1,384	$6,579	$1,205	$2,970	$1,745	**$1,460**
The number of accounts your agency sent to a debt collection agency in the most recently completed fiscal year	46	0	234	862	179	987	**2,308**
% of claims not paid after 90-days	7.0%	0.0%	10.3%	7.4%	6.0%	6.2%	**6.9%**
The total dollar amount of accounts sent to a debt collection agency in the most recently completed fiscal year	$72,570	$0	$305,952	$791,468	$233,066	$1,255,811	**$2,658,867**
Average $ per uncollectible account	$1,577.60	$0.00	$1,307.49	$918.18	$1,302.04	$1,272.35	**$1,062.94**

Key Observations:

- Across all respondents, the **average value of claims not paid after 90 days is $1,460**
- **61.2%** of claims not paid after 90 days end up going to collections
- **6.9%** of ambulance claims are sent to collections as uncollectible
- The average value of each claim sent to collections is **$1,063**
- The total lost revenue across all respondents for claims sent to collections is **$2.5 million**.

EMS Professional Attrition

As part of the ambulance agency survey, respondents provided data on employee/volunteer staffing, as well as attrition rates with the primary reasons EMS professionals left their agencies. The results are represented below.

Table 8: Agency Personnel, Staffing and Attrition

	Agency Type						
	City	County, 3rd Service	District Owned	Hospital Based	Private, Non-Profit	Private, For Profit	Overall Snapshot
# of employees/volunteers who left last year	8	3	27	32	21	27	**118**
Personnel/Staffing Type							
Non-Certified Driver	19	19	34	7	51	7	**137**
Emergency Medical Responder	11	7	24	2	28	5	**77**
EMT	37	35	77	77	117	84	**427**
Advanced EMT	0	11	6	5	16	1	**39**
Paramedic	3	14	19	131	36	47	**250**
Total Staff	70	86	160	222	248	144	**930**
Attrition Rate	**11.4%**	**3.5%**	**16.9%**	**14.4%**	**8.5%**	**18.8%**	**12.7%**
% Full Time Paid	4.7%	10.0%	12.0%	28.8%	7.4%	28.0%	**15.1%**
% Part Time Paid	0.0%	0.0%	1.0%	18.5%	5.8%	27.0%	**8.7%**
% Paid on Call	70.7%	10.0%	19.0%	3.0%	42.6%	6.0%	**25.2%**
% Volunteer	8.7%	58.0%	14.0%	0.0%	11.9%	0.0%	**15.4%**

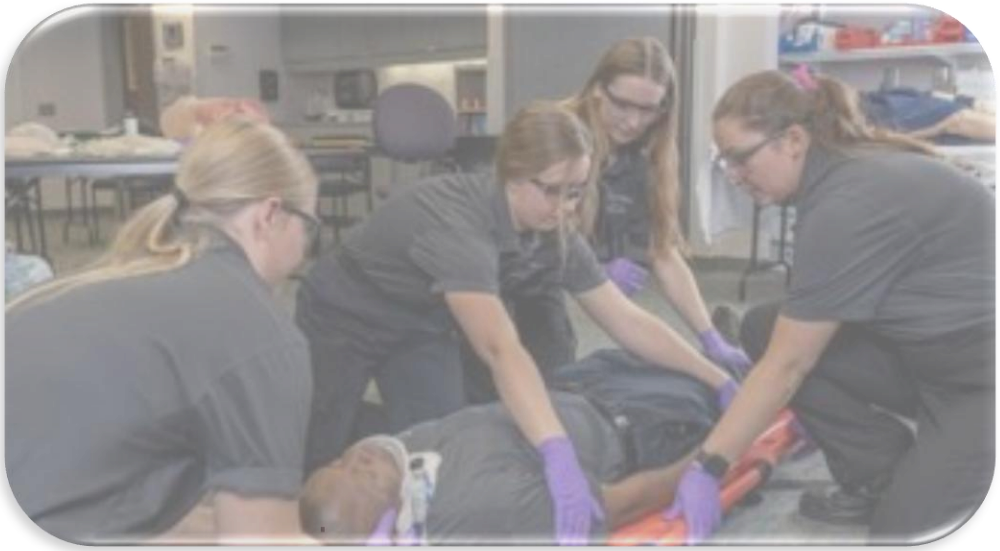
Key Observations:

- The overall EMS professional attrition rate reported by the survey respondents is 12.7%, with the highest rate in the Private, For-Profit agency type (18.8%) and the lowest rate found in the County, 3rd Service model (3.5%)

- Volunteer staffing may be under-represented based on likely low survey response rate from fully volunteer ambulance agencies

Table 9: Most Common Reasons for Leaving

City/County 3rd Service	District Owned	Hospital-Based	Private, Non-Profit	Private, For-Profit
Retirement	Wages & Benefits	Relocation	Wages & Benefits	Wages & Benefits
	New career, compensation	Retirement	Retirement	Educational Benefits
	Better Pay/Hours	Wages & Benefits	Burnout	
	Burnout	Pension		



Attrition in EMS is driven less by the work itself (*it's challenging everywhere*) and more by the employment model surrounding the work.

The difference between the attrition for Private, For-Profit EMS compared to City/County, 3rd Service EMS is likely not about one group treating employees/volunteers differently. It is more likely due to the structural differences in compensation and benefits, career stability, job expectations, organizational mission, and labor market dynamics.

Third-service agencies are typically government-operated, career-based and benefit-rich. They often provide pensions or retirement systems, strong health insurance, paid leave and predictable step increases, and long-term job security, thereby creating a "career destination."

Private EMS often competes with lower labor cost structures, leaner benefit packages, and fewer retirement options. Many employees treat private EMS as a stepping-stone, not a career home. People stay where long-term benefits exist.

* * * *

Recommendations from North Dakota Ambulance Agency Leaders

A key component of this project was soliciting feedback from the ambulance agency leaders, those with a 'frontline operational perspective', on how the North Dakota Legislature could best assist with ensuring essential ambulance service is financially sustainable within the state.

Responses to solicited feedback are summarized below.

Incentives that you feel could encourage individuals to become a volunteer or employee with your ambulance service

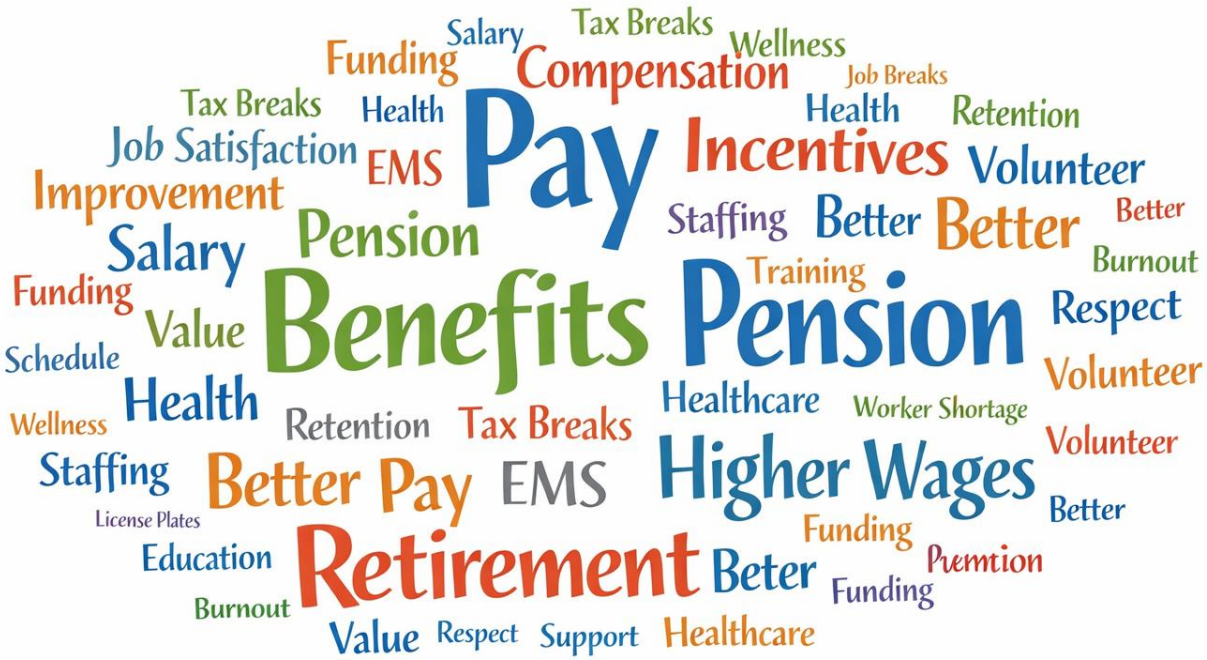
- Better availability, pay, retirement, insurance.
- Being heard and valued by the state.
- It's the same everywhere. People want higher pay and services can only offer so much.
- Culture is what keeps people at your service.
- I think the days of people volunteering are going away.
- Pay for 100% of initial training as well as on-going training, to include lodging, mileage, and meals.
- Wage increases.
- The EMS industry expects people to be out in ditches and in terrible conditions working for less money than people who flip burgers or scrub toilets.
- Wage increases across the industry would help people be interested in putting themselves in sometimes terrible situations.
- State Retirement eligibility.
- Healthcare benefits.
- People need to be compensated in some manner for their time and education.
- Access to modern, well-maintained equipment and ambulances.
- The ability to have their red plates no matter what their income is. Or the ability to have them and still pay for tabs if needed.

