



DIVISION OF HEALTHCARE ACCESS

Communications | Health Information Technology
Public Health Preparedness & Response | Rural Health Emergency Services

SOUTH DAKOTA AMBULANCE PROVIDER ASSESSMENT

Statewide Data Comparison | Provider Viability | Chargemaster Review

Last Update: August 2026



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ASSESSMENT NARRATIVE SUMMARY

This assessment, completed by Healthcare Strategists, brings together three analyses of South Dakota ambulance service activity, provider viability, and billing practices.

Ambulance Provider Data Comparison

The Ambulance Provider Data Comparison reviews statewide activity, performance, workforce outcomes, and system utilization through 2025. Reported call volume increased significantly, especially for 911 scene responses, although expanded ImageTrend reporting may explain part of the increase. Leading dispatch reasons remained consistent. Statewide response-time compliance improved from 93.8% to 95.6%, while the number of agencies meeting the 30-minute standard remained generally similar to prior years.

Ambulance Provider Viability Status Study

Based on responses from 57 providers, the Viability Status Study found that most respondents serve rural or frontier areas and depend heavily on volunteers or paid-on-call personnel. Half expressed a positive sustainability outlook; 20% considered their agencies unsustainable and 30% were uncertain. Recruitment and retention of both paid staff and volunteers were the leading challenges. Despite these pressures, service interruptions were rare, with only two agencies reporting an interruption during the past 15 years, both caused by unavailable volunteers.

Provider Chargemaster Review

The Chargemaster Review examined fee schedules, billing practices, reimbursement, and operating costs for three providers. Rates were generally competitive, and bundled billing based on transport level and mileage was practical for rural and governmental agencies. However, patient revenue often does not cover the cost of maintaining 24/7 readiness. Rising labor, fuel, vehicle, insurance, equipment, and compliance costs, combined with modest Medicare and Medicaid reimbursement growth, create persistent financial gaps, especially for low-volume rural and public systems.

Overall, the findings support preserving local ambulance response while strengthening workforce support, reimbursement and financial oversight, medical-priority dispatch, regional shared services, and long-term funding strategies.

***Source:** Healthcare Strategists analysis prepared for the South Dakota Department of Health using statewide ambulance service leadership survey responses, ImageTrend EMS data, provider-submitted financial and billing information, fee schedules, and interviews with selected ambulance service leaders.*



I. AMBULANCE PROVIDER DATA COMPARISON

Key Takeaways from Data Comparison

Call Volume

- Use of 911 continues to increase annually; this is likely a factor of an aging population.
- Reasons for calling 911 remain largely the same

Performance

- Agencies meeting the 30-minute response time standard in 2025 is similar to 2023 (5 vs. 3)
- Statewide response times for all calls have improved from 93.8% to 95.6%

NREMT Exam Pass Rates

- EMT pass rates have not changed significantly
- Paramedic pass rates improved dramatically in 2023 and 2024, but fell sharply in 2025

Payor Mix

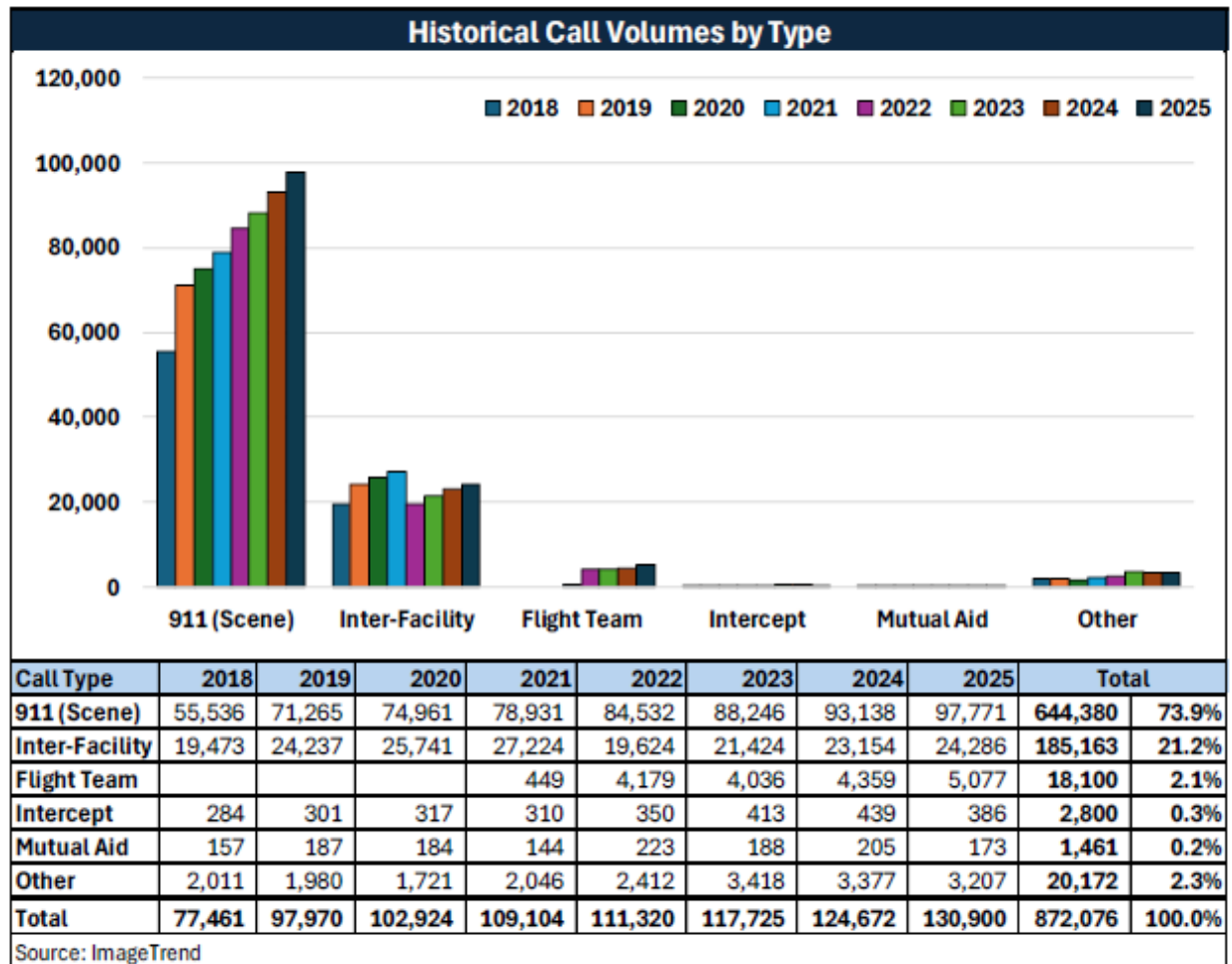
- Medicare and commercial payers have dropped since 2022
- Medicaid has seen a marked increase since 2022; supplemental Medicaid funding could have a significant impact on future fiscal sustainability

Dispatch

- Most calls are not going through the medical priority dispatch process to properly triage calls; this is the first step towards not sending all resources to all calls and transferring callers to a nurse advice line when deemed non-urgent
- The use of lights and siren during responses remains high, likely related to the lack of medical priority dispatching to properly identify non-emergency call types
- The use of lights and siren during transport (59%) is substantially higher than the national average, which is under 10%



