WEST VIRGINIA COALITION

ONE VOICE. ONE PURPOSE.

WV EMS Coalition

Legislative Recommendations 2024 Regular Session

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The Structure of EMS in WV and Funding Challenges

Many West Virginians wrongfully assume ambulance agencies are part of County Ambulance Authorities or local government because they are named after a county or city. The reality is most EMS agencies are either non-profit or private entities. They receive little to no funding from state, county, and municipalities to support the 911 emergency medical services that they provide.

The foundation for West Virginia's modern EMS system was developed during the 1970s and 1980s. Multiple federal agencies provided states with grant funding to support the purchase of ambulances and equipment. Dedicated volunteers staffed trucks to respond to calls for aid. This combination of grant funding and volunteer response help sustain EMS in local communities.

But through the 1990s, volunteerism decreased, and grant funding disappeared. EMS agencies were increasingly forced to rely on paid paramedics and EMTs to staff ambulances. Improvements in technology and new medications rapidly expanded the cost to equip and supply ambulances. Fewer volunteers and greater training requirements increased the need for paid staff. These factors and others precipitously raised operating costs for agencies without a corresponding source of revenue.

The Emergency Ambulance Service Act of 1975 establishes that county commissions have a duty to make emergency medical services available but only to the degree that they can afford it. The financial support provided by County Commissions to EMS agencies varies greatly from county to county.

Several EMS agencies that have historically received county assistance have seen their financial support significantly reduced in recent years as counties face their own financial troubles particularly in the coalfields where there has been a significant decline in tax collections.

West Virginia is the only state in our region that provides no permanent direct state assistance to EMS agencies for equipment, training, or operations. ***Ohio, Pennsylvania, Kentucky, Maryland, and Virginia have a source of dedicated and permanent state funding for EMS***.

At least ***15 organizations licensed by the Office of EMS to provide 911 response have ceased operations since 2022.*** These closures, including a mix of governmental, fire department, community non-profit and private EMS agencies, have gone largely unreported but have harmed emergency response in 14 counties. The West Virginia EMS Coalition anticipates additional closures without increased funding for EMS from the state, counties and improve insurance reimbursement.

The lack governmental support for 911 response creates significant challenges for EMS agencies attempting to maintain 24/7 coverage.

West Virginia's rural communities have longer transport times, larger service areas, and a lower volume of 911 calls. This results in a higher cost per response when compared to more densely populated states. A cost that private and government insurance inadequately covers.

Ambulance agencies are only reimbursed by insurance when transporting a patient. Unloaded mileage, such as from point of dispatch to point of patient pickup or return from a hospital to the station, is not reimbursed.

This is manageable for more urban based agencies near a hospital. But for some rural West Virginia agencies, the unloaded portion of the transport can be 2 hours or more of staff time and a hundred plus road miles when returning from one of the state's distant level 1 or 2 trauma centers like Morgantown or Charleston.

According to data reported by the Office of EMS to the Joint Committee on Volunteer Fire Departments and EMS, the average time on task for ambulances in rural communities without a hospital can be up to 212 minutes. Time on task is the time from when ambulance begins its response to the time when the ambulance is available to respond to another call.

This means an ambulance can be out of service for over 3 ½ hours. Longer times on task are most common in rural counties with fewer available EMS resources putting patients in greater risk of a delayed response during a medical emergency.

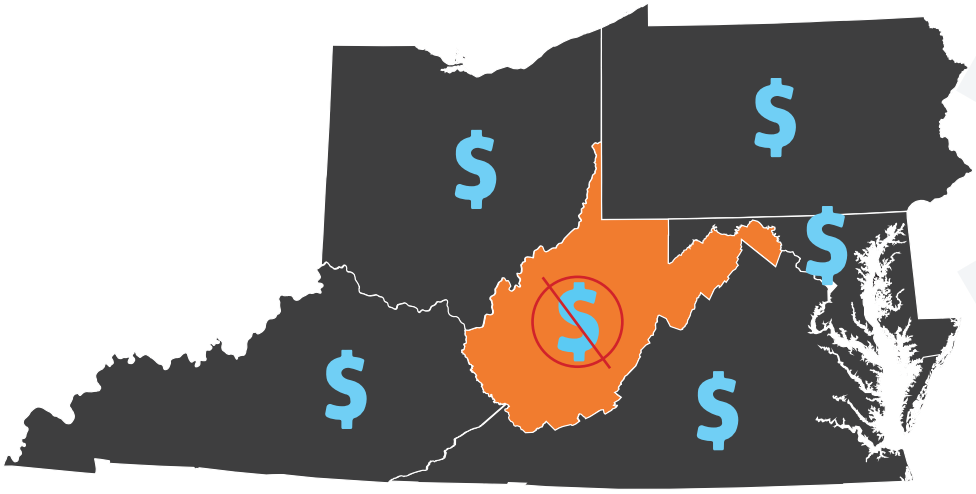
Ambulance agencies receive no payment in most cases if the patient refuses to be transported even if care was provided at the scene. This is a frequent occurrence when responding to a car wreck, a drug overdose or a request for assistance by a fall victim.

Between October 2022 and October 2023, EMS agencies were dispatched 1,099,000 times, but only transported 420,918 patients. This means EMS could bill for less than 40% of all responses. Even when services are covered, most insurance plans reimburse below the cost of care and many patients are responsible copays and deductibles that are difficult for EMS agencies to collect.

And while funding for emergency medical services continues to be inadequate. Costs continues to increase. The price of an ambulance has increased 20% the past two years, and the West Virginia EMS Coalition estimates the cost of a fully equipped and supplied ambulance to be approximately $300,000. This does not include ongoing readiness costs such as wages, benefits, fuel, insurance, vehicle maintenance or the replenishing of supplies and medication.

Thirty percent of transporting EMS agencies are located in low demand communities and average less than 1 patient transport per day. While West Virginians in these areas deserve timely ambulance response 24/7, the small number of transports make it challenging to fund operating expenses associated with maintaining readiness on insurance billings alone. The additional capital costs associated with purchasing fixed assets such as ambulances, major medical equipment and stations is a burden too great for many to manage.

Without significant assistance, additional agencies will cease operations and the remaining agencies may not be financially or operationally able to cover rural and low population areas as they have done in the past. This places West Virginians at-risk particularly in the 13 counties without a hospital where EMS is the last lifeline for those experiencing a medical emergency.



Funding of Essential Emergency Ambulances in West Virginia

$15 million annually to purchase equipped units for every county.

The Office of EMS conducted a study in 2023 and determined West Virginia needs a minimum of 244 ambulances to ensure adequate emergency response in all 55 counties on a 24/7 basis.

The fixed cost of readiness is challenging for EMS particularly small agencies with low patient volumes. An ambulance fully equipped with powered stretcher, heart monitor, ventilator, radio and other essential gear and medical supplies can cost between $250,000 and $300,000. And ambulances must be staffed and ready 24/7 even if no calls for help are received.

While every West Virginia community needs and deserves timely ambulance response, the low patient volumes in some areas makes it financially impossible to staff, purchase and equip ambulances with only insurance billing revenue.

The WV EMS Coalition proposes the state establish a grant program, similar to those that existed in the 1970s and 1980s, to supply the minimal number of ambulances recommended by the Office of EMS to each county.

