PWW|AG

EMS Financial Index

Driving Change Through Data and Best Practices

Q2 Index Report

August 2025

Foreword

As the President of the Academy of International Mobile Healthcare Integration (AIMHI), an organization committed to enhancing the efficiency and value of EMS systems, it is with great honor that I introduce the next installment of the EMS Financial Index. This important report, created in partnership with PWW Advisory Group (PWW|AG), provides unique insights into the financial challenges that many EMS agencies are facing today.

It is clear that EMS organizations are under significant pressure due to financial constraints, with resulting impacts on service delivery and staff retention. These challenges, if left unchecked, could threaten the sustainability of EMS operations in communities all across the country.

The EMS Financial Index seeks to address this pressing issue by providing EMS agencies with vital data and actionable insights aimed at improving their financial health. With contributions from over 1,500 agencies representing every type of EMS model (public, private, large, small, urban, rural), this report offers a comprehensive analysis of revenue cycle management (RCM) practices, with a focus on best practices that can help agencies optimize their financial outcomes and better serve their communities.

Rob Lawrence

President of AIMHI

As advocates for effectiveness and value in EMS, AIMHI recognizes the vital role that data-driven decision-making plays in the sustainability of EMS systems. The EMS Financial Index provides invaluable benchmarks and recommendations that will help EMS leaders navigate the complex financial landscape, enabling them to make informed decisions that strengthen their agencies and the broader EMS industry.

This quarterly report will continue to highlight key trends, regional variations, and specialized content that directly impacts the financial performance of EMS agencies. I encourage all EMS professionals to engage with the data and insights presented here to better understand the financial health of their own agencies and identify opportunities for improvement.

I look forward to seeing how the EMS Financial Index will contribute to the long-term success of EMS agencies across the country and help secure a more sustainable future for mobile healthcare.