CALL TYPES

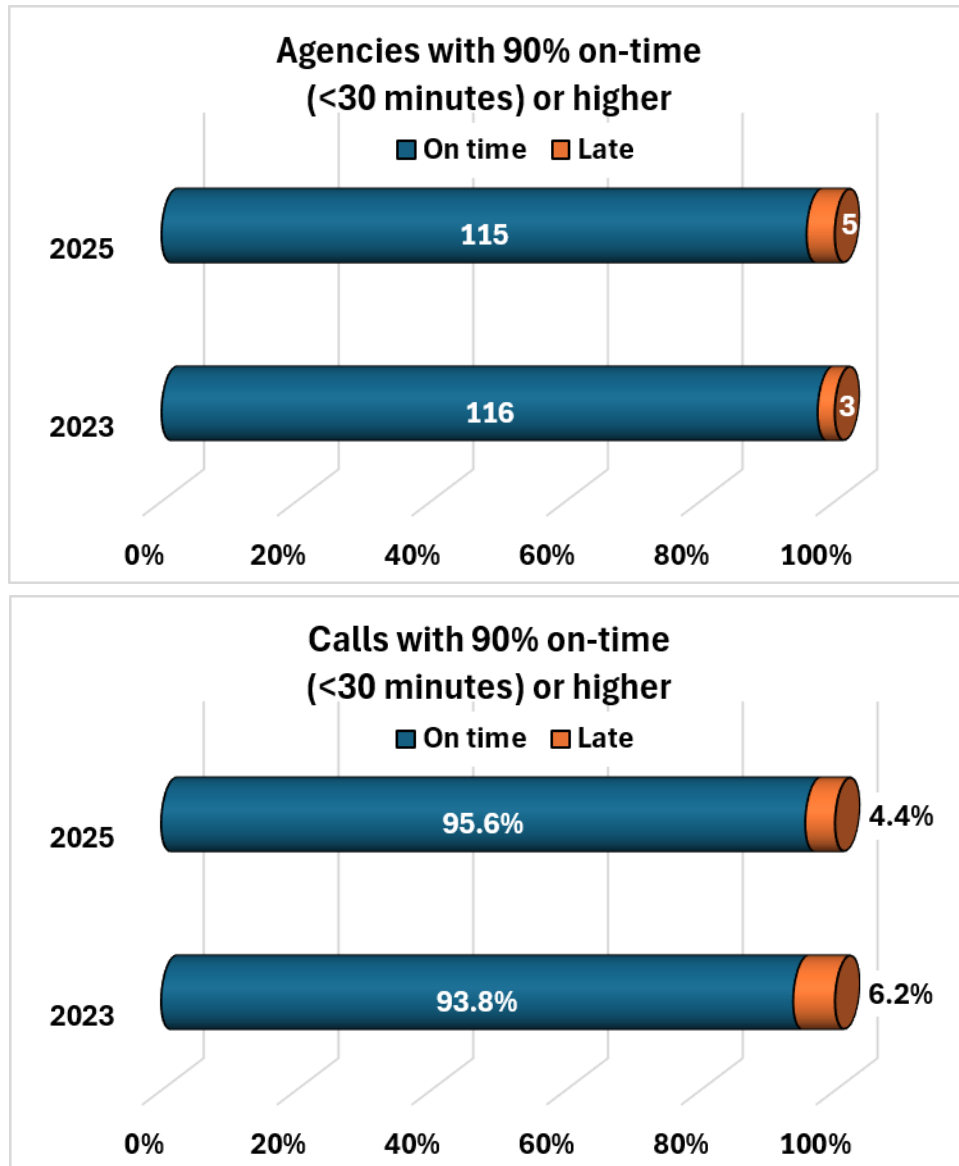


Top-10 Dispatch Reasons		
Reason	2018-23	2025
Sick Person	12.6%	18.1%
Fall	10.7%	10.1%
Transport Only (Medical)	6.9%	8.4%
Breathing Problem	7.8%	7.2%
Chest Pain / Cardiac Problem	6.0%	5.4%
Seizure / Convulsions	4.4%	4.6%
Traffic/Transportation Incident (MVA)	6.3%	4.0%
Unknown Problem/Person Down	5.3%	3.9%
Unconscious/Fainting/Near-Fainting	3.5%	3.8%
Traumatic Injury	3.5%	3.5%
Total	67.2%	69.0%

Source: ImageTrend, 2018-Jun 2023, 2025

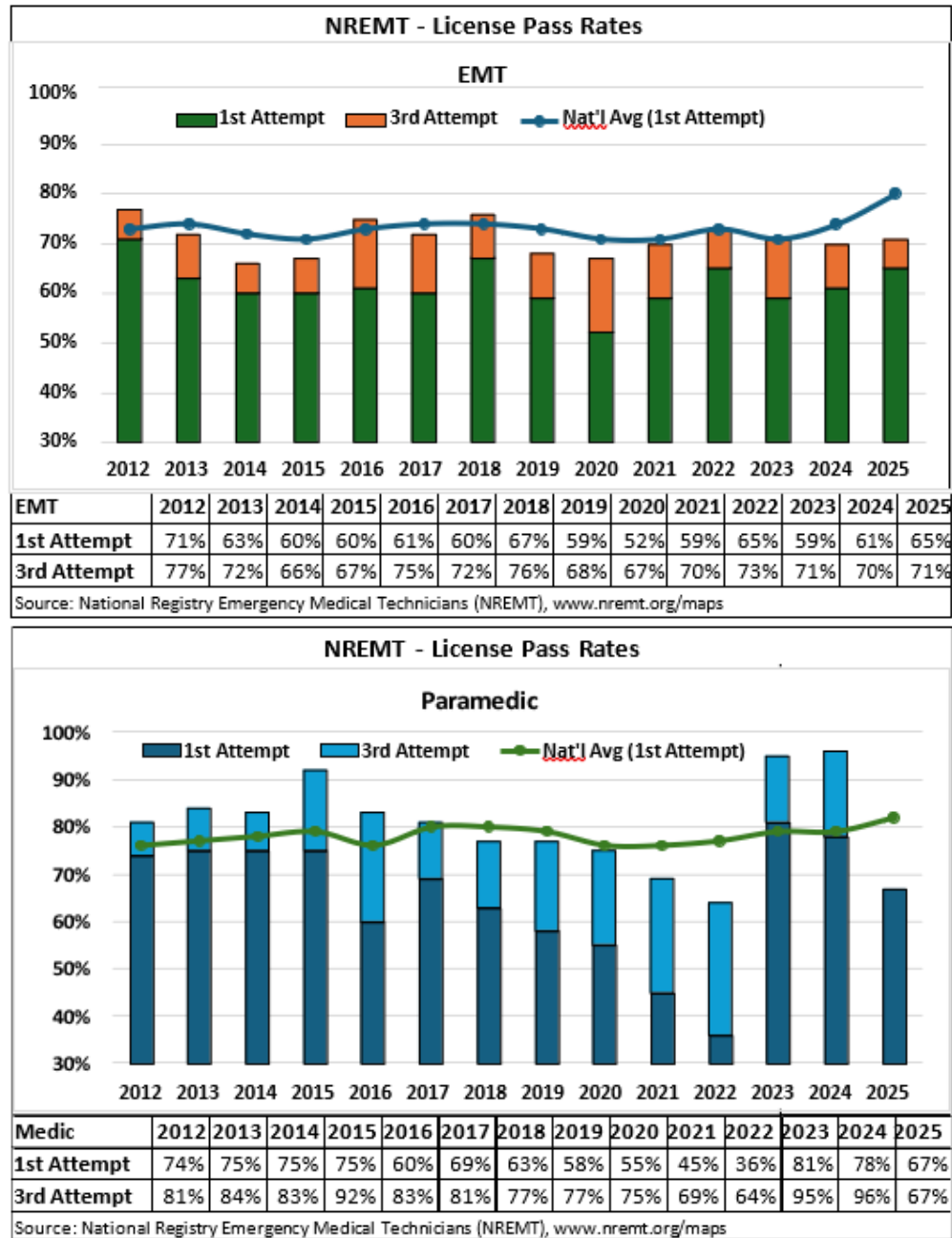


PERFORMANCE



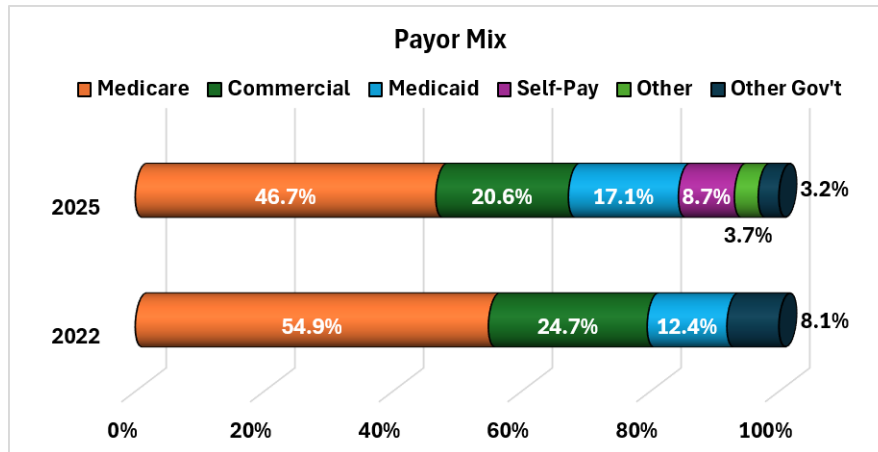


NREMT PASS RATES

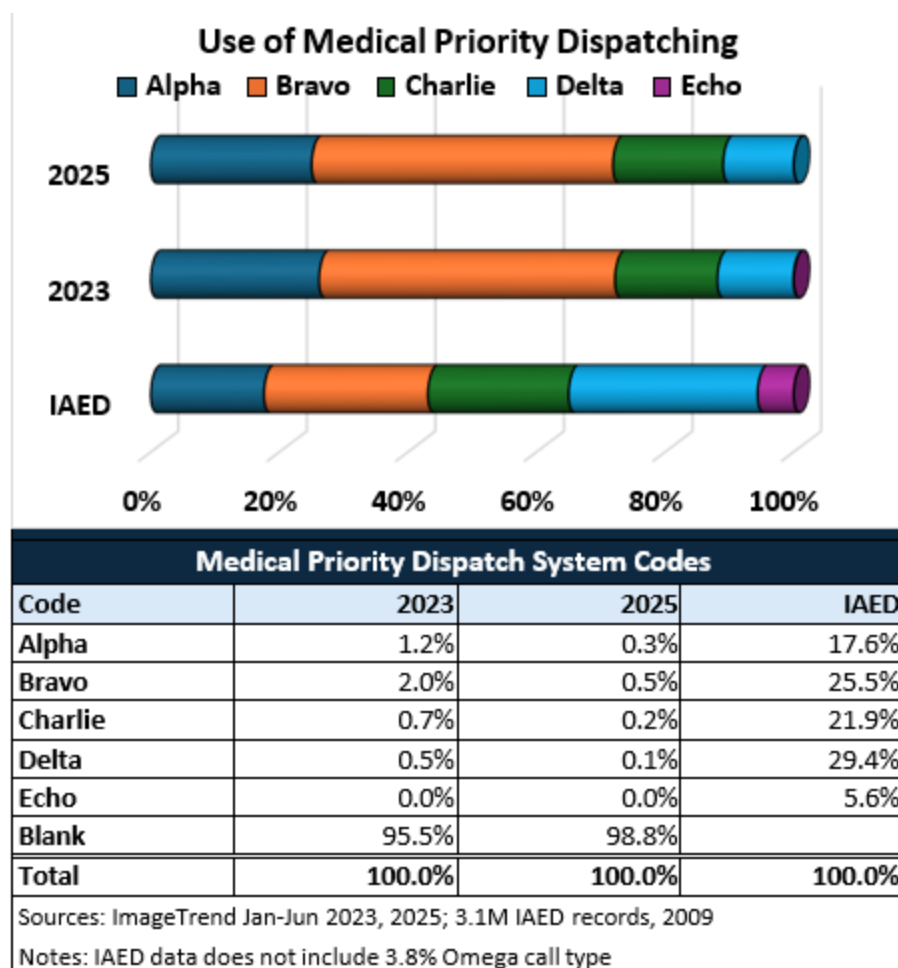




MISCELLANEOUS



Use of Lights & Siren		
Year	2023	2025
Response	82.8%	80.8%
Transport	56.0%	59.2%
Source: ImageTrend, Jan-Jun 2023, 2025		





