Summary and Recommendations: Improving Tennessee's Ambulance Services through Increased Funding, Collaboration, and Training

When a medical emergency occurs, the difference between life and death can often be measured in minutes. For example, survival chances decrease by 10% for every minute that immediate cardiopulmonary resuscitation (CPR) and use of an automated external defibrillator (AED) is delayed, according to the American Red Cross. Ambulance crews are on the front lines providing such care in Tennessee, responding to more than 488,000 emergency calls in 2024. Recognizing its importance, all 95 counties provided ambulance services before any state action occurred. Public Chapter 212, Acts of 2021, designated ambulance service as an essential service in Tennessee, requiring counties to ensure the service is provided within their borders, either by providing it directly themselves or by contracting for service with other counties, cities, or private entities.

Funding for ambulance services comes from a variety of sources. Patient charges—paid either directly by the patient or via their health insurance—are a considerable source of funding, but they typically don't cover the entire cost of running an ambulance service. When patient charges come up short, local governments in Tennessee cover the difference, and in recent years, the size of that difference has been increasing as reimbursements from patients and their insurers have not kept pace with the cost of providing these services. Concerns that the need for such financial assistance would continue to escalate led to the introduction of Senate Bill 160 by Senator Hensley and House Bill 83 by Representative Capley in the 114th General Assembly. As introduced, the bill would have required a municipality that does not provide ambulance service to reimburse the county for such service in proportion to the percentage of the county's population housed within the city, up to 50% of the service's total cost. The bill was amended and passed as Public Chapter 413, Acts of 2025, which directed the Tennessee Advisory Commission on Intergovernmental Relations to study (1) the economic impact of required ambulance services on counties, (2) how Tennessee's counties and municipalities provide such services, and (3) whether policy changes may improve the provision of these services. Additionally, the Act requires the commission to (4) review emergency and non-emergency transport reimbursements and (5) determine how counties and municipalities fund the deficit at which ambulance services operate. The commission has identified alternatives to the original bill that could help address the rising cost of ambulance services, and it has identified opportunities to take advantage of

collaboration between counties and cities and between ambulance services, as well as opportunities to improve access to training for emergency service personnel.

Both counties and cities contribute to ambulance services and could benefit from more cooperation.

Counties provide the bulk of local funding for county ambulance services. Currently, 63 counties provide ambulance services directly−three use their county hospital and 60 use a non-hospital service−and the remaining 32 counties maintain an agreement with a third-party for ambulance services. Counties' average spending to cover ambulance service costs from fiscal years 2020-21 to 2023-24 increased from $1,828,460 to $2,666,115, after trimming the data—that is, the counties with the most extreme values.

Eleven cities fund their own ambulance services, while others voluntarily assist their county's ambulance service either directly via funding agreements or in-kind contributions, for example by having their fire department respond to emergency medical calls or by collaborating to build a county ambulance bay on city-owned property. Several stakeholders said fire departments and ambulances tend to be dispatched to emergencies together, so there is a natural efficiency to housing them together.

A disagreement between Maury County and the City of Columbia over the extent to which the city should help fund the county's ambulance service led to the introduction of Senate Bill 160 and House Bill 83, which would have required cities to help fund county ambulance services. Stakeholders say that city residents already help fund county ambulance services through their county taxes, and the bill could have the unintended consequence of cities starting their own ambulance services to avoid the payments, resulting in counties paying more to provide service in outlying unincorporated areas. For these reasons and because of the voluntary cooperative arrangements many cities and counties have already adopted, **the commission does not recommend Senate Bill 160 and House Bill 83 as originally filed but instead encourages counties and cities to continue exploring mutually beneficial avenues to share costs and improve ambulance services.**

Recent and potential federal rule changes could lower the total payment for ambulance transport of TennCare patients.

Ambulance services in Tennessee benefit from the state's requirement that TennCare—Tennessee's Medicaid program—reimburse two state-directed payments to ambulance services for providing emergency transport to a TennCare-enrolled patient. First, the

state requires TennCare's three managed care organizations (MCOs) to reimburse ambulance services at rates that are at least 67.5% of the Medicare rate, including both the base rate and the mileage payment—though according to TennCare the current average reimbursement rate for the MCOs is closer to 75% of Medicare. For context, Medicare's base rate and mileage payments combine to pay about half the cost of transporting patients. Second, TennCare's MCOs also distribute a quarterly supplemental payment funded by a tax on ambulance service providers and matching federal dollars called the Ground Ambulance Assessment Program (GAAP). The sum of the TennCare base rate payment and the GAAP payment often exceeds what Medicare would pay for the same trip, with stakeholders reporting that the full payment often equals 120% or more of what Medicare would pay. Still, ambulance service providers say the combined TennCare payments are too low compared to the cost of providing the service.

An increase could bring TennCare payments closer to costs, but one recent rule adopted and another rule proposed by the Center for Medicare and Medicaid Services (CMS) limit these state-directed payments for emergency transport to 110% of the Medicare rate. As a result, Tennessee may have to reduce the sum of the state-directed payments to ambulance services. TennCare said, to do so, the GAAP payment would be reduced so the base reimbursement and GAAP together equal no more than 110% of the current Medicare fee schedule. This could result in a decrease in available funds for all ambulance services, including counties' primary ambulance service providers, and especially affect county services with a higher percentage of TennCare-enrolled patients. Some previously proposed increases, like raising the TennCare non-emergency transport reimbursement rate to 100% of the Medicare payment—non-emergency transports are not eligible for GAAP payments—or increasing the TennCare base reimbursement rate for all transports to 110% of the Medicare payment while removing the GAAP payment are likely still viable because the sum of the state-directed payments would not exceed 110% of the Medicare rate. For county ambulance service providers that cannot afford to offer non-emergency transport or rely on the current TennCare reimbursement rate, the state should consider action to help ambulance services navigate potential funding decreases.

The General Assembly should make funding for its existing ambulance equipment grant recurring.

Ambulance equipment is the third largest cost category for ambulance services nationally, following labor and vehicle costs. Nationally, equipment costs are about 4% of ambulance services' costs, and at that percentage, the total equipment cost for

ambulance services in Tennessee would be approximately $20 million per year. The General Assembly appropriated $5 million for ambulance equipment grants in 2025, but the grants were not recurring. The state did not provide a grant during the previous year but did provide a grant two years ago. Recurring grants are available for other essential services like emergency management, law enforcement, roads and bridges, solid waste, and storm water but not ambulance services. For these reasons, **the commission recommends the General Assembly make funding for the equipment grant recurring.**

Stakeholders say more training centers could improve staffing of ambulance services.

Healthcare providers say training is a bottleneck that prevents ambulance services and fire departments from hiring enough emergency medical technicians (EMTs) to replace EMTs that are leaving the profession, and studies have demonstrated that 25% to 31% of potential employees leave the workforce because of attrition during education or failure to achieve national certification. Turnover for EMTs and paramedics is greater than for similar healthcare professions, and employment length can sometimes be measured in months rather than years, according to staff of the Tennessee Board of Regents (TBR).

TBR offers training opportunities at the state's colleges and in high school dual enrollment programs, and TBR staff is hopeful that dual enrollment can increase the number of high school students earning their EMT basic certification as a senior. But representatives for ambulance services say that enrollees in those programs often go into other medical professions, like nursing or firefighting, rather than ambulance services.

To establish an additional workforce pipeline, some ambulance services created their own centers to train EMTs and advanced emergency medical technicians (AEMTs). Currently, there are 30 training centers, which is the maximum allowed under state law.

Representatives of ambulance services say that more training centers would help address staffing issues, and they say the cap should be removed or increased. TBR, which helps oversee the training centers, is open to increasing the cap if there is enough regulatory capacity to ensure the quality of those new centers—more training centers mean more work for the Office of EMS, which may need to hire additional staff to license and regulate the centers. Trainees must pass national exams to be licensed as emergency medical technicians, and judging by first attempt pass rates, quality of the training centers was not harmed when the cap was increased from 15 to 30 in 2022. Pass rates were approximately the same for training centers started before or after the increase—62% and 63%, respectively.

Other alternatives to the original bill could help address the rising cost of ambulance services.

In addition to increased county and city cooperation, the commission identified other opportunities for some local governments and ambulance services to increase revenue or reduce costs. For example, contracting with a third-party billing company can improve collection rates for ambulance service charges. Some ambulance services also provide non-emergency transport. Patient charges are often high enough to cover the full cost of non-emergency transport and can help partially offset the costs of emergency transport, though some ambulance services report they don't have the equipment or personnel needed to provide non-emergency transport in addition to emergency transport. Other ambulance services may find they can reduce some costs by sharing staff with other services. In particular, every ambulance service must employ a medical director to set standards for the care they provide. Although pay for a medical director can be upwards of $30,000 to $40,000 per year, it may be possible for several ambulance services to share a single medical director, with Vanderbilt LifeFlight saying it allows other services to share its medical director for approximately $10,000 per year.

Services also have an opportunity to receive revenue that would traditionally be unavailable. Health insurance—regardless of whether it is Medicare, TennCare, or a private insurer—typically reimburses ambulance services only for transporting a patient to an emergency room. According to Department of Health data, from 2021 to 2024, Tennessee ambulance services transported a patient to the hospital on approximately 40% of emergency call responses. The remaining outcomes, like treating an individual at the scene (approximately 13% of emergency call responses) or transporting them to an alternate destination (approximately 1% of emergency call responses), like a mental health facility, would be ineligible for reimbursement. This dynamic creates an incentive for ambulance services to transport patients to the emergency room, even if they may not need to go to the hospital. Though this generates money in the short term, unnecessary transports can contribute to longer "wall times"—when ambulances must wait at the hospital for their patient to be admitted to the emergency room—which prevents the ambulance from responding to other emergency calls. To address this issue, the State created a TennCare program—the Triage, Navigate, Treat and Transport program (TN-T2)—to reimburse ambulance services for treatment in place or transport to an alternate destination of TennCare-enrolled patients. This program was modeled after a federal version of the same program and made permanent by Public Chapter 919, Acts of 2022. In 2025, approximately 51% of licensed Tennessee ambulance services made at least one claim for reimbursement under the TN-T2 program.

While the specific examples mentioned here—contracting with third-party billing companies, expanding non-emergency transport, sharing medical directors, and using the TN-T2 program—may not be appropriate for all ambulance services, **the commission encourages ambulance services to explore opportunities for increasing revenue and reducing costs of their operations.**

Analysis: Ambulance Services

Emergency medical services are a complex, life-saving system, and ambulances make up an important part of that system. Survival chances decrease by 10% for every minute that immediate cardiopulmonary resuscitation (CPR) and use of an automated external defibrillator (AED) is delayed, according to the American Red Cross.[1] Ambulance crews are on the front lines providing such care in Tennessee, responding to more than 488,000 emergency calls in 2024.[2] Recognizing the importance of ambulance service, all 95 counties provided ambulance services before any state action occurred.[3] In 2021, Tennessee became one of 21 states[4] to designate ambulance service as an essential service when the General Assembly passed a law requiring counties to ensure the service is provided within their borders.[5]

Counties' financial support of their ambulance services continues to increase. For example, until a few years ago, Maury County provided a $635,000 subsidy to Maury Regional Health, but the hospital recently asked to increase the subsidy to more than $3 million.[6] The county and hospital eventually settled on a $2 million annual subsidy, and their current agreement includes a 5% annual increase for the length of the contract.[7] Seeking to offset the increased cost, Maury County asked the City of Columbia to contribute funds to the ambulance payment because so many of the emergency responses in Maury County occur in Columbia. The city declined the county's request.[8]

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[1] American Red Cross 2026.

[2] TACIR staff analysis of Department of Health EMS Services Directory, analyzed June 1, 2025.

