REFORMING HEALTHCARE ACCESS: ADDRESSING LIMITED EMERGENCY ACCESS TO HEALTHCARE IN RURAL NORTH DAKOTA COMMUNITIES

ABSTRACT

North Dakota citizens' access to emergency healthcare treatment is actively at risk as hospitals and urgent care facilities continue to close across the state. Rural communities' access to necessary healthcare treatments is especially impacted. This lack of accessibility inhibits North Dakota citizens' right to life, liberty, and safety by discriminating against rural and poor citizens who may be exposed to higher risks with limited healthcare access. While the federal Emergency Medical Treatment and Labor Act (EMTALA) is intended to ensure access to emergency stabilization and transfer regardless of a patient's ability to pay, questions remain about whether those obligations extend to keeping hospitals and emergency treatment facilities open. Additionally, no federal law currently guarantees that emergency facilities remain available to rural communities. As a result, communities are left vulnerable to time sensitive care being delayed, increases in patients' risk of adverse complications, and life-altering outcomes.

To address this critical gap between federal and state healthcare access and diminish its emergency care deserts, North Dakota must expand its authority based on federal regulation and enact legislation to secure emergency healthcare availability for all citizens.

Such a bill will help with the distribution of ambulance gaps by creating EMT scholarship incentives to practice in rural communities for a period of time. Additionally, it will expand the emergency transfer networks within North Dakota and make emergent telehealth support more accessible. Accordingly, by broadening healthcare access across North Dakota, patients will be protected and see improved health outcomes.

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I. INTRODUCTION

Across the United States, the emergency medical services workforce is shrinking.[1] This shortage is a growing crisis for the availability of emergency care services in life-or-death situations.[2] For example, emergency medical services' response times in rural communities can be exceedingly long

1. Joyce Froetschel, *The Crisis of Paramedic and EMS Shortages: A Rural Emergency*, HEALTHCARE BUS. TODAY (Nov. 20, 2024), https://www.healthcarebusinesstoday.com/paramedic-ems-shortages-rural-emergency/ [https://perma.cc/L9L9-F4AW].

2. *See id.*

because there are not enough personnel and resources available, which can lead emergency personnel to travel greater distances and often causes them to arrive too late.[3] Additionally, rural hospitals have to transfer patients emergently to other facilities because they do not provide advanced care resources.[4] This further limits emergency medical coverage to rural areas as emergency personnel are tied up for extended periods during transfers.[5]

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires emergency departments to provide medical screening to anyone who arrives at a hospital's emergency department needing care.[6] Then, the hospital must stabilize and treat the patient regardless of the patient's "insurance status or ability to pay."[7] EMTALA also requires unstable patients to be transferred if "appropriate."[8] This transfer requirement can extend rural emergency personnel's obligations, leaving the rural community with limited coverage.[9] Although EMTALA's goal is to ensure everyone receives equal access to emergency medical care, it does not require rural hospital emergency medical services to remain open.[10] As a result, small rural hospitals may still face financial pressures that lead to closures.[11] Additionally, Senators have raised concerns that reductions in Medicaid

3. *Id.*

4. *Id.*

5. *Id.*

6. *See* Theresa Ryan Schultz, Jacqueline Forbes & Ashley Hafen Packard, *Emergency Medical Treatment and Labor Act: Impact on Health Care, Nursing, Quality, and Safety*, 33 QUALITY MGMT. HEALTH CARE 39, 42 (2023) ("The key points of EMTALA include: (a) the need to complete a medical screening examination; (b) ensuring that the patient is stabilized; (c) arranging appropriate transfer; (d) ensuring that receiving facility has accepted the patient; and (e) ensuring on-call provider response when indicated.").

7. *Id.* at 39.

8. *See* JENNIFER A. STAMAN, OVERVIEW OF THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) AND EMERGENCY ABORTION SERVICES, CONG. RSCH. SERV. (2023) ("EMTALA restricts hospitals from transferring unstable patients unless the transfer is 'appropriate' and meets certain conditions. Among these conditions, a transfer may occur if the hospital informs the patient of its EMTALA obligations and the risks of transfer, and the patient makes a written request for the transfer to another medical facility.").

9. *See generally* Schultz, Forbes & Packard, *supra* note 6 (emphasizing that EMTALA imposes additional responsibilities and workforce demands on emergency department personnel).

10. *See generally* MICHELLE R. HACKLEY, EMTALA: A PRACTICAL PRIMER FOR RISK PROFESSIONALS 3 (2021) (governing hospitals' obligations to provide all persons with equal access to emergency medical services without imposing a duty to continue operating); 42 U.S.C. § 1395dd (requiring hospitals to screen, stabilize, and treat patients who present at the emergency department with an emergency medical condition, but not requiring hospitals to remain open); 42 C.F.R. § 489.24 (requiring Medicare participating hospitals to provide a medical screening examination and necessary stabilizing treatment if an emergency medical condition exists without insisting hospitals maintain ongoing operations).

11. *See* Alana Semuels, *The Surprising Reason Rural Hospitals Are Closing*, TIME (July 1, 2025, at 10:19 CT), https://time.com/7298891/rural-hospitals-closing-explained-health-care/ [https://perma.cc/GED4-ZM3S].

spending could threaten the financial viability of rural hospitals nationwide.[12] This reduction lessens any leverage rural hospitals have to negotiate discounts with private insurers compared to urban hospitals.[13] The gap in rural emergency medical funding and legislation has contributed to hospital closures across the country.[14] Therefore, state action is necessary to implement legislation that prevents limited access of emergency medical services in rural North Dakota communities.[15]

In North Dakota, every citizen has inalienable rights of life, liberty, and safety.[16] Yet, North Dakota residents living in rural communities do not have equal access to healthcare compared to citizens in urban areas.[17] This gap in healthcare access raises challenges because patients must wait longer and travel farther distances to receive emergency medical care.[18] As a result, these delays put citizens' rights to life and liberty at risk and emphasize the need for North Dakota to enact legislation that supports the expansion of emergency healthcare services in rural communities.[19]

II. LEGAL BACKGROUND

Federal and state law establish the framework for how emergency medical services can guarantee access to healthcare for North Dakota citizens.[20] At the federal level, EMTALA and federal funding play a role in ensuring citizens in rural communities have access to healthcare.[21] At the state level, the North Dakota Legislature has enacted bills and looked into future solutions that provide emergency healthcare to its residents.[22]

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12. Heather Saunders, Alice Burns & Zachary Levinson, *How Might Federal Medicaid Cuts in the Enacted Reconciliation Package Affect Rural Areas?*, KFF (July 24, 2025), https://www.kff.org/medicaid/how-might-federal-medicaid-cuts-in-the-enacted-reconciliation-package-affect-rural-areas/ [https://perma.cc/PQJ9-RBY4].