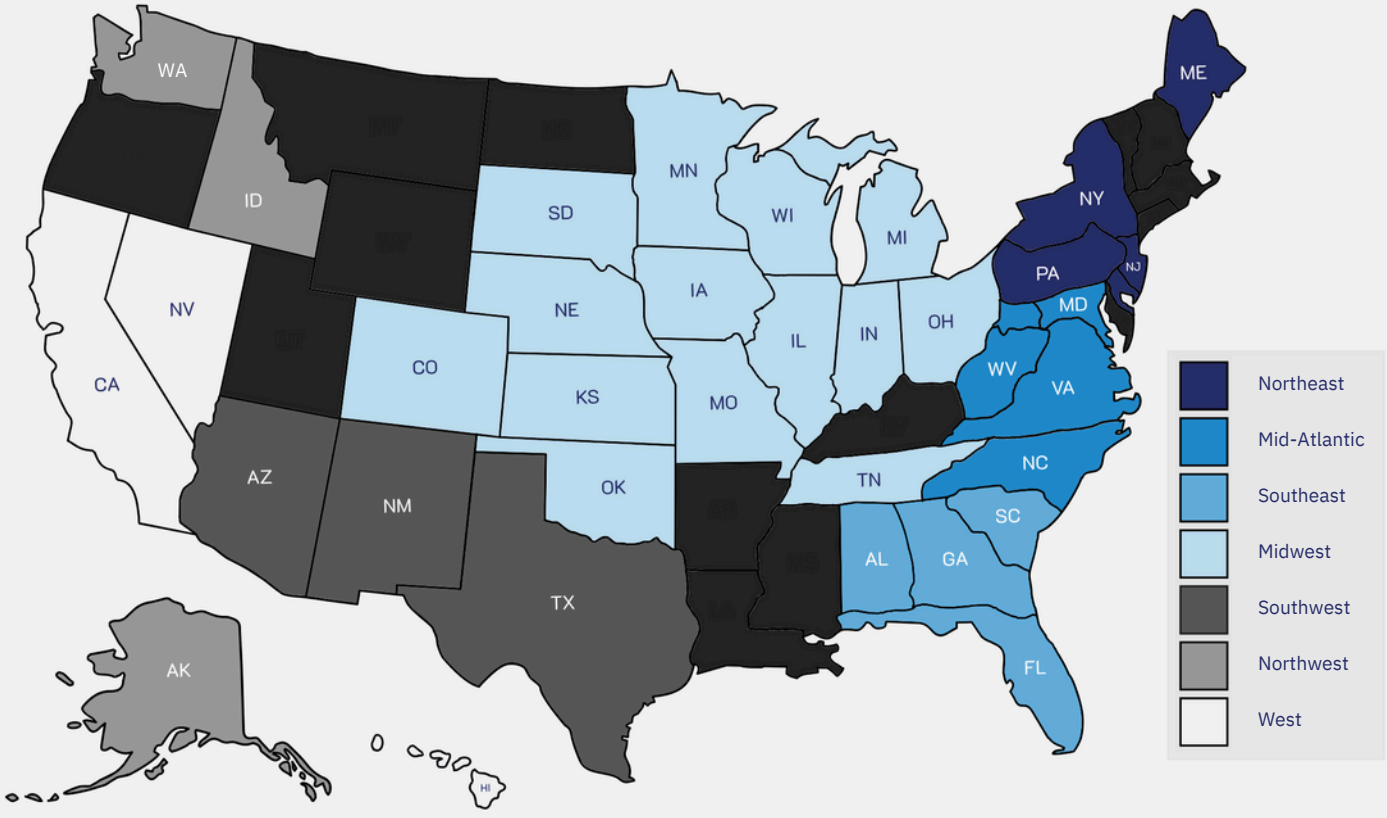
Introduction

PWW Advisory Group (PWW|AG), in partnership with EMS|MC, presents our EMS Financial Index report for Q2. Many EMS agencies across the country are struggling financially, leading to challenges retaining and recruiting staff, resulting in service delivery challenges and even closures of EMS agencies.

It is our hope that sharing benchmark data, along with best practice recommendations, will help EMS agencies assess their revenue cycle management (RCM) practices and outcomes to improve their financial health.
In this report, we focus on several key metrics related to the sustainability of ambulance services across the U.S.:

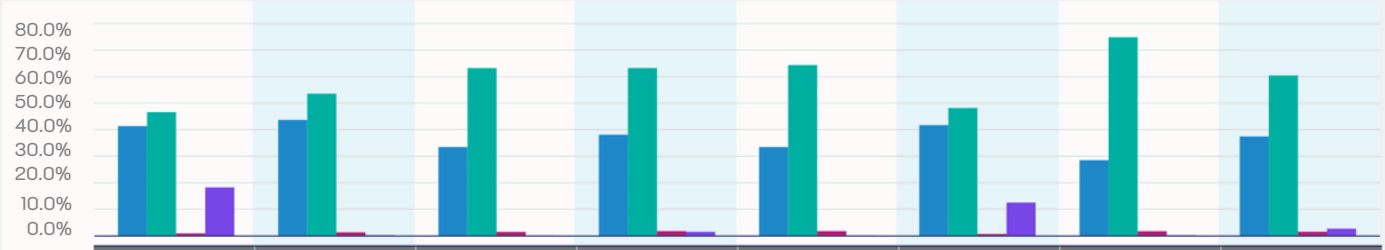
- Emergency Response Service Mix
- Patient Financial Responsibility for Claims Billed to Commercial Insurance
- Medicare Fee for Service vs. Medicare Advantage
- Treatment in Place Services

Geographic Key



Index: Emergency Response Service Mix

Emergency Response Service Mix-Billed Services



	Northeast	Mid-Atlantic	Southeast	Midwest	Southwest	Northwest	West	National
BLS	41.6%	44.1%	33.7%	38.5%	33.1%	41.8%	28.9%	38.2%
ALS	46.8%	54.0%	63.6%	62.4%	64.3%	48.6%	75.2%	60.8%
ALS2	1.1%	1.6%	2.0%	2.1%	2.5%	1.0%	2.1%	1.8%
SCT	18.7%	0.5%	0.7%	1.9%	0.6%	12.9%	0.01%	3.0%

Observations:

According to EMS|MC's 2024 national database, **38.2%** of emergency response services were billed at the Basic Life Support (BLS) level, while **60.8%** were billed at the Advanced Life Support (ALS) level. The highest ALS service mix was reported in the West (75.2%), and the lowest in the Northeast (46.8%). In contrast, data from the Medicare Ground Ambulance Data Collection System (GADCS) showed **56.1%** of EMS transports received BLS care, with only **43.9%** receiving ALS. Similarly, a 2025 patient care report review by PWW|AG of a high-performing ambulance agency found that **59.3%** of patients received BLS care and **33.9%** received ALS care. These variances may be attributed to billing practices that permit ALS-level reimbursement when a response meets ALS protocol criteria and an ALS assessment is conducted — even if no ALS interventions are ultimately performed. In such cases, reimbursement is based on the nature of the response and assessment, not the level of care administered.

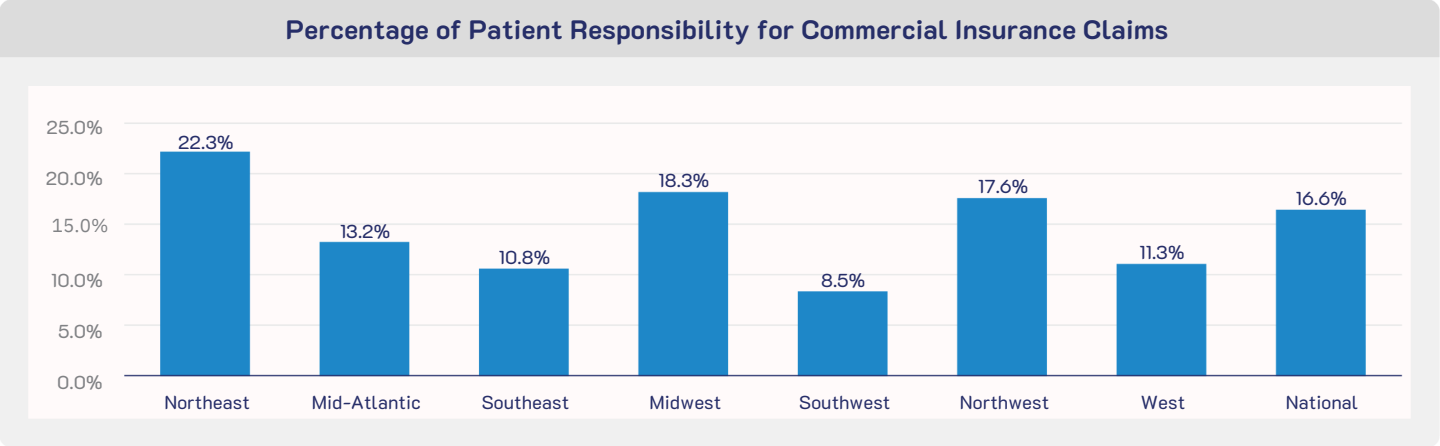
Discussion:

The difference between ALS care billed in the PWW|AG Financial Index, the GADCS report, and the findings in this analysis may rest with the ability of ambulance agencies to receive ALS level reimbursement under specific circumstances and dispatch protocol use. This occurs when the response is of a nature that local protocol indicates the patient should receive an ALS response and an ALS assessment is provided, however, no ALS care is actually administered to the patient. Under this scenario, ALS reimbursement is allowed even though ALS interventions were not actually administered to the patient.

Recommended Action:

Recent EMS system delivery innovations emphasize BLS ambulance deployment, with some ALS Quick Response Vehicle (QRV) backup. These design changes are evidence-based, since study findings indicate that most EMS patients receive BLS care[1]. Additionally, studies have found that patient outcomes are better with fewer paramedics deployed in an EMS system[2,3]. Agencies should consider implementing an ALS assessment policy to maximize reimbursement by billing an ALS level of care under specific conditions. This applies when dispatch protocols indicate an ALS response, and the patient receives an ALS assessment — either by an ALS ambulance crew or an ALS QRV. This billing approach is appropriate even if BLS care is actually administered to the patient.