[3] Fiscal Review Committee 2021.

[4] National Conference of Legislatures 2025.

[5] Public Chapter 212, Acts of 2021.

[6] Interview with Sheila Butt, mayor, and Doug Lukonen, finance director, Maury County, and James Dunn, counsel, Frost Brown Todd, May 28, 2025.

[7] Maury County and Maury Regional Health Emergency Medical Services Agreement, 2024 to 2027.

[8] Interview with Sheila Butt, mayor, and Doug Lukonen, finance director, Maury County, and James Dunn, counsel, Frost Brown Todd, May 28, 2025; and interview with Tony Massey, city manager, Chris Cummins, fire chief, and Thad Jablonski, assistant city manager, City of Columbia, May 21, 2025.

That denial led to the introduction of Senate Bill 160 by Senator Hensley and House Bill 83 by Representative Capley in the 114th General Assembly.[9] As introduced, the bill would have required a municipality that does not provide ambulance service to reimburse the county for such service in proportion to the percentage of the county's population housed within the city, up to 50% of the service's total cost.[10] The bill was amended and passed as Public Chapter 413, Acts of 2025, which directed the Tennessee Advisory Commission on Intergovernmental Relations to study (1) the economic impact of required ambulance services on counties, (2) how Tennessee's counties and municipalities provide such services, and (3) whether policy changes may improve the provision of these services. Additionally, the Act requires the commission to (4) review emergency and non-emergency transport reimbursements and (5) determine how counties and municipalities fund the deficit at which ambulance services operate.[11]

Counties' provision of ambulance services varies by how they provide the service, directly or indirectly, and how much they spend on those services, and how much they are reimbursed.

Tennessee requires counties to provide ambulance services, and counties provide those services both directly and indirectly.

The statute that requires counties to provide ambulance services says that a county can either provide the service directly, contract with a public, private, or nonprofit entity who will provide the service themselves, establish an interlocal agreement with one or more governmental entities to secure service from that government's ambulance service, or enter into an agreement with a hospital or other healthcare facility.[12] County approaches to funding the required ambulance services vary based on whether they choose to operate the service directly, operating their own ambulance service, or provide the service indirectly, either by contracting with another county, city, or private provider, or establishing an interlocal agreement.

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[9] Interview with Sheila Butt, mayor, and Doug Lukonen, finance director, Maury County, and James Dunn, counsel, Frost Brown Todd, May 28, 2025.

[10] Original Version of House Bill 83, Senate Bill 160, 114th General Assembly.

[11] Public Chapter 413, Acts of 2025.

[12] Tennessee Code Annotated, Section 7-61-102(b).

Providing Ambulance Services Directly

Counties that choose to provide ambulance services directly create and run their own ambulance service. In these cases, the county owns the ambulance service and is responsible for all associated costs. Costs include operating costs, like payroll, along with capital expenditures like ambulance vehicle purchases and equipment spending.[13] Counties use general fund, special revenue fund, or enterprise fund dollars to fund the service in addition to reimbursements for services from insurance providers.[14]

Staff of the Local Government Audit office of the Comptroller said that counties choose the fund they use for their ambulance service based on how they want to measure costs, revenues, transparency, and rate-setting. Counties that use general fund dollars, they said, are treating the ambulance service as a "core public service." These counties expect taxpayers to subsidize most or all of the ambulance service's costs. Most counties who provide their own ambulance service use this structure.[15]

Counties that use special revenue funds do so to keep the service's transactions separate from general county transactions, but the service is still not intended to run like a business. In this setup, there are dedicated ambulance revenue streams such as taxes, fees, and grants.[16] For example, Anderson County's ambulance service has a special revenue fund. In 2024, the county reported revenues from patient charges, earmarked property taxes, grants, and other sources of revenue from the ambulance service.[17] When the ambulance service's revenue fell $550,000 short of the service's expenditures, the county covered the deficit with a subsidy.[18]

If a county uses an enterprise fund for their ambulance service, they intend for the service to be handled like a business. In these cases, user charges are expected to cover the costs

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[13] Buttorff et al. 2025.

[14] TACIR staff analysis of Comptrollers' Local Government Audit data, county Annual Financial Reports, and TACIR staff survey of counties.

[15] Email from Lee Ann West, audit manager, Local Government Audit, Comptroller of the Treasury, March 30, 2026.

[16] Ibid.

[17] TACIR staff analysis of Comptrollers' Local Government Audit data, county Annual Financial Reports and TACIR staff survey of counties; and interview with Terry Frank, mayor, and Nathan Sweet, EMS director, Anderson County, June 16, 2025.

[18] Interview with Terry Frank, mayor, and Nathan Sweet, EMS director, Anderson County, June 16, 2025.

of operating the service.[19] Maury County is the only county identified by commission staff whose ambulance service is accounted for by an enterprise fund, and that is because the service is attached to the county's hospital, Maury Regional Health.[20]

Four counties—Greene, Hamblen, Unicoi, and Washington—have joint county/city ambulance services. For example, Unicoi County EMS was "established in 2020 as a joint venture by Unicoi County, the Town of Erwin, and the Town of Unicoi."[21] The cities support the ambulance services, financially or otherwise. Unicoi County said their ambulance service had an operating deficit of $250,436 in fiscal year 2023-24, an increase from $165,990 in fiscal year 2021-22 and $224,472 in fiscal year 2022-23.[22] The county contributed $147,200 to Unicoi County EMS for the year ended June 30, 2024.[23] The cities that are part of the joint ambulance venture said they contributed $31,000 (Erwin) and $37,000 (Unicoi) for ambulance service. The Town of Erwin also said their fire department responds to the same incidents as county ambulance services and the Town of Erwin provides building space for the ambulance service to use.[24]

Providing Ambulance Services Indirectly

Counties that choose to contract with a private provider for ambulance services sign a contract with an ambulance provider that designates the provider as the primary emergency ambulance service within the county's jurisdiction. A county may publish a request for proposals and choose their preferred option from the contractors who bid for the services.[25] Some counties formalized an arrangement that already existed with a contract.[26] In either case, counties avoid the cost of starting and maintaining their own ambulance service.

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[19] Email from Lee Ann West, audit manager, Local Government Audit, Comptroller of the Treasury, March 30, 2026.

[20] TACIR staff analysis of Comptrollers' Local Government Audit data, county Annual Financial Reports, and TACIR staff survey of counties.

[21] Unicoi County Emergency Medical Services 2025.

[22] TACIR staff survey of Tennessee Counties.

[23] Division of Local Government Audit 2024.

[24] TACIR staff survey of Tennessee Cities.

[25] Interview with Dwight Van de Vate, chief of staff, and Kevin Parton, senior director of Public Health, Knox County, and Chris Gobble, principal council, Stones River Group, June 9, 2025; and interview with Jonah Keltner, mayor, Lewis County, May 19, 2025.

[26] Phone call with Jason Luallen, director, Finance Department, McMinn County, March 31, 2026.

But counties with contracted providers, when renegotiating ambulance service contracts, may face increased rates. For example, Maury Regional Hospital (MRH) provides Lewis County's ambulance service, and that agreement has existed since at least 2006. The previous agreement that had been in place since 2014 required Lewis County to pay MRH about $150,000 per year to provide ambulance services within the county. In 2022, MRH sought a payment increase from the county. Lewis County put a bid out for services and in 2023, after comparing rates, agreed to a new contract with MRH that included a $472,500 payment for ambulance services—a 215% increase—with an annual escalator (increase) for the following five years.[27] Services may also ask for an increase in payment even if they have historically provided the service at no cost. Dyer County, for example, said that West Tennessee Healthcare requested payment to provide ambulance services for the first time in 2022 after providing the service at no cost previously. The parties ultimately agreed to an annual subsidy of more than $1 million, and Dyer County implemented a wheel tax to help cover the new cost.[28]

When using private providers, counties often include contractual performance benchmarks to ensure adequate service. For example, Knox and Blount County used fines to enforce standards written into their separate contracts with American Medical Response. Knox County said they assessed and collected fines for insufficient response times over the life of their previous contract with AMR.[29] The county said that the insufficient response times and the associated fines led to a new, updated contract that better structured AMR's operations within the county around Knox County's desired level of service, and the county said that they are happier with the current arrangement.[30] Blount County also assessed fines based on insufficient response times that did not meet the standards they and AMR set in their contract, but the county has not always collected the total amount of fines assessed.[31]

Commission staff identified several overlapping categories that indicate exactly how a county provides their service. The county either provides the service directly or indirectly, as described above. Within those two categories, the provider may be a government, for-profit, or non-profit organization. Some counties use another

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[27] Interview with Jonah Keltner, mayor, Lewis County, May 19, 2025.

[28] Phone call with David Quick, mayor, Dyer County, March 31, 2026.

[29] Feinberg 2024.

[30] Interview with Dwight Van de Vate, chief of staff, and Kevin Parton, senior director of public health, Knox County, and Chris Gobble, principal council, Stones River Group, June 9, 2025.

[31] Jones 2021.

government to provide their service; consider, for example, Lewis County's agreement with Maury Regional Health, Maury County's hospital. Finally, the service can either be attached to a hospital or operate independent of a hospital. See table 1.

Table 1. How Counties Provide Ambulance Service

	Direct			Indirect		
	Government				For Profit	Non-Profit
Hospital	(3 counties) Madison** Maury** Williamson**			(8 counties) Benton Claiborne Chester Dyer Lewis Lincoln McNairy Wayne		
Non-Hospital	(60 counties)				(19 counties)	(5 counties)
	Anderson	Hamilton	Sumner		Blount	Carter
	Bedford	Hancock	Trousdale		Carroll	Grundy
	Bledsoe	Hardeman	Unicoi*		Cocke	Hamblen
	Bradley	Hardin	Union		Decatur	Hawkins
	Campbell	Haywood	Van Buren		Franklin	Weakley
	Cannon	Hickman	Warren		Henderson	
	Cheatham	Jackson	Washington*		Henry	
	Clay	Jefferson	White		Houston	
	Coffee	Johnson	Wilson		Humphreys	
	Crockett	Lake	Pickett		Loudon	
	Cumberland	Lauderdale	Putnam		Knox	
	Davidson	Lawrence	Roane		Marion	
	DeKalb	Macon	Robertson		McMinn	
	Dickson	Marshall	Rutherford		Obion	
	Fayette	Meigs	Scott		Perry	
	Fentress	Monroe	Sevier		Polk	
	Gibson	Montgomery	Shelby		Rhea	
	Giles	Moore	Smith		Sequatchie	
	Grainger	Morgan	Stewart		Tipton	
	Greene*	Overton	Sullivan			

Source: TACIR staff analysis of ambulance service private acts and websites; Tennessee Secretary of State Business Entity Search.

* Indicates a joint county-city ambulance service

** Indicates that a county hospital provides the county's ambulance service

National data and stakeholder interviews identified major categories of expenditures for ambulance services that may vary by type of service.

National data collected by the Center for Medical Services identifies labor[32] as the largest portion of ambulance service costs (71% of total ground ambulance costs) followed by capital expenditures like vehicles (9% of total ground ambulance costs)[33] and equipment (4% of total ground ambulance costs).[34] Some differences exist in cost breakdowns depending on ownership category, how Medicare designates the area's population density (urban, rural, super rural), Medicare transport volume, and more. For example, labor makes up a greater share of government owned services' costs compared to other ownership groups (see Ownership Category, below). On the other hand, the more rural a service (by Medicare' definition), the less labor makes up of the share of costs (see Service Area Pop. Density, below). Medicare has its own definition for urban, rural, and super rural services.[35] See figure.