13. Semuels, *supra* note 11.

14. *See generally id.* (explaining that inadequate reimbursement and legislative decisions can impact the financial viability of rural hospitals).

15. *See generally* discussion *supra* notes 1–14.

16. N.D. CONST. art. I, §1.

17. *See States With the Biggest Discrepancies Between Urban and Rural Healthcare Access*, CONCORDIA U. TEX., https://absn.concordia.edu/states-rural-urban-healthcare-disparities/ [https://perma.cc/39N2-EKRW] (noting North Dakota has the largest healthcare access gap nationwide, "with rural residents facing 2,079 more people per primary care physician than urban residents").

18. *Id.*

19. *See generally* discussion *supra* notes 16–18.

20. *See generally supra* notes 6–19.

21. *See* discussion *infra* Sections II.A.1, II.A.2.

22. *See* discussion *infra* Section II.B.

A. FEDERAL EMERGENCY HEALTHCARE LEGISLATION

Federal law establishes specific obligations for Medicare-participating hospitals that provide emergency medical care services and shapes how states supplement those protections.[23] Although federal EMTALA requirements allow patients access to emergency medical care; the statute does not require hospitals to stay open.[24] As a result, EMTALA protections ensure access to emergency services only where a hospital or emergency department already exists.[25] This limitation to emergency healthcare access leaves rural communities vulnerable when hospitals close or reduce ambulance services.[26] This gap in federal emergency medical care necessitates state intervention to ensure that access to emergency medical services remains available for rural communities.[27] Additionally, the federal government has decreased federal funding and tried to counteract these reductions through state rural healthcare funding.[28] However, the deficit still outweighs the federal rural healthcare funding given to states.[29] Ultimately, this federal funding provides North Dakota the opportunity to improve emergency medical services across the state.[30]

1. The Emergency Medical Treatment and Active Labor Act

In 1986, Congress passed EMTALA under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to ensure patients had access to

23. *See* Office of Inspector General, U.S. Dep't of Health & Hum. Servs., *The Emergency Medical Treatment and Labor Act (EMTALA)*, HHS-OIG (Sep. 11, 2024), https://oig.hhs.gov/reports/featured/emtala/ [https://perma.cc/46H8-8KN8] (defining Medicare-participating hospitals as hospitals that have entered into provider agreements with the federal government and, as a condition of participation in Medicare, must comply with EMTALA).

24. *See generally* 42 U.S.C. § 1395dd (establishing Medicare-participating hospitals' obligations to provide emergency medical screening and stabilizing treatment); 42 C.F.R. § 489.24 (implementing EMTALA by defining participating hospitals and delineating when those statutory obligations are triggered).

25. *See id.*

26. *See id.*

27. *See supra* notes 16–19, 23–25 and accompanying text.

28. *See generally* Saunders, Burns & Levinson, *supra* note 12 (stating federal Medicaid funding will be reduced by approximately $911 billion across ten years and that to address funding concerns, states will be given grants for rural health programs totaling $50 billion throughout five years); Jacob Orledge, *North Dakota Receives $199 Million in Federal Grant for Rural Health Care*, N.D. MONITOR (Dec. 29, 2025, at 13:41 CT), https://northdakotamonitor.com/2025/12/29/north-dakota-receives-199-million-in-federal-grant-for-rural-health-care/ [https://perma.cc/JG4Q-ZHQA] (noting the federal government awarded North Dakota $199 million dollars for the first year of the grant program).

29. *See generally* Saunders, Burns & Levinson, *supra* note 12 (explaining that federal funding is estimated to "decrease by $137 billion over 10 years—about $87 billion more than is appropriated for the rural health fund").

30. *See generally* discussion *infra* Section II.A.2.

emergency care, regardless of their ability to pay.[31] Additionally, the purpose of the EMTALA statute is to prevent "patient dumping," which occurs when hospitals refuse treatments to uninsured or underinsured patients.[32] Moreover, EMTALA requires hospitals not to discriminate against patients and to treat all persons equally who have similar medical conditions and seek emergency care.[33]

Under EMTALA, North Dakota citizens are guaranteed emergency healthcare access.[34] The act "requires anyone coming to an emergency department for care to be stabilized and treated, regardless of their insurance status or ability to pay."[35] Additionally, hospitals participating in Medicare programs are obligated to screen patients who request examinations or treatments in an emergency department to determine if they have an emergency medical condition.[36] If such a condition exists, hospitals must then provide patients stabilizing treatment and examinations for their emergency medical condition.[37] If that hospital lacks the capability to stabilize a patient, or if the patient requests a transfer, the hospital must arrange an appropriate transfer.[38]

However, EMTALA protections only go so far when a hospital closes.[39] EMTALA mandates hospitals to provide emergency care when they remain

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31. HACKLEY, *supra* note 10, at 3.

32. *See id.* at 25 (describing patient dumping occurs when an unstable individual with an emergency medical condition is transferred from another hospital); Steve Alder, *What is the Emergency Medical Treatment and Labor Act (EMTALA)?*, HIPAA J. (Jan. 8, 2026), https://www.hipaajournal.com/emergency-medical-treatment-and-labor-act-emtala/ [https://perma.cc/87YL-6KHS] (noting "[a] study conducted in 1986 found that 87% of emergency transfers to a public hospital occurred due to a lack of insurance or funds to pay for treatment").

33. *See generally id.* (stating "the Joint Commission on Accreditation of Hospitals, the American College of Emergency Physicians, and several states include language in their regulations requiring covered healthcare providers and physicians to provide care 'when medically indicated – regardless of race, creed, sex, nationality, or sources of payment for care'").

34. *See* 42 U.S.C. § 1395dd.

35. Schultz, Forbes & Packard, *supra* note 6; *see* 42 U.S.C. § 1395dd (stating "if any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists").

36. *See* STAMAN, *supra* note 8 ("Under the Act, this condition is one in which an individual exhibits 'acute symptoms . . . such that the absence of immediate medical attention could reasonably be expected to jeopardize an individual's health or result in serious impairment to bodily functions or dysfunction to bodily organs or parts.' Pursuant to the Act and accompanying regulations, elements of an emergency medical condition may include severe pain, psychiatric disturbances, or substance abuse symptoms." (omission in original)).

