EMERGENCY MEDICAL SERVICES DAY AT THE CAPITOL 2026

Briefing Booklet

BY THE EMS CHIEFS, MANAGERS AND DIRECTORS SECTION OF THE
EMERGENCY MEDICAL SERVICES ASSOCIATION OF COLORADO

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emsac@emsac.org www.emsac.org

Legislative Executive Summary

HB26-1069 — Modernizing Emergency Medical Services in Colorado

The Ask:

Please support HB26-1069, the Availability of Emergency Medical Services Act, which modernizes Colorado's EMS system to improve access to care, strengthen public safety, and reduce unnecessary healthcare spending.

1. How HB26-1069 Updates Colorado Law and Strengthens EMS Availability

Emergency medical services (EMS) are a foundational public safety function and often the first—and in many rural and frontier communities, the only—point of medical care available during a crisis. EMS clinicians respond 24/7 to medical emergencies, behavioral health crises, public health incidents, and disasters, delivering time-critical care in challenging environments.

Colorado law and Medicaid policy, however, have not kept pace with how emergency care is delivered today. Existing statutes largely define emergency services around transport to a hospital, even when patients can be safely treated on scene or connected to appropriate non-hospital care. This outdated framework contributes to unnecessary emergency department (ED) utilization, longer ambulance turnaround times, and reduced EMS availability—particularly in rural and mountain communities.

HB26-1069 modernizes Colorado law by:

- Updating the statutory definition of emergency services to include treatment on scene, transport to appropriate alternative destinations, and telemedicine evaluation—not just hospital transport.
- Clarifying that EMS and Community Integrated Healthcare Service agencies are authorized participants in the emergency care continuum.
- Recognizing modern co-response models, including behavioral health professionals responding alongside public safety.
- Requiring Medicaid and state-regulated health plans to reimburse EMS for appropriate care, whether that care results in transport or is safely resolved on scene.

By aligning statute and payment policy with real-world emergency response, HB26-1069 improves system flexibility, preserves ambulance availability, and strengthens public safety statewide—without expanding scope of practice or creating new mandates.

2. Treatment-in-Place (TIP) and Mobile Integrated Health (MIH)

Treatment-in-Place (TIP) allows licensed EMS clinicians, under physician medical direction, to assess, treat, and safely resolve low-acuity emergencies on scene when ED transport is not clinically necessary. TIP is the foundation for Mobile Integrated Health (MIH)—known in Colorado as Community Integrated Healthcare Services—which expands EMS capacity to include behavioral health response, follow-up care, chronic disease management, and care coordination.

These services are:

- Delivered by licensed EMS clinicians
- Governed by approved protocols, training, and quality assurance
- Provided under physician medical direction

TIP and MIH do not replace hospitals or emergency departments; they preserve ED capacity for patients who truly need hospital-based care. Although these services are already being delivered across Colorado, they are often not reimbursed, creating a gap between clinical best practice and payment policy.

3. Aligning Medicaid Policy with Real Healthcare Costs

Colorado's Medicaid and insurance reimbursement structure generally pays EMS only when a patient is transported to a hospital, even when treatment on scene is clinically appropriate and medically supervised. This encourages higher-cost care and avoidable ED utilization.

Colorado's All-Payer Claims Database (APCD) shows:

- Medicaid low-acuity ED visits: approximately $1,200–$2,200
- Commercial ED visits: up to $6,000
- EMS TIP encounters: approximately $400–$700

Replacing avoidable ED visits with EMS treatment on scene can save $1,000–$5,000 per encounter, but current policy prevents reimbursement for this lower-cost care.

Colorado Medicaid example:

When EMS treats a patient on scene instead of transporting to the ED, Medicaid can save nearly $700 per encounter, while the patient receives faster, appropriate care and EMS resources return to service sooner. HB26-1069 enables this lower-cost pathway by authorizing reimbursement for treatment on scene and telemedicine-supported EMS care.

4. Proven Medicare Savings and Bipartisan Federal Alignment

Federal Medicare experience confirms these savings. A national analysis summarized by the National Association of EMTs (NAEMT) found:

- $537 average net savings per TIP encounter
- $1.2–$1.5 billion in estimated annual Medicare savings
- A 193% return on investment, as identified by the Congressional Budget Office during the COVID-19 public health emergency

Importantly, these savings occurred after Medicare paid EMS for treatment without transport.