II. AMBULANCE PROVIDER VIABILITY STATUS STUDY

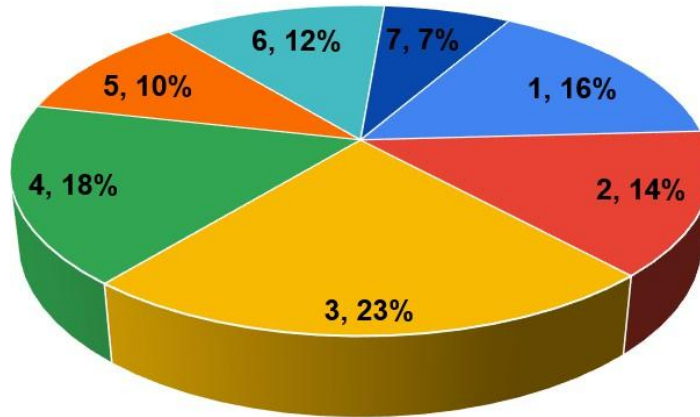
Item	Volunteer	Paid
Financial Analysis		
Cost/Staffed 24/7 Unit	\$81,281	\$658,511
Cost per Response	\$801	\$1,021
Patient Revenue/Total Revenue	64%	58%
Revenue/Transport	\$646	\$656
Breakeven Transports/Year/Unit	127	1,110
Survey Answer to Transports/Year to Breakeven/Unit	117	1,463
Volunteer Staffing (Avg/High/Low)		
Volunteer Roster Size	15.7/40/6	
Volunteers with 15% or Higher Participation	7.5/24/0	
Survey Answer to Volunteers Needed to Staff One Unit	16.7/40/3	