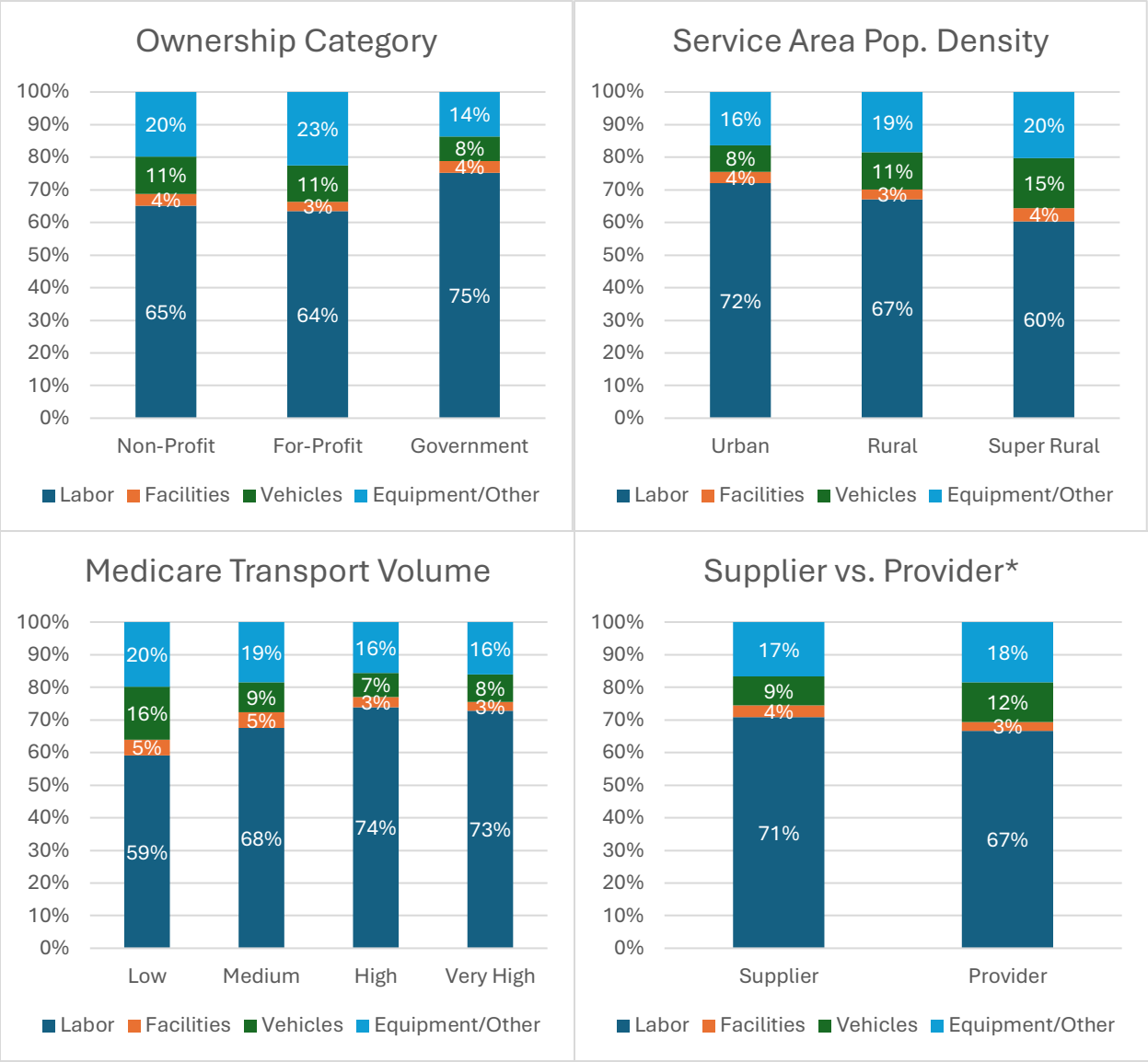
[32] Buttorff et al. 2025. Labor costs included compensation for EMT-Basic, EMT-Intermediate, EMT-Paramedic, Medical Directors, Administrative roles, and employees with other responsibilities.

[33] Buttorff et al. 2025. Including vehicle purchase costs, payments on vehicles, and other costs of ownership to organizations.

[34] Buttorff et al. 2025. Equipment costs included medication, medical equipment, supplies, and consumables. Urban services spent more than rural and super rural services, and for-profit organizations spent more than non-profit and government organizations.

[35] Medicare defines services in a rural area as services that are furnished (1) in an area outside a Metropolitan Statistical Area (MSA); or (2) an area identified as rural using the most recent version of the Goldsmith Modification even though the area is within an MSA. For a thorough explanation of how CMS defines rural, see Rural Health Information Hub, "What is Rural Health?" Super-rural zip codes are specific to ambulances and include the lowest quartile of all rural counties by population density. See PaymentBasics 2021.

Figure. Differences in Makeup of Ambulance Cost Categories



Source: Mulcahy et al 2024.

*Suppliers are non-institutional services, like local fire departments or private for-profit entities, while Providers are institutionally based, like a service affiliated with a hospital.

Most Tennessee counties' primary ambulance service providers are government-operated non-hospital services.[36] These services tend to spend more of their budget on labor than ambulance services in other sectors, and they also spend less of their budget

[36] TACIR staff analysis of ambulance service private acts and websites; and Tennessee Secretary of State Business Entity Search.

on vehicles. The "equipment/other" category is a comparatively smaller portion for government-owned ambulance services' budget (14% of ambulance spending) than for non-profit (20% of ambulance spending) and for-profit services (23% of ambulance spending).[37]

Most Tennessee counties financially support their ambulance service, and the amount of financial support is increasing.

When ambulance service revenue comes up short, local governments in Tennessee are responsible for covering the difference. Patient charges—paid either directly by the patient or via their health insurance—are a considerable source of funding, but for most counties in Tennessee they don't cover the cost of running an ambulance service.

The amount of necessary county support for ambulance services is growing. Based on financial data analyzed by commission staff, Tennessee counties' average ambulance collected patient charges increased from $1,299,068 in fiscal year 2021-22 to $1,600,699 in fiscal year 2023-24, a 23% increase. Over that same period, Tennessee counties' average ambulance expenditure increased from $1,828,460 to $2,666,115, a 46% increase. As a result, the average difference between revenue and expenditures for Tennessee counties increased from $511,785 in fiscal year 2021-22 to $1,031,068 in fiscal year 2023-24, a 101% increase.[38] See table 2.

[37] Mulcahy et al. 2024.

[38] TACIR staff analysis of Comptrollers' Local Government Audit data, county Annual Financial Reports, and TACIR staff survey of counties. Calculated by removing the top and bottom 2.5% of the 80 counties with available financial data.

Table 2. County Ambulance Services, Average Revenue and Expenditures Fiscal Years 2021-22 through 2023-24

	Fiscal Year 2021-22	Fiscal Year 2022-23	Fiscal Year 2023-24
Average Revenue	$1,299,068	$1,298,633	$1,600,699
Average Expenditures	$1,828,460	$1,901,387	$2,666,115
Average Difference	$(511,785)	$(620,852)	$(1,031,068)

Source: TACIR staff analysis of Comptrollers' Local Government Audit data, county Annual Financial Reports, and TACIR staff survey of counties. 76 counties represented. Parentheses indicate negative numbers.

Eighty-two of Tennessee's 95 counties provided financial support to their ambulance service in fiscal year 2023-24, either by funding the ambulance service's operating deficit or by paying a subsidy to the contracted provider.[39] The funds for that support came from the counties' general funds, transfers from other funds, local tax revenue,[40] or the ambulance services' fund balances were sufficient to cover the deficit.[41]

The 13 counties that did not provide financial support to their ambulance service either contracted with an ambulance service that did not require a subsidy (11) or collected ambulance service patient charges that were greater than ambulance expenditures (2). Ambulance service representatives and TACIR staff analysis both indicate that counties that did not financially support their ambulance services had situations that were difficult to replicate. For example, Decatur County said they "worked a miracle" with the company that owns the local hospital to avoid paying for ambulance services.[42] Greene

[39] TACIR staff analysis of Comptrollers' Local Government Audit data, county Annual Financial Reports, and TACIR staff survey of counties.

[40] Local tax revenue was mostly property tax revenue but also included bank excise tax; business tax; and local utilities, Tennessee Valley Authority, and other payments-in-lieu-of-tax revenues.

[41] TACIR staff analysis of Comptrollers' Local Government Audit data, county Annual Financial Reports, and TACIR staff survey of counties.

[42] Phone call with Mike Creasy, mayor, Decatur County, March 31, 2026.

County operated at a profit in fiscal years 2021-22 and 2022-23 thanks to their non-emergency ambulance operation but reported a loss in fiscal year 2023-24.[43]

Both counties and cities contribute to ambulance services and could benefit from more cooperation.

State law makes counties responsible for ensuring ambulance services are available in the county,[44] but cities can—and 11 do—operate and fund their own ambulance services.[45] For example, until 2023, Wilson County used their own ambulance service to serve the entirety of the county, including two ambulances that covered the city of Mt. Juliet and the rest of western Wilson County. Since Mt. Juliet started their own ambulance service in 2023, the city's service responds to those calls instead, assuming they have an ambulance free.[46] Otherwise, Wilson County's ambulance service—or the nearest ambulance—would respond instead.

Cities without their own ambulance service but with a fire service also provide emergency services. City firefighters serve as first responders for emergencies within the city limits, often reaching the scene before the county ambulance and providing stabilizing care until the ambulance can arrive.[47] Their firefighters may be equally as trained or more trained than county ambulance personnel. Fire department representatives often said they employed Emergency Medical Technicians (EMTs) and Advanced EMTs,[48] and the city of Gallatin, among others, employs licensed paramedics.[49] The fire department may pay for and provide their own medicine, like Brentwood Fire

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[43] TACIR staff analysis of Comptrollers' Local Government Audit data, county Annual Financial Reports, and TACIR staff survey of counties.

[44] Tennessee Code Annotated, Section 7-61-102.

[45] TACIR staff analysis of Department of Health EMS Services Directory, analyzed June 1, 2025.

[46] Interview with Mark Foulks, fire chief, and Eric Newman, EMS chief, Mt. Juliet Fire Department, June 24, 2025; interview with Brian Newberry, EMS director, Wilson County, August 7, 2025; and Humbles 2023.

[47] Interview with Tony Massey, city manager, Chris Cummins, fire chief, and Thad Jablonski, assistant city manager, City of Columbia, May 21, 2025; interview with Dwight Van de Vate, chief of staff, and Kevin Parton, senior director of public health, Knox County, and Chris Gobble, principal council, Stones River Group, June 9, 2025.

[48] TACIR staff survey of Tennessee cities.

[49] TACIR staff survey of Tennessee cities; and interview with Jeff Beaman, fire chief, Gallatin Fire Department, July 10, 2025.

does when it responds to calls before Williamson Health's ambulances arrive.[50] The exact level of contribution depends on how often a fire department operates in tandem with the county ambulance service. The City of Clarksville said they spent $34 million on its fire department in 2025, and 70% of the department's calls overlap with Montgomery County's ambulance service.[51] The City of Columbia said they spent over $9 million on their fire department, and about 70% of the department's responses were medical trips.[52]

But city fire departments are also limited in how they contribute. Under current Department of Health rules, medical directors set the allowed level of medical care in an area. Non-transport fire departments cannot receive ambulance licensure under Tennessee's current law, which prevents them from employing their own medical director to set the level of care the fire department can provide. As a result, the level of care a city fire department can provide is set by the county ambulance service's medical director and what care they decide area emergency medical personnel—including both ambulance services and fire departments—can provide.[53]

Some cities voluntarily contribute funding to county ambulance services. Greeneville maintains an agreement with Greene County to fund 30% of the county's ambulance service,[54] and many small cities in Hamilton County at one point sent the county funds and, in two cases, their own ambulance assets to join the county's covered ambulance service area.[55] Cities also provide in-kind contributions, like sharing city property with the county ambulance service or even cooperatively building joint ambulance and fire stations. In Sumner County, the city of Portland worked with the county, the county

[50] Interview with Brian Collins, fire chief, Brentwood Fire Department, June 24, 2025.