Figure 1: Word Cloud - Incentives for Personnel Recruitment & Retention

This Word Cloud depicts how often certain terms appear in the written responses submitted by survey respondents.

For example, the terms "*Pay*", "*Benefits*" and "*Pension*" appear larger in the Word Cloud because these terms were most often used in the written responses.

The more often a term appears in responses, the larger they are depicted on the Word Cloud.



What are your suggestions on ideas on how the State could best financially support your ambulance service.

- Continue to offer the EMS Rural Assistance Grant which is a huge help. Help to find a way for better reimbursement rates on ambulance services.
- Reimbursement mechanism for treatment in place and better Medicaid & Medicare reimbursement.
- Reimbursement for treatment in place and other non-billable calls for service.
- Delinquent bills and insurance reimbursement are what all services need. For our service being private it would be great to get grant money to help with purchases for equipment and supplies that are expensive.
- Fight for better reimbursement rates (Medicare hasn't changed in over 2 decades yet our costs have gone through the roof); insurance coverage for EVERYONE; tax dollars based off coverage area; grants for ALL services (not just low population areas); free equipment; add EMS as essential services.
- help with our non-paid calls
- Our EMS grant funding from the state dropped by $30.000.00 this year. WHY? We had the same number of responses in 2023 and 2024. It took almost 6 months from the time we submitted the grant application to when we found out what we were awarded. This is a huge blow to our budget. Very hard to make a budget with this uncertainty.
- Grant finders and grant writers.
- Funding for available services to cover the cost of readiness, not just grants based on call volume.

Figure 2: Word Cloud - Best Ways the Legislature Could Help

This Word Cloud depicts how often certain terms appear in the written responses submitted by survey respondents.

For example, the terms "*Funding*", "*Support*" and "*Assistance*" appear larger in the Word Cloud because these terms were most often used in the written responses.

The more often a term appears in responses, the larger they are depicted on the Word Cloud.