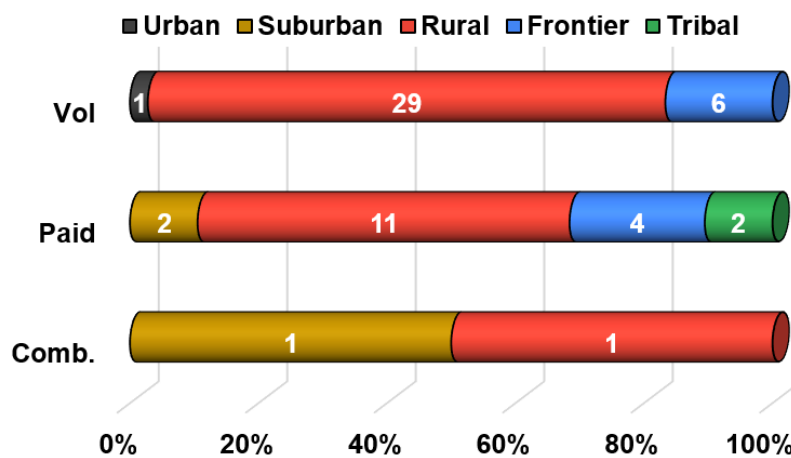
DEMOGRAPHICS

Survey Charts

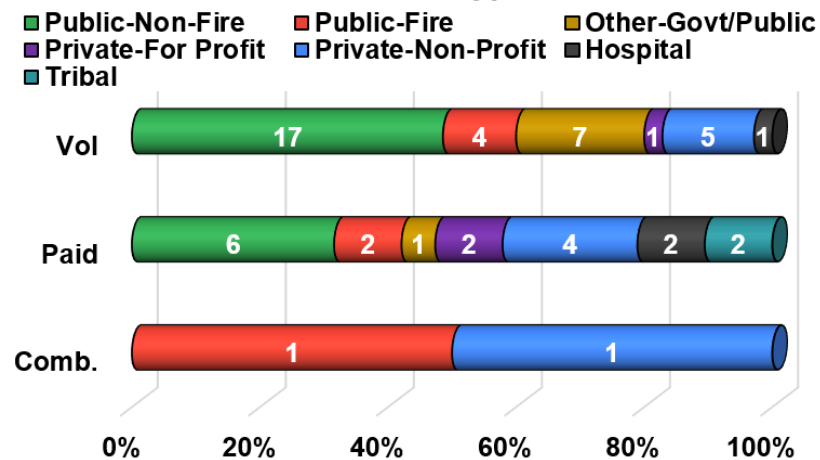
Region



Primary Service Area



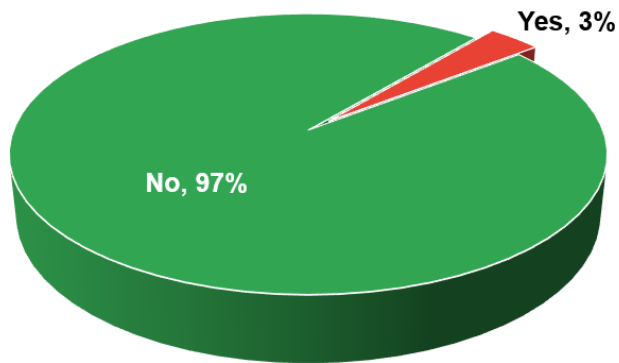
Provider Type



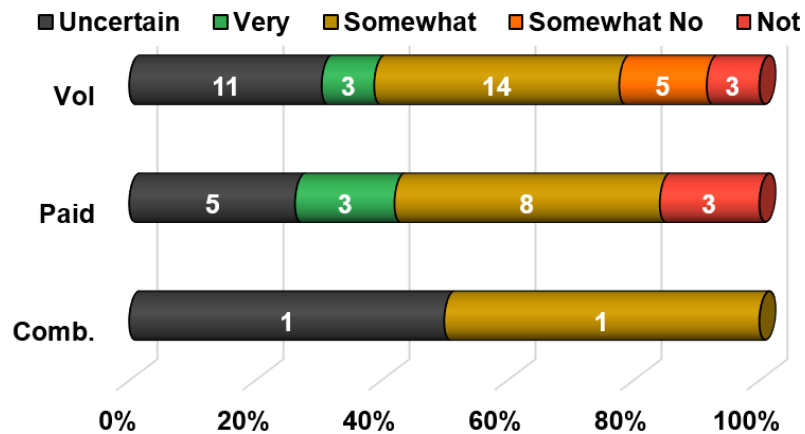


SUSTAINABILITY

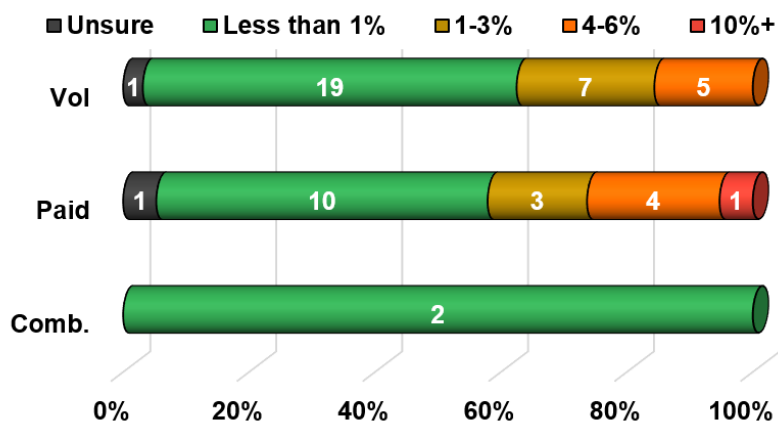
Service Interruption



5-Year Sustainability

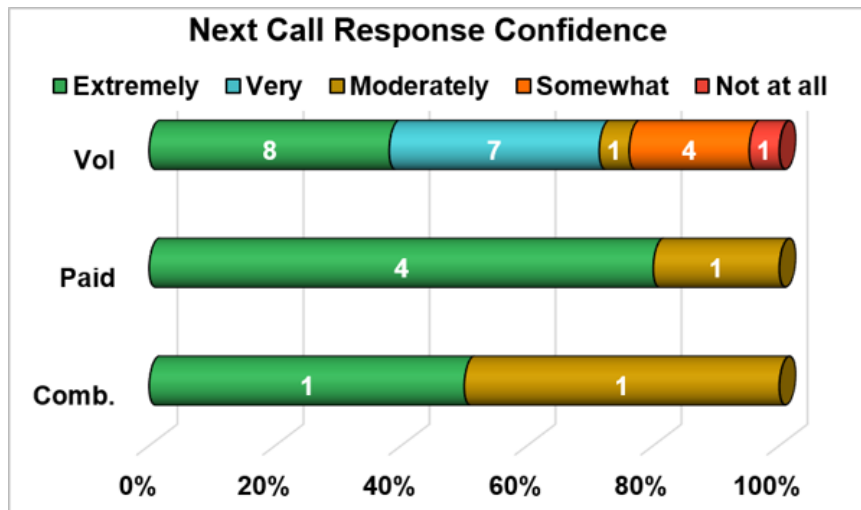


Mutual Aid Use



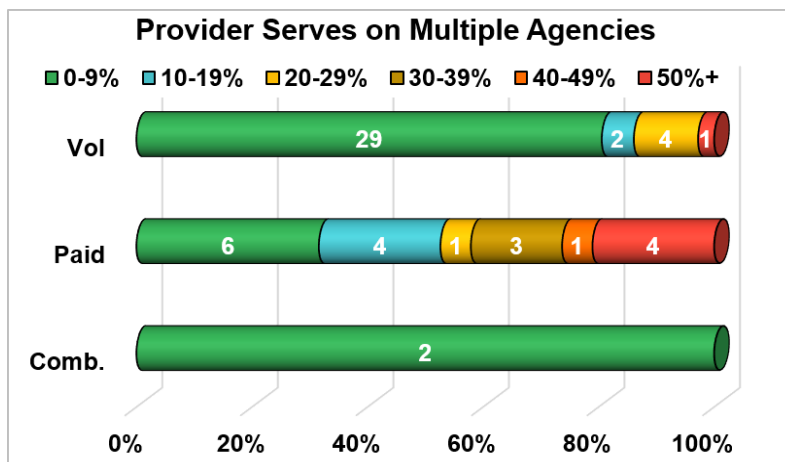
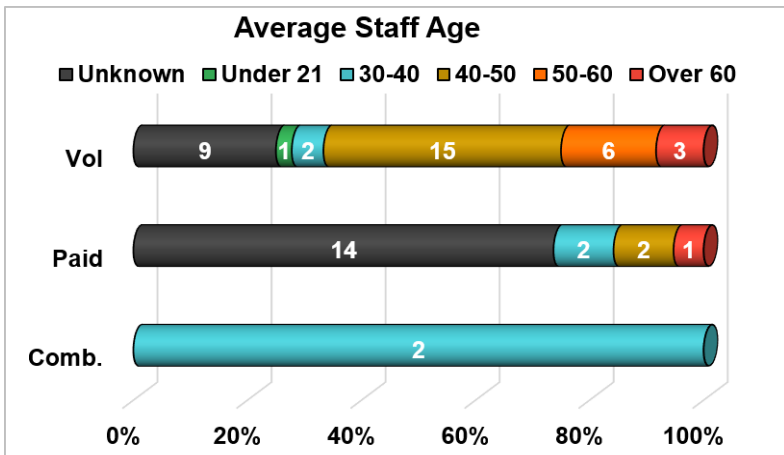
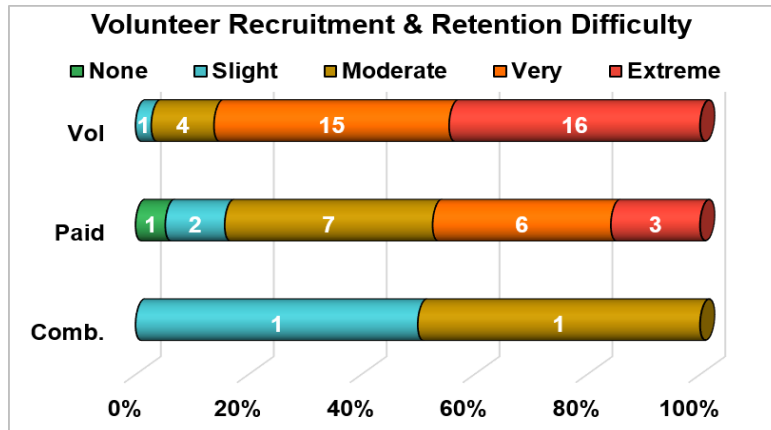


SUSTAINABILITY



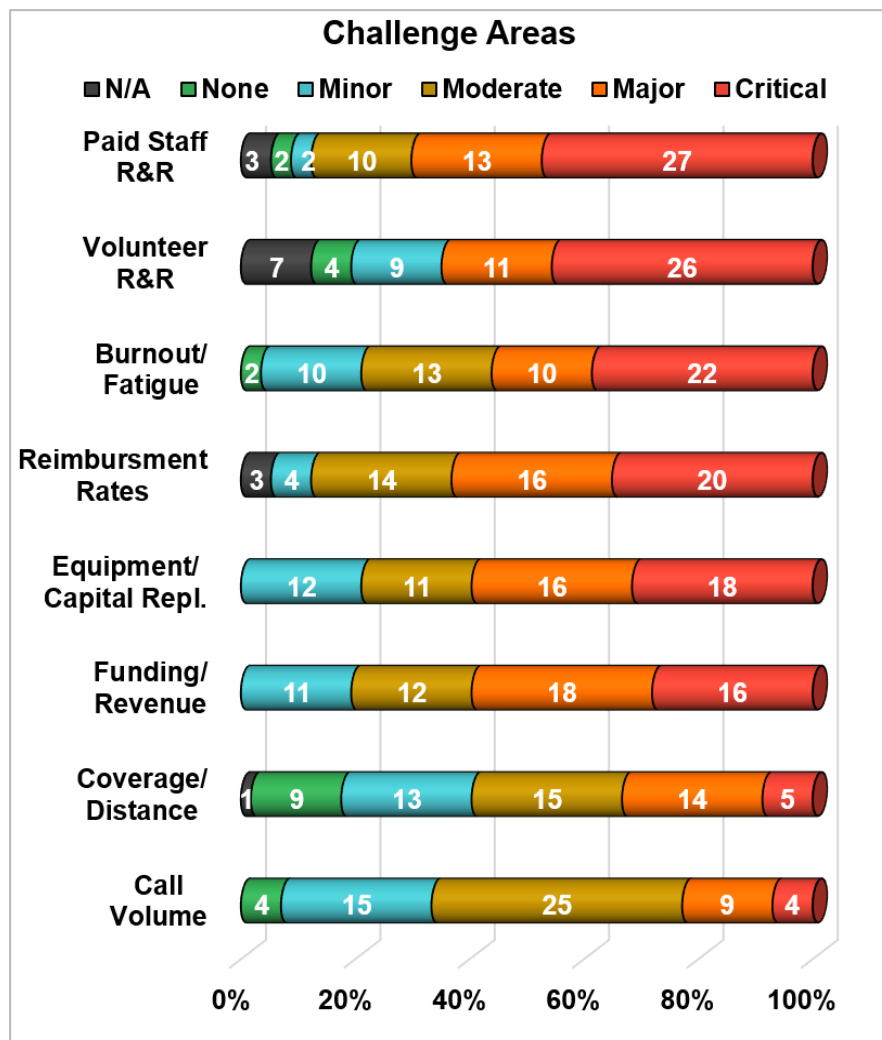
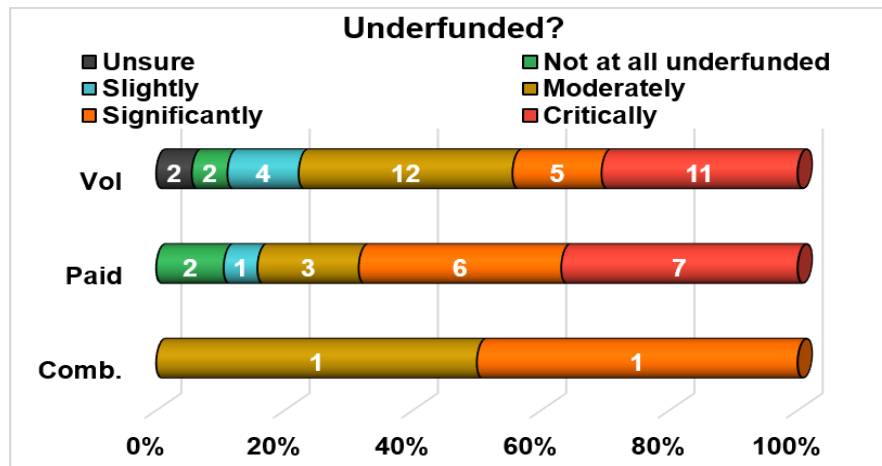


STAFFING



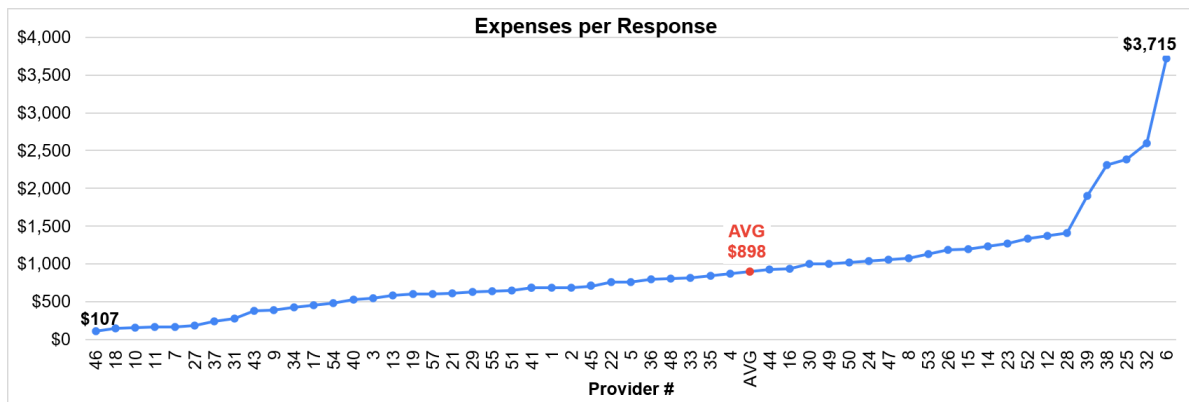
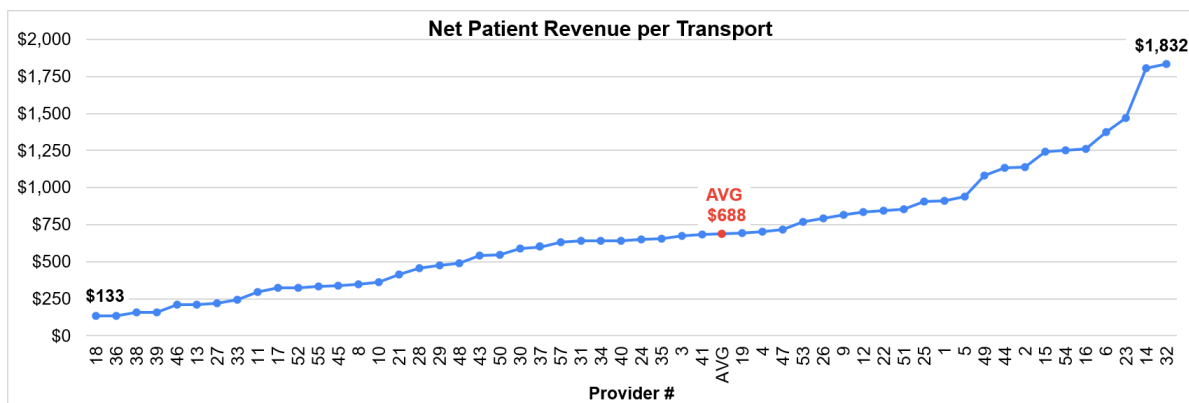
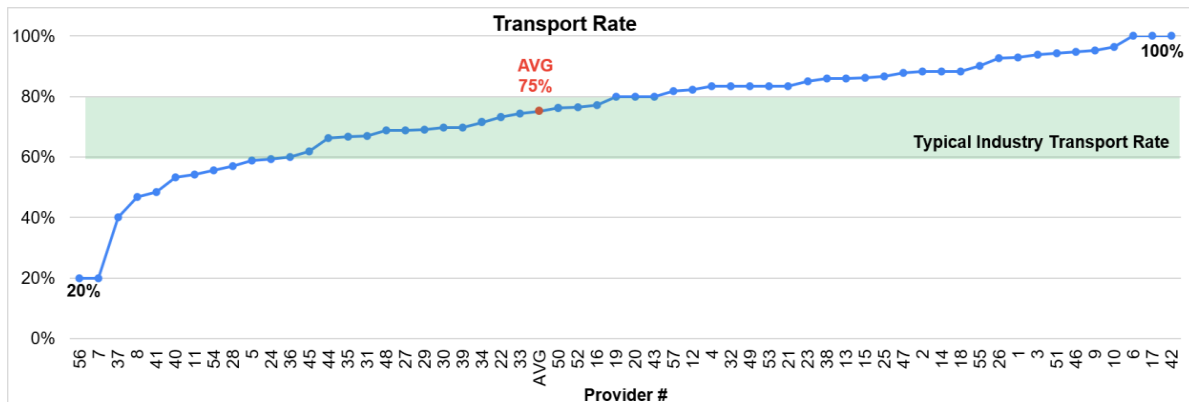