37. *Id.*

38. Schultz, Forbes & Packard, *supra* note 6.

39. *See generally* Saunders, Burns & Levinson, *supra* note 12 (noting rural hospital closures can leave communities with reduced access to emergency and other healthcare services).

open, but the statute fails to require emergency medical care services remain available when hospitals close.[40] Thus, North Dakota needs to step in to mend the gaps of emergency care in rural areas across the state.[41]

2. Federal Rural Healthcare Funding

Medicaid plays a large role in funding rural healthcare services in the United States.[42] In rural communities, it "covers nearly half of all births and one fifth of inpatient discharges."[43] During the 2025 House Budget Committee meeting, the House of Representatives reported H.R. 1, the One Big Beautiful Bill Act, which Congress later enacted into law as a budget reconciliation package that significantly changes federal Medicaid spending.[44] However, the Congressional Budget Office "estimates that the enacted reconciliation package would reduce federal Medicaid spending by an estimated $911 billion over ten years, and result in 10 million more uninsured people nationwide."[45] Although Congress created a Rural Health Transformation Program, starting in fiscal year 2026, that includes $50 billion in funding for five years, federal spending in rural communities is estimated to decline by $137 billion, which far exceeds the new funding.[46] These reductions will only increase financial pressure on rural hospitals and could lead to staff reductions, limited quality improvements, fewer services, and hospital closures that directly impact emergency healthcare access.[47]

In 2026, the Centers for Medicare and Medicaid Services awarded North Dakota a $199 million grant for the first fiscal year as part of a five-year program.[48] The federal grants given to states were added to "the One Big Beautiful Bill Act as a way to offset the cuts to Medicaid" and focus on improving rural healthcare access.[49] As Governor Kelly Armstrong stated,

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40. *See* 42 U.S.C. § 1395dd (excluding requirements of emergency medical care when a hospital closes); *see also* Michael Standaert, *Threats to Ambulance Services Increase Rural Health Insecurity*, N.D. NEWS COOP. (Aug. 29, 2023), https://www.newscoopnd.org/threats-to-ambulance-services-increase-rural-health-insecurity/ [https://perma.cc/WLN3-JVE2] (describing how shortages of rural ambulance services leave communities with diminished access to emergency medical care).

41. *See generally* discussion *supra* notes 10–15.

42. Saunders, Burns & Levinson, *supra* note 12.

43. *Id.*

44. *See* One Big Beautiful Bill Act, H.R. 1, 119th Cong. (2025).

45. Saunders, Burns & Levinson, *supra* note 12.

46. *See id.*

47. *Id.*

48. Orledge, *supra* note 28 ("Each state is eligible for a minimum of $500 million, but could receive up to $1 billion, over the five years.").

49. *Id.* Other states who received similar amounts to North Dakota include the following: Texas received $281 million, Montana received $233 million, Minnesota received $193 million, South Dakota received $189 million, and New Jersey received $147 million. *Id.*

"[w]e have a once-in-a-generation opportunity to rethink and reshape how health care is delivered to our rural communities."[50] In a January 2026 special session, the legislature met to focus on reforming the rural healthcare "[w]orkforce, preventive care and healthy eating, bringing high-quality health care closer to North Dakotans and connecting technology and data with medical providers."[51] The legislature will be limited in how these funds are used because last fall the North Dakota Health and Human Services applied for the Rural Health Transformation Program and the state is planning on following the funding framework set out in that application.[52] The North Dakota Health and Human Services wants "to establish a framework for the distribution, prioritization and compliance monitoring of the grant funding."[53] Now that North Dakota has a fund to ensure rural healthcare access, legislators need to ensure the funding also goes to emergency medical services.[54]

B. NORTH DAKOTA EMERGENCY HEALTHCARE ACCESS LAWS

Over the years, North Dakota has instituted various modes of examining and regulating its emergency medical services, including legislative studies, bill amendments, and specific funding initiatives.[55] For example, in 2007, the North Dakota Legislative Committee approved House Bill 1162, which required the State Health Council to study emergency services personnel coverage annually.[56] The University of North Dakota Center for Rural Health also conducted a study and identified substantial difficulties in providing emergency medical services to rural communities.[57] These difficulties included worker shortages, high response times, lower levels of training, and limited resources.[58] In response, the North Dakota Legislature requires the State Health Council to adopt laws regarding "minimum training, testing, certification, licensure, and quality review standards for emergency medical

50. *Id.*
51. *Id.*
52. *Id.*
53. *Id.*
54. *See generally id.* (stating "[Rep. Jon] Nelson and other legislators said this funding could play a transformative role in addressing health care challenges in rural North Dakota such as travel barriers to care, hiring and retaining skilled workers, expanding access to behavioral health services and improving emergency medical services").
55. *See* N.D. Legis. Council Staff, *Study of Emergency Medical Services Within North Dakota Background Memorandum*, Rep. No. 99050 (July 2007) https://ndlegis.gov/sites/default/files/resource/committee-memorandum/99050.pdf [https://perma.cc/L5UH-KSWV]; N.D. CENT. CODE § 23-46.
56. N.D. Legis. Council Staff, *supra* note 55.
57. *See id.*
58. *Id.*

services personnel, instructors, and training institutions."[59] The legislature also expanded Medicaid and private insurance coverage for pre-hospital emergency medical services.[60] Further, the legislature authorized local governments to levy property taxes to support emergency medical services in that area.[61] House Bill 1365 continued to expand emergency medical services funding when it "require[d] areas to form rural ambulance districts and give them the ability to levy a local tax after approval from voters to help support that service."[62]

Most recently, at the 2025 legislative session, the North Dakota House of Representatives passed Senate Bill No. 2033, which was created to address failures in rural ambulance services.[63] The purpose of Senate Bill 2033 was to provide guidance and support for distressed ambulatory services.[64] The House proposed amendments to the bill, which reduced costs from $150,000 to $7,000.[65] Additionally, the House created "distressed ambulance workgroups" which develop ambulatory coverage plans when areas cannot provide ambulatory services and their licenses are downgraded.[66] According to the plan, after an ambulatory service license has been revoked, "its service area would be divided to adjacent ambulatory services without a vote."[67] Further straining the workload of the surrounding ambulatory services personnel.[68]

In 2025, the legislature also proposed Senate Bill No. 2332, which provides a study that reviews grant funding for emergency services and

59. N.D. CENT CODE § 23-27-04.3; N.D. Legis. Council Staff, *supra* note 55, at 3.

60. N.D. Legis. Council Staff, *supra* note 55, at 2.

61. *Id.* at 5 ("The 2007 Legislative Assembly approved House Bill No. 1162 providing for the State Health Council to study the minimum requirements of reasonable emergency medical services. In addition, the bill provides that the board of county commissioners must conduct an annual review of the emergency medical services coverage within that county and submit an annual report to the State Health Officer. A taxing district that levies property taxes for support of emergency medical services is to ensure that every emergency medical services operation that operates in that taxing district receives a benefit of this tax.").