[51] Interview with Joe Pitts, mayor, Freddie Montgomery, fire chief, Jobe Moore, deputy chief of logistics, and Jimy Eley, deputy chief of operations, City of Clarksville, June 13, 2025.

[52] Interview with Tony Massey, city manager, Chris Cummins, fire chief, and Thad Jablonski, assistant city manager, City of Columbia, May 21, 2025.

[53] Interview with Joe Pitts, mayor, Freddie Montgomery, fire chief, Jobe Moore, deputy chief of logistics, and Jimy Eley, deputy chief of operations, City of Clarksville, June 13, 2025; interview with Brian Collins, fire chief, Brentwood Fire Department, June 24, 2025; interview with Travis Solomon, fire chief, and Jody Durham, deputy chief of operations, Oak Ridge Fire Department, December 9, 2025; interview with Jeff Beaman, fire chief, Gallatin Fire Department, July 10, 2025; and Tennessee Department of Health Rule 1200-12-01-.14(3)-(4).

[54] Interview with TJ Manis, EMS director, Greene County, August 14, 2025.

[55] Interview with Small Cities Coalition of Hamilton County, August 13, 2025.

ambulance service, and the county school system to construct a joint fire/EMS station in an area of need.[56]

The original version of Senate Bill 160 and House Bill 83, which was amended to become this TACIR study, would have required cities to help pay for county ambulance services by reimbursing a portion of county spending on ambulance services equal to the city's proportion of the county's population, up to 50% of the cost of providing ambulance service.[57] Representatives of cities opposed the bill primarily on the grounds that city residents are already helping to fund county ambulance services through their county taxes. They said, if the bill were to pass, city residents would be paying for the same service twice—once when they pay county taxes, and once when they pay city taxes.[58]

Specifically, because under the bill cities would have been responsible for these payments only if they don't operate their own ambulance services, representatives for cities said many cities would likely start their own ambulance services.[59] City representatives identified two primary pieces of logic for this: if a city is going to pay for ambulance services, (1) the city would prefer to manage those dollars themselves to get their desired level of ambulance service,[60] and (2) the city would prefer to employ their own medical director and make their own decisions about the level of care their residents receive.[61] A scenario where cities created their own ambulance service rather than pay toward county

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[56] Interview with David Connor, executive director, Tennessee County Services Association, and Anthony Holt, executive director, Tennessee Association of County Mayors, April 29, 2025.

[57] Original version of Senate Bill 160 by Senator Hensley and House Bill 83 by Representative Capley, 2025.

[58] TACIR staff survey of Tennessee cities; and interview with Jeff Peach, city attorney, Murfreesboro, May 15, 2025.

[59] Interview with Mark Foulks, fire chief, and Eric Newman, EMS chief, Mt. Juliet Fire Department, June 24, 2025; and interview with Brian Collins, fire chief, Brentwood Fire Department, June 24, 2025.

[60] Interview with Tony Massey, city manager, Chris Cummins, fire chief, and Thad Jablonski, assistant city manager, City of Columbia, May 21, 2025 (stating Maury Regional Health's decision to spend an extra $1.4 million on hiring and retention "would not have been their first move"); and interview with Marc Alley, emergency/fire management consultant, County Technical Services Association, February 20, 2026 (stating Crossville may start an ambulance service because they were not getting their desired response time from county ambulances).

[61] Interview with Jeff Beaman, fire chief, Gallatin Fire Department, July 10, 2025; interview with Brian Collins, fire chief, Brentwood Fire Department, June 24, 2025; interview with Mark Foulks, fire chief, and Eric Newman, EMS chief, Mt. Juliet Fire Department, June 24, 2025; and interview with Travis Solomon, fire chief, and Jody Durham, deputy chief of operations, City of Oak Ridge, December 9, 2025.

services could fracture emergency response systems by creating areas of the county that county ambulances do not use and therefore distancing the service from areas around the city but not within city limits.[62] Additionally, counties could end up paying more to provide service in outlying unincorporated areas, both because of the necessary driving time to reach those areas and the payor mix in cities that then made up a large portion of the service's business. These outcomes could cause a city's decision to create their own ambulance service to snowball. For example, Brentwood Fire said that if Franklin created their own ambulance service, Williamson Health would likely be unable to maintain its level of service in Brentwood, and Brentwood would consider alternatives to Williamson Health.[63] If Franklin and Brentwood splintered off, Nolensville may experience a lower standard of care because the cities pulling out would fracture the system.[64]

County and city representatives can avoid these outcomes by voluntarily creating and strengthening mutually beneficial avenues to share costs and improve ambulance services, like the examples described above. When counties and cities maintained some form of cooperative agreement, that cooperation received praise from the associated stakeholders.[65] Some city representatives expressed concern that, in a mandated situation, favorable agreements that they had jointly crafted with their county cohorts would be upended.[66] Rather, counties and cities should voluntarily cooperate to identify cost sharing arrangements.

Recent and potential federal rule changes could lower the total payment for ambulance transport of TennCare patients.

Ambulance services in Tennessee benefit from the State's requirement that TennCare—Tennessee's Medicaid service—reimburses two state-directed payments to ambulance services for transporting a TennCare-enrolled patient. First, the state requires TennCare's three managed care organizations (MCOs) to reimburse ambulance services at rates that

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[62] Comment at commission meeting by Jeff Peach, City Attorney, Murfreesboro, February 13, 2026.

[63] Interview with Brian Collins, fire chief, Brentwood Fire Department, June 24, 2025.

[64] Email from David Windrow, former Nolensville fire chief, December 9, 2025.

[65] Interview with Brian Collins, fire chief, Brentwood Fire Department, June 24, 2025; interview with Mark Foulks, fire chief, and Eric Newman, EMS Chief, Mt. Juliet Fire Department, June 24, 2025; and interview with Joe Pitts, mayor, Freddie Montgomery, fire chief, Jobe Moore, deputy chief of logistics, and Jimy Eley, deputy chief of operations, City of Clarksville, June 13, 2025.

[66] Interview with Small Cities Coalition of Hamilton County, August 13, 2025; and interview with Joe Pitts, mayor, Freddie Montgomery, fire chief, Jobe Moore, deputy chief of logistics, and Jimy Eley, deputy chief of operations, City of Clarksville, June 13, 2025.

are at least 67.5% of the Medicare rate.[67] The current average reimbursement rate for the MCOs is closer to 75% of Medicare, with some services receiving the statutory minimum of 67.5% of the Medicare allowable and some services negotiating a higher rate.[68]

Second, ambulance service providers receive a supplemental payment of $229.50 for every transport of a TennCare-enrolled patient through the Ground Ambulance Assessment Program (GAAP). The GAAP is funded by collecting an assessment from ambulance service providers for each transport they complete. Under current law, the assessment is either the lesser of $20 or an amount sufficient to ensure the statewide assessment does not exceed 6% of statewide net operating revenues.[69] That tax generates matching federal funds, which are drawn down, added to the account, and disbursed quarterly. While ambulance service representatives said this payment offsets some of the loss on the cost of transports,[70] it is important to note that the services fund the program via their $20 tax payment without help from any outside state dollars.[71]

The effect of these payments on total revenue from patient charges matters more for counties whose ambulance services transport a greater share of patients enrolled in TennCare. The number of TennCare enrollees varies by county. See map 1.

[67] Tennessee Code Annotated, Section 71-5-165(a).

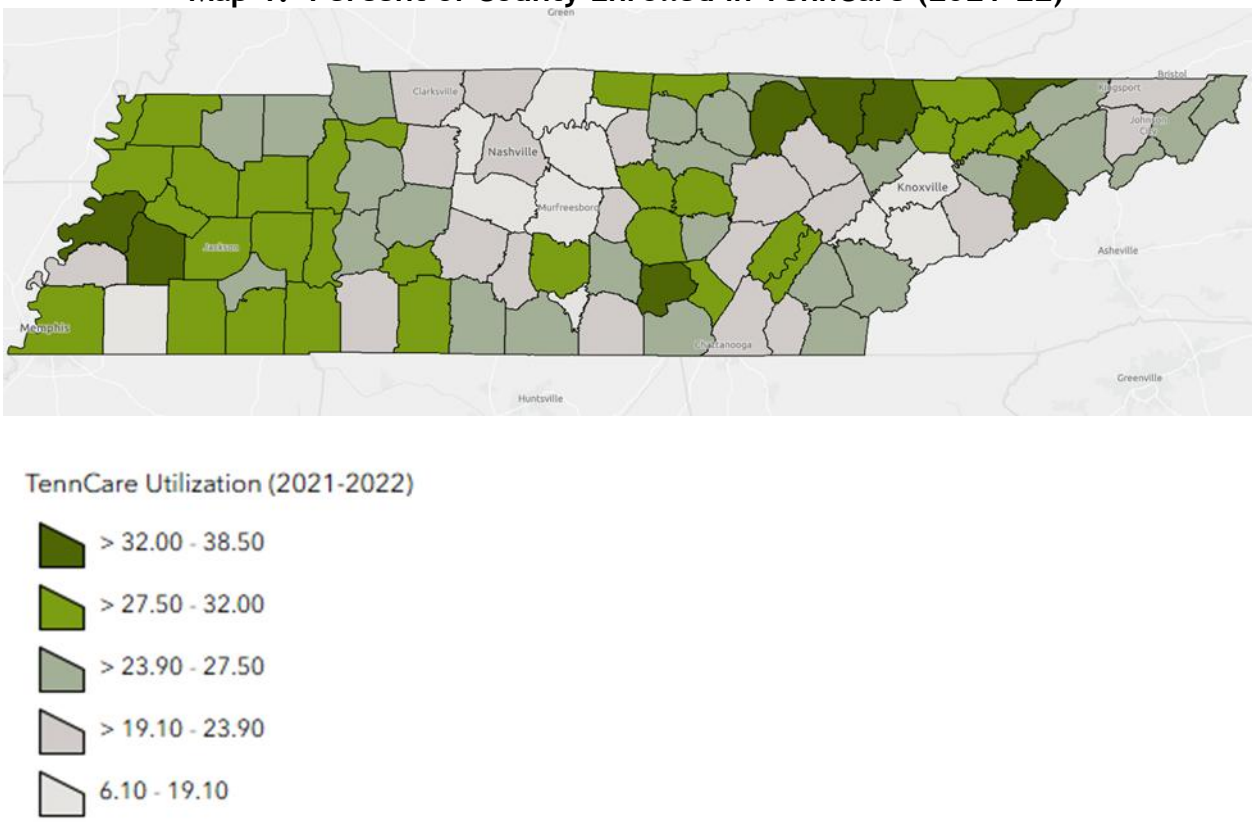
[68] Interview with Zane Seals, chief financial officer, Ashley Reed, legislative chief, and Samantha Rummage, fiscal chief of staff, TennCare, September 2, 2025.

[69] Tennessee Code Annotated, Section 71-5-1504.

[70] Interview with Tim Booher, president, and Keith Douglas, administrative liaison, Tennessee Ambulance Services Association, and Caroline Simmons, counsel, McMahan, Winstead & Richardson, July 31, 2025.

[71] Tennessee Code Annotated, Section 71-5-1504; interview with Zane Seals, chief financial officer, Ashley Reed, legislative chief, and Samantha Rummage, fiscal chief of staff, TennCare, September 2, 2025; and interview with Tim Booher, president, and Keith Douglas, administrative liaison, Tennessee Ambulance Services Association, and Caroline Simmons, counsel, McMahan, Winstead & Richardson, July 31, 2025.