CHALLENGES





PER TRIP





Paid Ambulance Providers														
Provider #	Revenue	Pt. Rev.	Expenses	Cost/Response	Pt Rev/Tx	Responses	Transports	24/7 Units	PT Units	Total Units	Sustain Tx/Year	Patient Revenue	Deficit	
8	\$866,667	15%	\$860,000	\$1,075	347	800	375	1	1.5	1.8	1,954	\$130,000	\$(730,000)	-85%
11	\$1,700,000	92%	\$1,650,000	\$168	294	9,800	5,300	3	1	3.5		\$1,557,200	\$(92,800)	-6%
12	\$500,000	50%	\$500,000	\$1,370	833	365	300	1	0	1.0	300	\$250,000	\$(250,000)	-50%
13	\$341,865	50%	\$545,100	\$582	212	936	805	1	0	1.0	1,500	\$170,932	\$(374,168)	-69%
14	\$2,850,000	95%	\$2,100,000	\$1,235	1,805	1,700	1,500	2	0	2.0	600	\$2,707,500	\$607,500	29%
16	\$1,973,236	80%	\$1,523,966	\$939	1,263	1,623	1,250	2	1	2.5	1,600	\$1,578,589	\$54,623	4%
19	\$1,200,000	70%	\$1,200,000	\$600	692	2,000	1,600	2	0	2.0	1,500	\$840,000	\$(360,000)	-30%
22	\$1,000,000	80%	\$985,000	\$758	842	1,300	950	1	1	1.5	1,000	\$800,000	\$(185,000)	-19%
23	\$3,540,000	97%	\$3,500,000	\$1,273	1,471	2,750	2,335	2	3	3.5	2,600	\$3,433,800	\$(66,200)	-2%
25	\$767,052	30%	\$698,340	\$2,383	906	293	254	1	0	1.0	450	\$230,116	\$(468,225)	-67%
28	\$4,589,003	18%	\$4,503,157	\$1,408	454	3,198	1,819	2	0	2.0	2,700	\$826,021	\$(3,677,136)	-82%
29	\$1,084,412	72%	\$1,499,027	\$630	476	2,378	1,641	1	1	1.5	2,800	\$780,777	\$(718,250)	-48%
34	\$400,000	80%	\$300,000	\$429	640	700	500	1	0	1.0	1,500	\$320,000	\$20,000	7%
38	\$64,393	24%	\$261,176	\$2,311	159	113	97	1	0	1.0		\$15,454	\$(245,722)	-94%
41	\$450,000	70%	\$650,000	\$684	685	950	460	1	0	1.0	450	\$315,000	\$(335,000)	-52%
45	\$191,751	54	\$350,173	\$709	338	494	306	1	0	1.0	550	\$103,546	\$(246,627)	-70%
48	\$1,715,427	41	\$1,677,345	\$803	490	2,089	1,435	4	0	4.0	3,000	\$703,325	\$(974,020)	-58%
50	\$419,960	64	\$657,543	\$1,019	547	645	491	1	0	1.0	900	\$268,774	\$(388,769)	-59%
Average	\$1,314,098	58%	\$1,303,379	\$1,021	\$656	1,721	1,133	1.5	0.6	1.8	1,463	Fiscal Breakeven		
High	\$4,589,003	97%	\$4,503,157	\$2,383	\$1,805	9,800	5,300	4	3	4.0	3,000	Transports	Transports/Unit	
Low	\$64,393	15%	\$261,176	\$168	\$0	113	97	1	-	1.0	300	1,988	1,110	

Notes:

- Revenue and Expenses are from 2025
- PT units = part-time or peak units; assumed operating 12 hours per day (i.e., 0.5 of a 24/7 unit)
- Sustain Tx/Year = What the provider believes it needs to be sustainable
- Fiscal Breakeven = The number of transports needed to be fully sustainable using 100% patient revenue



Volunteer Ambulance Providers

Provider #	Revenue	Pt. Rev.	Expenses	Cost/Response	Pt Rev/Tx	Responses	Transports	24/7 Units	PT Units	Total Units	Sustain Tx/Year	Patient Revenue	Deficit	
1	\$30,800	77%	\$19,311	\$690	912	28	26	1	1	1.5	0	\$23,716	\$4,405	23%
2	\$100,484	85%	\$116,916	\$690	1,139	85	75	1	0	1	80	\$85,411	\$(31,505)	-27%
3	\$80,000	90%	\$62,000	\$544	673	114	107	1	0	1	100	\$72,000	\$10,000	16%
4	\$156,841	67%	\$156,704	\$871	701	180	150	1	0	1	0	\$105,083	\$(51,621)	-33%
5	\$20,000	47%	\$13,000	\$765	940	17	10	1	0	1	30	\$9,400	\$(3,600)	-28%
6	\$123,514	40%	\$133,748	\$3,715	1,372	36	36	1	0	1	40	\$49,405	\$(84,343)	-63%
7	\$5,000	0%	\$6,000	\$171	-	35	7	1	0	1	0	\$0	\$(6,000)	-100%
9	\$100,386	95%	\$48,248	\$392	815	123	117	1	0	1	50	\$95,367	\$47,119	98%
10	\$50,000	97%	\$22,000	\$157	359	140	135	1	2	2	0	\$48,500	\$26,500	120%
15	\$249,790	92%	\$256,855	\$1,195	1,242	215	185	2	2	3	150	\$229,807	\$(27,048)	-11%
17	\$18,500	70%	\$18,000	\$450	324	40	40	1	0	1	10	\$12,950	\$(5,050)	-28%
18	\$17,778	45%	\$10,000	\$147	133	68	60	1	0	1	60	\$8,000	\$(2,000)	-20%
21	\$331,650	60%	\$354,225	\$616	415	575	480	1	0	1		\$198,990	\$(155,235)	-44%
24	\$169,598	23%	\$104,744	\$1,037	650	101	60	2	0	2	135	\$39,008	\$(65,736)	-63%
26	\$117,409	60%	\$113,901	\$1,186	792	96	89	1	1	1.5	80	\$70,446	\$(43,455)	-38%
27	\$20,000	60%	\$15,000	\$188	218	80	55	1	0	1		\$12,000	\$(3,000)	-20%
31	\$116,413	90%	\$68,478	\$280	639	245	164	1	0	1	164	\$104,772	\$36,294	53%
32	\$196,232	70%	\$234,004	\$2,600	1,832	90	75	2	0	2		\$137,363	\$(96,641)	-41%
33	\$600,000	30%	\$820,000	\$820	242	1,000	743	2	0	2	700	\$180,000	\$(640,000)	-78%
35	\$20,000	85%	\$33,000	\$846	654	39	26	1	0	1	25	\$17,000	\$(16,000)	-48%
36	\$100,000	10%	\$100,000	\$800	133	125	75	2	2	3	50	\$10,000	\$(90,000)	-90%
37	\$12,000	50%	\$6,000	\$240	600	25	10	1	0	1	30	\$6,000	\$-	0%
40	\$51,705	62%	\$49,522	\$527	641	94	50	1	1	1.5	100	\$32,057	\$(17,465)	-35%
43	\$12,000	90%	\$9,500	\$380	540	25	20	1	0	1	20	\$10,800	\$1,300	14%
44	\$100,000	60%	\$74,000	\$925	1,132	80	53	1	0	1	85	\$60,000	\$(14,000)	-19%
46	\$17,700	85%	\$8,000	\$107	212	75	71	1	1	1.5	85	\$15,045	\$7,045	88%
47	\$130,022	80%	\$174,116	\$1,055	717	165	145	1	0	1	130	\$104,018	\$(70,098)	-40%
49	\$150,000	90%	\$150,000	\$1,000	1,080	150	125	1	0	1	250	\$135,000	\$(15,000)	-10%
51	\$125,000	100%	\$100,000	\$645	856	155	146	2	2	3	200	\$125,000	\$25,000	25%
52	\$76,474	43%	\$176,353	\$1,336	326	132	101	1	0	1	293	\$32,884	\$(143,469)	-81%
53	\$350,000	80%	\$497,000	\$1,135	767	438	365	1	1	1.5	450	\$280,000	\$(217,000)	-44%
54	\$71,042	88%	\$43,278	\$481	1,250	90	50	1	2	2	60	\$62,517	\$19,239	44%