Index: Patient Financial Responsibility for Claims Billed to Commercial Insurance



Observations:

Overall, **16.6%** of the reimbursement to ambulance agencies for services covered by commercial insurance is paid by the patient. This is generally due to either deductibles, coinsurance, or underpayments by the commercial insurer. The percentage is highest in the Northeast (22.3%) and lowest in the Southwest (8.5%).

Discussion:

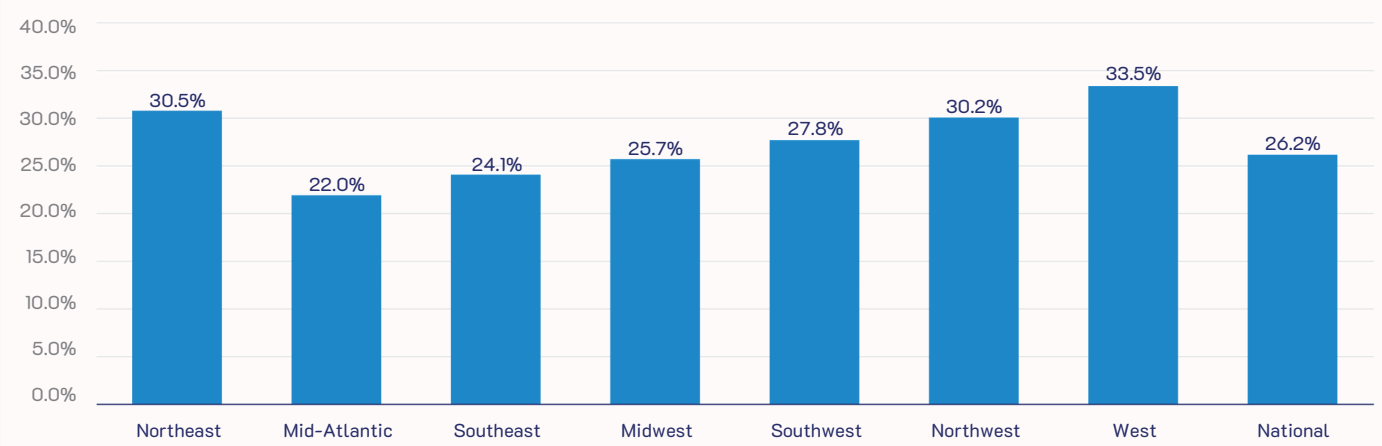
Balance billing the patient for outstanding ambulance claims is a hotly debated issue in many states across the country, and was the focus of the Congressionally mandated Advisory Committee on Ground Ambulance and Patient Billing (GAPB). When insurers provide inadequate reimbursement, patients are left with an uncovered balance. States like California and Texas have passed legislation requiring insurers to reimburse ambulance services at rates set by local jurisdiction, as long as those charges are locally approved. Some states' balance billing laws also include provisions requiring insurers to reimburse at a multiple of the local Medicare Fee Schedule if fees are not locally regulated. However, these state-laws only apply to state-regulated insurance plans, which are only a small percentage of health plans in most states — with most being employer-sponsored plans covered by Federal ERISA law. Recommendation 12 in the report issued by the GABP Advisory Committee to Congress is that federally regulated insurers must reimburse ambulance claims at the amount specified in a State balance billing law under Recommendation 12. According to the 2024 National Survey by the Kaiser Family Foundation (KFF), 63% of people who work for private employers and get health insurance through that employer have self-funded plans that are not state-regulated.

Recommended Actions:

It is generally easier to change state law than it is to change federal law, and if Congress accepts this recommendation by the Advisory Committee on Ground Ambulance and Patient Billing, federally regulated insurers will be required to follow state statutes. These statutes should include the provision that to prevent balance billing, insurers must reimburse non-contracted ambulance agencies directly, and at a sustainable payment rate, such as locally established and approved fees, or multiples of the Medicare Ambulance Fee Schedule. A compendium of state balance billing laws can be found at the National Conference of State Legislatures EMS Legislation Database. Currently, there are 18 states that have some provision of balance billing laws for ground ambulance services, with several more states pending similar legislation.