HB26-1069 aligns Colorado with bipartisan federal efforts, including the EMS ROCS Act, the CARE Act, and the Community Paramedicine Act. Colorado U.S. Senator Michael Bennet, a cosponsor of the EMS ROCS Act, has emphasized that EMS providers should be compensated for appropriate care and that patients should not be forced into unnecessary hospital visits.

5. Real-World Impact for Patients and Communities

HB26-1069 does not change who calls 9-1-1 or who responds changes what care looks like when hospital transport is not necessary.

Example: Diabetic Emergency

Today, patients whose low blood sugar is corrected on scene are often transported anyway, resulting in hours of waiting, no additional treatment, and thousands of dollars in costs. Under HB26-1069, EMS can treat, confirm stability and follow-up, avoid unnecessary transport, and return to service—delivering safe care at a fraction of the cost.

Example: Suspected Urinary Tract Infection

Patients with symptoms suggesting a UTI are commonly transported to crowded EDs solely because EMS is only reimbursed for transport. Under HB26-1069, EMS can evaluate the patient, consult via telemedicine, initiate treatment, and arrange follow-up—reducing costs, ED congestion, and patient stress.

Bottom Line: Colorado is already paying for avoidable emergency department care by paying for higher cost ambulance transports. Colorado Medicaid data, APCD analysis, and federal Medicare evidence all point in the same direction: reimbursing EMS for Treatment-in-Place and Mobile Integrated Health delivers better care at lower cost, improves access—especially in rural communities—and strengthens public safety.

HB26-1069 modernizes Colorado's EMS system, aligns state and federal policy, and delivers the right care, at the right place, at the right cost.

Please support HB26-1069.

6. How to get answers to your questions:

- Katie Wolf-Perkins, Howes/Wolf: 720-365-3990
- Jeannie Vanderburg, Capstone Group: 303-249-8150
- William Mutch, Mutch Government Relations: 720-308-3497

Availability of Emergency Medical Services Act (HB26-1069)

By Representatives Feret and Stewart and Senator Mullica

The Ask:

Please support HB26-1069, which modernizes emergency medical and public safety response in Colorado, improves access to care, and reduces unnecessary healthcare costs.

What Does HB26-1069 Do?

HB26-1069 updates Colorado law to reflect how emergency response is delivered today by:

• Expanding the definition of "first responder" to include mental health professionals who respond to public safety emergencies, supporting modern co-response and behavioral health models.

• Clarifying that emergency services include treatment on scene, transport to appropriate alternative destinations, and telemedicine evaluation, not just transport to a hospital.

• Requiring reimbursement under Medicaid and state-administered health plans for:

  o Ambulance transport to a hospital or other appropriate destination;

  o Treatment in Place (TIP) when care is safely provided on scene; and

  o Telemedicine evaluation to prevent unnecessary emergency department use.

• Strengthening the statutory and payment framework for Community Integrated Health (CIH) and community paramedicine.

How Does HB26-1069 Lower Healthcare Costs?

• Avoids unnecessary emergency department visits, one of the most expensive entry points into the healthcare system.

• Prevents avoidable hospital admissions and readmissions through treatment on scene and coordinated follow-up care.

• Shifts care to lower-cost settings such as homes, primary care, and behavioral health services when appropriate.

• Improves system efficiency, allowing EMS units to return to service faster and reducing strain on hospitals and public safety resources.

• Uses existing infrastructure: TIP relies on EMS capacity already available statewide, while CIH builds on that foundation with targeted, lower-cost investments such as training, care coordination, and telemedicine.

Bottom Line: HB26-1069 is a cost-containment bill, a rural access bill, and a public safety bill. It modernizes emergency response, improves access to care, and reduces unnecessary healthcare spending.

Please support HB26-1069

What Is Mobile Integrated Health (MIH) and Treatment-in-Place (TIP) in EMS?

Treatment-in-Place (TIP) is a service in which EMS clinicians assess, treat, and resolve a low-acuity emergency on scene without transporting the patient to an ED. It is the foundation for the provision of Mobile Integrated Health services.

Mobile Integrated Health (MIH) is known as Community Integrated Health Care services in Colorado to provide expanded, community-based care under physician medical direction.

Both TIP and MIH improve access to care by treating patients where they are, lowering healthcare cost by avoiding unnecessary transport to hospital emergency department and avoiding hospital readmissions.