Map 1. Percent of County Enrolled in TennCare (2021-22)



Source: Tennessee Livability Indicators Dashboard, East Tennessee State University, "TennCare Utilization."

Ambulance service providers say TennCare and Medicare's base reimbursement rates are too low. Nationally, the median total cost of providing emergency ambulance transport from May 2021 to May 2025 was $1,335.[72] Tennessee could work with the Center for Medicare and Medicaid Services (CMS) to increase TennCare rates, but Medicare rates are regulated at the federal level without the state's input.[73]

State action to increase the TennCare base rates could bring TennCare payments closer to costs but would need federal approval. Because mandated rates for TennCare's MCOs are classified as state directed payments (SDPs),[74] TennCare must seek the federal government's approval through the Center for Medicaid Services (CMS) for the new mandated rate. TennCare already completes the re-approval process for directed

[72] PWW Advisory Group 2025b (analyzing Buttorff et al. 2025).

[73] 42 Code of Federal Regulations Chapter IV.

[74] See Center for Medicaid Services 2021.

payments annually, including the current mandated ambulance transport rate of 67.5% of the Medicare allowable. TennCare said that the process is arduous—the application is "20-plus pages with 40-plus multi-part questions"—and even though CMS promises a 90-day approval period, the process can take more than six months and involve multiple rounds of back-and-forth questions.[75]

TennCare also expressed concern[76] that an increase in the state directed payments for ambulance services could run afoul of recent federal legislation that limited state directed payments for inpatient hospital services,[77] outpatient hospital services,[78] nursing facility

[75] Interview with Zane Seals, chief financial officer, Ashley Reed, legislative chief, and Samantha Rummage, fiscal chief of staff, TennCare, September 2, 2025.

[76] Ibid.

[77] 42 Code of Federal Regulations Section 440.10. Inpatient hospital services are defined as services that (1) are ordinarily furnished in a hospital for the care and treatment of inpatients; (2) are furnished under the direction of a physician or dentist; and (3) are furnished in an institution that (i) is maintained primarily for the care and treatment of patients with disorders other than mental diseases; (ii) is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; (iii) meets the requirements for participation in Medicare as a hospital; and (iv) has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of 42 Code of Federal Regulations Chapter IV, unless a waiver has been granted by the Secretary.

[78] 42 Code of Federal Regulations Section 440.20. Outpatient hospital services are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that (1) are furnished to outpatients; (2) are furnished by or under the direction of a physician or dentist; and (3) are furnished by an institution that (i) is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and (ii) Meets the requirements for participation in Medicare as a hospital; and (4) may be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of "outpatient hospital services" those types of items and services that are not generally furnished by most hospitals in the State.

services,[79] and qualified practitioner services[80] to 110% of the specified total published Medicare payment rate in non-expansion states like Tennessee.[81] Some counties' ambulance service providers are hospitals, like Maury Regional Health, and therefore their providers' reimbursement rates would be limited to 110% of the Medicare payment rate.

Currently, because most counties' primary ambulance service providers seem to be outside the definitions for the categories whose state directed payments are limited to 110%, it is possible that TennCare could avoid the limits and increase ambulance service payments to most counties' service providers by applying for federal approval of those directed payments separately from hospital-based providers. However, based on TennCare's description of the application process and the federal government's current directive to reduce Medicaid payments to equal with Medicare rates,[82] these solutions are difficult and perhaps unachievable.

Moreover, a newly proposed rule from the Centers for Medicare and Medicaid Services (CMS) that would take effect in 2029 would limit all state directed payments, including those to non-hospital ambulance service providers, to 110% of the Medicare payment rate. This would render methods of avoiding the current 110% limit—like applying for ambulance directed payments separately or carving out hospital-based providers—moot. This new rule would decrease the reimbursement dollars available for counties'

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[79] 42 Code of Federal Regulations Section 440.40. Nursing facility services are defined as services that are (i) needed on a daily basis and required to be provided on an inpatient basis under §§ 409.31 through 409.35 of 42 Code of Federal Regulations Chapter IV. (ii) provided by (A) a facility or distinct part (as defined in § 483.5(b) of 42 Code of Federal Regulations Chapter IV) that meets the requirements for participation under subpart B of part 483 of 42 Code of Federal Regulations Chapter IV, as evidenced by a valid agreement between the Medicaid agency and the facility for providing nursing facility services and making payments for services under the plan; or (B) if specified in the State plan, a swing-bed hospital that has an approval from CMS to furnish skilled nursing facility services in the Medicare program; and (iii) ordered by and provided under the direction of a physician.

[80] 42 Code of Federal Regulations Section 438.6(a). Qualified practitioner services at an academic medical center are defined as professional services provided by both physicians and non-physician practitioners affiliated with or employed by an academic medical center.

[81] Public Law 119-21, Section 71116, 119th Congress, 1st Session (2025).

[82] Interview with Johnny Lai, director, and Vincent Pinkney, deputy director, Managed Care Operations, TennCare, March 25, 2026.

ambulance providers, especially those where TennCare patients make up a greater portion of their patient pool than other counties.[83]

The sum of the base rate payment for emergency ambulance transport (67.5% of Medicare's 2026 base $284.56 payment, approximately $192.08) and the GAAP payment a flat rate of $229.50 per TennCare transport in 2026) is $421.58, approximately 148% of the base Medicare rate. The actual percentage of Medicare paid by TennCare's MCO's ends up slightly lower because the addition of mileage dollars decreases the ratio. For example, the sum of the base rate and mileage payment for emergency transport in an urban area is $516.35; a provider who receives the average paid by TennCare's MCOs, 75% of the base Medicare rate, and the GAAP payment would receive $616.76, or 120% of the base Medicare rate. Even if a service only receives the state-mandated minimum of 67.5%, the sum paid to the ambulance service would be 112% of the Medicare rate, more than the new limits. Per both Medicare's current and proposed rules, Tennessee's state directed payments will have a grandfathering period to reduce their payments by 10% increments until the rates are in line with federal guidelines. TennCare says they will do so by continuing to pay their base rate and reducing the GAAP payment to the degree necessary to meet the 110% limit.[84] This required decrease would limit the reimbursement dollars available to ambulance services and further widen the deficit between what counties spend on ambulance services.

Some previously proposed state actions to raise reimbursement rates for ambulance service providers are likely still viable. For example, in the 114th General Assembly, Senate Bill 748 by Senator Yager and House Bill 201 by Representative Hicks would have increased the TennCare reimbursement rate for non-emergency transportation to 100% of the Medicare payment rate. Because non-emergency transport trips are not eligible to receive the GAAP supplemental payment, the only current state directed payment for these trips is the 67.5% TennCare base rate. Because it is the only payment, increasing the TennCare base rate to 110% would not exceed the upcoming 110% limit set by CMS. The Fiscal Review Committee found that this bill would cost the state $2,265,800.[85]

Senate Bill 1805 by Senator Bailey and House Bill 1836 by Representative Hale, also in the 114th General Assembly, would have terminated the GAAP supplemental payment and increased the reimbursement rate for covered ambulance service to a TennCare-enrolled

[83] Center for Medicare and Medicaid Services 2026.

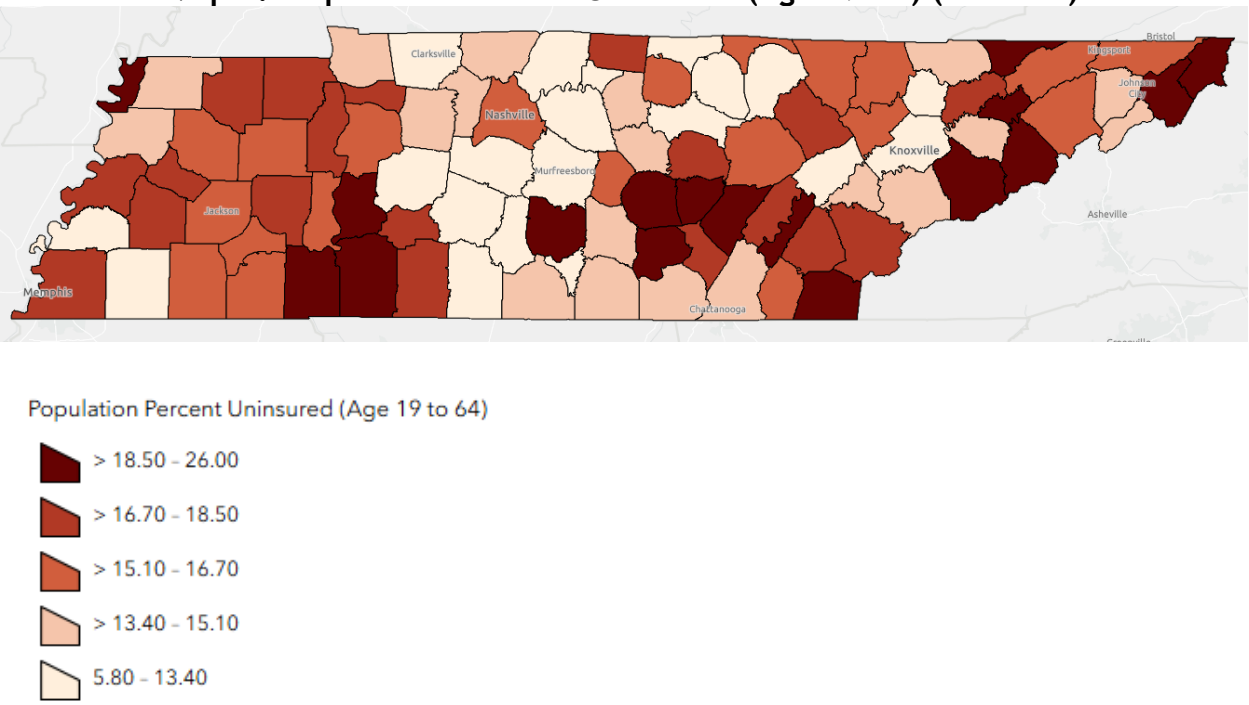
[84] Email from Samantha Rummage, fiscal chief of staff, Fiscal Division, TennCare, May 27, 2026.

[85] Fiscal Review Committee 2025a.

patient at a rate not less than 110% of the Medicare rate for the same service. Without the GAAP payment, a base reimbursement set at 110% of the Medicare rate would not exceed the upcoming limit set by CMS. The Fiscal Review Committee found that this bill would cost the state $14,045,300.[86]

Areas of the state with proportionally large percentages of their population who are not insured will not benefit as much from any insurance reimbursement rate increases. See map 2. Ambulance service representatives and county service specialists described direct pay bills as difficult to collect.[87]

Map 2. Population Percent Uninsured (Age 19-64) (2021-22)



Source: Tennessee Livability Indicators Dashboard, East Tennessee State University, "Uninsured Rates."

National data from 2022 show that ambulance services receive about 87.5% of their revenue from their patients, either directly from the patients themselves or from their insurers. Direct pay (9% of patient revenue) Medicare (36%), private insurance (28%),

[86] Fiscal Review Committee 2025b.

[87] Interview with Terry Frank, mayor, and Nathan Sweet, EMS director, Anderson County, June 16, 2025; and interview with Marc Alley, emergency/fire management consultant, County Technical Services Association, February 20, 2026.