- Many agencies attempt to budget for ambulances on a 5-year replacement schedule. Since the state needs approximately 244 ambulances, we suggest the state purchase 50 ambulances annually.
- The 50 ambulances would be equipped and supplied other essentials. At $300,000 per unit, this would require an investment of $15 million each state fiscal year.
- The ambulances would be given to counties on a rotating basis to assign to their Ambulance Authority, or a transporting emergency medical services agency licensed under §16-4C that is designated by the county commission to provide emergency response through the county emergency dispatch center. Approximately, 20% of the ambulances needed statewide would be replaced each year.
- The authority or agency assigned the unit would be responsible for all insurance and maintenance.
- After 5 years, the ambulances would become the property of the ambulance authority or licensed 911 EMS response agency to which they were assigned. If prior to 5 years, the authority or agency ceases operations or no longer utilizes the ambulance for emergency response the unit would be returned to the county for reassignment to another licensed EMS agency.
- The program would expand the availability of ambulances and equipment on state contract lowering costs for all EMS agencies. Current law, 16-4C-6(n)(1), provides licensed EMS agencies access to state purchasing. However, many of the costliest items are unavailable because the state does not currently purchase or have contracts for them.
- As part of the ambulance grant program, the state should contract for the purchase of multiple styles of ambulances and all equipment and supplies required by the Office of EMS for ALS ambulances.
- If possible, the state should attempt to contract with multiple manufacturers of similar equipment to address supply chain limitations and to ensure compatibility with equipment already owned by the Ambulance Authority or EMS agency.

- Counties and EMS agencies awarded an ambulance would submit a request for the ambulance, equipment, and supplies from the state purchasing list up to $300,000. This will ensure that EMS agencies receive ambulances and equipment that meet the needs of their community and that are compatible with existing resources.

- The long-term financial stability of the program would also be protected by having counties and agencies select an ambulance and other items from a state purchasing list within an allocated budget. Ambulance costs have risen 20% in the past 2 years. As costs continue to rise, counties and agencies could modify their requests to remain within the allocated budget. This will reduce the need for the state to grow the line item for the program during the initial 5-year grant cycle.

- All 55 counties would benefit from the program and ambulances would be distributed based on the OEMS formula that considers factors such as population density and call volumes.

- The program would relieve counties and ambulance agencies of the burden of financing essential, high-cost fixed assets like ambulances, stretchers, and heart monitors. Instead of servicing debt, available resources could be focused on operating expenses such as staff, fuel and insurance.

- Counties and EMS agencies would be responsible for ensuring the ambulances remained in service by funding the operating costs of the units through direct funding, EMS levies and fees, and insurance reimbursement.

- Local funding of EMS would be incentivized. Counties and EMS agencies would be required to demonstrate to the Office of EMS the availability of adequate local funding to support the operation of the ambulance prior to receiving the units.

- The ambulances provided by the state would support the minimal level of emergency service as calculated by the Office of EMS. Most counties and agencies would need to fully fund additional units to account for breakdowns and repairs, travel time to trauma centers and enhanced response.

- Volunteer and rural agencies would receive priority during the first two years of the program. The average age of the units in each county would also be considered. However, every county should receive at least one unit during the first two years of the program.

- If state government experiences a significant loss of tax revenue, the program could be suspended until conditions improve without substantially harming the EMS system because the state would not be contributing to ongoing operating expenses.

- The presentation of ambulances to counties and agencies would provide state officials with the ability to demonstrate their support for emergency medical services in a visible and tangible way.

- West Virginia would join our neighboring states of Pennsylvania, Maryland, Virginia, Kentucky, and Ohio in providing state support for emergency medical services agencies.

- Because the State would be providing ambulances and equipment rather than direct financial aid, taxpayers would be assured their funding was being used responsibly. There would be limited need for additional audits and reviews to determine how the counties and agencies spent appropriated funds.

OEMS recommended minimum emergency response ambulances per county

County	pop(1000)	2023 Response Vol. Approx	Vehicles Req
Barbour County	15.414	1979	3
Berkeley County	129.49	18427	15
Boone County	20.968	5121	3
Braxton County	12.185	1989	2
Brooke County	21.733	3357	3
Cabell County	92.73	24187	11
Calhoun County	6.068	568	1
Clay County	7.814	1293	1
Doddridge County	7.698	1028	2
Fayette County	39.487	9264	5
Gilmer County	7.325	982	2
Grant County	10.968	1448	2
Greenbrier County	32.435	6870	5
Hampshire County	23.468	4147	3
Hancock County	28.172	3511	4
Hardy County	14.192	1905	3
Harrison County	64.915	11930	9
Jackson County	27.716	5666	4
Jefferson County	58.979	1303	7
Kanawha County	175.515	42524	20
Lewis County	16.767	2668	3
Lincoln County	19.901	2151	3
Logan County	31.316	8403	5
Marion County	55.952	9597	8
McDowell County	29.752	923	4
Marshall County	25	3009	3
Mason County	17.85	3114	3
Mercer County	58.7	16368	8
Mineral County	26.855	3516	3
Mingo County	22.573	4169	4
Monongalia County	106.869	14819	12
Monroe County	12.296	1708	2
Morgan County	17.43	2357	3
Nicholas County	24.335	4086	4
Ohio County	41.447	7482	5
Pendleton County	6.011	838	1
Pleasants County	7.586	828	2
Pocahontas County	7.819	1263	2
Preston County	34.172	3981	4
Putnam County	57.015	5849	7
Raleigh County	72.882	18429	8
Randolph County	27.6	5578	5
Ritchie County	8.207	1591	2
Roane County	13.834	1400	2
Summers County	11.762	1441	2
Taylor County	16.342	1882	3
Tucker County	6.568	953	2

Tyler County	8.183	684	2
Upshur County	23.712	3764	4
Wayne County	37.998	4940	5
Webster County	8.167	1624	2
Wetzel County	14.025	2573	2
Wirt County	5.091	578	1
Wood County	83.34	17354	10
Wyoming County	20.527	4229	3
Total	1775.156	311648	244