Index: Claims Not Paid by Commercial Insurance

Percentage of Ambulance Claims Not Paid by Commercial Insurance



	Percentage of Claims NOT Paid	Average Insurance Payment	Average Patient Payment	Percentage of Payment Patient Paid
Northeast	30.5%	$1,106	$318	22.3%
Mid-Atlantic	22.0%	$487	$74	13.2%
Southeast	24.1%	$603	$73	10.8%
Midwest	25.7%	$826	$185	18.3%
Southwest	27.8%	$888	$82	8.5%
Northwest	30.2%	$927	$198	17.6%
West	33.5%	$1,496	$190	11.3%
National	26.2%	$887	$176	16.6%
Low	12.2% (KS)	$412 (MD)	$21 (IN)	2.6% (NJ)
High	44.6% (TX)	$2,803 (NJ)	$717 (NY)	54.7% (NY)

Average Patient Payment is $176

Observations:

26.2% of ambulance claims billed to commercial insurers across the EMS|MC national database result in no payment from health insurers. The percentage is highest in the West region (33.5%) and lowest in the Mid-Atlantic Region (22.0%). These findings could represent either high-deductible plans, very tight medical necessity requirements, or health plans that do not cover ambulance services.

Discussion:

During the proceedings of the GAPB Advisory Committee, it was reported that emergency ambulance services were not considered an “essential health benefits” in all plans. Therefore, insurance plans are free to exclude ambulance services from their covered benefits.

Patients are often unaware of this exclusion until after the claim has been submitted. This lack of coverage means that the patient is responsible for the payment of the ambulance service received. Furthermore, the prevalence of high-deductible health plans (>$10,000) may also play a factor in this finding.

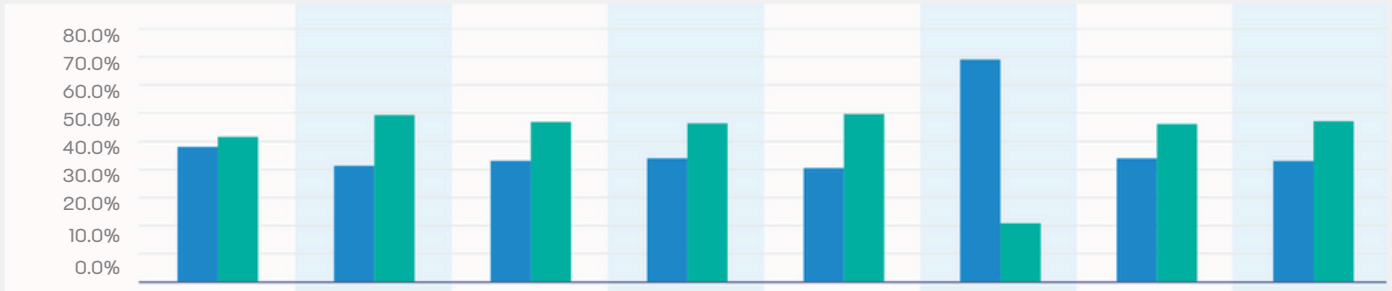
In some cases, the ambulance service provided may be a covered benefit. However, the cost of the claim is applied to the patient’s deductible, with no actual benefit being paid by the commercial insurer. A recommendation from the GAPB Advisory Committee is for Congress to incorporate Ground Ambulance Emergency Medical Services within the definition of emergency services as part of the Essential Health Benefit (EHB) Requirements under Recommendation 5. The GAPB Advisory Committee also specifies that the patient cost-sharing requirement should be the lesser of $100 or 10% of the rate established by Recommendation 12.

Recommended Actions:

Similar to the recommended actions in the previous sections, ambulance agencies should work with their state ambulance associations and state legislature to address these coverage issues. They should advocate for state-level requirements that mandate the coverage of ambulance services as an essential health benefit (EHB). Additionally, they should also work to place caps on patient cost-sharing requirements. Such laws must include a sustainable payment rate (i.e., a multiple of Medicare or locally-established or approved rates) that insurers must pay to non-contracted providers if ambulance services are going to have to give up balance billing.