Medicaid (17%), and other sources[88] (10%) are all sources of revenue.[89] Comprehensive Tennessee data was unavailable, but commission staff's survey of Tennessee counties yielded similar data from 19 counties covering fiscal year 2019-20 through 2023-24. These counties received revenue from the same sources in a similar breakdown—direct pay (10% of patient revenue), Medicare (49%), private insurance (18%), Medicaid/TennCare (13%), and other sources (11%).[90]

This array of payors is referred to as an ambulance service's payor mix, and the makeup of a service's payor mix influences how much revenue the service generates. Typically, private insurers pay the highest reimbursement rates. A 2025 blind study of commercial payors by Alston and Bird found that the average commercial rate (ACR) in Tennessee for Advanced Life Support transports was $1,143 per transport.[91] Tennessee-specific data showing the average Medicare payment in the state was unavailable, but national data was available to show the average ($1,147) and median ($625) Medicare payment for Advanced Life Support transport.[92]

The General Assembly should make funding for its existing ambulance equipment grant recurring.

Equipment costs make up about 4% of the average ambulance service's costs, nationally.[93] Tennessee specific data was not available; however, applying that same percentage to Tennessee figures demonstrates the effect of equipment spending on ambulance services' costs. Four percent of county spending on primary ambulance service providers, just under $493 million, would be just under $20 million.[94] These supplies can be difficult to obtain, depending on their place of origin and demand for medications. Wilson County's ambulance service said that the supply chain of medicine has caused cost increases, and

[88] Defined as "TriCare or the Veterans Administration…workers compensation or unknown." See Health Management Associates 2025.

[89] Health Management Associates 2025.

[90] TACIR staff survey of Tennessee Counties.

[91] Alston and Bird 2025.

[92] PWW Advisory Group 2025a (analyzing Mulcahy et al. 2024).

[93] Buttorff et al. 2025.

[94] TACIR staff analysis of Comptrollers' Local Government Audit data, county Annual Financial Reports, and TACIR staff survey of counties.

they expected increases based on new federal tariffs.[95] City fire departments, which represent a major portion of city contributions to county ambulance services, also experience equipment costs. Brentwood Fire said that when Williamson Health stopped supplying some of the fire departments, the department experienced an immediate increase in costs and needed to double their equipment budget for the following year.[96]

The state has required counties to provide 12 services[97] and provides grants for most of them. Of the 12 required county services in Tennessee, 10 receive grant funding from the state. Five (emergency management, law enforcement, roads and bridges, solid waste, and storm water) receive recurring grants, three receive non-recurring grants (ambulance services, jails, and medical examiners), and two do not receive grants (courthouses and growth management). See table 3.

[95] Interview with Brian Newberry, EMS director, Wilson County, August 7, 2025.

[96] Interview with Brian Collins, fire chief, Brentwood Fire Department, June 24, 2025.

[97] UT County Technical Assistance Service, "Required and Optional Services."

Table 3. State Funding for Required County Services

Required County Service	Grant(s)	Partial Reimbursements	Direct Funding	Zero
Ambulance Service	X	X		
Education	X		X	
Civil Defense	X			
Courthouse				X
Growth Management Policy				X
Health Department*	X		X	
Law Enforcement	X			
Jail	X (infrequent)	X (state inmates)		
Medical Examiner	X (infrequent)	X (state autopsy)		
Roads and Bridges	X		X	
Solid Waste	X			
Storm Water	X			

Source: UT County Technical Assistance Service "Required and Optional Services"; Tennessee Department of Health 2025; Tennessee Code Annotated, Section 71-5-165; Tennessee Code Annotated, Section 49-3-103; Tennessee Emergency Management Agency. "Preparedness Grants and Programs"; Tennessee Emergency Management Agency "FEMA Public Assistance"; Tennessee Department of Health "Healthcare Resiliency in Tennessee"; Tennessee Code Annotated, Section 68-2-603(a)(4); Tennessee Office of Criminal Justice Programs (OCJP) "Violent Crime Intervention Funding (VCIF) and Downtown Public Safety Grants (DPSG)"; Office of the Governor 2025; Tennessee Code Annotated, Section 41-8-106; Tennessee Code Annotated, Section 41-4-115; Tennessee Code Annotated, Section 38-7-104; Tennessee Department of Health Rule 1200-15-03-.04; UT County Technical Assistance Service "State-Aid Highway Program"; Tennessee Department of Environment and Conservation (TDEC) "Grants Administration—Materials Management Program."; Tennessee Department of Environment and Conservation "Sewer Overflow & Stormwater Reuse Grant (OSG)."

* Grants available at state level. State pays county health director's salary.

The General Assembly appropriated $5 million for ambulance equipment grants in 2025,[98] which equaled $23,000 for each licensed ambulance service in the state. The same amount went to each ambulance service, and the grants were available to every ambulance service.[99] That previous grant funding for equipment was non-recurring, so services could not rely on the grant as they budgeted. The State did not provide a grant during the previous year but did provide a grant two years ago.[100] Changing the

[98] Public Chapter 1142, Acts of 2026.

[99] Tennessee Ambulance Service Association 2025.

[100] Tennessee Department of Health 2023.

equipment grant from non-recurring to recurring could help ambulance services better plan for the revenue.

Stakeholders say more training centers could improve staffing of ambulance services.

In Tennessee, the level of care provided by ambulance services is classified by both the equipment on the vehicles and the staff onboard (see Skills by Level of Licensure, below). The categories and their classes are based on whether the service provides Advanced or Basic Life Support. Advanced Life Support (ALS) is defined as care provided by advanced emergency medical technicians (AEMTs), or other EMS personnel having a higher level of licensure, who treat life-threatening or aggravating medical emergencies under medical control. Basic Life Support (BLS) is defined as care provided by EMS personnel, authorized through the appropriate level of licensure, who treat life-threatening medical emergencies under medical control.[101]

The bulk of Tennessee's ambulance services are divided into two categories by Tennessee Department of Health licensure rules based on how much they serve the county or counties in which they operate. Services designated by the local government as primary emergency responders are Category A (148 services), and any volunteer, not for profit services are Category C (54 services).[102] Other less common categories and their counts include Categories B for non-primary providers (0), E for conditional licenses (13), G for Rotorwing (10), H for fixed wing (1), I for invalid vehicle service (23), and S for special (5).

Category A is divided into 4 levels. Levels 1 and 2 require that 100% and 90% of runs, respectively, are made with ALS-equipped ambulances and staffed with 1 paramedic and 1 EMT (or higher level of certification). Level 3 requires that 100% of runs are made with ALS-equipped ambulances and staffed with two AEMTs. Level 4 requires that 90% of runs are made with ALS equipped ambulances staffed with an AEMT and EMT. Category C ambulances must operate at this level, as a minimum. Primary ambulance service providers (the service that 911 dispatch sends to emergencies by default) must make at least 90% of runs with an ALS-equipped ambulance staffed with at least an AEMT and EMT or better.[103]

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[101] Tennessee Department of Health Rule 1200-12-01-.14(1)(a) and (b).

[102] TACIR staff analysis of Department of Health EMS Services Directory, analyzed June 1, 2025.

[103] Tennessee Department of Health Rule 1200-12-01-.14(3).

Each certification outlined above relies on the skills of the ambulance staff to provide a particular level of service. There is a clear career progression path for ambulance crews through several levels of licensure, from Emergency Medical Responders (EMRs) to Critical Care Paramedics. See Table 4.

Table 4. Skills by Level of Licensure

Licensure	Examples of Skills	
Emergency Medical Responder (EMR)	Bag-valve-mask, cricoid pressure (Selleck's maneuver), CPR, obstruction removal, hemorrhage control, assist with spinal immobilization, extremity stabilization and splinting, emergency moves for endangered patients	
Emergency Medical Technician (EMT)	Oxygen setup and administration, long spine board, traction splint, cardiac arrest management, bleeding/shock control management, long bone and joint immobilization, airway management, medication administration	
Advanced Emergency Medical Technician	Intravenous fluids, IV therapy, bleeding/shock control management, wound dressing, analgesic administration, intraosseous infusion initiation, continuous positive airway pressure (CPAP) application	
Paramedic	Dynamic cardiology, endotracheal intubation, pleural decompression, pain medication administration	
Critical Care Paramedic	Chest tube placement, cricothyrotomy, initiate blood transfusion, assist with arterial line management, ventricular assist device monitoring, intracranial pressure monitoring, electrocardiograms	

Source: Tennessee EMS Board 2024; and Tennessee Department of Health 2024.

According to ambulance service providers, staffing shortages have not recovered since worsening during the COVID-19 pandemic. Ambulance service industry members and county representatives consistently focused on staffing issues as inhibitors. For example, the Tennessee Ambulance Service Association (TASA) said staffing is an issue and Knox County said there is a shortage of ambulance workers in Tennessee.[104] Williamson Health said that their ambulance service is not fully staffed despite being able to offer employees benefits like favorable scheduling and higher pay.[105] The Tennessee County Services Association said they're not sure that any ambulance provider would describe themselves as "well-staffed."[106] Wilson County was the only stakeholder interviewed who said that they have heard services are back to being fully staffed, compared to the previous five years when they were short-staffed.[107]

Ambulance service providers also said that retention rates have not recovered since the COVID-19 pandemic. Anderson County reported that "always recruiting" is the "new normal."[108] Wilson, Dickson, and Giles County reported employees leaving to work in other ambulance services for better pay or schedules, which the original county may be unable to finance or finalize in enough time to retain the employee.[109] Wilson, Giles, and Dickson County each reported needing recent pay increases to remain competitive with

[104] Interview with Tim Booher, president, and Keith Douglas, administrative liaison, Tennessee Ambulance Services Association, and Caroline Simmons, counsel, McMahan, Winstead & Richardson, May 6, 2025; and interview with Dwight Van de Vate, chief of staff, and Kevin Parton, senior director of public health, Knox County, and Chris Gobble, principal council, Stones River Group, June 9, 2025.

[105] Interview with Phil Mazzuca, CEO, Michael Wallace, EMS chief, Todd Tilghman, director of revenue cycle, and Melissa Headley, assistant director of revenue cycle, Williamson Health, and Rogers Anderson, mayor, Williamson County, and Jeffrey Moseley, senior member, Buerger Moseley & Carson, PLC, and Keith Douglas, administrative liaison, Tennessee Ambulance Services Association, and Caroline Simmons, counsel, and JP Homik, counsel, McMahan Winstead & Richardson, June 3, 2025.

[106] Interview with David Connor, executive director, Tennessee County Services Association, and Anthony Holt, executive director, Tennessee Association of County Mayors, April 29, 2025.

[107] Interview with Brian Newberry, EMS chief and deputy director, Wilson County Emergency Management Agency, August 7, 2025.

[108] Interview with Terry Frank, mayor, and Nathan Sweet, EMS director, Anderson County, June 16, 2025.

[109] Interview with Brian Newberry, EMS chief and deputy director, Wilson County Emergency Management Agency, August 7, 2025; interview with Bob Rial, Mayor, and Donny Bear, EMS director, Dickson County, July 30, 2025; and interview with Graham Stowe, mayor, and Willow Chavez, EMS chief, Giles County, May 28, 2025.

surrounding counties.[110] Anderson County said employees leave for other reasons—pharmacy school, hospital jobs, and leaving EMS completely were all mentioned as common motives.[111] TBR staff said that the employment length of an average EMT is about eight months now, compared to about 5 years historically.[112] In 2021, the national turnover rate was 24% for EMTs and 26% for paramedics, higher than other healthcare professions in the same year (e.g., 19.5% for all hospital staff, 18.7% for registered nurses).[113]

In Tennessee, EMTs average $40,090 per year, while paramedics average $57,880 (2024). The average annual wages vary across Tennessee MSAs. For example, paramedics average $38,220 in Kingsport/Bristol and average $69,130 in Cleveland.[114] According to O*Net, a labor data collector sponsored by the United States Department of Labor, Tennessee will need 9% (280) more EMTs and 11% (390) more paramedics, from 2022 to 2032.[115]

Because increasing levels of care require increasing levels of employee skill, training is an essential aspect of staffing. A study of United States paramedic education programs found that 1 in 3 students are lost from the workforce due to "attrition during the educational program or failure to certify after course completion.[116] See also Powell et al 2024. The Tennessee Board of Regents (TBR) offers training opportunities at the state's colleges and expressed confidence in their training capabilities, saying that emergency service program offerings and capabilities have expanded across the state. They said that TBR schools have awarded an increasing number of certificates and degrees, including

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[110] Interview with Brian Newberry, EMS chief and deputy director, Wilson County Emergency Management Agency, August 7, 2025; interview with Bob Rial, mayor, and Donny Bear, EMS director, Dickson County, July 30, 2025; and interview with Graham Stowe, mayor, and Willow Chavez, EMS chief, Giles County, May 28, 2025.