Estimated Costs for Ambulance and required equipment and medical supplies

Item	Cost per item	# needed per unit	Total per ambulance
Column1	**Column2**	**Column3**	**Column4**
2x2, 4x4 Guaze	$ 0.25	40	$ 10.00
5x9 Bandage	$ 0.20	5	$ 1.00
Abdominal Pads	$ 9.79	2	$ 19.58
Acetamenophen - Children	$ 2.53	1	$ 2.53
Adenosine	$ 14.10	6	$ 84.60
AED Pads	$ 41.00	2	$ 82.00
AED Unit	$ 1,075.00	1	$ 1,075.00
Albuterol	$ 0.27	4	$ 1.08
Amiodarone	$ 7.53	2	$ 15.06
Atropine	$ 18.13	3	$ 54.39
Backboard	$ 120.99	2	$ 241.98
Bedpans	$ 2.49	1	$ 2.49
Benadryl	$ 6.71	2	$ 13.42
Biohazard bags	$ 0.90	4	$ 3.60
Burn Sheet	$ 3.05	4	$ 12.20
BVM - 3 sizes	$ 11.25	3	$ 33.75
Cardiac Monitor	$ 28,757.02	1	$ 28,757.02
Cardizem	$ 14.57	1	$ 14.57
Cervical Collar	$ 7.38	4	$ 29.52
Chest seal	$ 20.00	2	$ 40.00
Chewable Aspirin	$ 3.25	1	$ 3.25
Cold Pack	$ 1.29	4	$ 5.16
Conform Roll Gauze	$ 0.40	6	$ 2.40
Cylinder Holder for portable O2	$ 453.00	2	$ 906.00
Dexamethosone	$ 5.09	1	$ 5.09
Dextrose 25	$ 1.66	2	$ 3.32
Dopamine	$ 36.10	1	$ 36.10
Duo-Neb	$ 0.52	4	$ 2.08
Elastic Bandage	$ 0.78	3	$ 2.34
Emesis Bags	$ 1.70	4	$ 6.80
Epinephrine	$ 34.65	6	$ 207.90
ET Tube - 14 sizes	$ 3.88	14	$ 54.32
ET Tube Holder	$ 5.35	2	$ 10.70
EZ10 Needle Sets - 3 sizes	$ 110.00	6	$ 660.00
EZ10 Power Driver	$ 299.00	1	$ 299.00
Fentanyl	$ 2.33	4	$ 9.32
Flow Meter	$ 39.00	2	$ 78.00
Flowsafe CPAP	$ 72.60	2	$ 145.20
Foil Blanket	$ 7.14	1	$ 7.14
Furosemide	$ 7.63	8	$ 61.04
Glucose Monitor	$ 21.95	1	$ 21.95
Glucose Strips	$ 0.41	50	$ 20.50
Glugagon	$ 360.15	1	$ 360.15
Haloperidol	$ 13.09	2	$ 26.18
Hot Pack	$ 1.29	4	$ 5.16
igel O2 Resus	$ 42.00	3	$ 126.00
Ipratropium	$ 0.17	3	$ 0.51
IV Catheters - 5 sizes	$ 3.00	30	$ 90.00

IV Warmer	$	575.00	1	$	575.00
Labetalol	$	7.61	1	$	7.61
Larygoscope blades	$	9.50	8	$	76.00
Larygoscope handle with blades	$	154.00	1	$	154.00
Lidocaine Bag	$	6.95	1	$	6.95
Lidocaine Syringe	$	5.85	3	$	17.55
Magnesium Sulfate	$	3.12	1	$	3.12
Mask, Aerosol	$	1.12	5	$	5.60
Meconium Aspirator	$	7.25	1	$	7.25
Midazolam	$	1.76	2	$	3.52
Morphine	$	3.86	2	$	7.72
Narcan	$	36.77	2	$	73.54
Nasal Cannula	$	1.31	10	$	13.10
Nebulizer, Hand held	$	0.77	5	$	3.85
Nitroglycerin	$	20.04	1	$	20.04
Non-rebreathing Oxygen Mask	$	1.65	10	$	16.50
Normal Saline	$	4.85	3	$	14.55
Normal Saline 1 liter	$	4.25	2	$	8.50
OB kit	$	7.52	2	$	15.04
Ondansetron IV	$	0.83	2	$	1.66
Ondansetron ODT	$	0.22	2	$	0.44
Oral Airways - 7 sizes	$	2.14	7	$	14.98
Oral Glucose	$	7.95	2	$	15.90
Prefil Flush	$	0.95	5	$	4.75
Pulse Ox	$	25.79	1	$	25.79
Sharp Container	$	6.50	2	$	13.00
Sodium BiCarb	$	21.90	1	$	21.90
Soft Restraints	$	5.30	1	$	5.30
Splints	$	1.04	4	$	4.16
Stair Chair - powered	$	14,000.00	1	$	14,000.00
Sterile Water	$	4.30	1	$	4.30
Stethoscope	$	17.49	1	$	17.49
Thermometer	$	19.99	1	$	19.99
Thiamine	$	12.13	2	$	24.26
Tourniquet	$	25.00	2	$	50.00
Tranexamic Acid	$	15.93	2	$	31.86
Trauma Dressing	$	0.65	2	$	1.30
Triangle Bandage	$	0.79	4	$	3.16
Urinal	$	0.99	1	$	0.99
Powered Ambulance Stretcher	$	32,500.00	1	$	32,500.00
Stretcher Load System	$	5,750.00	1	$	5,750.00
Type III Ambulance on F-450 Chassis	$	150,000.00	1	$	150,000.00
Radio System with Accessories and Antennas	$	8,500.00	1	$	8,500.00
LUCAS Chest Compression System	$	20,000.00	1	$	20,000.00
Annual Service Contracts ($6,000 x 5 years)	$	30,000.00	1	$	30,000.00
Total*				***$***	***295,690.07***

***These are estimated costs. EMS equipment and supply costs are rapidly increasing and can vary greatly based on supplier and the specific specifications of the purchasing agency.

Continuation of Salary Enhancement Fund

$10 million annually to supplement salaries for EMS workers.

The Office of EMS has recommended the state maintain a minimum of 244 emergency ambulances to aid our communities. But ambulances are more than metal, rubber and flashing lights, they are the EMTs and Paramedics that care for patients and EMS personnel are increasingly in short supply.

According to a survey conducted by the American Ambulance Association of nearly 20,000 employees working at 258 EMS organizations nationally, overall turnover among paramedics and EMTs ranges from 20 to 30 percent annually. With these percentages, ambulance agencies face 100% turnover over a four-year period.

COVID exacerbated this shortage. The pandemic created substantial burnout among EMTs, Paramedics and other personnel. Retirements have increased. With wages rising across all professions, EMS personnel are leaving for other higher paying, lower stress careers. Some are moving to states with better funded EMS systems where they can earn higher wages. Those that remain are frequently refusing to work the overtime hours that were necessary to keep the EMS system functioning even prior to COVID-19.

A career in EMS is difficult and dangerous work. EMTs and Paramedics routinely encounter violent patients particularly when responding to a drug overdose or when caring for patients with behavioral health conditions.

According to the U.S. Centers for Disease Control and Prevention, there are 2,000 EMS professionals injured every year in a violence related incident. The rate of violence related injuries with lost workdays for EMS personnel is 22 times higher than the national average for all workers. More than half of assault-related injuries result in lost work time.

And because of the lack of financial support from state and local governments to fund the cost of readiness and 911 response, ambulance agencies in West Virginia struggle to compensate EMS professionals competitively with neighboring states. Employees can often earn $2-3 more per hour simply by crossing the border.

UNITED STATES BUREAU FOR LABOR STATISTICS 2022
PARAMEDIC WAGES BY STATE

Paramedics	Mean Hourly Wage	Mean Annual Wage
West Virginia	$21.55	$44,290
Kentucky	$19.92	$42,850
Maryland	$29.96	$62,310
Ohio	$22.50	$46,790
Pennsylvania	$25.41	$52,850
Virginia	$24.66	$51,300

UNITED STATES BUREAU FOR LABOR STATISTICS 2022
EMT WAGES BY STATE

Emergency Medical Technicians	Mean Hourly Wage	Mean Annual Wage
West Virginia	$14.96	$31,130
Kentucky	$14.17	$30,940
Maryland	$26.01	$54,110
Ohio	$17.00	$35,370
Pennsylvania	$17.06	$35,470
Virginia	$19.12	$39,770

EMS agencies are not just competing to recruit and retain EMTs and paramedics against other states, they are also competing for a workforce against other better paying health care professions in West Virginia which offer regular hours, holidays off and a more predictable work environment.