62. Standaert, *supra* note 40; *see* H.B. 1365, 68th Legis. Assemb., Reg. Sess. (N.D. 2023).

63. S.B. 2033, 69th Legis. Assemb., Reg. Sess. (N.D. 2025); Grant Coursey, *N.D. Legislators Pass Bill to Help Failing Ambulance Services*, BISMARCK TRIBUNE (Apr. 13, 2025, at 12:00 CT), https://www.ems1.com/legislation-funding/n-d-legislators-pass-bill-to-help-failing-ambulance-services [https://perma.cc/2L2D-F2EX].

64. *Id.* ("An ambulance service is determined to be distressed if it self-indicates a substantial likelihood to close in the next year or fail to comply with federal or state law or regulations.").

65. *Id.*

66. *Id.* (stating distressed ambulance workgroups "include at least one representative each from the affected ambulance service, county commission, city council, law enforcement, school board and the public").

67. *Id.*

68. *See generally supra* notes 63–67.

public safety needs.[69] This bill was originally created to award grants from the legacy fund but was later changed to a study.[70] For the 2025 through 2027 biennium, the North Dakota Legislative Assembly appropriated grants to address the emergency medical services crisis.[71] However, the North Dakota Legislature needs to further implement strategies to retain emergency personnel, as the numbers are shrinking.[72]

Despite legislative efforts, these reforms have not resolved challenges that emergency medical response services face in rural communities.[73] The legislature has recently formed a new interim committee referred to as the Emergency Response Services Committee, which will study staff recruitment and retention.[74] Legislator Todd Porter, who is on this committee and owns Metro-Area Ambulance Service, noted that "he thinks one of the most important fixes is recruiting more young people to the profession."[75] Other legislators have also indicated that additional statutory solutions are expected to be developed for consideration in the 2027 legislative session.[76] While these measures show that the North Dakota Legislature is aware of the rural

69. EMERGENCY RESPONSE SERVS. COMM., REPORT ON GRANT FUNDING FOR EMERGENCY SERVICES AND PUBLIC SAFETY, N.D. LEGIS. COUNCIL (2025).

70. *Id.* ("The original version of Senate Bill No. 2332 created a legacy earnings emergency services and public safety fund and an advisory board. The legacy earnings emergency services and public safety fund would have received $25 million in legacy fund earnings each biennium. The advisory board included representation from firefighters, law enforcement, and emergency medical services (EMS). The advisory board would have been responsible for awarding grants from the legacy earnings emergency services and public safety fund. The Department of Emergency Services would have been responsible for the distribution and administration of the grant program. This bill was changed to the study that is referenced.").

71. *Id.* ("For the 2025–27 biennium, the Legislative Assembly appropriated $15,000,000 for these grants, of which $6,895,000 is from the general fund, $7,000,000 is from the community health trust fund and $1,125,000 from the insurance tax distribution fund.").

72. *Id.* ("As of May 6, 2025, there are 255 licensed EMS agencies in North Dakota, including 16 advanced support ground ambulances, 101 basic life support ground ambulances, 10 critical care air ambulances, 5 industrial ambulance services, 110 quick response units, and 13 substations of basic life support ground ambulances.").

73. *See generally* discussion *supra* notes 16–19, 55–72 and accompanying text.

74. Michael Achterling, *New Legislative Committee Seeks to Advance Solutions for Strained Rural Emergency Services*, N.D. MONITOR (Aug. 20, 2025, at 18:09 CT), https://northdakotamonitor.com/2025/08/20/new-legislative-committee-seeks-to-advance-solutions-for-strained-rural-emergency-services/ [https://perma.cc/TSF5-LDCD]; H.B. 1311, 69th Legis. Assemb., Reg. Sess. (N.D. 2025).

75. Achterling, *supra* note 74 (emphasizing the need to utilize Career and Technical Education centers, to engage high school students in initial training and further maintain interest in these essential careers); *Paramedic Training in North Dakota*, FIRSTRESPONDERSHUB, https://www.firstrespondershub.com/programs/north-dakota/paramedic [https://perma.cc/42BA-H5AK] (noting North Dakota has 10 accredited paramedic training programs).

76. *See id.* ("Grueneich said he expects to have legislation drafted ahead of the 2027 legislative session to help emergency services. He added the committee plans to hold four more meetings during the interim with the last meeting focused on debating and editing draft legislation.").

emergency healthcare challenges, they do not establish a concrete plan to ensure that rural citizens have accessible emergency healthcare.[77]

III. THE CURRENT EMERGENCY MEDICAL SERVICES ACCESS GAP IN NORTH DAKOTA

Notwithstanding federal mandates and state legislative measures, North Dakota citizens lack critical access to emergency medical treatment in rural communities.[78] North Dakota has specifically struggled with the closure of rural hospitals, staffing shortages, service limitations, and transport risks based on increased travel time.[79] Additionally, while recent Medicaid reductions have resulted in $199 million over five years in federal rural health funding for the state, its ability to protect and expand emergency services will depend on how it allocates those funds.[80]

A. FEDERAL FUNDING RURAL HEALTHCARE PLAN

North Dakota has an opportunity to fund rural emergency healthcare services.[81] North Dakota received federal funding through a five-year statewide federal investment program.[82] The goal of this program is to improve the rural health system and make it sustainable.[83] It addresses that there are workforce shortages, facilities that are financially unstable, communities who have access to care gaps, and advanced technology systems which can improve emergency services across the state.[84] The program is aimed at rebuilding North Dakota's rural healthcare system in various ways.[85]

First, the program will rebuild and retain rural healthcare workers.[86] The legislature wants to "increase rural provider retention, reduce health professional shortages, and expand remote monitoring and AI-assisted care."[87] However, emergency services personnel are not listed as a health

77. *See generally* discussion *supra* notes 20–30.

78. *See States With the Biggest Discrepancies Between Urban and Rural Healthcare Access*, *supra* note 17.

79. *See generally* discussion *infra* Sections III.B.1, III.B.2.

80. *See generally* discussion *infra* Section III.A.

81. *See Rural Health Transformation*, N.D. HEALTH & HUM. SERVS. (2025), https://www.hhs.nd.gov/rural-health-transformation [https://perma.cc/6DJ7-R5AM].