Option 1: Create a 'North Dakota Ambulance Delinquent Accounts Stabilization Grant Program'

Purpose

To provide temporary financial relief to licensed ambulance agencies experiencing significant unpaid or delinquent patient accounts, in order to:

- Stabilize rural EMS cash flow
- Reduce reliance on local subsidies
- Prevent service degradation due to delayed reimbursement
- Support continued statewide readiness and response capability

Program Structure

Administering Agency

- ND Department of Health and Human Services (DHHS), Division of EMS or,
- A contracted statewide EMS grant administrator

Eligible Applicants

Grants would be available to:

- Licensed ground ambulance service providers operating in North Dakota
- Public, nonprofit, or authorized quasi-governmental EMS entities
- Agencies providing 911 emergency response or essential service coverage

Priority consideration for:

- Rural and frontier agencies
- Volunteer or mixed staffing models
- Agencies serving medically underserved regions

Eligible Delinquent Accounts

Grant funds could be applied only to accounts that meet defined criteria, such as:

- Accounts related to emergency responses or medically necessary patient transport
- Claims that have exhausted reasonable billing follow-up and sent to collections
- Payer categories including:
    - Uninsured patients
    - Underinsured patients
    - Denied Medicaid/Medicare claims
    - Unpaid commercial balances

Exclusions could include:

- Elective/non-emergency patient transport
- Accounts already written off through settlement
- Balances attributable to billing contractor error

Allowable Use of Grant Funds

Funds may be used for:

- Offset of Uncollectible Emergency Accounts
    - Direct reimbursement for documented delinquent receivables tied to EMS responses.

- Cash Flow Stabilization
    - Short-term operational support when delayed payments threaten staffing or readiness.

- Billing and Revenue Cycle Improvements
    - A portion of funding could support:
        - ✓ claims processing modernization
        - ✓ billing compliance training
        - ✓ software upgrades
        - ✓ denial management systems

- Patient Financial Assistance Pathways
    - Encourage agencies to develop hardship policies rather than relying solely on collections.

Table 10: Example of Estimated Cost of Uncollectible Ambulance Claims

2024 Statewide Ambulance Responses[2]	95,617
Average transport % across survey respondents	83.1%
Estimate of billable ambulance transports	**79,416**
% of Delinquent Accounts Across Agencies Surveyed	6.9%
Estimate of Statewide Claims sent to Collections	5,463
Average $ value of claims sent to collections	$1,062.94
Total cost of unpaid ambulance claims	**$5,806,614**
Average Medicaid reimbursement for an ambulance claim	
BLS Emergency Base Reimbursement	$517.24
Mileage Reimbursement	$10.37
Average transport miles	34
Average mileage reimbursement	$352.75
Average Total Reimbursement	**$869.99**
Total Medicaid expenditure if all uncollectible claims were reimbursed at the Medicaid reimbursement rate	**$4,752,570**
% of uncollectible revenue reimbursed by Medicaid	**81.8%**

Grant Calculation Formula Options

The Legislature could choose one or combine several approaches:

Option 1: Percentage of Verified Delinquent Accounts

Grant equals:

- 50–75% of eligible delinquent receivables over 120 days with a maximum annual cap.

Example: $Grant = 0.60 \times Eligible\ Delinquent\ Receivables$

Option 2: Delinquent Burden Threshold Trigger

Grant eligibility begins when delinquent accounts exceed:

- X% of annual operating budget, or
- # of patient transports unpaid beyond 120 days

[2] https://ndlegis.gov/sites/default/files/pdf/committees/69-2025/27.5022.02000_1015.pdf

Option 3: Rural-Weighted Distribution

Apply higher match rates for frontier agencies:

- Urban: 50% reimbursement
- Rural: 65% reimbursement
- Frontier: 80% reimbursement

Option 4: Per-Patient Transport Delinquency Support Pool

Provide a fixed amount per unpaid patient transport after 120 days, such as:

- $614.23 per unpaid emergency patient transport (the current North Dakota Medicaid base reimbursement for an ALS-emergency call)

Documentation and Verification Requirements

To ensure accountability, agencies must submit:

- Aging report of accounts receivable
- Number of claims unpaid beyond threshold
- Payer mix breakdown
- Documentation that standard billing steps were taken
- Certification that amounts are not otherwise reimbursed

State may consider requiring:

- Independent audit sampling
- Standardized reporting template
- DHHS review prior to payment

Safeguards for Program Integrity

Not Supplanting Other Funding Requirement

Grant funds may not replace existing local subsidy commitments.