UNITED STATES BUREAU FOR LABOR STATISTICS MAY 2022 STATE
OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES - WEST VIRGINIA

Profession	Mean Hourly Wage	Mean Annual Wage
Registered Nurses	$34.73	$72,230
Dental Assistants	$30.90	$64,280
Hearing Aid Specialists	$30.39	$63,210
Respiratory Therapists	$29.17	$60,670
Recreational Therapists	$22.31	$46,400
Surgical Assistant	$21.93	$45,620
Licensed Practical Nurses	$21.89	$45,539
Paramedics	21.55	$44,290
Pharmacy Technicians	$16.93	$35,210
Phlebotomists	$16.83	$35,000
EMTs	$14.96	$31,130

The EMS Salary Enhancement Fund created by SB 737 and funded by the Legislature in the budget during the 2023 regular session was a positive first step towards addressing this problem. The fund supported salary enhancements and mental health assistance for EMS personnel in all 55 counties. Making the fund permanent, while also refining the distribution formula, would provide the stability that would allow agencies the ability to increase salaries to more competitive levels without the fear of moral crushing pay reductions in future years.

First Responder Mental Health

Ensuring that our First Responders have the tools necessary to be ready and able to serve the citizens of West Virginia benefits everyone. The West Virginia EMS Coalition identified a variety of issues around First Responder Mental Health. To address these concerns, the coalition convened a task force to perform a gap analysis and develop a list of priorities that would support resiliency and mental health.

SB 737 from the 2023 regular legislative session provided funding for EMS salary enhancement and crisis response. From this funding, $1 million was divided across all 55 counties for training to develop Critical Incident Stress Management Teams. The recommendations below could be funded with this same budget allocation in the next fiscal year.

- Develop and maintain a centralized database of mental health resources available. This should include but not be limited to identifying those resources that are trained to specifically treat first responders. It should also include resources that are available in West Virginia and immediately accessible in surrounding states. This could be achieved by incorporation into a mobile application.

- Implementation of a statewide mobile application to increase access to first responder resilience and mental health resources. This application should have interactive resources, peer support, connection to appropriate providers, and the ability for WV (OEMS/DHHR) to obtain blinded/ aggregate data on usage. The coalition has identified two products that could meet those needs with annual estimated costs of $600,000.

- Authorize WV OEMS to employ a full time WV EMS Mental Health Coordinator to oversee all aspects of resilience and response in WV. This position will oversee the development and operation of regional CISM teams, coordination of resilience and mental health programs in WV, and coordinate mental health instructors. Estimated annual cost of $90,000.

- Provide funding for certain Mental Health First Aid, Resilience, and Suicide Prevention instructor (train the trainer) courses to establish a cadre of in-state instructors who would be able to teach courses to EMS providers. Estimated initial cost of $150,000.

- Develop regional peer support teams overseen by WV First Responder Mental Health Coordinator for surveillance, resilience, and response. These teams will consist of providers trained in individual and group Critical Incident Stress Management (CISM). This team should have the support of a reimbursement account for travel, lodging, and training for its members to provide services. Estimated annual cost of $100,000.

Elimination and Replacement of Licensure and Certification Fees

$360,000 should be directed to the Office of EMS budget. The minimal funding would allow OEMS to eliminate all licensure and certification fees without negatively impacting the office's ability to still perform its statutorily required functions.

EMS agencies and personnel are required to pay a variety of licensure and certification fees. These fees, established by legislative rule title 64 series 48, include EMS agency and vehicle licensure fees and certification and renewal fees for paramedics, EMTs and other emergency medical personnel.

These fees were lower or did not exist prior to 2011 but were implemented due to budget cuts within the agency. These fees have become a financial burden for many smaller agencies and a disincentive for volunteers to obtain and renew their certifications.

OFFICE OF EMS LICENSE AND CERTIFICATION FEES FROM LEGISLATIVE RULE 64CSR48 CHANGE FROM 2007 TO 2021

	2007	CURRENT
Agency License Application Fee	$200	$500
Agency License Renewal Fee	$200	$300
EMS vehicles permit	$100	$200
Agency License Modifiation	$100	$100
Initial Certification via National Registry or state examination	$0	$75
Recertification via National Registry or state process	$0	$37.50
Legal Recognition	$0	$100
Certification expired beyond two years	$0	$100
National Criminal Background Check	$0	$45

Expansion of the Prudent Layperson Statute to include payment when no transportation is provided

Ambulance agencies dispatched by 911 receive no payment for services in most cases if the patient refuses to be transported even if care was provided at the scene. This is a frequent occurrence when responding to a car wreck or drug overdose. According to the Office of EMS between October 2022 and October 2023, EMS agencies were dispatched 1,099,000 times, but only transported 420,918 patients. This means EMS could bill for less than 40% of all responses.

Current West Virginia insurance law (33-15-21, 33-16-3i, 33-24-7e, 33-25-8d and 33-25A-8d) requires insurers to provide coverage for emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

33-1-21 defines “emergency medical services”, “prudent layperson” and emergency medical condition for the prudent layperson”.

However, insurance companies only provide payment to ambulance agencies for emergency services if the patient is transported. Ambulance services receive no reimbursement for patient care, medical supplies, pharmaceuticals, oxygen, and other equipment utilized if there is no transportation provided.

The current Prudent Layperson Statute should be updated to clarify that emergency medical services provided by an ambulance do not require the patient to be transported for the medical treatment to be a covered service by the insurer.

WEST VIRGINIA LEGISLATURE

2024 REGULAR SESSION

Introduced

Senate Bill 444

By Senators Deeds, Smith, Stover, and Stuart

[Introduced January 15, 2024; referred

to the Committee on Human Resources; and then to

the Committee on Finance]

NOTE:
SAME AS
HB 4869

A BILL to amend and reenact §33-15-21 of the Code of West Virginia, 1931, as amended; to amend and reenact §33-16-3i of said code; to amend and reenact §33-24-7e of said code; to amend and reenact §33-25-8d of said code; and to amend and reenact §33-25A-8d of said code, all relating to clarifying that health insurance coverage for emergency services, when a prudent layperson acting reasonably would have believed that an emergency medical condition existed, includes pre-hospital screening and stabilization of emergency condition by ambulance service if the patient declines to be transported against medical advice.

Be it enacted by the Legislature of West Virginia:

ARTICLE 15. ACCIDENT AND SICKNESS INSURANCE.

§33-15-21. Coverage of emergency services.

From July 1, 1998:

(a) Every insurer shall provide coverage for emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(b) The coverage for prehospital screening and stabilization of an emergency medical condition shall include ambulance services provided under the provisions of §16-4-1, *et seq.* of this code. The insurer shall pay claims for prehospital screening and stabilization of emergency condition by ambulance service if the insured is transported to an emergency room of a facility provider or if the patient declines to be transported against medical advice.

~~(b)~~ (c) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the

authorization was based on a material misrepresentation about the covered person's health condition made by the referring provider, the provider of the emergency services or the covered person.

~~(c)~~ (d) Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan.