Volunteer Ambulance Providers														
Provider #	Revenue	Pt. Rev.	Expenses	Cost/Response	Pt Rev/Tx	Responses	Transports	24/7 Units	PT Units	Total Units	Sustain Tx/Year	Patient Revenue	Deficit	
55	\$30,000	50%	\$32,000	\$640	333	50	45	2	2	3	50	\$15,000	\$(17,000)	-53%
57	\$200,000	85%	\$200,000	\$606	630	330	270	2	2	3	200	\$170,000	\$(30,000)	-15%
Average	\$116,186	64%	\$124,291	\$801	\$646	150	120	1.2	0.6	1.5	117	Fiscal Breakeven		
High	\$600,000	100%	\$820,000	\$3,715	\$1,832	1,000	743	2	2	3	700	Transports	Transports/Unit	
Low	\$5,000	-	\$6,000	\$107	\$0	17	7	1	-	1	-	192	127	

Notes:

- Revenue and Expenses are from 2025
- PT units = part-time or peak units; assumed operating 12 hours per day (i.e., 0.5 of a 24/7 unit)
- Sustain Tx/Year = What the provider believes it needs to be sustainable
- Fiscal Breakeven = The number of transports needed to be fully sustainable using 100% patient revenue



Paid Ambulance Providers – Cost per Staffed 24/7 Unit									
Paid Provider	Revenue	Expenses	Cost/ Response	Responses	Transports	Tx Rate	24/7 Units	PT Units	Cost/Staffed 24/7 Unit
8	\$866,667	\$860,000	\$1,075	800	375	47%	1	1.5	\$491,429
11	\$1,700,000	\$1,650,000	\$168	9,800	5,300	54%	3	1	\$471,429
12	\$500,000	\$500,000	\$1,370	365	300	82%	1	0	\$500,000
13	\$341,865	\$545,100	\$582	936	805	86%	1	0	\$545,100
14	\$2,850,000	\$2,100,000	\$1,235	1,700	1,500	88%	2	0	\$1,050,000
16	\$1,973,236	\$1,523,966	\$939	1,623	1,250	77%	2	1	\$609,586
19	\$1,200,000	\$1,200,000	\$600	2,000	1,600	80%	2	0	\$600,000
22	\$1,000,000	\$985,000	\$758	1,300	950	73%	1	1	\$656,667
23	\$3,540,000	\$3,500,000	\$1,273	2,750	2,335	85%	2	3	\$1,000,000
25	\$767,052	\$698,340	\$2,383	293	254	87%	1	0	\$698,340
28	\$4,589,003	\$4,503,157	\$1,408	3,198	1,819	57%	2	0	\$2,251,578
29	\$1,084,412	\$1,499,027	\$630	2,378	1,641	69%	1	1	\$999,351
34	\$400,000	\$300,000	\$429	700	500	71%	1	0	\$300,000
38	\$64,393	\$261,176	\$2,311	113	97	86%	1	0	\$261,176
41	\$450,000	\$650,000	\$684	950	460	48%	1	0	\$650,000
45	\$191,751	\$350,173	\$709	494	306	62%	1	0	\$350,173
48	\$1,715,427	\$1,677,345	\$803	2,089	1,435	69%	4	0	\$419,336
50	\$419,960	\$657,543	\$1,019	645	491	76%	1	0	\$657,543
56				565	112	20%	1	2	\$0
Average	\$1,314,098	\$1,303,379	\$1,021	1,721	1,133	69%			\$658,511
High	\$4,589,003	\$4,503,157	\$2,383	9,800	5,300	88%			\$2,251,578
Low	\$64,393	\$261,176	\$168	113	97	20%			\$0

Notes:

- Revenue and Expenses are from 2025
- PT units = part-time or peak units; assumed operating 12 hours per day (i.e., 0.5 of a 24/7 unit)



Volunteer Ambulance Providers – Cost per Staffed 24/7 Unit									
Provider #	Revenue	Expenses	Cost/ Response	Responses	Transports	Tx Rate	24/7 Units	PT Units	Cost/ Staffed 24/7 Unit
1	\$30,800	\$19,311	\$690	28	26	93%	1	1	\$12,874
2	\$100,484	\$116,916	\$690	85	75	88%	1	0	\$116,916
3	\$80,000	\$62,000	\$544	114	107	94%	1	0	\$62,000
4	\$156,841	\$156,704	\$871	180	150	83%	1	0	\$156,704
5	\$20,000	\$13,000	\$765	17	10	59%	1	0	\$13,000
6	\$123,514	\$133,748	\$3,715	36	36	100%	1	0	\$133,748
7	\$5,000	\$6,000	\$171	35	7	20%	1	0	\$6,000
9	\$100,386	\$48,248	\$392	123	117	95%	1	0	\$48,248
10	\$50,000	\$22,000	\$157	140	135	96%	1	2	\$11,000
15	\$249,790	\$256,855	\$1,195	215	185	86%	2	2	\$85,618
17	\$18,500	\$18,000	\$450	40	40	100%	1	0	\$18,000
18	\$17,778	\$10,000	\$147	68	60	88%	1	0	\$10,000
21	\$331,650	\$354,225	\$616	575	480	83%	1	0	\$354,225
24	\$169,598	\$104,744	\$1,037	101	60	59%	2	0	\$52,372
26	\$117,409	\$113,901	\$1,186	96	89	93%	1	1	\$75,934
27	\$20,000	\$15,000	\$188	80	55	69%	1	0	\$15,000
31	\$116,413	\$68,478	\$280	245	164	67%	1	0	\$68,478
32	\$196,232	\$234,004	\$2,600	90	75	83%	2	0	\$117,002
33	\$600,000	\$820,000	\$820	1,000	743	74%	2	0	\$410,000
35	\$20,000	\$33,000	\$846	39	26	67%	1	0	\$33,000
36	\$100,000	\$100,000	\$800	125	75	60%	2	2	\$33,333
37	\$12,000	\$6,000	\$240	25	10	40%	1	0	\$6,000
40	\$51,705	\$49,522	\$527	94	50	53%	1	1	\$33,015
43	\$12,000	\$9,500	\$380	25	20	80%	1	0	\$9,500
44	\$100,000	\$74,000	\$925	80	53	66%	1	0	\$74,000
46	\$17,700	\$8,000	\$107	75	71	95%	1	1	\$5,333
47	\$130,022	\$174,116	\$1,055	165	145	88%	1	0	\$174,116
49	\$150,000	\$150,000	\$1,000	150	125	83%	1	0	\$150,000
51	\$125,000	\$100,000	\$645	155	146	94%	2	2	\$33,333
52	\$76,474	\$176,353	\$1,336	132	101	77%	1	0	\$176,353
53	\$350,000	\$497,000	\$1,135	438	365	83%	1	1	\$331,333
54	\$71,042	\$43,278	\$481	90	50	56%	1	2	\$21,639



Volunteer Ambulance Providers – Cost per Staffed 24/7 Unit									
Provider #	Revenue	Expenses	Cost/ Response	Responses	Transports	Tx Rate	24/7 Units	PT Units	Cost/ Staffed 24/7 Unit
55	\$30,000	\$32,000	\$640	50	45	90%	2	2	\$10,667
57	\$200,000	\$200,000	\$606	330	270	82%	2	2	\$66,667
Average	\$116,186	\$124,291	\$801	150	120	78%	1.2	0.6	\$86,055
High	\$600,000	\$820,000	\$3,715	1,000	743	100%	2	2.0	\$410,000
Low	\$5,000	\$6,000	\$107	17	7	20%	1	-	\$5,333

Notes:

- Revenue and Expenses are from 2025
- PT units = part-time or peak units; assumed operating 12 hours per day (i.e., 0.5 of a 24/7 unit)



Volunteer Participation									
Provider #	Roster Size	Active Members (i.e., >15%)	Members Needed for 24/7 Unit	24/7 Units	PT Units	Total Units	Active Members	% of Ideal Staffing	% of Ideal Staffing/Unit
3	6	4	10	1	0	1.0	67%	60%	60%
4	23	23	25	1	0	1.0	100%	92%	92%
5	17	5	25	1	0	1.0	29%	68%	68%
6	12	6	20	1	0	1.0	50%	60%	60%
9	14	5	10	1	0	1.0	36%	140%	140%
15	14	5	15	2	2	3.0	36%	93%	31%
17	7	5	14	1	0	1.0	71%	50%	50%
20	13	5	20	1	1	1.5	38%	65%	43%
21	40	15	6	1	0	1.0	38%	667%	667%
24	20	7	15	2	0	2.0	35%	133%	67%
26	7	6	3	1	1	1.5	86%	233%	156%
27	6	0	21	1	0	1.0	0%	29%	29%
31	25	7	12	1	0	1.0	28%	208%	208%
33	22	10	30	2	0	2.0	45%	73%	37%
35	10	8	8	1	0	1.0	80%	125%	125%
36	10	6	12	2	2	3.0	60%	83%	28%
37	13	10	15	1	0	1.0	77%	87%	87%
40	8	3	15	1	1	1.5	38%	53%	36%
43	11	7	15	1	0	1.0	64%	73%	73%
44	14	5	14	1	0	1.0	36%	100%	100%
46	11	3	13	1	1	1.5	27%	85%	56%
47	19	5	19	1	0	1.0	26%	100%	100%
49	8	6	20	1	0	1.0	75%	40%	40%
52	22	14	18	1	0	1.0	64%	122%	122%
53	24	24	36	1	1	1.5	100%	67%	44%
57	38	4	40	2	2	3.0	11%	95%	32%
Average	15.7	7.5	16.7			1.5	50%	115%	98%
High	40	24	40			3.0	100%	667%	667%
Low	6	0	0			1.0	0%	29%	28%

Notes:

- Active members are participating in 15% or more of the calls



Survey Notes:

- Sioux Falls Fire Rescue omitted as it only provides backup ambulance service (i.e., 2 transports in 2025)
- Providers with incomplete data for a particular section were omitted from that section
- Vol = Volunteer and Paid-on-Call (POC) with 90% or greater volunteer staff
- Comb. = Combination agencies with both volunteer/POC and paid staff
- Paid = Paid agencies with 50% or greater career staff



III. PROVIDER CHARGEMASTER REVIEW

Introduction

The South Dakota Department of Health requested an analysis of selected ambulance provider fee schedules and billing practices to determine whether current charges are appropriate, whether simplification would be beneficial, and how those charges compare with underlying service costs. This report focuses on three providers and uses the information made available by each organization to identify billing patterns and financial pressures for South Dakota emergency medical services (EMS) agencies.