How MIH and TIP Are Used - Under MIH programs, EMS clinicians may:

- Respond to low-acuity medical or behavioral health emergencies
- Perform on-scene clinical assessment and treatment
- Consult with physician medical control
- Use telemedicine when appropriate
- Refer patients to primary care, behavioral health, or follow-up services

TIP and MIH are used only when the patient can be safely treated and referred, and when ED transport is not clinically necessary.

Clinical Oversight and Safety - MIH and TIP services are:

- Delivered by licensed EMS clinicians
- Operated by licensed EMS or Community Integrated Healthcare Service Agencies
- Provided under physician medical direction
- Governed by approved protocols, quality assurance, and training requirements

These services do not replace hospitals or emergency departments. They ensure that ED care is reserved for patients who truly need it.

Why Statutory Clarity Is Needed

Colorado's reimbursement system pays EMS only when patients are transported by the most expensive means, an ambulance, to the most expensive place, a hospital. Higher-cost care is financially encouraged over lower-cost, clinically appropriate care.

TIP and MIH services are already being delivered but not reimbursed.

Federal Leadership: Colorado Senator Michael Bennet

"*Emergency services are a critical lifeline for Coloradans in times of crisis. It is crucial that EMS professionals receive compensation for their lifesaving services. Coloradans should not be forced to make unnecessary trips to the hospital, and our emergency providers should not go without pay for the care they provided.*"

—US Senator Michael Bennet

In January 2026, US Senator Peter Welch reintroduced the Emergency Medical Services Reimbursement for On-scene Care and Support (EMS ROCS) Act, bipartisan legislation requiring Medicare reimbursement for medically necessary EMS care provided on scene, even when transport is not needed. Senator Bennet is a Senate cosponsor, affirming that Medicare should pay EMS for appropriate care—not force unnecessary emergency department (ED) transport.

What Is Treatment-in-Place (TIP)?

TIP allows licensed ambulance services to assess, treat, and safely resolve a patient's condition on scene—under medical direction—when ED transport is not clinically necessary. TIP improves patient care, reduces ED crowding, and preserves EMS availability. It is also the foundation for Community Integrated Healthcare Services.

Federal Policy Alignment

- EMS ROCS Act – Requires Medicare payment for TIP, correcting the long-standing "no transport, no payment" gap.
- CARE Act – Directs CMS to test TIP through a five-year CMMI pilot, further validating on-scene care under Medicare.
- Community Paramedicine Act – Establishes federal grants to support Mobile Integrated Health / Community Paramedicine (MIH/CP) programs, particularly in rural and underserved areas.

Why This Matters for Colorado

Together, these policies:

- Reduce unnecessary ED visits and healthcare costs
- Improve EMS response availability and system resilience
- Support rural and mountain communities with long transport distances
- Align Colorado law with bipartisan federal Medicare reform

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Treatment-in-Place Saves Colorado Medicaid Money!

Colorado's Medicaid reimbursement model is heavily influenced by the outdated Medicare fee schedule. Under this model, an EMS agency that responds to a 9-1-1 call and provides care to a patient on scene is only reimbursed if the ambulance also takes the patient to a hospital emergency department (ED). This incentivizes EMS agencies to transport patients who could be safely and more affordably cared for at home.

More than 20 states have updated their Medicaid strategies to reimburse EMS agencies that provide treatment in place (TIP), when medically appropriate. This strategy helps reduce over-utilization, preserve valuable medical resources for the highest acuity patients, improve EMS sustainability, and save healthcare costs.

States That Reimburse for TIP

According to CIVHC[1], individuals enrolled in Medicaid in Colorado "experience significantly higher rates of potentially preventable ED visits compared to people with other coverage types." We estimate Colorado will save nearly $700 every time it reimburses an EMS agency that provides treatment in place in lieu of transporting a patient to the hospital.• EMS ROCS Act – Requires Medicare payment for TIP, correcting the long-standing "no transport, no payment" gap.

Medicaid Cost Savings with TIP vs. Transport

Cost of TIP in Lieu of Transport	
Ambulance TIP Reimbursement	$392.77
Ambulance Mileage	N/A
Emergency Room Reimbursement	N/A
Total	**$392.77**

Cost of Transport to Hospital ED	
Ambulance Transport Reimbursement (A0427)	392.77
Ambulance Mileage (15)	97.65
Emergency Room Reimbursement	600.02
Total	**$1,090.42**

Bipartisan legislation to establish Medicare reimbursement for TIP services has been introduced in both the U.S. House (H.R.2538) and Senate (S.3145). A limited-scale TIP model utilized by Medicare during the pandemic was shown to procedure savings of more than $500 per patient encounter.