~~(d)~~ (e) The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition.

~~(e)~~ (f) As used in this section:

(1) "Emergency medical services" means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;

(2) "Prudent layperson" means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;

(3) "Emergency medical condition for the prudent layperson" means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;

(4) "Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided,* That this provision may not be construed to prohibit, limit or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

(5) "Medical screening examination" means an appropriate 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; and

(6) "Emergency medical condition" means a condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

ARTICLE 16. GROUP ACCIDENT AND SICKNESS COVERAGE.

§33-16-3i. Coverage of emergency services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall provide as benefits to all subscribers and members coverage for emergency services. A policy, provision, contract, plan or agreement may apply to emergency services the same deductibles, coinsurance and other limitations as apply to other covered services: *Provided,* That preauthorization or precertification shall not be required.

(b) From July 1, 1998, the following provisions apply:

(1) Every insurer shall provide coverage for emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(2) The coverage for prehospital screening and stabilization of an emergency medical condition shall include ambulance services provided under the provisions of §16-4-1, *et seq.* of

this code. The insurer shall pay claims for prehospital screening and stabilization of emergency condition by ambulance service if the insured is transported to an emergency room of a facility provider or if the patient declines to be transported against medical advice.

~~(2)~~ (3) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the referring provider, the provider of the emergency services or the covered person.

~~(3)~~ (4) Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan.

~~(4)~~ (5) The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition.

~~(5)~~ (6) As used in this section:

(A) "Emergency medical services" means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;

(B) "Prudent layperson" means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;

(C) "Emergency medical condition for the prudent layperson" means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;

(D) "Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability that no

medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided,* That this provision may not be construed to prohibit, limit or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

(E) "Medical screening examination" means an appropriate 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; and

(F) "Emergency medical condition" means a condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

ARTICLE 24. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL SERVICE CORPORATIONS AND HEALTH SERVICE CORPORATIONS.

§33-24-7e. Coverage of emergency services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall provide as benefits to all subscribers and members coverage for emergency services. A policy, provision, contract, plan or agreement may apply to emergency services the same deductibles, coinsurance and other limitations as apply to other covered services: *Provided,* That preauthorization or precertification shall not be required.

(b) From July 1, 1998, the following provisions apply:

(1) Every insurer shall provide coverage for emergency medical services, including

prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(2) The coverage for prehospital screening and stabilization of an emergency medical condition shall include ambulance services provided under the provisions of §16-4-1, *et seq.* of this code. The insurer shall pay claims for prehospital screening and stabilization of emergency condition by ambulance service if the insured is transported to an emergency room of a facility provider or if the patient declines to be transported against medical advice.

~~(2)~~ (3) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the referring provider, the provider of the emergency services or the covered person.

~~(3)~~ (4) Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan.

~~(4)~~ (5) The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition.

~~(5)~~ (6) As used in this section:

(A) "Emergency medical services" means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;

(B) "Prudent layperson" means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical

condition exists for which emergency treatment should be sought;

(C) "Emergency medical condition for the prudent layperson" means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;

(D) "Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided,* That this provision may not be construed to prohibit, limit or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

(E) "Medical screening examination" means an appropriate 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; and

(F) "Emergency medical condition" means a condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

ARTICLE 25. HEALTH CARE CORPORATIONS.

§33-25-8d. Coverage of emergency services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall provide as benefits to all subscribers and members coverage for emergency services. A policy, provision, contract, plan or

agreement may apply to emergency services the same deductibles, coinsurance and other limitations as apply to other covered services: *Provided,* That preauthorization or precertification shall not be required.

(b) From July 1, 1998, the following provisions apply:

(1) Every insurer shall provide coverage for emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(2) The coverage for prehospital screening and stabilization of an emergency medical condition shall include ambulance services provided under the provisions of §16-4-1, *et seq.* of this code. The insurer shall pay claims for prehospital screening and stabilization of emergency condition by ambulance service if the insured is transported to an emergency room of a facility provider or if the patient declines to be transported against medical advice.

~~(2)~~ (3) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health condition made by the referring provider, the provider of the emergency services or the covered person.

~~(3)~~ (4) Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan.

~~(4)~~ (5) The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition.

~~(5)~~ (6) As used in this section:

(A) "Emergency medical services" means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;

(B) "Prudent layperson" means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;

(C) "Emergency medical condition for the prudent layperson" means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;

(D) "Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided,* That this provision may not be construed to prohibit, limit or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

(E) "Medical screening examination" means an appropriate 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; and

(F) "Emergency medical condition" means a condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

ARTICLE 25A. HEALTH MAINTENANCE ORGANIZATION ACT.

§33-25A-8d. Coverage of emergency services.

(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall provide as benefits to all subscribers and members coverage for emergency services. A policy, provision, contract, plan or agreement may apply to emergency services the same deductibles, coinsurance and other limitations as apply to other covered services: *Provided,* That preauthorization or precertification shall not be required.

(b) From July 1, 1998, the following provisions apply:

(1) Every insurer shall provide coverage for emergency medical services, including prehospital services, to the extent necessary to screen and to stabilize an emergency medical condition. The insurer shall not require prior authorization of the screening services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. Prior authorization of coverage shall not be required for stabilization if an emergency medical condition exists. Payment of claims for emergency services shall be based on the retrospective review of the presenting history and symptoms of the covered person.

(2) The coverage for prehospital screening and stabilization of an emergency medical condition shall include ambulance services provided under the provisions of §16-4-1, *et seq.* of this code. The insurer shall pay claims for prehospital screening and stabilization of emergency condition by ambulance service if the insured is transported to an emergency room of a facility provider or if the patient declines to be transported against medical advice.

~~(2)~~ (3) An insurer that has given prior authorization for emergency services shall cover the services and shall not retract the authorization after the services have been provided unless the authorization was based on a material misrepresentation about the covered person's health

condition made by the referring provider, the provider of the emergency services or the covered person.

~~(3)~~ (4) Coverage of emergency services shall be subject to coinsurance, copayments and deductibles applicable under the health benefit plan.

~~(4)~~ (5) The emergency department and the insurer shall make a good faith effort to communicate with each other in a timely fashion to expedite postevaluation or poststabilization services in order to avoid material deterioration of the covered person's condition.

~~(5)~~ (6) As used in this section:

(A) "Emergency medical services" means those services required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care;

(B) "Prudent layperson" means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether an emergency medical condition exists for which emergency treatment should be sought;

(C) "Emergency medical condition for the prudent layperson" means one that manifests itself by acute symptoms of sufficient severity, including severe pain, such that the person could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health, or, with respect to a pregnant woman, the health of the unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part;

(D) "Stabilize" means with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, with reasonable medical probability that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility: *Provided,* That this provision may not be construed to prohibit, limit or otherwise delay the transportation required for a higher level of care than that possible at the treating facility;

(E) "Medical screening examination" means an appropriate 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; and

(F) "Emergency medical condition" means a condition that manifests itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or with respect to a pregnant woman the health of the unborn child, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

~~(6)~~ (7) Each insurer shall provide the enrolled member with a description of procedures to be followed by the member for emergency services, including the following:

(A) The appropriate use of emergency facilities;

(B) The appropriate use of any prehospital services provided by the health maintenance organization;

(C) Any potential responsibility of the member for payment for nonemergency services rendered in an emergency facility;

(D) Any cost-sharing provisions for emergency services; and

(E) An explanation of the prudent layperson standard for emergency medical condition.