[111] Interview with Terry Frank, mayor, and Nathan Sweet, EMS director, Anderson County, June 16, 2025.

[112] Interview with Jothany Reed, vice chancellor for academic affairs, Zachary Adams, assistant vice chancellor for academic affairs and workforce alignment, John Williams, assistant vice chancellor for government and public relations, Tennessee Board of Regents, and David Blevins, director of EMS education programs, Roane State Community College, July 31, 2025.

[113] American Ambulance Association, Newton 360, Doverspike Consulting, and The Center for Organizational Research 2021; and Nursing Solutions Inc. 2021.

[114] U.S. Bureau of Labor Statistics "Occupational Employment and Wage Statistics."

[115] O*Net, "Tennessee Employment Trends."

[116] Ball et al. 2023.

1,362 EMT certificates (a 16.7% increase), 468 paramedic certificates (a 37.8% increase), 138 paramedic associate degrees (a 2.5% increase), and 948 AEMT certificates (no increase) over the last 3 years. They also said that enrollment has increased across all programs, including the EMT (a 3.1% increase), AEMT (a 3.6% increase), paramedic (a 40.2% increase), and paramedic associates degree (a 9.1% increase) programs.[117]

Still, stakeholders reported that not enough trained personnel are available. The Tennessee Ambulance Services Association (TASA) said that ambulance services have a difficult time hiring, in part, because the spots available in colleges are now being filled by individuals who are training to become nurses, firefighters, or other non-ambulance employees. As a result, TASA said, the graduating classes of trained EMS workers are not enough to meet the needs of the state.[118] A Meigs County official told them that they are in a "critical need crunch" for employees, reporting that national testing is difficult to pass and the college courses are unaffordable.[119]

Ambulance services gained a way to directly train their own employees when the General Assembly, after a 2018 pilot program, passed a law allowing ambulance services to start a total of 15 training centers operated by the ambulance services themselves.[120] These training centers allow ambulance services to hire individuals to work for their service and then train them to the level the service needs. Greene County, for example, said that they recently hired two individuals out of high school and plan to use their training center to help the new employees reach AEMT status while working for the service.[121] The

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[117] Email from Zachary Adams, assistant vice chancellor for academic affairs and workforce alignment, July 30, 2025.

[118] Interview with Phil Mazzuca, CEO, Michael Wallace, EMS chief, Todd Tilghman, director of revenue cycle, and Melissa Headley, assistant director of revenue cycle, Williamson Health, and Rogers Anderson, mayor, Williamson County, and Jeffrey Moseley, senior member, Buerger Moseley and Carson, PLC, and Keith Douglas, administrative liaison, Tennessee Ambulance Services Association, and Caroline Simmons, counsel, and JP Homik, counsel, McMahan Winstead and Richardson, June 3, 2025.

[119] TACIR staff survey of Tennessee counties.

[120] Public Chapter 489, Acts of 2019.

[121] Interview with Phil Mazzuca, CEO, Michael Wallace, EMS chief, Todd Tilghman, director of revenue cycle, and Melissa Headley, assistant director of revenue cycle, Williamson Health, and Rogers Anderson, mayor, Williamson County, and Jeffrey Moseley, senior member, Buerger Moseley and Carson, PLC, and Keith Douglas, administrative liaison, Tennessee Ambulance Services Association, and Caroline Simmons, counsel, and JP Homik, counsel, McMahan Winstead and Richardson, June 3, 2025.

Board of Regents emphasized that these centers cannot train paramedics.[122] These centers can train three classes of 20 students per year to become emergency medical technicians and advanced emergency medical technicians for a total of 60 students annually.[123] Greene County reported that these programs have "deepened the pipeline of EMTs" in the area; their service even runs EMS education at the local high schools.[124] The General Assembly raised the cap on the number of allowed training centers from 15 to 30 in 2022;[125] the cap remains at 30 today, and 30 training centers are licensed to operate.[126] Stakeholders mentioned raising or removing the cap as potential alternatives to help improve the availability of EMS workers.[127]

Removing the cap would eliminate the waiting list but could cause issues for regulators. A representative from the Office of Emergency Medical Services, which regulates the training centers, said that each new training service requires additional resources and time from their office and they have not received a staff increase related to the previous increase from 15 to 30 training centers.[128] TBR also emphasized the importance of slow

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[122] Interview with Jothany Reed, vice chancellor for academic affairs, Zachary Adams, assistant vice chancellor for academic affairs and workforce alignment, John Williams, assistant vice chancellor for government and public relations, Tennessee Board of Regents, and David Blevins, director of EMS education programs, Roane State Community College, July 31, 2025.

[123] Tennessee Code Annotated, Section 68-140-331.

[124] Interview with TJ Manis, EMS director, Greene County, August 14, 2025.

[125] Public Chapter 684, Acts of 2022.

[126] Tennessee Code Annotated, Section 68-140-331.

[127] Interview with Jothany Reed, vice chancellor for academic affairs, Zachary Adams, assistant vice chancellor for academic affairs and workforce alignment, John Williams, assistant vice chancellor for government and public relations, Tennessee Board of Regents, and David Blevins, director of EMS education programs, Roane State Community College, July 31, 2025; interview with Tim Booher, president, and Keith Douglas, administrative liaison, Tennessee Ambulance Services Association, and Caroline Simmons, counsel, McMahan, Winstead & Richardson, May 6, 2025; and interview with Phil Mazzuca, CEO, Michael Wallace, EMS chief, Todd Tilghman, director of revenue cycle, and Melissa Headley, assistant director of revenue cycle, Williamson Health, and Rogers Anderson, mayor, Williamson County, and Jeffrey Moseley, senior member, Buerger Moseley & Carson, PLC, and Keith Douglas, administrative liaison, Tennessee Ambulance Services Association, and Caroline Simmons, counsel, and JP Homik, counsel, McMahan Winstead & Richardson, June 3, 2025.

[128] Email from Russell Gupton, EMS consultant at-large/statewide, Tennessee Department of Health, Office of Emergency Medical Services.

growth to allow regulation and quality assurance.[129] At commission staff's request, the Office of EMS provided data from the 30 training centers, including the date the center was certified, how many students the centers have trained in the last three years, the end date of the last class the center produced, and the center's three-year average pass rate. That data indicates that only 1,059 of the 5,040 available seats from 2022 through 2025; in other words, ambulance training centers used about 21% of the statutory cap. One ambulance training center is currently on the waiting list to join the 30 approved training centers, and one ambulance training center has not produced a graduate since 2019.[130]

Because the centers do not seem to operate at capacity and one service is not currently using their training center, one option to eliminate the waiting list is to change the cap to 30 active training centers and remove the currently inactive training centers. While quick, this change presents a few problems. First, the General Assembly would need to create and apply a definition for "active," which requires more drafting of legislation compared to a simple increase or cap removal. Second, while a service may not currently have a need for training capacity, the service did have a need at one time and was able to obtain licensure to conduct that training. Removing a training center from the approved list would prevent the service from responding to training needs in the future. Finally, while only one service is currently on the waiting list, any future additions to the waiting list would be unable to join until another service becomes inactive, meaning the General Assembly may need to revisit the cap quickly.[131]

Another alternative is to increase the cap from 30 active training centers to a higher number. TBR said they would support further increases when they became necessary.[132] Trainees must pass national exams to be licensed as emergency medical technicians, and judging by first attempt pass rates, quality of the training centers was not harmed when the cap was increased from 15 to 30 in 2022. Pass rates were approximately the same for

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[129] Interview with Jothany Reed, vice chancellor for academic affairs, Zachary Adams, assistant vice chancellor for academic affairs and workforce alignment, John Williams, assistant vice chancellor for government and public relations, Tennessee Board of Regents, and David Blevins, director of EMS education programs, Roane State Community College, July 31, 2025.

[130] TACIR staff analysis of EMS training center data provided by the Tennessee Department of Health, Office of Emergency Medical Services.

[131] Ibid.

[132] Interview with Jothany Reed, vice chancellor for academic affairs, Zachary Adams, assistant vice chancellor for academic affairs and workforce alignment, John Williams, assistant vice chancellor for government and public relations, Tennessee Board of Regents, and David Blevins, director of EMS education programs, Roane State Community College, July 31, 2025.

training centers started before or after the increase—62% and 63%, respectively.[133] An increase of the same size would allow regulators to respond to the increase without being overwhelmed. Additionally, the state and training centers have proposed an increase of this size before and were able to successfully amend the law to approve that change.[134]

There are other opportunities for local governments and ambulance services to increase revenue and reduce costs.

In addition to increased county and city cooperation, the commission identified other opportunities for some local governments and ambulance services to increase revenue or reduce costs. While these opportunities may not be applicable to or feasible for all counties, counties who are able to implement these changes will be able to increase the revenue generated by their primary ambulance service provider or reduce the cost of providing that service.

Third party billing.

Contracting with a third-party billing company can improve collection rates for ambulance service charges. When an ambulance service provider bills a patient or patient's insurance for providing their services, they rely on the payor to reimburse the service for the cost of providing transportation to the patient's necessary destination. In some instances, insurance may refuse to pay or pay less than the service expects.[135] For example, an insurance company may refuse to reimburse a billed claim for emergency transport if they deem that emergency transport was not medically necessary according

[133] Interview with Jothany Reed, vice chancellor for academic affairs, Zachary Adams, assistant vice chancellor for academic affairs and workforce alignment, John Williams, assistant vice chancellor for government and public relations, Tennessee Board of Regents, and David Blevins, director of EMS education programs, Roane State Community College, July 31,2025; and TACIR staff analysis of EMS training center data provided by the Tennessee Department of Health, Office of Emergency Medical Services.

[134] Public Chapter 684, Acts of 2022.

[135] Interview with Stephan Russ, executive medical director, Vanderbilt LifeFlight, July 11, 2025.

to their policy's definition.[136] Insurance may pay less than expected if the transport was provided by an out-of-network ambulance service provider.[137] In these instances, an ambulance service without a third party billing company would need to invest the hours themselves to litigate the claim with the insurance company or otherwise accept the lower or zero-dollar payment.

A representative from Vanderbilt LifeFlight said that their service has seen a steady decrease in the funds reimbursed from Medicare at the same time as an increase in the use of Medicare Advantage plans. These advantage plans, they said, are incentivized to deny claims at a high rate to better manage the insured group's resources.[138] Denial rates were unavailable because insurance companies are not required to report that data. Vanderbilt LifeFlight said that these Advantage plans may deny a claim and say they need more information and then review the new information for several months before eventually paying or denying it again. Additionally, they said that insurance companies are using artificial intelligence to review and respond to claims for reimbursement,[139] and a recent study found that insurers are increasingly adopting AI claim review products that have been found to deny claims at a high rate.[140] Vanderbilt LifeFlight said that when claims are denied, they move them to bad debt for the hospital.[141]

Representatives from some ambulance services said they already outsourced their billing to a third-party. Dickson County said they outsourced the billing because it is not cost effective for them to do it in-house, and that the county's collection rates on payments improved after the service outsourced their billing.[142] Wilson County Emergency Management Agency said that the ambulance service quality controls their billing before

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[136] See, e.g., TennCare's requirement and definition of "medical necessity." Department of Finance and Administration Rule 1200-13-16-.01(31) (medically necessary is defined in Tennessee Code Annotated Section 71-5-144); Department of Finance and Administration Rule 1200-13-16-.03 (TennCare only pays for medically necessary services); Tennessee Code Annotated, Section 71-5-144 (a medically necessary service is one that is recommended by a licensed physician treating the enrollee, required to treat the enrollee's medical condition, safe and effective, not experimental or investigational, and the least costly alternative course of diagnosis or treatment that is adequate to treat the condition).