Annual Caps

Limit awards to avoid disproportionate allocation:

- Minimum: $25,000
- Maximum: $500,000 (example)

One-Time or Temporary Program Design

Structure as:

- Pilot program (biennium), or
- Transitional support while broader EMS readiness reforms are implemented

Collections Policy Requirement

Agencies must maintain a reasonable patient financial hardship policy.

Policy Alignment and Long-Term Strategy

Legislators could frame this program as:

- A short-term stabilization tool
- Not a substitute for systemic EMS funding reform
- Complementary to readiness payments and Medicaid treat-in-place reimbursement

Option 2: Create a More Stable, Statewide EMS Readiness & Workforce Funding Program Based on Funding Response and Readiness vs. Patient Transport

The data from this survey shows a structural mismatch, FFS reimbursement averages approximately $482/transport below cost on average, while readiness and non- patient transport work is real (and often unpaid). Local tax subsidy is already carrying many systems, but it varies by community capacity. A statewide, predictable "readiness" investment directly targets the gap and stabilizes staffing.

What the program could include:

1. Base "readiness" payments to licensed ambulance agencies tied to coverage obligations (hours of coverage, response capability, service area, and call demand), not just patient transports.
2. Workforce support is built into the base funding (e.g., on-call stipends, minimum staffing grants, and/or a statewide benefits/insurance pool option to lower benefit costs and improve retention).
3. Allow/require Medicaid reimbursement for treatment-in-place and clinically appropriate non-patient transport responses (so agencies are paid for care delivered even when transport isn't needed), paired with a simple documentation standard.
4. Dedicated capital replacement matching grants (ambulances/major equipment) to address the documented $12.9 million 5-year need without forcing ambulance fee spikes or service cuts.
5. Accountability that is easy to comply with, but meaningful: basic reporting on response performance, staffing levels, and financials—focused on sustainability and access, not punishment.

Potential benefit: This approach directly addresses the two biggest threats surfaced by the survey data, structural underpayment under FFS and workforce instability, while reducing pressure on local property taxes and helping ensure consistent EMS access statewide.

North Dakota EMS Readiness Funding Formula Concept

Goal

Fund ambulance agencies based on their '*cost of readiness*' (24/7 response capability) with rural/frontier adjustments, then add performance/workforce/capital add ons that target the most significant financial risks.

Step 1 — Place Each Licensed Ambulance Agency into a 'Readiness Tier'

Tiers would reflect coverage obligation + staffing type (paid, paid on-call, volunteer), as opposed to patient transports.

Readiness Tiers (example)

Tier 1 — Limited Readiness (Part-time / Paid On-call)

- Coverage < 24/7 OR paid on-call model without guaranteed crew availability
- Minimum capability: BLS response with defined call-back protocol

Tier 2 — 24/7 BLS Staffing

- 24/7 dispatch availability
- BLS ambulance available with documented staffing plan

Tier 3 — 24/7 ALS Staffing

- 24/7 ALS availability (paramedic level)
- ALS ambulance available with documented staffing plan

Tier 4 — High-Volume / Multi-Unit / Regional Service Model

- 24/7 ALS, multiple units, high-call or regional referral coverage
- Multiple ambulances available with documented staffing plan

North Dakota could modify the tier definitions to match state EMS licensing categories, but the key is: tier = required readiness capacity, not financial need.

Step 2 — Calculate Base Readiness Payment (BRP)

Each agency gets an annual base payment:

$$BRP = \text{Tier Base} \times \text{Rural Weight} \times \text{Service Area Weight} \times \text{Call Burden Weight}$$

A) Tier Base (illustrative amounts)

- Tier 1: **$75,000**
- Tier 2: **$175,000**
- Tier 3: **$325,000**
- Tier 4: **$500,000**

(These are examples, the legislature could set amounts using the funding it can sustain.

Step 3 — Apply Rural/Frontier Weighting (Rural Weight)

Use an objective, mappable measure.