NOTE: The purpose of this bill is to clarify that health insurance coverage for emergency services when a prudent layperson acting reasonably would have believed that an emergency medical condition existed includes prehospital screening and stabilization of emergency condition by ambulance service if the patient declines to be transported against medical advice.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.

Require insurance companies to reimbursement ambulance agencies for providing treatment in place or transportation to alternative destinations

Updating and clarifying the Prudent Layperson Statute would help address situations where a patient refuses to be transported to a trauma facility.

Additionally, some patients may not need transported to a hospital emergency room after being evaluated and could be more appropriately cared for in-place with the consultation of a physician or at an alternative facility.

The West Virginia EMS Coalition supports the adoption of legislation similar to the Arkansas Triage, Treat, And Transport To An Alternative Destination Act which was adopted by the Arkansas legislature in 2023. The bill requires insurance plans to cover ambulance services to treat an enrollee in place, triage and transport an enrollee to an alternative destination, and an encounter between an ambulance service and enrollee that results in no transport if the ambulance service is coordinating the care of the enrollee with a physician through telemedicine.

An actuarial statement prepared for the legislation by national consulting firm, Segal, stated, "The expected utilization is extremely low based on data received by the plans. Furthermore, any increase in covered ambulance services will likely be offset by savings realized because of treatment triaged to less costly service areas."

This legislation would also be similar to a treatment model that U.S. Senators Shelley Moore Capito and Joe Manchin and U.S. Representatives Carol Miller and Alex Mooney have asked the Center for Medicare & Medicaid Service to consider to help address the workforce challenges faced by West Virginia hospitals and Emergency Medical Service providers. This proposal for a limited number of services is estimated to save $3 million in unnecessary emergency room visits.

DRAFT

Treatment in Place/Alternative Destination Legislation

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 4C. EMERGENCY MEDICAL SERVICES ACT.

§16-4C-3. Definitions.

As used in this article, unless the context clearly requires a different meaning:

(a) "Ambulance" means any privately or publicly-owned vehicle or aircraft which is designed, constructed or modified; equipped or maintained; and operated for the transportation of patients, including, but not limited to, emergency medical services vehicles; rotary and fixed wing air ambulances; gsa kkk-A-1822 federal standard type I, type II and type III vehicles; and specialized multipatient medical transport vehicles operated by an emergency medical services agency;

(b) “Alternative destination” means a lower-acuity facility that provides medical services, including without limitation:

(i) A federally qualified health center;

(ii) An urgent care center;

(iii) A physician office or medical clinic, as selected by the patient; and

(iv) A behavioral or mental healthcare facility including without limitation a crisis stabilization unit.

“Alternative destination” does not include a:

(i) Critical access hospital;

(ii) Dialysis center;

(iii) Hospital;

(iv) Private residence; or

(v) Skilled nursing facility;

(c)~~(b)~~ "Commissioner" means the Commissioner of the Bureau for Public Health;

(d)~~(c)~~ "Council" means the Emergency Medical Service Advisory Council created pursuant to this article;

(e)~~(d)~~ "Director" means the Director of the Office of Emergency Medical Service in the Bureau for Public Health.

(f)~~(e)~~ "Emergency Medical Services" means all services which are set forth in Public Law 93-154 "The Emergency Medical Services Systems Act of 1973" and those included in and made a part of the emergency medical services plan of the Department of Health and Human Resources inclusive of, but not limited to, responding to the medical needs of an individual to prevent the loss of life or aggravation of illness or injury;

(g)~~(f)~~ "Emergency medical service agency" means any agency licensed under section six-a of this article to provide emergency medical services;

(h)~~(g)~~ "Emergency medical service personnel" means any person certified by the commissioner to provide emergency medical services as set forth by legislative rule;

(i)~~(h)~~ "Emergency medical service provider" means any authority, person, corporation, partnership or other entity, public or private, which owns or operates a licensed emergency medical services agency providing emergency medical service in this state;

(j)~~(i)~~ "Governing body" has the meanings ascribed to it as applied to a municipality in subdivision (1), subsection (b), section two, article one, chapter eight of this code;

(k)~~(j)~~ "Line officer" means the emergency medical service personnel, present at the scene of an accident, injury or illness, who has taken the responsibility for patient care;

(l)~~(k)~~ "Medical command" means the issuing of orders by a physician from a medical facility to emergency medical service personnel for the purpose of providing appropriate patient care;

(m)~~(l)~~ "Municipality" has the meaning ascribed to it in subdivision (1), subsection (a), section two, article one, chapter eight of this code;

(n)~~(m)~~ "Patient" means any person who is a recipient of the services provided by emergency medical services;

(o)~~(n)~~ "Service reciprocity" means the provision of emergency medical services to citizens of this state by emergency medical service personnel certified to render those services by a neighboring state;

(p)~~(o)~~ "Small emergency medical service provider" means any emergency medical service provider which is made up of less than twenty emergency medical service personnel; and

(q)~~(p)~~ "Specialized multipatient medical transport" means a type of ambulance transport provided for patients with medical needs greater than those of the average population, which may require the presence of a trained emergency medical technician during the transport of the

patient: Provided, That the requirement of "greater medical need" may not prohibit the transportation of a patient whose need is preventive in nature.

(r) “Telehealth services” means the use of synchronous or asynchronous telecommunications technology or audio only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include e-mail messages or facsimile transmissions.

§16-4C-26 Triage, Treat and Transport to Alternative Destination.

(a) An emergency medical services agency may triage and transport a patient to an alternative destination in this state or treat in place if the ambulance service is coordinating the care of the patient through medical command or telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint.

(b) On or before May 28, 2024, the commissioner shall submit a proposed legislative rule to the Emergency Medical Services Advisory Council for review, and on or before June 30, 2024, shall file the proposed legislative rule with the Office of the Secretary of State, in accordance with the provisions of §29A-3-1 *et seq.* of this code, to establish standards for emergency medical service agencies to triage, treat and transport to alternative destinations.

CHAPTER 33. INSURANCE.

ARTICLE 63. COVERAGE OF EMERGENCY MEDICAL SERVICES TO TRIAGE AND TRANSPORT TO ALTERNATIVE DESTINATION OR TREAT IN PLACE

§33-63-1 Coverage of Emergency Medical Services to Triage and Transport to Alternative Destination or Treat in Place

(a) The following terms are defined:

(1) “911 call” means a communication indicating that an individual may need emergency medical services;

(2) “Alternative destination” means a lower-acuity facility that provides medical services, including without limitation:

(i) A federally qualified health center;

(ii) An urgent care center;

(iii) A physician office or medical clinic, as selected by the patient; and

(iv) A behavioral or mental healthcare facility including without limitation a crisis stabilization unit.

“Alternative destination” does not include a:

(i) Critical access hospital;

(ii) Dialysis center;

(iii) Hospital;

(iv) Private residence; or

(v) Skilled nursing facility;

(3) "Emergency medical service agency" means any agency licensed under Chapter 16, article 4C, section six-a of this code to provide emergency medical services;

(4) "Medical command" means the issuing of orders by a physician from a medical facility to emergency medical service personnel for the purpose of providing appropriate patient care;

(5) "Telehealth services" means the use of synchronous or asynchronous telecommunications technology or audio only telephone calls by a health care practitioner to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include e-mail messages or facsimile transmissions.