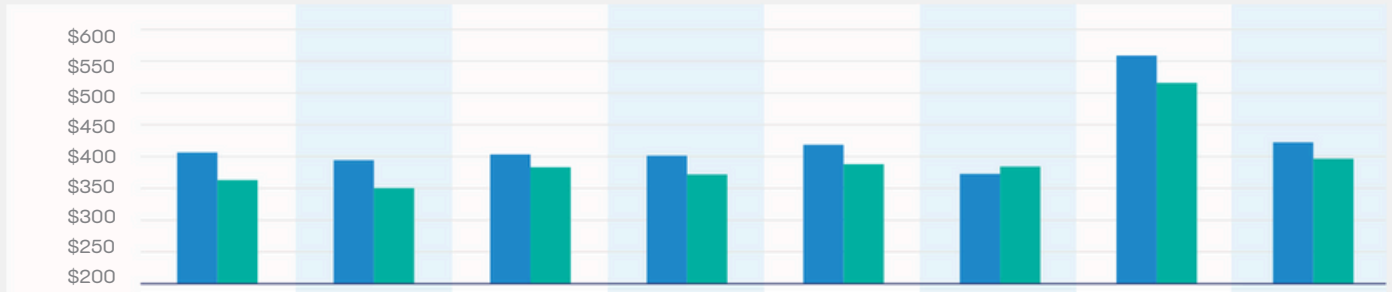
Index: Medicare vs. Medicare Advantage

Percentage of Ambulance Claims



	Northeast	Mid-Atlantic	Southeast	Midwest	Southwest	Northwest	West	National
Medicare	48.2%	41.0%	43.2%	43.9%	40.5%	79.3%	43.9%	43.1%
Medicare Advantage	51.8%	59.0%	56.8%	56.1%	59.5%	20.7%	56.1%	56.9%

Average Ambulance Claim Reimbursement



	Northeast	Mid-Atlantic	Southeast	Midwest	Southwest	Northwest	West	National
Medicare	$407	$393	$403	$402	$419	$372	$560	$421
Medicare Advantage	$363	$349	$383	$372	$388	$385	$516	$396

Observations:

These tables illustrate the percentage of Medicare Fee for Service (FFS) claims versus Medicare Advantage (MA) claims, as well as the average reimbursement from each type of payer. MA prevalence is highest in the Southwest (59.5%) and lowest in the Northwest (20.7%). Nationally, MA claims represent **56.9%** of all ambulance claims in the database, with Medicare FFS representing **43.1%** of claims. Nationally, the average reimbursement from MA plans is $25 lower than Medicare FFS, with the biggest difference in the Mid-Atlantic region ($44). Meanwhile, in the Northwest region, the average MA reimbursement is $12 higher than the Medicare FFS reimbursement.

Discussion:

Medicare Advantage plans are becoming the preferred Medicare plan for most Americans. A June 2025 report from the Congressional Budget Office (CBO) projects that the Medicare Advantage share will grow from 54% of eligible Medicare beneficiaries in 2024 to about 64% in ten years if it continues on its current trajectory.

The challenge for ambulance agencies now is that based on the data provided through the EMS|MC database, MA reimbursements for ambulance services are **$25** less than traditional Medicare on average. This is likely due to higher deductibles and copays in MA plans compared to traditional Medicare. If the CBO projections are correct, ambulance agencies may continue to experience decreased reimbursements from patients covered by Medicare.

For example, a BLS Emergency transport in Texas with 5 loaded miles would result in allowable amounts of $438 for the base rate and $9.15 per mile, for a total allowable amount of $484. Traditional Medicare would reimburse 80% of the total allowed amount of $484, which is $387, leaving a copayment of $97 for the patient or their supplemental insurance. If the patient was covered by a Medicare Advantage plan with a flat $300 copayment, Medicare reimbursement would be equal to $184, leaving the patient responsible for the $300. However, patients with Medicare Advantage plans do not typically have subscriptions to supplemental coverage, leaving them to pay the full $300 out of their own pockets.