Sources:

1. Center for Improving Value in Health Care. https://civhc.org/2025/03/25/data-dive-potentially-preventable-ed-visits/

2 . Agency for Healthcare Research and Quality. https://hcup-us.ahrq.gov/reports/statbriefs/sb311-ED-visit-costs-2021.pdf

Aligning Colorado Medicaid with APCD Data and Proven Medicare Savings

The Problem

Colorado's current Medicaid and insurance policies reimburse EMS only when patients are transported to the emergency department (ED) even when treatment on scene is clinically appropriate and medically supervised.

This creates a system that Incentivizes the most expensive care setting, drives avoidable ED utilization, and fails to pay for EMS care that prevents ED visits.

What Colorado's APCD Shows

Colorado's All-Payer Claims Database documents thousands of low-acuity ED visits each year with current payments far exceeding possible EMS Treatment-in-Place (TIP) and Mobile Integrated Healthcare (MIH) payments:

- Medicaid ED visits: $1,200–$2,200
- Commercial ED visits: up to $6,000
- Proposed EMS TIP encounters: ~$400–$700

Replacing avoidable ED visits with EMS treatment on scene could save $1,000–$5,000 per encounter, but current policy prevents reimbursement for that lower-cost care.

Medicare Evidence Confirms the Savings

A national analysis summarized by the National Association of EMTs (NAEMT) reviewed Medicare experience under the CMS ET3 model and pandemic waivers:

- $537 average net savings per TIP encounter
- $1.2–$1.5 billion in annual Medicare savings
- 193% return on investment identified by the Congressional Budget Office during COVID

Savings occurred after Medicare paid EMS for treatment without transport.

The Solution

HB26-1069 aligns Colorado policy with both state APCD data and proven federal Medicare evidence by:

- Require reimbursement for EMS Treatment-in-Place and telemedicine evaluation and replacing high-cost ED care with lower-cost, appropriate EMS care.

Treatment in Place Real - World Example 1

Caring for a patient with a Urinary Tract Infection (UTI)

What Happens Today (Without HB26-1069)

Scenario: A 52-year-old woman calls 9-1-1 because he feels weak, feverish, and confused. She lives alone and is worried.

What EMS must do today:

- EMS evaluates and finds no life-threatening emergency
- Symptoms suggest a possible UTI
- But EMS is only paid if they transport her

Result:

- She is taken to a crowded ER, waits hours - often overnight, receives basic tests and antibiotics, and the ambulance and hospital bed are tied up

Outcome:

- Delayed care
- High-cost EMS Transport and ED - $6,000
- ED crowding
- Stressful for patient and family

What Happens With HB26-1069 - Same patient. Same EMS crew.

- EMS evaluates and stabilizes the patient, uses telemedicine to consult a clinician, A treatment plan is initiated, gets her prescription for an antibiotic, she is referred to her primary care or urgent follow-up, and transport is reserved only if needed.

Result:

- She gets care faster, avoids long ER wait, has lower out-of-pocket costs, and EMS remains available for emergencies

Outcome:

- Appropriate care
- Lower cost MIH/TIP - $400-$700
- Less ED congestion
- Better system efficiency

Why This Example Matters

This is a common, everyday 9-1-1 call. HB26-1069 doesn't change who calls for help — it changes what help looks like. Same patients. Same responders. Smarter care. Lower cost.

Treatment in Place Real - World Example 2

A Patient with a Diabetic Emergency

What Happens Today

Scenario:

A 58-year-old woman with diabetes calls 9-1-1 because she feels dizzy and confused. EMS finds her blood sugar is low.

What EMS does today:

- EMS treats her with glucose, her blood sugar returns to normal and she feels fine and she's often transported to the hospital because the ambulance is only paid for the transport.

Result:

- She is taken to the emergency room anyway
- She waits hours and receives no additional treatment
- The ambulance is unavailable for other calls
- The ambulance and ER bills thousands of dollars for a resolved issue

Outcome:

- Unnecessary transport
- High cost
- Patient frustration
- Wasted EMS and hospital resources

What Happens With Treatment in Place - Same patient. Same EMS crew.