The scope of work included the following tasks:

1. Discuss the review with the ambulance provider's leadership
2. Analyze existing fee schedules
3. Assess the approach to charges in comparison to costs
4. Determine if simplifying or reducing itemization would be beneficial
5. Ensure consistency with payer and regulatory requirements

Assessment Methodology

The review considered three providers selected for the study. The analysis relied on provider-supplied financial information, fee schedules, billing details, and interview outreach; however, the completeness and comparability of available data varied by provider.

Data Requested

- Current charge list
- 2025 income and expense
- 2025 payer mix
- Trip-level detail for 2025 including type of service, payer type, gross charges, net charges, net collections, trip date, invoice date, payment date

Interviews Conducted

- State EMS Agency Staff
- Provider #1 EMS Leadership
- Provider #2 Finance Director and Hospital Director
- Provider #3 Ambulance Leadership

Discussions and Findings

1. *Overview of participating ambulance providers*

Provider #1

This municipal organization staffs approximately 27 full-time firefighter-paramedics and two fully staffed fire stations serving 50,000 citizens in two counties. A public agency



that provides multiple public safety functions, some expenses are shared across service lines. The city supplied departmental income statements for 2025, allowing a reasonable representation of ambulance service costs. Billing details by primary payer and the current ambulance fee schedule were also provided. This is the largest of the three providers, receiving 3,751 EMS calls and running 2,057 transports in 2025. The city was also able to provide the most detailed and meaningful data for this study.

Provider #2

This county-operated provider is an advanced life support (ALS) ambulance service covering a rural area of approximately 1,800 square miles. It operates three ambulances with 24/7 coverage based at the county hospital, receives approximately 550 calls per year, and performed 443 transports in 2025. The provider submitted an annual income statement, ambulance fee schedule, and detailed payment data. Trip detail was provided in two separate files, which were cross-referenced to create data to support this study.

Provider #3

A community-based ambulance service, Provider #3 offers basic life support (BLS) emergency and non-emergency services in one city. Staffed with a combination of volunteer and paid responders, it answers 911 emergency calls in a rural environment. Management reported 170 transports in 2025.

2. Analysis of existing fee schedules

The fee schedules reviewed for the participating providers are summarized below.

AMBULANCE FEE SCHEDULES - SOUTH DAKOTA			
	Provider #1	Provider #2	Provider#3
ALS1 Emergency	\$ 1,350	\$ 1,054	n/a
ALS2 Emergency	\$ 1,550	\$ 1,554	n/a
ALS Non Emergency	\$ 1,350	\$ 1,054	n/a
BLS Emergency	\$ 1,000	\$ 930	950
BLS Non Emergency	\$ 1,000	\$ 859	n/a
SCT	\$ 1,550		n/a
Mileage	\$ 21	\$ 50	18
Call no Transport		\$ 145	n/a

Note: Provider #3 is only licensed to run BLS.



Average patient charge based on 2025 averages is calculated below.

AVERAGE PATIENT CHARGE (APC)					
	Average Base	Miles	Charge per mile	Mileage Charge	APC
Provider #1	\$ 1,250.00	20	\$ 21.00	\$ 415	\$ 1,665
Provider #2	\$ 1,050.00	18	\$ 50.00	\$ 875	\$ 1,925
Provider#3	\$ 950.00	36	\$ 18.00	\$ 648	\$ 1,598

Current rates are competitive among the participating providers, but they were not developed to achieve full cost recovery. As a result, these operations continue to depend on other revenue sources, including tax revenues, subsidies, grants, and other local or supplemental funding. The review verifies that the participating agencies rely on bundled pricing, with charges driven by transport base rate and mileage rather than extensive itemization.

3. Analysis of Charges Compared to Costs

Ambulance expenses are rising faster than transport-related revenue for many EMS agencies. This pressure is especially acute in public and rural systems, where readiness costs remain high even when transport volume is limited. Labor, benefits, equipment replacement, fleet maintenance, compliance requirements, and long-distance response coverage all contribute to cost growth. In these environments, transport billing revenue alone is often insufficient to support the full cost of service, creating ongoing reliance on taxes, subsidies, grants, volunteers, or supplemental reimbursement programs.

The data received from Provider #1 and Provider #2 illustrate this widening gap between ambulance revenue and operating cost (Provider #3 has not provided cost data).

2025 FINANCIAL METRICS							
Provider	Net Patient Income	Other Amb Income	Total Ambulance Income	Total Ambulance Expense	Amb Income less Amb Expense	Net Amb Revenue per Trip	Amb Cost per Trip
#1	\$ 1,431,474	\$ 111,509	\$ 1,542,983	\$ 3,976,366	\$ (2,544,892)	\$ 750	\$ 1,933
#2	\$ 388,970	\$ 27,204	\$ 416,174	\$ 758,668	\$ (342,494)	\$ 858	\$ 1,564
#3	\$ 154,088		\$ 154,088			\$ 906	

Factors driving the disparity between revenue and expenses include:

- Labor, the single largest cost driver, generally comprises 71% of total cost. Crew wage increases are largely tied to labor agreements and typically increase at a higher rate than inflation.
- Other costs, especially fuel, vehicle costs, and insurance, are increasing more than overall inflation.
- Contracted ambulance rate increases are usually tied to inflation or government pricing (i.e., Medicare and Medicaid) and only a small percentage of payers respond. Public



sensitivity to high ambulance pricing contributes to the reticence of EMS providers to increase charges. Medicaid rate increases in South Dakota have been nominal, averaging less than 2%. 2026 rates increased 1.25% over 2025.

- Medicare rate increases are tied to inflation and applied annually. Increases are typically around 2% to 3% and apply to 58% of volume per the data collected.

4. *Benefits of simplifying or reducing itemization*

Providing ambulance care in emergency and non-emergency settings requires specialized staffing, equipment, vehicles, supplies, and medications. In practice, EMS agencies typically use one of two charging models: a chargemaster approach, which itemizes a wide range of individual services and supplies, or bundled billing, which applies an inclusive rate for the transport level plus a separate mileage charge. For most rural and governmental EMS providers, bundled billing is the more practical model because it simplifies administration and aligns more closely with how major payers process claims.

Key advantages of bundled pricing include:

- Clearer for payers. Ambulance bills can be hard to interpret. Bundled charges are easier to read and reduce confusion caused by multiple unfamiliar line items.
- More consistent reimbursement. Commercial insurers are often more likely to process and pay standardized bundled transport charges than highly itemized claims, which can trigger selective denials.
- Simpler to manage. A bundled fee schedule is easier to maintain and update than a large chargemaster with many individual prices.

For South Dakota EMS agencies, bundled pricing is the preferred billing structure. It is generally easier for patients to understand, simpler for agencies to maintain, and more likely to support consistent reimbursement than highly itemized billing.

5. *Consistency with Payer and Regulatory Requirements*

This review evaluated each provider's billing and compliance practices based on the information available. Effective revenue cycle management (RCM) is essential to maximizing reimbursement, supporting operational sustainability, and maintaining compliance with payer and government requirements.

The primary areas of focus are organized into three levels:

Level 1 Monthly Monitoring

- Payer mix trends
- Type of service mix trends

- Average Patient Charges

Level 2 Benchmarking



- Net collection rate (NCR)
- Accounts receivable over 120 days
- Bad debt write-off rate
- Self-pay collection rate

Level 3 Compliance

- Coding reviews
- Days to first payment
- Denial rate
- Payment on first invoice rate

The provider data reflected 2025 activity captured as of June 2026. Based on the information available, selected key performance indicators (KPIs) were tested for this report. To preserve anonymity, three separate, provider-specific reports were prepared to support individual review and follow-up action.

PROVIDER #1: City-Run, Firefighter-Staffed, Serving Two Counties

This is the largest of the three providers, receiving 3,751 EMS calls and running 2,057 transports in 2025. The city was also able to provide the most detailed and meaningful data for this study. Billing is outsourced to the largest billing service provider serving EMS in the United States.

Level 1 Analysis

The following charts show key metrics that should be reviewed periodically (quarterly or semi-annually) and analyzed when variations between periods are significant. Data used should be at least 6 months old to allow for trailing payments and write-offs.

PAYER MIX		
Payer Type	Trips	Payer Mix
Medicare	594	28.9%
Medicare Advantage	606	29.5%
Medicaid SD	266	12.9%
Medicaid MCO	4	0.2%
Insurance	310	15.1%
Facility	44	2.1%
Other Govt Payors	38	1.8%
Patient	177	8.6%
Third Party Liability (TPL)	18	0.9%
Total	2,057	100.0%

Findings: Payer mix categories are clearly identified and are consistent with other large billing organizations. Medicare and Medicaid account for 71.5% of all trips, making this provider highly dependent on government fee schedules. Private insurance covers 15% of all trips.

Level 2 Benchmarking



Net Collection Rate (NCR): NCR measures what is received (actual revenue) compared to what is allowed by each payer (expected revenue). By comparing collections to gross revenue less contractual allowances, a clear picture is drawn on the effectiveness of operational and billing practices. A decline in net collection rate should be promptly researched to determine the cause. Key areas to review include payer mix shifts, type of service shifts, high outstanding accounts receivable, and increased denials.

Creating benchmarks for each payer and tracking changes regularly provide critical insights into potential problems.

NET COLLECTION RATE (NCR)	
Payer	Provider #1
Medicare & Medicare Advantage	87.6%
Medicaid & Medicaid MCO	89.0%
Insurance	73.6%
Facility	55.9%
Other Govt Payors	87.3%
Third Party Liability (TPL)	45.2%

Finding: These NCRs align with common industry benchmarks reflecting sound collection practices in these payer categories.