Rural Weight (example using RUCA or a North Dakota-defined approach)

- Urban/metro: **1.00**
- Large rural: **1.15**
- Small rural: **1.30**
- Frontier: **1.50**

Alternatively, the legislature could use population density or transport distance to the hospital as the cost driver.

Step 4 — Add Service Area and "Distance Reality" Weighting

This protects big geographic coverage areas with low population.

Service Area Weight (example)

Based on **primary response area** (square miles) or **road miles**, capped to avoid extremes:

- <250 sq mi: **1.00**
- 250–750: **1.10**
- 751–1,500: **1.20**
- 1,500: **1.30**

Optional "Hospital Distance" Weight (a more clinical approach)

Add 0.05–0.20 based on median patient transport time to an ED:

- <20 minutes: +0.00
- 20–40: +0.05
- 41–60: +0.10
- 60: +0.15 (or +0.20)

Step 5 — Apply Call Burden Weight

This step helps avoid funding very low-response volume agencies while still providing funding for acknowledged workload.

Call Burden Weight (example)

Use **responses**, not patient transports (captures non-patient-transport responses):

- <300 responses/year: **0.95**
- 300–999: **1.00**
- 1,000–2,499: **1.10**
- 2,500+: **1.20**

Step 6 — Add Targeted "Add-Ons" (workforce + non-patient transport + capital)

These address the exact stress points the data highlights: staffing attrition, unpaid non-patient transports, and looming fleet replacement.

A) Workforce Stability Add on (WSA)

Reward agencies that meet basic staffing and retention benchmarks or help those that are actively fixing it. Two potential options:

Option 1: Straight per-FTE support

- Pay determined amount per FTE for credentialed EMS staff maintained year-round
- Higher for paramedics than EMTs (higher expense for paramedics)

Option 2: Vacancy/coverage trigger

- If vacancy rate > threshold OR documented on-call gaps: agency becomes eligible for workforce stabilization grant (temporary, renewable with improvement plan)

B) Non-Patient Transport Care Add on (NTCA)

Because responses with no patient transport are real workload and only about half the agencies bill for them.

- Fund determined amount per documented non-patient transport response, capped annually
- Require minimal criteria: assessment + documentation + medical director QA inclusion

This is also a bridge until Medicaid treat-in-place is fully implemented.

C) Capital Match Pool (CMP)

Separate bucket, not built into the base (prevents base funds being consumed by fleet replacement).

- State match: 50/50 or 60/40 rural/frontier enhanced match
- Eligible purchases: ambulances, cardiac monitors, radios/communication, stretchers, safety gear
- Require replacement plan and lifecycle schedule

Step 7 — Program Integrity Safeguards

1) Minimum Floor + Maximum Cap

- Floor ensures small rural agencies don't collapse
- Cap prevents one or two large services from consuming the pool

Example:

- Minimum total award: $100,000
- Maximum base award: $1.5 million (before capital grants)

2) "Maintenance of Effort" (MOE) to Prevent Supplanting Current / Historical funding

Require local government to maintain baseline support (e.g., prior-year local subsidy within 10%) unless hardship waiver for unusual gaps in funding availability.

3) Use-of-Funds Limitations

At least **60%** of base readiness funds must support:

- Staffing, pay, benefits, training, QA/QI, readiness infrastructure

4) Mutual Aid Participation Requirement

Eligible agencies must participate in ND mutual aid/regional coordination.

Example

Tier 3 ALS agency in **frontier** county, 1,200 sq mi response area, 900 responses/year:

- Tier Base = $325,000
- Rural Weight (frontier) = 1.50
- Area Weight (751–1,500) = 1.20
- Call Weight (300–999) = 1.00

BRP = 325,000 × 1.50 × 1.20 × 1.00 **= $585,000/year** (plus add ons, if eligible)

Example for Tier Base Amounts

To size the appropriation:

1. Estimate how many agencies fall into each tier
2. Apply expected average weights
3. Add a fixed % for add on/capital funding pools
4. Pick appropriation to hit a target "readiness investment" statewide

Keep base readiness about 70–80% of total program dollars, and reserve 20–30% for add on/capital.