82. *Id.*

83. *See id.*

84. *See id.*

85. *See id.*

86. *Id.*

87. *Id.* (citation modified).

professional job.[88] Therefore, amendments to include emergency medical services personnel in the rural healthcare initiative are needed to improve North Dakota rural communities.[89] Second, North Dakota wants to make rural healthcare systems more efficient through modern technology.[90] The goal for this technology is to "modernize and connect health data systems, increase transparency, and create savings through shared infrastructure and cooperative purchasing," which reduces costs and improves care.[91] Technology advancements through telehealth services need to be included for emergency healthcare.[92] Emergency medical care services are not explicitly listed in the improvement plan for technology advancements and need to be added in order to allow rural residents proper emergency care.[93] Since North Dakota was granted federal funding for rural healthcare improvements, the legislators need to guarantee that the funding stabilizes the emergency medical services workforce and patient outcomes within rural communities.[94]

B. RURAL HOSPITAL CLOSURES

Across the United States, seven hundred fifty-six hospitals face the possibility of shutting down due to financial issues, and "more than 40% of those hospitals [are] at immediate risk of closure."[95] In North Dakota, as of December 2025, thirteen hospitals are at risk of closure, and four hospitals are at immediate risk of closure in two to three years.[96] Many hospitals have closed for various reasons such as an increase in older and poorer patient populations, and states refusing the expansion of Medicaid under the Affordable Care Act (ACA).[97] When these hospitals close, other facilities are

88. *See infra* notes 153–61 (excluding emergency personnel from the health professional loan programs); *see also* Standaert, *supra* note 40 (noting "[a]mbulance services are not considered essential services").

89. *See generally supra* notes 76–77.

90. *Rural Health Transformation*, *supra* note 81.

91. *Id.* (citation modified).

92. *See generally id.* (noting the program only generally discusses expanding "telehealth hubs, mobile clinics, and remote patient monitoring").

93. *See generally id.* (noting emergency medicine is not addressed in the North Dakota rural health program).

94. *See supra* text accompanying notes 48–54.

95. Molly Gamble, *756 Hospitals at Risk of Closure, State by State*, BECKER'S HOSP. REV. (Dec. 26, 2025), https://www.beckershospitalreview.com/finance/756-hospitals-at-risk-of-closure-state-by-state/ [https://perma.cc/Y8HJ-M499].

96. *Id.* (noting that the thirteen hospitals at risk of closing in North Dakota are 34% of hospitals in North Dakota, and the four hospitals that are at immediate risk of closure in two to three years are 11% of hospitals in North Dakota).

97. *North Dakota is the #4 State with the Fewest Rural Hospital Closures Since 2005*, STACKER (Dec. 9, 2021), https://stacker.com/stories/north-dakota/north-dakota-4-state-fewest-rural-hospital-closures-2005 [https://perma.cc/74ZD-KZ6F].

required to admit uninsured patients through the federal EMTALA law, thus increasing uncompensated care and financial strain on the remaining hospitals.[98] A similar situation occurred during the COVID-19 pandemic when hospitals had to delay nonessential services that produce revenue and limit treatment to high-risk patients.[99] These delays leave hospitals with a larger portion of uncompensated care because federal law ensures uninsured patients continue to be seen under federal EMTALA laws.[100] This lack of revenue causes a ripple effect to trauma centers shutting down.[101] Hospitals that close their trauma centers will only push the burden to other communities and neighboring ambulance services; thus, this issue needs to be addressed to avoid emergency care deserts across North Dakota.[102]

1. Emergency Medical Services Staff Shortages

North Dakota needs emergency medical personnel as they are the first to respond to emergent situations such as a motorcycle crash, someone in cardiac arrest, a pregnant woman in labor, or a farming accident in rural communities.[103] As staffing shortages and funding concerns continue, the sustainability of ambulatory services is at risk.[104] In addition, while the North Dakota Legislature approved legislation that will mandate and fund ambulance districts, staffing shortages and increased costs still create a burden on the industry.[105] In fact, some organizations have seen six-month short-staffed periods, leaving the remaining employees overworked.[106] Financial burdens related to the industry further prohibit paramedics and EMTs from getting adequately compensated.[107] These costs include staffing and equipment prices that range from $700,000 to $1 million per year.[108] In addition, new ambulance costs have doubled ranging from $100,000 to over $200,000.[109]

98. *See generally id.* (noting that refusing to expand Medicaid "leaves hospitals with a greater share of uncompensated care as uninsured patients continue to be treated").

99. *Id.*

100. *Id.*; *see* 42 U.S.C. § 1395dd.

101. *See id.*

102. *See generally id.* (noting rural hospital closures increase demand on surrounding healthcare systems).

103. *See* Standaert, *supra* note 40.

104. *Id.*

105. *See id.*

106. *Id.*

107. *See id.*

108. *See id.* ("Staffing plus equipment costs for a service of two people operating an ambulance available 24 hours a day, seven days a week ranges from between $700,000 to around $1 million annually, according to a study led by Yvonne Jonk at the University of Southern Maine.").

109. *Id.*

2. Transport Risks

Transport risks are another cost associated with emergency medical care access for North Dakota residents, which increase the number of ambulance deserts.[110] A study at the University of Southern Maine found that "North Dakota has one of the lowest rates for ambulances per square mile, but one of the highest rates of ambulances per 100,000 residents."[111] Additionally, the study found that throughout North Dakota, every county has at least one ambulance desert.[112] These deserts exist "where it takes 25 minutes or longer for an ambulance to arrive on scene."[113] With ambulance deserts in every county in North Dakota, this creates a "high cost" for emergency services.[114] In North Dakota, a response to an emergency situation can incur costs ranging from $1,000 to $41,000.[115] These burdens have not helped patients get access to care.[116] Additionally, the distances patients have to travel between towns due to ambulance deserts and hospital closures have increased patient burdens and created greater challenges when accessing care.[117]

Another aspect of staffing shortages is that emergency medical services personnel need to remain updated on skills and certain certification requirements.[118] A way to do so is for the state to provide more money to have mobile labs such as Simulation in Motion (SIM-ND) administered through the University of North Dakota.[119] Additionally, the state should expand the SIM-ND mobile lab program so that more rural ambulance personnel can receive free on-site training without requiring long commutes associated with maintaining their certifications.[120] Thus, rural communities are faced with various challenges when providing care to their citizens.[121]

110. *See id.*
111. *Id.*
112. *Id.*
113. *Id.*
114. *Id.*
115. *Id.*
116. *See generally supra* notes 110–15.
117. *See States With the Biggest Discrepancies Between Urban and Rural Healthcare Access*, *supra* note 17.
118. Standaert, *supra* note 40.
119. *Id.* (describing how SIM-ND mobile labs provide simulation-based training using lifelike mannequins to rural healthcare providers, reducing travel barriers to emergency medical education).
120. *Id.*
121. *See generally* discussion *supra* Sections III.B.1, III.B.2.