- EMS treats her low blood sugar on scene, confirms she is stable and that she understands follow-up care, reviews medication, diet, and warning signs
- No hospital transport is required

Result:

- Patient stays safely at home
- No ER visit or bill
- EMS clears faster and returns to service
- Medicaid and Commercial pays hundreds, not thousands, of dollars

Outcome:

- Safe care
- Lower cost
- Faster EMS availability
- Better patient experience

Emergency Medical Services is an Essential Service

By Representatives Johnson and Lukens

Issue Summary

Emergency medical services (EMS) are a core public safety and healthcare function, providing immediate, lifesaving care in urban, rural, and frontier communities across Colorado. EMS professionals respond to medical emergencies, disasters, and public health crises, serving as a critical bridge between the community and the healthcare system.

Draft Bill 26-0043 formally designates emergency medical services—including ground and air ambulance services—as essential services under Colorado law, aligning EMS with other critical public services that support community resilience and emergency preparedness.

What Does an Essential Services Bill do?

- Designates EMS as an Essential Service – Formally recognizing ground and air ambulance services as essential to public health and safety statewide.
- Modernizes EMS Definitions – Updating statutory language to reflect current EMS operations and clarify emergency, non-emergency, and air ambulance services.
- Strengthens Emergency Funding Tools – Allowing use of the Governor's Disaster Emergency Fund and EMS Account transfers to support EMS operations during declared emergencies.
- Supports Local Flexibility – Permitting local governments to use existing revenues and EMS funds to sustain essential services without imposing new mandates.
- Clarifies Workforce Expectations – Confirming EMS professionals are not required to respond while off duty, while reinforcing expectations during active service and declared emergencies.

Why This Matters

- Public Safety: EMS is the frontline of emergency medical response.
- Rural Access: In many communities, EMS is the only immediate healthcare resource.
- Disaster Readiness: Dedicated funding tools improve emergency response capacity.
- Modern Healthcare Alignment: Recognizes EMS as part of the healthcare continuum.
- Local Control: Preserves flexibility without new statutory requirements.

EMS is the public health safety net; when all else fails we call 911. It is an essential service and it is time for the law to recognize that. This legislation modernizes Colorado law to support emergency response, healthcare access and community resilience while preserving local control.

Colorado Has an EMS Staffing Crisis

Overview

Colorado reports 23,084 licensed EMS providers, including 6,214 paramedics, responding to more than 818,000 emergency calls annually. At first glance, this suggests an adequate workforce. However, licensure counts alone do not indicate whether emergency medical care is reliably available across the state, particularly in rural and frontier communities.

What the Data Shows

Colorado's EMS system is already operating as a healthcare delivery system, not just a transport service:

- 818,569 EMS responses statewide with 606,583 patient transports
- 35,697 patients treated in place and 86,697 refusals of care or transport
- More than 15% of responses involved behavioral health emergencies

These non-transport encounters require significant clinical time and reduce unit availability, particularly in systems with limited staffing depth.

What the Data Does Not Show

The snapshot does not provide the information needed to assess system reliability or workforce stress, including:

- How many licensed providers are actively practicing
- Full-time vs part-time staffing levels
- Vacancy, turnover, or burnout rates
- Rural coverage gaps or service fragility
- Unit availability, mutual aid reliance, or delayed responses
- Whether Treatment-in-Place and community care are adequately reimbursed

As a result, licensure totals can mask real operational risk.

Where the Risk Likely Exists

The data suggests targeted system strain, not a universal provider shortage. The most likely pressure points are:

- Paramedic and ALS availability and distribution especially in rural areas
- Rural and frontier EMS coverage
- Behavioral-health-capable EMS response

These challenges are driven by expanded clinical responsibilities without aligned staffing models or sustainable funding.

Policy Implications

If Colorado expects EMS to deliver behavioral health response, Treatment-in-Place, and community-based care, policy must reflect modern EMS practice. That requires better workforce data, aligned reimbursement, and targeted support where the system is most fragile.

For Policymakers

Colorado does not face a statewide EMS provider collapse—but it does face a growing capacity and sustainability risk. Addressing that risk now will protect access to emergency care, particularly in rural communities, and prevent a quiet erosion of system reliability.