[137] TennCare Policy Manual. Policy No: PRO 08-001.

[138] Interview with Stephan Russ, executive medical director, Vanderbilt LifeFlight, July 11, 2025.

[139] Ibid.

[140] Mello, Trotsyuk, Mahamadou, and Char 2026.

[141] Interview with Stephan Russ, executive medical director, Vanderbilt LifeFlight, July 11, 2025.

[142] Interview with Bob Rial, mayor, and Donny Bear, EMS director, Dickson County, July 30, 2025.

sending it to a billing company who handles it from that point forward.[143] Vanderbilt LifeFlight said, despite their resources, that they are in the process of outsourcing their billing process because insurance payors are way ahead in the technological arms race and there are companies better suited to deal with the approval process, including fighting AI denials.[144]

Ambulance services who are not already using a third-party billing company could improve their collection rates—and, thereby, the available funds for their ambulance service—by contracting with a billing company who can manage claims and maximize the amount reimbursed while also investing the resources necessary to navigate the evolving insurance reimbursement landscape.

Non-emergency transport.

Some ambulance services also provide non-emergency transport. Definitions may vary slightly, but Medicaid defines non-emergency transport as transportation to and from appointments and services for patients who have a legitimate need for the services where there is no immediate threat to the life or health of the patient.[145] Representatives of ambulance services who perform non-emergency transport described transport for dialysis, bariatric transport, hospital discharges, and interfacility transport as portions of their operations. Some ambulance services, like Anderson County and Giles County, provide limited or case-specific non-emergency transport, while others, like Tennessee Carriers, make it most or all of their service model.[146]

Unlike emergency transport, non-emergency transport is a planned and scheduled operation. Depending on the patient's insurance, either the service or patient must obtain authorization from the patient's insurance before they provide the non-emergency transport, which generally helps ensure reimbursement, though Tennessee Carriers and

[143] Interview with Brian Newberry, EMS chief and deputy director, Wilson County Emergency Management Agency, August 7, 2025.

[144] Interview with Stephan Russ, executive medical director, Vanderbilt LifeFlight, July 11, 2025.

[145] Center for Medicaid Services 2016.

[146] Interview with Sally Wynn, vice president of strategy and innovation, Luke Wynn, vice president of operations, and Martha Kendall, senior director of NEMT governance, Tennessee Carriers, and Estie Harris, counsel, HB Strategies, June 20, 2025; interview with Terry Frank, mayor, and Nathan Sweet, EMS director, Anderson County, June 16, 2025; and interview with Graham Stowe, mayor, and Willow Chavez, EMS chief, Giles County, May 28, 2025.

Greene County both said that they experience some denials.[147] The scheduled nature of these trips allows the service to allocate resources more efficiently than emergency calls. The service can establish the exact level of vehicle and employee necessary for the trip, schedule the trip during specific hours, and even keep specific non-emergency vehicles so that they do not have to pull ambulances out of the field.[148]

Because of the reimbursement structures used to pay for non-emergency transport, patient charges are often high enough to cover the full cost of non-emergency transport.[149] Services can negotiate different payment models with insurers. Tennessee Carriers said that most of their business comes from "per member per month" reimbursement, where two of TennCare's MCOs pay Tennessee Carriers a monthly rate to transport TennCare patients based on the total population of Medicaid-insured members in Tennessee. Tennessee Carriers also performs fee for service transport with one MCO, where Tennessee Carriers provides transport and is then reimbursed for that transport specifically.[150] Anderson County and Greene County said that they have specific arrangements with area medical facilities to perform non-emergency transport.[151] Currently, TennCare's non-emergency transport fees are set at 67.5% of the Medicare rate.[152] Senate Bill 748 by Senator Yager and House Bill 201 by Representative Hicks, proposed last during the 114th General Assembly, would have increased the TennCare reimbursement rate for non-emergency transportation to 100% of the Medicare payment rate.

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[147] Interview with Sally Wynn, vice president of strategy and innovation, Luke Wynn, vice president of operations, and Martha Kendall, senior director of NEMT governance, Tennessee Carriers, and Estie Harris, counsel, HB Strategies, June 20, 2025; and interview with TJ Manis, EMS Director, Greene County, August 14, 2025.

[148] Interview with Sally Wynn, vice president of strategy and innovation, Luke Wynn, vice president of operations, and Martha Kendall, senior director of NEMT governance, Tennessee Carriers, and Estie Harris, counsel, HB Strategies, June 20, 2025.

[149] Interview with Sally Wynn, vice president of strategy and innovation, Luke Wynn, vice president of operations, and Martha Kendall, senior director of NEMT governance, Tennessee Carriers, and Estie Harris, counsel, HB Strategies, June 20, 2025; and Farooq 2025.

[150] Interview with Sally Wynn, vice president of strategy and innovation, Luke Wynn, vice president of operations, and Martha Kendall, senior director of NEMT governance, Tennessee Carriers, and Estie Harris, counsel, HB Strategies, June 20, 2025.

[151] Interview with Terry Frank, mayor, and Nathan Sweet, EMS director, Anderson County, June 16, 2025; and interview with TJ Manis, Greene County EMS Director, August 14, 2025.

[152] Tennessee Code Annotated, Section 71-5-165.

Though non-emergency transport can be profitable, some county ambulance services report they don't have the equipment or personnel needed to provide non-emergency transport in addition to their legally required emergency transport. Dickson County said that they cannot afford to add additional miles from non-emergency transport to their already-ageing ambulances.[153]

Cost-sharing mechanisms.

Other ambulance services may find they can reduce some costs by sharing staff with other services. For example, in Tennessee, an area's ambulance service is responsible for employing a medical director who creates and maintains the standard of pre-hospital medical care used by the other emergency medical service entities in the area, including fire, hazmat, and police.[154] Although a medical director can cost an ambulance service upwards of $30,000 to $40,000 per year, ambulance services can share a single medical director. Vanderbilt LifeFlight said it provides medical direction for eight services for approximately $10,000 per year through their EMS Center of Excellence.[155]

Reimbursement for treatment in place or transport to alternate destinations.

Services may also use the Triage, Navigate, Treat and Transport program (TN-T2) program to generate revenue that would traditionally be unavailable. Health insurance—regardless of whether it is Medicare, TennCare, or a private insurer—typically reimburses ambulance services only for transporting a patient to an emergency room.[156] According to Department of Health data, from 2021 to 2024, Tennessee ambulance services transported a patient to the hospital on approximately 40% of emergency call responses. The remaining outcomes, like treating an individual at the scene and not transporting (approximately 13% of emergency call responses) or transporting them to an alternate destination (approximately 1% of emergency call responses), like a mental health facility,[157] would be ineligible for reimbursement under the traditional model. This dynamic creates an incentive for ambulance services to transport patients to the emergency room, even if they may not need to go to the hospital.

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[153] Interview with Bob Rial, mayor, and Donny Bear, EMS director, Dickson County, July 30, 2025.

[154] Tennessee Department of Health Rule 1200-12-01-.14(4).

[155] Interview with Stephan Russ, executive medical director, Vanderbilt LifeFlight, July 11, 2025; and Vanderbilt University Medical Center EMS Center of Excellence "Medical Direction."

[156] See, e.g., Medicare.gov "Ambulance services."

[157] TACIR staff analysis of TNEMSIS emergency response data (Tennessee Office of Emergency Medical Services).

Though this generates money in the short term, unnecessary transports can contribute to longer "wall times"—when ambulances must wait at the hospital for their patient to be admitted to the emergency room—which prevents the ambulance from responding to other emergency calls.[158] To address this issue, the State created a TennCare program—TN-T2—to reimburse ambulance services for treatment in place or transport to an alternate destination of TennCare-enrolled patients. This program was modeled after a federal version of the same program and made permanent by Public Chapter 919, Acts of 2022. In 2025, about 50% of licensed Tennessee ambulance services made at least one claim for reimbursement under the TN-T2 program.[159]

[158] Shaw et al. 2025.

[159] Interview with Johnny Lai, director, and Vincent Pinkney, deputy director, Managed Care Operations, TennCare, March 25, 2026.

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Appendix A: Public Chapter 413, Acts of 2025

State of Tennessee

PUBLIC CHAPTER NO. 413

SENATE BILL NO. 160

By Hensley, Jackson, Walley

Substituted for: House Bill No. 83

By Capley, Doggett, Crawford

AN ACT to amend Tennessee Code Annotated, Title 7, Chapter 61, relative to ambulance service.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The Tennessee advisory commission on intergovernmental relations (TACIR) shall study the economic impact on counties that are required to provide ambulance services, which counties provide services directly or franchise those services, which municipalities provide ambulance services, and whether policy changes may benefit the overall health and delivery of ambulance services in this state.

SECTION 2. TACIR shall further study emergency and non-emergency transport reimbursement including from commercial payors, Medicare, Medicaid, and the way counties and municipalities fund the deficit at which these services operate.

SECTION 3. TACIR may request information and input from other appropriate state and local governmental entities, as necessary, and such entities shall comply with TACIR's request. The study must be conducted from TACIR's existing resources.

SECTION 4. Upon completion of the study required by Sections 1 and 2, TACIR shall report its findings and recommendations, including any proposed legislation, to the chair of the state and local government committee of the senate and the chair of the committee of the house of representatives having jurisdiction over subject matters pertaining to state and local government, and provide a copy of the report to the legislative librarian. The report may be delivered electronically.

SECTION 5. This act takes effect upon becoming a law, the public welfare requiring it.

SENATE BILL NO. 160

PASSED: April 21, 2025

RANDY McNALLY
SPEAKER OF THE SENATE

CAMERON SEXTON, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 9th day of May 2025

BILL LEE, *GOVERNOR*

Appendix B. Summary of TennCare Cost and Utilization Report Database, 2024

Statewide Activity and Revenue:

- Total transports: 1,251,189 (Emergency 778,299; Non-Emergency 472,890)
- Gross transport revenue: $1.8B (Emergency $1.1B; Non-Emergency $675.4M)
- Total Bad Debt Expense: $209.3M
- Net transport revenue: $633.8M*
- Assessment total: $11,927,820

Fleet, Equipment, and Quality:

- Vehicles: 1,894 (Avg. year of manufacture: 2018.69; Range 1986–2025)
- Stretchers: 1,626 hydraulic; 205 manual (7.9:1 ratio)

Top 10 Ambulance Services by Total Transports:

1. Memphis Fire Department—88,873
2. Nashville Fire Department—85,181
3. Shoals Ambulance—59,678
4. Rural/Metro of Tennessee—52,681
5. Medical Center EMS (Benton, Chester, Dyer, Madison, McNairy)—46,355
6. Hamilton County EMS—37,609
7. Amerimed EMS—31,845
8. Acadian Ambulance Service—31,713
9. Healthcare Transport—29,924
10. Rutherford County EMS—29,522

Source: TennCare Cost and Utilization Report 2025.
*Net Transport Revenue = Gross Revenue - Bad Debt Expense - Contractual Allowances