IV. LEGISLATIVE ACTION IS NEEDED TO CLOSE THE RURAL EMERGENCY HEALTHCARE ACCESS GAP IN NORTH DAKOTA

Rural North Dakota's lack of access to emergency medical services cannot be resolved by one small solution.[122] While federal laws like EMTALA provide important safeguards once a patient reaches an emergency department, it does not ensure that emergency care is available nearby when needed.[123] As more rural hospitals close or limit services, the state of North Dakota itself must provide solutions.[124] Thus, the following sections demonstrate the economic impacts to healthcare access and lay out the recommendations to the North Dakota Legislature for enacting a bill on rural emergency healthcare.[125] Additionally, the following subsections address the ramifications that would occur if the legislature denies enacting legislation.[126]

A. ECONOMIC IMPACTS TO HEALTHCARE ACCESS

Economic disparities make it difficult for rural healthcare systems to remain financially sustainable, particularly for emergency services that require round-the-clock staffing.[127] As a result, rural residents face unequal access to care based solely on their geographical location.[128] This raises concerns about fairness to life and public safety.[129] By addressing economic disparities, North Dakota can improve healthcare by making it more affordable and limiting transportation barriers so patients can receive culturally competent care.[130] For example, North Dakota has previously

122. *See generally* discussion *infra* Sections IV.A, IV.B.1, IV.B.2.

123. *See generally* 42 U.S.C. § 1395dd (requiring Medicare-participating hospitals with emergency departments to provide emergency medical screening and stabilizing treatment, without guaranteeing geographical access to emergency care).

124. *See generally supra* notes 95–102.

125. *See generally* discussion *infra* Sections IV.A, IV.B.1, IV.B.2.

126. *See generally* discussion *infra* Section IV.C.

127. *See generally States With the Biggest Discrepancies Between Urban and Rural Healthcare Access*, *supra* note 17 ("Rural communities often have lower incomes and higher rates of uninsured residents, which can impact the financial viability of healthcare physicians. Physicians may be less likely to set up practices in areas where many patients are unable to afford care.").

128. *See generally id.* (noting that states with spread out geographical towns, such as North Dakota, face the greatest challenges in rural patient healthcare access).

129. *See* N.D. CONST. art. I, §1.

130. Patrick Kim, *Health Equity and Disparities in North Dakota*, STATE REGS TODAY (Jan. 2024), https://www.stateregstoday.com/health/healthcare/health-equity-and-disparities-in-north-dakota [https://perma.cc/7YMB-SLXJ] (explaining culturally competent care as providing practitioners with training on "cultural sensitivity and competency services to effectively address the unique needs" among marginalized communities).

discussed "expanding funding for community health clinics, mobile clinics, and telehealth services."[131]

Recently, the federal government expanded funding for North Dakota to create a Rural Health Transformation Program.[132] This program gives North Dakota the opportunity to increase rural communities' access to healthcare.[133] The incentive for this program is to build a comprehensive, sustainable health system that makes "North Dakota the healthiest state in the nation."[134] The objectives include strengthening the rural health workforce, making North Dakota healthy again, bringing quality care to rural communities, and implementing technology to do so.[135] These goals are essential to improve North Dakota's rural healthcare system; however, emphasizing emergency care within this program is necessary for life-saving access to rural North Dakota populations.[136]

B. RECOMMENDATIONS FOR IMPLEMENTING LEGISLATION

In North Dakota, there are many ways to improve access to primary healthcare services.[137] The ways that will help ensure rural North Dakota communities get emergency medical care include implementing EMT incentives and scholarships and establishing a telemedicine healthcare system.[138] These strategies can play a role in reducing healthcare disparities in rural communities.[139]

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131. *Id.*

132. *Rural Health Transformation*, *supra* note 81.

133. *See id.*

134. *Id.*

135. *Id.*

136. *Id. See generally Amid Rural EMS Struggles*, *North Dakota Lawmakers Weigh Solutions*, (Dec. 19, 2025) FIREHOUSE, https://www.firehouse.com/ems/news/55339462/amid-rural-ems-struggles-north-dakota-lawmakers-weigh-solutions [https://perma.cc/Q425-RGEP] (explaining North Dakota lawmakers are proposing emergency medical services legislation for the 2027 legislative session).

137. *See* Zemichael Gizaw, Tigist Astale, & Getnet Mitike Kassie, *What Improves Access to Primary Healthcare Services in Rural Communities? A Systematic Review*, NAT'L LIBR. OF MEDICINE, PUB MED CENT. (Dec. 6, 2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9724256/ [https://perma.cc/37K3-28SJ] (stating various ways to improve primary care access such as, "community health programs or community-directed interventions, school-based healthcare, student-led healthcare services, outreach services or mobile clinics, family health program, empanelment, community health funding schemes, telemedicine, promoting the role of traditional medicine, working with non-profit private sectors and non-governmental organizations" (citation modified)).

138. *See supra* Sections IV.B.1, IV.B.2; *Rural Attorney Recruitment and Retention Program - Guidelines,* N.D. CT. SYS., https://www.ndcourts.gov/Media/Default/lawyers/Rural%20Attorney%20Recruitment%20Program/Rural%20Attorney%20Recruitment%20Program%20Guidelines.pdf [https://perma.cc/PV6N-PF35]; *Amid Rural EMS Struggles North Dakota Lawmakers Weigh Solutions*, *supra* note 136.

139. *See generally* Gizaw, Astale & Kassie, *supra* note 137 (listing telemedicine as a strategy to improve healthcare access services in rural communities).

1. EMT Incentives and Scholarships

North Dakota lawmakers state that emergency medical service staff shortages exist beyond the amount staff is paid.[140] Currently, there are twenty-eight paramedic positions that are open across the state, varying in a $6,500 wage gap across eight regions that the North Dakota Workforce Services breaks into.[141] However, other factors exist as to why North Dakota has staff shortages in rural areas.[142] It appears the citizens of North Dakota do not want to live in rural communities.[143] This means that it is harder for the Job Service of North Dakota to get emergency services personnel employed there.[144] The Job Service of North Dakota has tried to implement solutions by holding job fairs and using the nine workforce centers across the state to help small communities with the staffing shortages of emergency medical personnel.[145] Additionally, lawmakers want more education in schools promoting a career path in the emergency medical services field and awareness that job positions are open across the state, particularly in rural areas.[146]

These solutions will only go so far in helping North Dakota with its shortages of emergency medical services staff.[147] Other professions in North Dakota have programs that have helped address gaps in employment shortages through loan retention programs.[148] For example, lawyers in North Dakota who are licensed to practice law in the state, are in good standing, willing to relocate their office, live in close proximity, and practice full-time in the participating rural community for at least five consecutive years, can apply for a rural loan retention program.[149] To qualify, the community the attorney lives in must have a population of 5,000 or less and the county needs to have a population of 16,000 or less.[150] Moreover, only eight attorneys can participate in this program at once.[151] This program is funded through "the

140. *See Amid Rural EMS Struggles North Dakota Lawmakers Weigh Solutions*, *supra* note 136.

