The Challenge in EMS Legislation Is Funding, Not Ideas

If you want to know where EMS policy is really moving in 2026, do not just look at scope bills or workforce bills. Look at the bills tied to reimbursement, dedicated funds, grant programs, and payment reform. That is where states stop talking about EMS as a public good and start deciding whether they are actually willing to pay for it. This year alone, Washington enacted HB 2531 on its ambulance transport fund, Maine advanced LD 2119 on treatment in place, community paramedicine, and alternate destination transport, Colorado is still moving HB 26-1069 on EMS availability and reimbursement, West Virginia passed HB 5168 creating new EMS funding streams, California is moving AB 1607 to keep the Maddy EMS funding mechanism alive, and Alabama's SB 269 is pushing reimbursement requirements and balance billing limits for ground ambulance services.

The details differ, but the pattern remains the same. Washington's bill, which aligned its ambulance transport quality assurance fee program with federal rules, is now law. Maine's bill would expand reimbursement for treatment in place, community paramedicine, and alternate destination transport, and it came out of committee with an ought-to-pass-as-amended recommendation. Colorado's bill would require Medicaid reimbursement for treatment on scene, telemedicine support, and transport to appropriate destinations other than hospitals, and would also carry a state fiscal note. West Virginia took a direct funding route by creating county EMS funds and directing lottery dollars into EMS support. California is trying to extend the Maddy EMS Fund structure to January 1, 2037. Alabama's bill would set reimbursement expectations for ground ambulance providers and prohibit surprise billing, but it also carries a real fiscal price tag for state-related health plans.

That is the point EMS leaders need to keep in front of them. The second a bill touches funding, it stops being an EMS-only conversation. It becomes a state finance conversation, a payer conversation, an IT conversation, a staffing conversation, and in some cases, a political survival conversation. A good idea is not enough. The bill has to survive the machinery that comes with money.

In many states, that process starts in some version of a health committee. These bills usually get their first real review in a committee that understands health care delivery, access, reimbursement, and public impact. That matters because the first question is often whether the policy makes sense. The next question is whether the state can afford to carry it.

As a former EMS regulator for Nevada, I will use their system for the process. Note, most states have a similar process. Under Nevada's fiscal note process, the estimate is not supposed to come only from the agency most closely tied to the subject matter. The affected agency or agencies have to prepare the estimate. The Fiscal Analysis Division is responsible for notifying executive branch agencies, boards, commissions, and local governments to prepare

fiscal notes when warranted. The threshold for requiring a fiscal note is an apparent increase in expenditures or a decrease in revenue of more than $2,000. Agencies then have a short window to complete and return those estimates to the Legislative Counsel Bureau, with review by the Governor's Finance Office.

That is where EMS leaders can lose sight of what is happening. An EMS funding bill in Nevada would not just trigger a memo from the EMS office. It could trigger multiple fiscal analyses across the state government. The EMS side may have to estimate rulemaking, program oversight, provider education, compliance review, data reporting, audit work, and whether the proposal creates enough new workload to justify additional positions. But once reimbursement, claims processing, or a new funding mechanism is involved, other agencies start counting their own costs too.

If the bill creates or changes a health care reimbursement pathway, Nevada Medicaid will be central to it. That means the state may have to estimate claims edits, fee schedule work, provider enrollment changes, billing guidance, portal changes, training, vendor support, and ongoing administration.

Then the cost spreads further. The Governor's Technology Office could have to price software changes, interfaces, cybersecurity review, and system support. Human Resources could be pulled in if new classifications, recruitment, payroll support, or state staff training are needed. Purchasing may need to account for procurement, contracts, and software licensing. The Controller's Office may also be affected if the bill changes how vendors, claims, or financial transactions must be processed. Depending on the bill, Risk Management and State Public Works could also have their own costs to estimate.

That is why Nevada fiscal notes can get big in a hurry. It is not just a question of whether a bill pays EMS agencies. It is a question of whether the state now needs a billing analyst, new compliance staff, training for state users, training for EMS agencies, claims edits inside Medicaid systems, vendor support, software maintenance, reporting tools, audit capacity, help-desk support, updated manuals, and maybe even new space or equipment. In Nevada, those numbers are reviewed by the Governor's Finance Office before they are compiled and sent forward.

That means those reports do not just sit in a drawer. They move through the committees, the Legislative Counsel Bureau, and the Governor's office, where lawmakers and staff are deciding whether the bill remains politically and financially viable. If the combined fiscal note comes in too high, the number itself can become the opposition. A bill can have a good policy case and still die because the state does not want to hire the people, buy the software, change the systems, or absorb the downstream cost.

That is also why these bills need support well beyond EMS. A funding bill has a better chance when hospitals, physicians, nurses, county leaders, health systems, nonprofits, and local

stakeholders are all pushing in the same direction. When those groups split, the bill gets much harder to move. That is where many EMS proposals start to lose momentum.

For EMS leaders, that is the practical takeaway. If you want a funding bill to move, do not build an EMS coalition only. Build a health care coalition. Talk to the hospital association early. Talk to physicians. Talk to nursing. Talk to county leaders, veteran advocates, nonprofit partners, major employers, payers, and anyone else who will either help carry the bill or quietly kill it. In Nevada, written testimony, exhibits, and public comment can still matter, especially as a bill nears and lawmakers decide whether it is worth the fiscal exposure.

The biggest mistake EMS can make is assuming the need speaks for itself. It does not. Legislatures do not move funding bills on need alone. They move them when the policy case is clear, the implementation plan is believable, the fiscal note is defensible, and the coalition is broad enough that voting yes feels safer than voting no. That is the real work. The idea is usually the easy part. The hard part is proving the bill can survive the fiscal process and the politics that come with it.

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