(b) Notwithstanding the provisions of §33-1-1 et seq. of this code, an insurer subject to §33-15-1 et seq., §33-16-1 et seq., §33-24-1 et seq., §33-25-1 et seq., and §33-25A-1 et seq. of this code which issues or renews a health insurance policy on or after July 1, 2020, shall provide coverage for:

(1) An emergency medical services agency to:

(A) Treat an enrollee in place if the ambulance service is coordinating the care of the enrollee through telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; or

(B) Triage or triage and transport an enrollee to an alternative destination if the ambulance service is coordinating the care of the enrollee through telehealth services with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint; or

(2) An encounter between an ambulance service and enrollee that results in no transport of the enrollee if:

(A) The enrollee declines to be transported against medical advice; and

(B) The emergency medical service agency is coordinating the care of the enrollee through telehealth services or medical command with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint.

(c) The coverage under this section:

(1) Only includes emergency medical services transportation to the treatment location;

(2) Is subject to the initiation of response, triage and treatment as a result of a 911 call that is documented in the records of the emergency medical services agency;

(3) Is subject to deductibles or copayment requirements of the policy, contract or plan;

(4) Does not diminish or limit benefits otherwise allowable under a health benefit plan, even if the billing claims for medical or behavioral health services overlap in time that is billed by the ambulance service also providing care.

(c) The reimbursement rate for an emergency medical services agency who triages, treats, and transports a patient to an alternative destination, or triage, treat, and do not transport a patient if the patient declines to be transported against medical advice, if the ambulance service is coordinating the care of the enrollee through medical commend or telemedicine with a physician for a medical-based complaint or with a behavioral health specialist for a behavioral-based complaint under this section shall be reimbursed at the same rate as if the patient were transported to an Emergency Room of a Facility Provider.

NOTE: The purpose of this bill is to establish that an emergency medical services agency may triage and transport a patient to an alternative destination in this state or treat in place if the ambulance service is coordinating the care of the patient through medical command or telehealth services and to require insurance plans to provide coverage for those services.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.

Reduce the Certification Period for Emergency Medical Responders, Emergency Medical Technicians, Advanced Emergency Medical Technicians and Paramedics from 4 years to 2 years

Legislative Rule 64 CSR 48 Section 6.6 currently sets the certification period for these levels of certification at 4 years. The 4-year period was established in 2016 to reduce the frequency EMS personnel were required to retest to retain their certification and to reduce the burden on the Office of EMS that was having issues maintaining and administering validated tests. Prior to 2016, West Virginia issued 2-year certifications.

Since the 2016 rule revision setting certification periods at 4-years, West Virginia has become a national registry state utilizing the National Registry of Emergency Medical Technicians' certification as the basis for state certification.

Under the NREMT certification, EMS personnel are no longer required to take a state licensure exam to recertify. They submit the WVOEMS online application and pay the legislated fee. OEMS accesses the National Registry database and confirms EMS personnel have met the requirements for certification and issues a state certification. This process has streamlined renewals and provided greater certainty to EMS personnel and their agencies.

The WV EMS Coalition believes that recertification can be further improved by reducing the certification period from 4 years to 2 years as it was prior to 2016. NREMT issues 2 years certifications while the West Virginia certifications last for 4 years. This has required EMS personnel and their agencies to track dual paths of recertification and continuing education and training. Aligning both the national and state certifications to the same two-year period would simplify the recertification process reducing the administrative burden on agencies.

The WV EMS Coalition and the Emergency Medical Services Advisory Council have both endorsed this change and had hoped it would be made during the current rulemaking review cycle. The Office of EMS was unable to file a rule change within the required deadlines for the current cycle due to the restructuring occurring within DHHR.

We would encourage the Legislature to make this revision in Code, rather than by rule, so that it can be implemented in 2024 rather than waiting until 2025.

Public Notice of Disciplinary Action

Most licensing boards, like the Boards of Medicine and Nursing, publish the names of individuals who are subject to disciplinary action. The Office of EMS does not currently have the clear authority to publish the names of EMS personnel that they have disciplined. This makes it difficult for agencies, under some circumstances, to have the information necessary to properly protect patients. The WV EMS Coalition requests legislative action to expressly authorize the Office of EMS to provide public notice of disciplinary actions.

WEST VIRGINIA LEGISLATURE

2024 REGULAR SESSION

Introduced

Senate Bill 445

By Senators Deeds, Grady, Rucker, Smith, Stover,

and Stuart

[Introduced January 15, 2024; referred

to the Committee on Government Organization]

NOTE:
SAME AS
HB 4868

A BILL to amend and reenact §16-4C-8 and §16-4C-9 of the Code of West Virginia, 1931, as amended, all relating to reducing the certification periods for emergency medical services personnel from four years to two years to align certification periods with those of the National Registry of Emergency Medical Technicians; to reducing the certification renewal fees to correspond with the shorter certification period; and requiring the Office of Emergency Medical Services to publish disciplinary actions taken against certified emergency medical services personnel on its website.

Be it enacted by the Legislature of West Virginia:

ARTICLE 4C. EMERGENCY MEDICAL SERVICES ACT.

§16-4C-8. Standards for emergency medical services personnel.

(a) Every ambulance operated by an emergency medical services agency shall carry at least two personnel. At least one person shall be certified in cardiopulmonary resuscitation or first aid and the person in the patient compartment shall be certified as an emergency medical technician-basic at a minimum except that in the case of a specialized multi-patient medical transport, only one staff person is required and that person shall be certified, at a minimum, at the level of an emergency medical technician-basic. The requirements of this subsection will remain in effect until revised by the legislative rule to be promulgated pursuant to §16-4C-8(b) of this code.

(b) On or before May 28, ~~2010~~ 2024, the commissioner shall submit a proposed legislative rule to the Emergency Medical Services Advisory Council for review, and on or before June 30, ~~2010~~ 2024, shall file the proposed legislative rule with the Office of the Secretary of State, in accordance with the provisions of §29A-3-1 *et seq.* of this code, to establish certification standards for emergency medical vehicle operators and to revise the requirements for emergency medical services personnel.

(c) As of the effective date of the legislative rule to be promulgated pursuant to §16-4C-8(b), emergency medical services personnel who operate ambulances shall meet the requirements set forth in the legislative rule.

(d) Any person desiring emergency medical services personnel certification shall apply to the commissioner using forms and procedures prescribed by the commissioner. Upon receipt of the application, the commissioner shall determine whether the applicant meets the certification requirements and may examine the applicant if necessary to make that determination.

(e) The applicant shall submit to a national criminal background check, the requirement of which is declared to be not against public policy.

(1) The applicant shall meet all requirements necessary to accomplish the national criminal background check, including submitting fingerprints, and authorizing the West Virginia Office of Emergency Medical Services, the West Virginia State Police, and the Federal Bureau of Investigation to use all records submitted and produced for the purpose of screening the applicant for certification.

(2) The results of the national criminal background check may not be released to or by a private entity.