141. *Id.*

142. *See id.*

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

147. *See generally supra* notes 140–46.

148. *See Rural Attorney Recruitment and Retention Program - Guidelines*, *supra* note 138.

149. *Id.*

150. *Id.*; *Rural Attorney Recruitment Program*, N.D. CT. SYS., https://www.governmentjobs.com/careers/ndcourts/jobs/newprint/3736723 [https://perma.cc/M78M-XQEY].

151. *Rural Attorney Recruitment and Retention Program - Guidelines*, *supra* note 138.

state of North Dakota, the North Dakota State Bar Association, and a participating community" to retain attorneys in eligible communities.[152]

Similar retention programs can be applied to emergency medical service jobs in North Dakota.[153] Currently in North Dakota, the state has established a loan repayment program for qualifying healthcare professionals who provide services in rural areas that need care named the North Dakota Healthcare Professional Student Loan Repayment Program.[154] The healthcare professions that qualify for this program do not apply to emergency medical service jobs.[155] The healthcare practitioners eligible for this program need to provide services in areas that are statistically underserved and are at least twenty miles outside city limits of a city with more than 40,000 residents.[156] Additionally, the healthcare practitioner must practice in this community full time for up to five years.[157] Depending on the healthcare profession, the payment practitioners get varies.[158] However, they need to provide services that qualify under certain criteria.[159] The criteria for healthcare professionals to qualify includes, the "health care professional's specialty, need for the specialty in the area, education and experience, date of availability and anticipated term of availability, [and] willingness to accept Medicaid and Medicare patients . . . ."[160] Overall, the North Dakota Legislature should add emergency medical services personnel to the list of professions that qualify for loan forgiveness based on the shortages of staff

152. *Rural Attorney Recruitment Program*, *supra* note 150.

153. *See generally supra* notes 148–52.

154. Kalee Werner & Stacy Kusler, *North Dakota Health Service Corps: Loan Repayment Programs*, N.D. HEALTH & HUM. SERVS., https://ndlegis.gov/assembly/68-2023/testimony/SHUMSER-2127-20230110-12795-N-KRISTIN_ROERS.pdf [https://perma.cc/BLJ5-UTR7].

155. *See id.* (noting that the eligible disciplines are Physicians (MD/DO), Advanced Practice Registered Nurses, Physician Assistants, Clinical Psychologists (licensed by the State Board of Psychologist Examiners), Behavioral Health Professionals who are Licensed Addiction Counselors, Licensed Professional Counselors, Licensed Social Workers, Registered Nurses, or Specialty Practice Registered Nurses).

156. *Id.*

157. *Id.*

158. *See id.* (showing that physicians get a state match of $100,000 and community match of $50,000, APRNs and PAs get a state match of $20,000 and community match of $2,000, clinical psychologists get a state match of $60,000 and a community match of $15,000, and Behavioral Health gets a state match of $20,000 and a community match of $2,000); *Health Professionals Can Apply Now for Student Loan Repayment Programs. Programs Support Access to Care for Underserved and Rural Areas of North Dakota*, N.D. HEALTH & HUM. SERVS. (Jan. 9, 2025), https://www.hhs.nd.gov/news/health-professionals-can-apply-now-student-loan-repayment-programs-programs-support-access [https://perma.cc/D5H8-5QVB] (stating that "student loan assistance ranges from $22,000 to $50,000 depending on the service commitment and health profession" and the "service contracts vary from two to five years" (citation modified)).

159. *See* Werner & Kusler, *supra* note 154.

160. *Id.* (citation modified).

that are affecting the emergency healthcare access gaps in rural North Dakota communities.[161]

Furthermore, including emergency medical services personnel in the North Dakota Healthcare Professional Student Loan Repayment Program would improve healthcare access in rural communities.[162] In addition, legislators could incentivize greater participation in this program by increasing the number of emergency personnel who qualify for the program.[163] As a result, expanding incentives would increase retention for emergency services personnel in rural areas and help stabilize the emergency medical workforce throughout the state.[164] Thus, allowing emergency medical services personnel to qualify for the loan repayment program would help attract and retain healthcare professionals in North Dakota.[165]

2. Expansion to Transfer Frameworks and Emergent Telehealth Support

The North Dakota Legislature is facing negative effects of short staffing for emergency medical services across the state.[166] By implementing telemedicine in North Dakota, the legislature would ease staffing shortages for emergency medicine in rural counties.[167] In rural communities, volunteer paramedics are on the decline.[168] Without this help, rural ambulance services are starting to shut down, shifting the responsibilities of emergency medical services in rural communities to neighboring communities.[169]

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161. *See generally supra* notes 104–09, 153–60 and accompanying text; Werner & Kusler, *supra* note 154 (noting the qualifications for selection criteria includes a need for the specialty in the area).

162. *See generally* discussion *supra* notes 153–60.

163. *See generally Rural Attorney Recruitment and Retention Program - Guidelines*, *supra* note 138 (stating "[n]o more than 8 attorneys may participate in the program at any given time"); *Health Professionals Can Apply Now for Student Loan Repayment Programs. Programs Support Access to Care for Underserved and Rural Areas of North Dakota*, *supra* note 158 (noting "[t]hese programs assisted 116 eligible North Dakota health professionals with their student loan obligations in 2024").

164. *See States With the Biggest Discrepancies Between Urban and Rural Healthcare Access*, *supra* note 17 (noting that "[s]tates with extreme shortages, such as North Dakota . . . might not have enough incentives in place to keep medical professionals in rural communities").

165. Will Albert, *Health Professionals Can Apply for Student Loan Repayment Programs*, KXNEWS (Feb. 3, 2025), https://www.kxnet.com/news/state-news/health-professionals-can-apply-for-student-loan-repayment-programs/ [https://perma.cc/SF79-5V67] ("Director of the Primary Care Office for HHS, Natalie Jung, says these kinds of programs make a real difference in keeping folks in the state. 'It does make North Dakota more competitive that we have these programs to attract and retain our medical professionals that are interested,' said Jung.").

166. *Amid Rural EMS Struggles North Dakota Lawmakers Weigh Solutions*, *supra* note 136.