Self-Pay Collection Rate: This metric is the ratio between payments and gross collections and measures the effectiveness of follow-up, alternative payment options, and ease of making payments for uninsured patients.

SELF PAY COLLECTION RATE	
Provider 1	13.7%

Finding: A self-pay rate of 8% to 12% range is seen in most areas. This result reflects active collection activities. Also, use of alternative payment options positively impacted this metric.

Accounts Receivable Balances and Bad Debt Write-offs: Reviewing these two metrics together highlights several findings.

BALANCES OVER 120 DAYS	
Provider 1	5.1%

BAD DEBT WRITE OFF RATE	
Provider 1	19.2%



Finding: Provider #1 has high bad debt write-offs but low balances over 120 days, indicating that aged accounts receivable are resolved regularly and referred to collections promptly, which increases the likelihood of additional payments.

Level 3 Compliance

Coding review: This provider uses bundled billing, charging only a base rate and allowable mileage. During the interview, we reviewed the billing data with the provider and determined that base charges and mileage were billed correctly.

Other compliance metrics: The data collected did not include first invoice dates, payment dates, or denials. Generally, standard billing reporting does not include this level of detail. Trip-by-trip review or customized reports should be made available to review periodically to track these metrics.

PROVIDER #2: Rural County-Based ALS

As a small, rural ambulance service, provider #2 relies on the county hospital financial resources for ambulance billing.

Level 1 Analysis

The following charts show key metrics that should be reviewed periodically (quarterly or semi-annually) and analyzed when variations between periods are significant. Data used should be at least 6 months old to allow for trailing payments and write-offs.

PAYER MIX		
	Trips	Mix
Medicare	230	47.4%
Medicare Advantage	55	11.3%
Medicaid SD	45	9.3%
Medicaid MCO	1	0.2%
Insurance	50	10.3%
Facility	38	7.8%
Patient	36	7.4%
Transfer to Hospital	30	6.2%
Total	485	100.0%

Findings: Payer mix categories are clearly identified and are consistent with other large billing organizations. Medicare and Medicaid account for 68.2% of all trips, making this provider highly dependent on government fee schedules. Private insurance covers 10.3% of all trips.

Other represented 6.2% of volume and appears to reflect transports transferred into the hospital billing system. Ambulance reporting does not include billing detail for these trips, which limits visibility into ambulance-specific activity and makes direct comparison less reliable.



Level 2 Benchmarking

Net Collection Rate (NCR): NCR measures what is received (actual revenue) compared to what is allowed by each payer (expected revenue). By comparing collections to gross revenue less contractual allowances, a clear picture is drawn on the effectiveness of operational and billing practices. A decline in net collection rate should be promptly researched to determine the cause. Key areas to review include payer mix shifts, type of service shifts, high outstanding accounts receivable, and increased denials.

Creating benchmarks for each payer and tracking changes regularly provide critical insights into potential problems.

NET COLLECTION RATE (NCR)	
Payer	Provider #2
Medicare & Medicare Advantage	96.8%
Medicaid & Medicaid MCO	96.0%
Insurance	81.9%
Third Part Liability	86.5%

Finding: These NCRs align with common industry benchmarks reflecting sound collection practices in these payer categories.

Self-Pay Collection Rate: This metric is the ratio between payments and gross collections and measures the effectiveness of follow-up, alternative payment options, and ease of making payments for uninsured patients.

SELF PAY COLLECTION RATE	
Patient	2.7%

Findings: A self-pay collection rate of 8% to 12% is common nationally. This lower rate warrants investigation. A likely cause is the movement of patient payments to the hospital system.

Accounts Receivable Balances and Bad Debt Write-offs

BALANCES OVER 120 DAYS	
Balance	6.0%

BAD DEBT WRITE OFF RATE	
Bad Debt	7.5%

Finding: These metrics fall within the normal range, but the transfer of self-pay trips to the hospital billing system likely distorts these figures.

Level 3 Compliance

Coding review: This provider uses bundled billing, charging only a base rate and allowable mileage. An interview with the finance director, hospital management, and billing department provided a deeper dive into coding and compliance.



Findings: Coding of base rates and mileage is accurate. Review of Medicare billings validated compliance with Medicare-specific billing codes and billing of loaded miles.

Other compliance metrics: The data collected did not include first invoice dates, payment dates, or denials. Generally, standard billing reporting does not include this level of detail. Trip-by-trip review or customized reports should be available to review periodically to track these metrics.

PROVIDER #3: Rural BLS Provider

As the smallest ambulance service, provider #3 relies on the county hospital financial resources for ambulance billing.

Level 1 Analysis

The following charts show key metrics that should be reviewed periodically (quarterly or semi-annually) and analyzed when variations between periods are significant. Data used should be at least six months old to allow for trailing payments and write-offs.

PAYER MIX		
	Trips	Mix
Medicare	230	47.4%
Medicare Advantage	55	11.3%
Medicaid SD	45	9.3%
Medicaid MCO	1	0.2%
Insurance	50	10.3%
Facility	38	7.8%
Patient	36	7.4%
Transfer to Hospital	30	6.2%
Total	485	100.0%

Level 2 Benchmarking

Net Collection Rate (NCR): NCR measures what is received (actual revenue) compared to what is allowed by each payer (expected revenue). By comparing collections to gross revenue less contractual allowances, a clear picture is drawn on the effectiveness of operational and billing practices. A decline in net collection rate should be promptly researched to determine the cause. Key areas to review include payer mix shifts, type of service shifts, high outstanding accounts receivable, and increased denials.

NET COLLECTION RATE (NCR)	
	Provider#3
Medicare	88.8%
Medicaid SD	100.0%



NET COLLECTION RATE (NCR)	
	Provider#3
Insurance	61.3%
Motor Vehicle-Other	100.0%
Workers Compensation-Other	48.6%

Findings: Provider #3 does not separately capture Medicare Advantage and Medicaid MCO activity in the primary financial code field, and those accounts appear to be recorded as commercial insurance for reporting purposes, making meaningful NCR analysis difficult. Overall, NCRs are within the normal range. However, Medicare Advantage and Medicaid MCO need to be tracked separately to be thorough.

Creating benchmarks for each payer and tracking changes regularly provide critical insights into potential problems.

Self-Pay Collection Rate: This metric is the ratio between payments and gross collections and measures the effectiveness of follow-up, alternative payment options, and ease of making payments for uninsured patients.

SELF PAY COLLECTION RATE	
Patient	12.9%

Finding: A self-pay collection rate of 8% to 12% is common nationally.

Accounts Receivable Balances and Bad Debt Write-offs

BALANCES OVER 120 DAYS	
Balance	25.0%

BAD DEBT WRITE OFF RATE	
Bad Debt	2.0%

Finding: Provider #3 carries high-aged accounts receivable (25% of total accounts receivable) and has a very low bad debt write-off rate (2%), suggesting that old balances are stagnant and unlikely to generate additional cash. These aged accounts must be managed more actively, with old accounts sent to collections for resolution.



Level 3 Compliance

Coding review: This provider uses bundled billing, charging only a base rate and allowable mileage.

Finding: Coding of base rates and mileage is accurate.

Other compliance metrics: The data collected did not include first invoice dates, payment dates, or denials. Generally, standard billing reporting does not include this level of detail. Trip-by-trip review or customized reports should be made available periodically to track these metrics and identify billing delays, denial trends, and follow-up opportunities.

Billing and Compliance Findings

Billing and compliance inconsistencies limit comparability across providers. Provider #2 transferred 8% of transports to the hospital billing platform, eliminating ambulance-specific reporting on those accounts. Provider #3 reported accounts receivable over 120 days equal to 25% of total accounts receivable and does not separately capture Medicare Advantage and Medicaid MCO activity in the primary financial code field, making meaningful NCR analysis difficult. Provider #2 reporting also required multiple lookups from different files to approximate 2025 transports and revenue. Despite these limitations, Provider #2 submitted meaningful data and reporting that could serve as a useful model for South Dakota providers.



Appendix

The tables below provide comparison data for the three providers.

PAYER MIX			
	Provider #1	Provider #2	Provider#3
Medicare	28.9%	47.4%	51.3%
Medicare Advantage	29.5%	11.3%	
Medicaid SD	12.9%	9.3%	4.5%
Medicaid MCO	0.2%	0.2%	
Insurance	15.1%	10.3%	33.5%
Facility	2.1%	7.8%	
Other Govt Payors	1.8%		
Patient	8.6%	7.4%	7.4%
Other	0.9%	6.2%	3.3%
Total	100.0%	100.0%	100.0%

Trip Summary			
Payer	Provider #1	Provider #2	Provider#3
Medicare	594	230	138
Medicare Advantage	606	55	-
Medicaid SD	266	45	12
Medicaid MCO	4	1	-
Insurance	310	50	90
Facility	44	38	-
Other Govt Payers	38	-	-
Patient	177	36	20
Other	18	30	9
Total	2,057	485	269

NET COLLECTION RATE (NCR)			
Payer	Provider #1	Provider #2	Provider#3
Medicare & Medicare Advantage	87.6%	96.8%	88.8%
Medicaid & Medicaid MCO	89.0%	96.0%	100.0%
Insurance	73.6%	81.9%	61.3%
Facility	55.9%		
Other Govt Payers	87.3%		
Other		87%	
Motor Vehicle			100.0%
Workers Compensation			48.6%



NET COLLECTION RATE (NCR)			
Payer	Provider #1	Provider #2	Provider#3
TPL	45.2%		

SELF PAY COLLECTION RATE			
	Provider #1	Provider #2	Provider#3
Patient	13.7%	2.7%	12.9%

BAD DEBT WRITE OFF RATE			
	Provider #1	Provider #2	Provider#3
Bad Debt	19.2%	7.5%	2.0%

BALANCES OVER 120 DAYS			
	Provider #1	Provider #2	Provider#3
Balance	5.1%	6.0%	25.0%