Attachment A: Survey Instrument

PWW | AG

North Dakota Ambulance Survey - Establishing a Delinquent Billing State Grant Program

Section 4 of North Dakota House Bill No. 1322 (2025) directs the study of the feasibility and desirability of establishing a **delinquent billing reimbursement grant system for ambulance service providers.**

As part of the study, the North Dakota **Legislative Management** desires feedback from ambulance service providers to gather information to help develop the grant system and has contracted with **PWW Advisory Group** to conduct the survey.

Your individual responses to the questions below **will be kept confidential** and be used help determine a logical pathway to help develop a grant program to support ambulance services in North Dakota.

If you have any questions about the survey, or your response, please feel free to call or text Matt Zavadsky at 817-991-4487, or by email at matt.zavadsky@pwwag.com.

Thank you to the North Dakota EMS Association for their assistance with this project!

* Required

Agency Profile

1. Agency Name *

2. Your name *

3. Your email address *

4. Your best contact phone number *

5. Primary Service Area (Township, Borough, etc.) *

6. Agency Type *

- ◯ District Owned
- ◯ Hospital-Based
- ◯ Municipal/3rd Service
- ◯ County/3rd Service
- ◯ Fire-Based
- ◯ Private, Non-Profit
- ◯ Private, For-Profit
- ◯ Other

7. Annual response volume: *

8. Primary Service Area population: *

9. Primary Service Area square miles: *

How many of each type of staffing does your agency staff:

10. Non-Certified Driver

11. Emergency Medical Responder

12. EMT

13. Advanced EMT

14. Paramedic

What % of your staffing is...

15. Full Time Paid

16. Part Time Paid

17. Paid on Call

18. Volunteer

Annual dollar amount that your agency receives from the following sources

19. Total revenue from all sources your agency received during your last fiscal year

20. Revenue received from bills sent to insurers/patients for ambulance services provided (also known as "Fee for Service (FFS) revenue).

21. State grants

22. Federal Grants

23. Donations/Fundraisers

24. Local Tax Subsidy

25. Other Sources

What were the expenses for the following categories for your most recent fiscal year

26. Personnel Wages

27. Personnel Benefits

28. Equipment

29. Supplies

30. Fuel

31. Maintenance

32. Training/Education

33. Stations

34. Professional Fees

35. Software

36. Information Technology/Radios/Cell Service

37. Other

38. Total expenses for your last fiscal year

General

39. Number of ambulances owned by your agency

40. Anticipated vehicle or equipment asset purchases greater than $5,000 in the next 5 years.

41. Your average transport distance to the primary hospital that you transport patients to:

Revenue cycle information for your last fiscal year

42. Do you do your own billing, or do you have an agency that does your billing?

- ◯ Internal billing
- ◯ Outside billing agency

43. Total number of responses billed

44. Total dollar amount of ambulance bills sent to insurers/patients (gross amount billed)

45. Total number of billed services in which you received payment

46. Total dollar amount collected from ambulance billing

47. The total **number of accounts** billed and not paid after 90-days.

48. The **total dollar amount for accounts billed**, but not paid after 90-days.

49. The average length of delinquency for billing accounts, including the number and value of accounts 30, 60, and 90 days or more delinquent

50. The **dollar** amount of delinquent billings written off as uncollectable in the most recently completed fiscal year

51. The **number of accounts** your agency sent to a debt collection agency in the most recently completed fiscal year

52. The **total dollar amount** of accounts sent to a debt collection agency in the most recently completed fiscal year

53. The total number of responses that did not result in a patient transport

54. Do you bill for non-transport? *

- ◯ Yes
- ◯ No

Other Information

55. The number of employees and volunteers who left the ambulance service in the most recently completed fiscal year

56. Most common reasons given for leaving

57. Incentives that you feel could encourage individuals to become a volunteer or employee with your ambulance service.

58. What are your suggestions on ideas what the State could best financially support your ambulance service.