Example Medicare Advantage Reimbursement Scenario

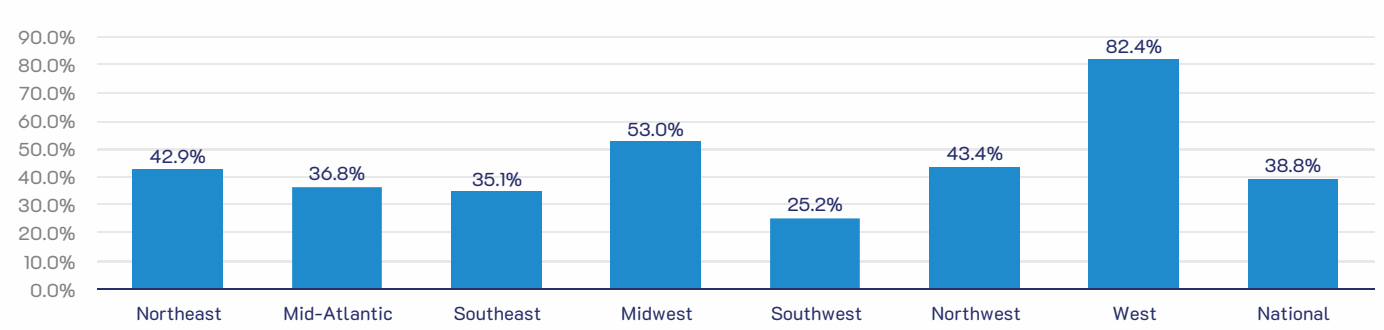
	BLS Base Rate	Mileage Rate $9.15 (Ex. 5 Miles)	Total	Medicare Payment	Patient Responsibility
Traditional Medicare	$438.00	$45.75	$483.75	$387.00	$96.75
Medicare Advantage	$438.00	$45.75	$483.75	$183.75	$300.00

Recommended Actions:

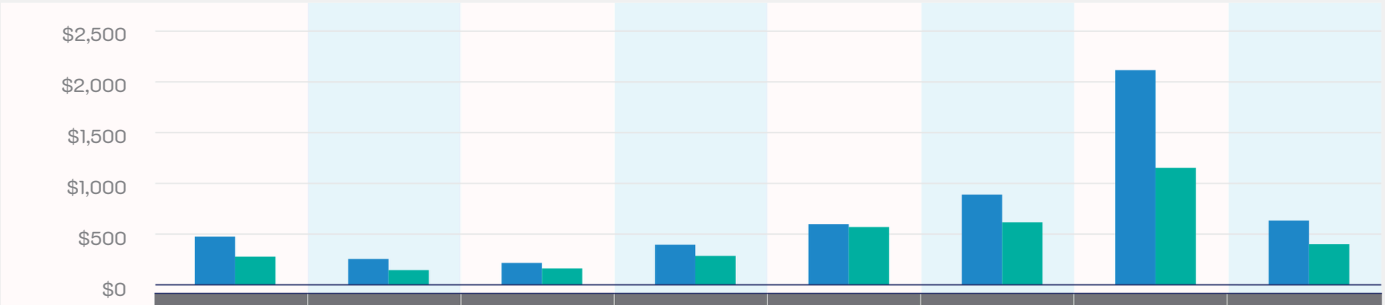
Ambulance agencies should closely monitor their Medicare FFS versus MA claim activity, tracking the trends of the percentage of claims and reimbursements over time. If MA claims are rising as a percentage of Medicare claims, agencies should work with MA plans to find more favorable reimbursement models. Some agencies have also contracted with MA insurers to facilitate alternate payment models that bring more value to the ambulance agency and the MA insurer.