The Emergency Medical Services Association of Colorado at a Glance

1,675 Members statewide

77 EMS agency members (ambulance services, fire departments, etc.)

225 EMS entities represented (response, training, hospitals, etc.)

168 Communities/towns in which members reside

54 Counties in which members reside

Snapshot: Emergency Medical Services in Colorado in 2026

23,084 EMS practitioners statewide
- **6,447** Advanced life support clinicians (paramedics, EMT-intermediates)
- **16,118** Basic life support clinicians (EMTs and advanced EMTs)

213 Ground ambulance services

29 Air ambulance services (helicopter and fixed-wing)

228 EMS training and education programs (in-house, hospital, collegiate)

965, 174 Calls for an ambulance
- 818,569 Responses by EMS agencies, >15% due to behavioral health emergencies
- 606,583 Patients transported
- 86,697 Patients refused care or transport
- 35,697 Patients treated in place (TIP) after 911 response
- 6,672 Community Integrated Health Care Services (CIHCS) patients

115 of 242 Colorado ambulance services respond to less than 500 calls a year (48%)

47% Of licensed EMS agencies are fire department-based

53% Of licensed agencies are all other models (hospital, county, municipal, private, private non-profit)

EMS Funding Challenges: What Legislators Need to Know

Why this matters

Emergency Medical Services (EMS) provide 24/7 emergency medical responses in every Colorado community, regardless of geography or ability to pay. Unlike most healthcare providers, EMS must maintain constant readiness—staff, vehicles, equipment, training, and medical oversight—whether calls occur or not. EMS funding has not kept pace with these requirements, creating growing financial instability and placing access to care at risk, particularly in rural and frontier areas.

Core EMS Funding Challenges

1. EMS Is Funded as Transportation, Not Healthcare

Most EMS revenue is tied to patient transport rather than medical necessity or outcomes. Medicare, Medicaid, and private insurers often do not pay for medically appropriate care delivered on scene, referral to alternative care, or use of telemedicine. This misalignment limits cost-saving care models and drives unnecessary hospital utilization.

2. Reimbursement Does Not Cover Readiness Costs

EMS agencies incur significant fixed costs to remain available 24/7. Reimbursement occurs only when a billable event happens and often fails to cover even the marginal cost of response—particularly for Medicaid and Medicare patients. Readiness itself is largely unreimbursed.

3. Rural and Frontier Communities Are Disproportionately Impacted

Rural EMS agencies face longer response distances, lower call volumes, and higher per-call costs while relying heavily on public payers. Without supplemental support, these agencies face service reductions, delayed response times, or closure—placing entire regions at risk.

4. Funding Is Fragmented and Unstable

EMS agencies rely on a patchwork of local funding, grants, and short-term programs that are not indexed to inflation or population growth. This instability makes long-term planning, workforce retention, and capital investment difficult.

5. Administrative and Compliance Costs Continue to Grow

Increasing regulatory, reporting, and billing requirements raise costs without corresponding funding. Smaller and rural agencies are disproportionately burdened by these unfunded mandates.

6. State Level EMS Infrastructure Is Underfunded

Critical statewide EMS functions—including Ground Ambulance Licensing, Peer Support programs, Regional Emergency Medical and Trauma Advisory Councils (RETACs), Regional Medical Direction and the Grant Program—are chronically underfunded or inconsistently supported. These programs are foundational to system safety, coordination, and rural access. When state funding is insufficient, costs shift to local agencies, increasing financial strain and risking gaps in emergency care availability.

Cost of an Ambulance in 2026

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Item	Cost
Ambulance	$ 475,000.00
Cardiac Defibrillator	57,174.00
Patient Stretcher	75,000.00
Medication and supplies	9,200.00
Rugged HIPPA Compliant computer	5,700.00
Spinal care & Air splints	4,600.00
Medication Pumps	3,000.00
Portable Airway suction	1,200.00
Two portable medical kits	2,000.00
Emergency Airway kit	2,000.00
Intraosseous kits	1,200.00
Automatic Patient Ventilator& CPAP	17,500.00
3 Mobile Ambulance radios	9,000.00
2 Portable Crew radios	9,000.00
Sub Total	**$ 672,062.00**
Annual Fuel, Maintenance, Insurance	48,300.00
Grand Total	**$ 720,362.00**

Cost of a Mobile Integrated Health Vehicle

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Ford Expedition with up-fitting	$ 87,000
Cardiac Monitor	48,000
Pixies Laboratory Analyzer	21,000
Other Laboratory Equipment	11,000
Jump Kit: airway, medication and supplies	8,225
iPad Pro	1,499
Portable Airway Suction	1,200
ADA Compliant Mobility Equipment	3,200
Software and applications	1,800
Vehicle Mounted Radio	7,500
Handheld Radio	4,000
Sub-Total	**$194,924**
Annual Fuel, Maintenance, and Insurance	29,625
Grand Total	**$224,549**