167. *Id.*

168. *Id.*

169. *Id.*

Recommendations that legislators could implement into an emergency medical services bill include expanding emergency medical access to paramedics when they are working in the field.[170] Technology from a company called Avel eCare would allow paramedics "to be connected by video with emergency medicine physicians, experienced medics or emergency nurses in the field."[171] Doing so would allow ambulance personnel to have any of their questions answered where there is cell reception.[172] It also allows the person working virtually to document the patient's response, so the ambulance personnel can focus on the patient's in-person needs.[173] Lastly, using this technological care system allows staff at the hospital the ambulance is arriving at to better prepare for specific care the patient needs.[174] Overall, implementing this care system would help provide essential emergency care to rural communities in North Dakota that are thinly stretched for emergency services and personnel.[175]

If North Dakota implements a telehealth medicine program into a bill, lawmakers will need to integrate a funding system to support it.[176] Other states that have implemented these services include South Dakota.[177] In South Dakota, the state uses general fund dollars to support the Avel eCare program, making it free of charge to agencies.[178] South Dakota paid $1.7 million in initial costs for equipment and additionally pays an annual subscription of $937,000 to support the program.[179] Doing so allows the program "to provide their services to 109 ambulances serving 105 communities in the state."[180]

North Dakota lawmakers are continuously working to understand the scope of the problem before implementing legislation; however, this issue needs to be addressed at the next legislative session.[181] North Dakota communities are losing emergency medical services staff, and something

170. *Id.*

171. *Id.* (noting Avel eCare "already operates its mobile service in South Dakota, Minnesota, Nebraska, and Kansas").

172. *Id.*

173. *Id.*

174. *Id.*

175. *See id.*

176. *See id.*

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.*

181. *See generally id.* ("Though some solutions were floated and passed during the 2025 legislative session, [North Dakota] lawmakers are working to understand the scope of the problem before proposing additional legislative changes in 2027.").

needs to be done to address this gap in care to citizens in the state.[182] Some North Dakota lawmakers, specifically Senator Josh Boschee, are trying to find solutions to this issue.[183] Boschee stated that considering how affordable the Avel eCare system is to support emergency medical personnel and further retain volunteer personnel, it is a great solution to the state's problem of emergency healthcare gaps.[184] Additionally, Boschee emphasizes that implementing a technological system for emergency medical personnel will create a support network for staff who are in ambulances taking care of patients in high-pressure situations.[185] This support network will further encourage ambulance personnel to want to retain their positions by serving longer in the industry.[186]

C. RAMIFICATIONS AND OUTCOMES

If the North Dakota Legislature denies a healthcare emergency access bill, various ramifications and outcomes would continue to cause disparities in rural healthcare.[187] To start, the consequences that gaps in healthcare access have on patient outcomes are significant.[188] Having a high gap in healthcare access means rural residents have fewer available primary care providers.[189] Leading residents to have longer waits, increased travel, higher costs, and a lack of patient choice in healthcare professionals.[190] Having access to primary care is necessary for patients' health.[191] It can "prevent[] chronic conditions, manage acute illnesses, and improve overall well-being."[192]

Out of the fifty states, North Dakota is ranked as the state with the largest discrepancy in urban versus rural healthcare access.[193] As rural primary care

182. *See generally supra* note 169 and accompanying text.

183. *See Amid Rural EMS Struggles North Dakota Lawmakers Weigh Solutions*, *supra* note 136.

184. *Id.*

185. *See id.*

186. *Id.*

187. *See generally States With the Biggest Discrepancies Between Urban and Rural Healthcare Access*, *supra* note 17 (noting various key factors that likely contribute to rural areas having less access to primary care than urban areas include healthcare workforce shortages, population density and geography, state-level healthcare policies, hospital and clinic closures, and economic disparities).

188. *See id.*

189. *Id.*

190. *Id.* ("In sparsely populated states, long travel distances between towns and medical facilities make it difficult for rural residents to access care.").

191. *Id.*

192. *Id.*

193. *Id.* (calculating "the average number of people per primary care physician in rural and urban areas").

providers in North Dakota treat 2,079 more patients than urban areas.[194] This means that North Dakota citizens living in urban areas have 352% better healthcare access to primary care physicians.[195] This is a result of "a combination of rural hospital closures, physician shortages, and economic factors [that] make it harder for residents to access primary care."[196] Additionally, regarding physician shortages, North Dakota would need to add 372 more physicians in rural areas to resemble the physician-to-population ratio in urban areas.[197] These statistics resemble the drastic need for North Dakota legislators to implement a bill that addresses these shortages.[198] If the North Dakota Legislature does not enact a bill based on improving rural healthcare access, this issue will only get worse.[199] Thus, North Dakota legislators need to act now to ensure patients have access to healthcare by focusing improvements on physician-to-patient ratios and emergency access that further improves patient outcomes.[200]

V. CONCLUSION

Across North Dakota, rural communities face immense gaps in emergency medicine.[201] Without implementing a targeted law to address this issue, North Dakota citizens will lose access to essential lifesaving mechanisms. This lack of emergency medicine in rural communities has been addressed through the federal EMTALA law; however, this only requires hospitals to provide care to patients without the ability to pay.[202] It does not require hospitals to remain open.[203] This causes healthcare deserts across the nation and the state of North Dakota.[204] The North Dakota Legislature needs to initiate emergency healthcare reform to provide its citizens with

194. *Id.* (stating North Dakota has a positive number of 2,079 additional patients per primary care physician in rural areas and "[a] positive number means PCPs in rural areas have to take care of X more people than those in urban areas, making it harder for rural residents to get care") (data retrieved from figure in source).

195. *Id.*

196. *Id.* (alteration in original).

197. *Id.* ("The deficit is calculated by comparing how many primary care physician's rural areas would need—if they had the same physician-to-population ratio as urban areas—to how many they currently have based on existing rural county ratios.") (data retrieved from figure in source).

198. *See id.* (stating "[t]hese findings underscore the critical need for healthcare workforce development initiatives to bring more primary care professionals to underserved rural areas").

199. *See generally supra* notes 187–98.

200. *See generally supra* notes 187–99.

201. *See generally States With the Biggest Discrepancies Between Urban and Rural Healthcare Access*, *supra* note 17.

202. *See* 42 U.S.C. § 1395dd.

203. *See generally id.* (requiring hospitals to perform screening examinations and provide necessary stabilizing treatment to patients with an emergency medical condition).

204. *See* Standaert, *supra* note 40.

emergency medicine in rural areas comparable to urban areas' ratio of care.[205] By implementing an EMS scholarship, the North Dakota Legislature can retain more ambulance staff and ensure greater access to emergency healthcare in rural communities.[206] In addition, adopting a telehealth emergency medical system will allow emergency medical services personnel to feel supported and gain greater access to a broader scope of care by being able to communicate with ER providers and nurse practitioners while in the field.[207] Taking these steps will allow North Dakota to close existing gaps in emergency medical services and provide necessary access to healthcare across rural communities in the state.

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205. *See States With the Biggest Discrepancies Between Urban and Rural Healthcare Access*, *supra* note 17.

206. *See generally* discussion *supra* Section IV.B.1.

207. *See generally* discussion *supra* Section IV.B.2.

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