Index: Reimbursement for Treatment in Place Services

Percentage of Treatment in Place (TIP) Claims Paid



Average Charge and Reimbursement for Treatment in Place (TIP)



	Northeast	Mid-Atlantic	Southeast	Midwest	Southwest	Northwest	West	National
Average Charge	$472	$253	$212	$397	$594	$891	$2,119	$634
Average Reimbursement	$278	$144	$157	$278	$570	$618	$1,151	$398

	Northeast	Mid-Atlantic	Southeast	Midwest	Southwest	Northwest	West	National
Services Billed	4,136	44,319	28,639	17,844	13,141	1,808	2,279	112,166
Services Reimbursed	1,775	16,303	10,059	9,466	3,311	784	1,877	43,575
Percentage Reimbursed	42.9%	36.8%	35.1%	53.0%	25.2%	43.4%	82.4%	38.8%
Average Charge	$472	$253	$212	$397	$594	$891	$2,119	$634
Average Reimbursement[1]	$278	$144	$157	$278	$570	$618	$1,151	$398
Potential Revenue[2]	$493,095	$2,348,284	$1,581,375	$2,627,572	$1,886,873	$484,551	$2,160,690	$17,324,984

[1] of paid claims

[2] Average Reimbursement X Services Paid

Observations:

Nationally, **38.8%** of ambulance claims for Treatment in Place (TIP) services are reimbursed to the ambulance agency. The West region has the highest percentage of claims paid (82.4%), while the Southwest region has the lowest percentage (25.2%). From a reimbursement perspective, the national average reimbursement for claims paid is **$398** on the average billed charges of **$634**. Reimbursement for TIP is highest in the West region at **$1,151**, and lowest in the Mid-Atlantic region at **$144**. Not surprisingly, as indicated in the May 2025 Index Report, the higher the billed charge, the higher the reimbursement.

Discussion:

Ambulance agencies across America are struggling financially and increasing their reliance on taxpayer support for services provided. Prudent EMS and public policy leaders should do everything possible to improve ambulance reimbursement for services provided and reduce taxpayer liability. Billing for TIP may be the most logical way for communities to increase fee-for-service revenues. The greatest cost for providing an ambulance response is generally not the cost of transport, but the readiness cost of putting an ambulance at an address within the timeframe established by the community. Through legally-compliant "compassionate billing" practices and policies, the financial impact on patients can be minimized.

Recommended Actions:

Ambulance agencies should evaluate any opportunities for billing for TIP services with key stakeholders, including modeling the potential revenue generated. Fees for TIP services should closely mirror fees for an emergency response, since the majority of the cost for the response is the cost of readiness, not the cost of transport. Medicare set the example for payers reimbursing the base-fee for TIP services, reimbursing at the appropriate ALS or BLS emergency base rate for TIP services under the Medicare ET3 model. While traditional Medicare does not yet cover these vital services, advocacy at the state level may warrant coverage by the State Medicaid plans, Medicaid MCOs and Commercial Insurers. Be prepared to discuss your current TIP program and the costs savings to these insurers in your advocacy efforts. Many commercial insurers, including Anthem BCBS, UHC, and others, have made public statements that TIP services are covered by their plans at rates similar to the transport rates for similar services.

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[1] Jarvis J, Taigman M. Using Red Lights and Sirens for Emergency Ambulance Response: How Often Are Potentially Life-Saving Interventions Performed?
Prehospital Emergency Care, 25(4), 549–555.
https://pubmed.ncbi.nlm.nih.gov/32678993/

[2] Dyson K, Bray J. Paramedic Exposure to Out-of-Hospital Cardiac Arrest Resuscitation Is Associated With Patient Survival Circulation: Cardiovascular Quality and Outcomes Volume 9, Number 2
**********.ahajournals.org/doi/10.1161/CIRCOUTCOMES.115.002317

[3] Vrotsos, K. M., Pirrallo, R. G., Guse, C. E., & Aufderheide, T. P. (2008). Does the Number of System Paramedics Affect Clinical Benchmark Thresholds?
Prehospital Emergency Care, 12(3), 302–306.
https://www.tandfonline.com/doi/full/10.1080/10903120802101355

PWW|AG

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PWW Advisory Group (PWW|AG) delivers innovative compliance solutions with diverse offerings across documentation, compliance, and HIPAA privacy and security.

PWW|AG also hosts leading EMS events like abc360 and XI (The Executive Institute), exemplifying excellence in ambulance coding and compliance.

Leverage the decades of expertise of PWW|AG to solidify your team's regulatory compliance.

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