(3) The applicant shall submit a fee of $75 for initial certification and a fee of $50 for recertification. The fees set forth in this subsection remain in effect until modified by legislative rule.

(f) An application for an original, renewal or temporary emergency medical service personnel certificate or emergency medical services agency license, shall be acted upon by the commissioner and the certificate or license delivered or mailed, or a copy of any order of the commissioner denying any such application delivered or mailed to the applicant, within 15 days after the date upon which the complete application, including test scores and background checks, if applicable, was received by the commissioner.

(g) Certification as an Emergency Medical Dispatcher, Emergency Medical Vehicle Operator, Emergency Medical Responder, Emergency Medical Technician, Advanced Emergency Medical Technician, Paramedic, Mobile Critical Care Paramedic, or Mobile Critical Care Nurse is valid for a period of two years with expiration dates determined by the Commissioner.

~~(g)~~(h) Any person may report to the commissioner or the Director of the Office of Emergency Medical Services information he or she may have that appears to show that a person certified by the commissioner may have violated the provisions of this article or legislative rules promulgated pursuant to this article. A person who is certified by the commissioner, who knows of or observes another person certified by the commissioner violating the provisions of this article or legislative rules promulgated pursuant to this article, has a duty to report the violation to the commissioner or director. Any person who reports or provides information in good faith is immune from civil liability.

~~(h)~~(i) The commissioner may issue a temporary emergency medical services personnel certificate to an applicant, with or without examination of the applicant, when he or she finds that issuance to be in the public interest. Unless suspended or revoked, a temporary certificate shall be valid initially for a period not exceeding 120 days and may not be renewed unless the commissioner finds the renewal to be in the public interest.

~~(i)~~(j) For purposes of certification or recertification of emergency medical services personnel, the commissioner shall recognize and give full credit for all continuing education credits that have been approved or recognized by any state or nationally recognized accrediting body.

~~(j)~~(k) Notwithstanding any other provision of code or rule, the commissioner recognizes that military personnel, National Guardsmen, members of the United States Coast Guard, and members of the Reserve Components of the Armed Services have advanced skills and training necessary to meet the requirements of this section to be certified as an emergency medical technician-paramedic upon application. Any person may seek automatic certification as an emergency medical technician-paramedic in this state if he or she has:

(1) Been honorably discharged from any branch of the United States military;

(2) Received paramedic or similar life-saving medical training in positions including, but not limited to, United States Army Combat Medic, United States Air Force Pararescue, United States Air Force Combat Rescue Officer, United States Navy Hospital Corpsman – Advanced Technical

Field, United States Coast Guard Health Services Technician, National Guard Health Care Specialist, the Reserve Components of any of the preceding positions, or can otherwise demonstrate that his or her occupation in the military received substantially similar training to be certified as required by the commissioner; and

(3) Received an honorable discharge within two years of the application date.

~~(k)~~(l) Notwithstanding any other provision of code or rule, the commissioner recognizes that military personnel, National Guardsmen, members of the United States Coast Guard, and members of the Reserve Components of the Armed Services have advanced skills and training necessary to meet the requirements of this section to be certified as an emergency medical technician-basic upon application. Any person may seek automatic certification as an emergency medical technician-basic in this state if he or she has:

(1) Been honorably discharged from any branch in the United States military;

(2) Received emergency medical technician training or similar life-saving medical training in positions including, but not limited to, United States Army Infantryman, United States Air Force Security Forces, United States Navy Hospital Corpsman, United States Coast Guard Aviation Survival Technician, United States Marines Infantryman, National Guard Infantryman, and Reserve Components of any of the preceding positions, or can otherwise demonstrate that his or her occupation in the military received substantially similar training to be certified as required by the commissioner; and

(3) Received an honorable discharge within two years of the application date.

~~(l)~~(m) Upon reviewing an application for certification pursuant to subsection ~~(j)~~(k) and subsection ~~(k)~~(l) of this section, the commissioner shall issue an appropriate certificate to the individual applying for certification as an emergency medical technician-paramedic or emergency medical technician-basic without further examination or education. If an individual certified pursuant to this section permits his or her certification to expire, the commissioner may require examination as a condition of recertification.

§16-4C-9. Complaints; investigations; due process procedure; grounds for disciplinary action.

(a) The commissioner may at any time upon his or her own motion, and shall, upon the written complaint of any person, cause an investigation to be conducted to determine whether grounds exist for disciplinary action under this article or legislative rules promulgated pursuant to this article.

(b) An investigator or other person who, under the direction of the commissioner or the director, gathers or reports information in good faith to the commissioner or the director, is immune from civil liability.

(c) After reviewing any information obtained through an investigation, the commissioner or director shall determine if probable cause exists that the licensee or certificate holder has violated any provision of this article or rules promulgated pursuant to this article.

(d) Upon a finding that probable cause exists that the licensee or certificate holder has violated any provision of this article or rules promulgated pursuant to this article, the commissioner or director shall provide a copy of the complaint and notice of hearing to the licensee or certificate holder. Upon a finding of probable cause that the conduct or continued service or practice of any individual certificate holder may create a danger to public health or safety, the commissioner may temporarily suspend the certification prior to a hearing or notice: *Provided,* That the commissioner may rely on information received from a physician that serves as a medical director in finding that probable cause exists to temporarily suspend the certification: *Provided, however,* That the commissioner shall simultaneously institute proceedings for a hearing in accordance with section 10 of this article.

(e) The commissioner or the director may enter into a consent decree or hold a hearing for the suspension or revocation of the license or certification or the imposition of sanctions against the licensee or certificate holder.

(f) The commissioner or the director issue subpoenas and subpoenas duces tecum to

obtain testimony and documents to aid in the investigation of allegations against any person or agency regulated by the article.

(g) The commissioner or the director may sign a consent decree or other legal document related to the complaint.

(h) The commissioner shall suspend or revoke any certificate, temporary certificate, or license when he or she finds the holder has:

(1) Obtained a certificate, temporary certificate, or license by means of fraud or deceit; or

(2) Been grossly incompetent, and/or grossly negligent as defined by the commissioner in accordance with rules or by prevailing standards of emergency medical services care; or

(3) Failed or refused to comply with the provisions of this article or any legislative rule promulgated by the commissioner or any order or final decision of the commissioner; or

(4) Engaged in any act during the course of duty which has endangered or is likely to endanger the health, welfare, or safety of the public.

(i) The commissioner or the director may, after notice and opportunity for hearing, deny or refuse to renew, suspend, or revoke the license or certification of, impose probationary conditions upon or take disciplinary action against, any licensee or certificate holder for any violation of this article or any rule promulgated pursuant to this article, once a violation has been proven by a preponderance of the evidence.

(j) Disciplinary action may include:

(1) Reprimand;

(2) Probation;

(3) Administrative penalties and fines;

(4) Mandatory attendance at continuing education seminars or other training;

(5) Practicing under supervision or other restriction;

(6) Requiring the licensee or holder of a certificate to report to the commissioner or director for periodic interviews for a specified period of time;

(7) Other disciplinary action considered by the commissioner or director to be necessary to protect the public, including advising other parties whose legitimate interests may be at risk; or

(8) Other sanctions as set forth by legislative rule promulgated pursuant to this article.

(k) The commissioner shall suspend or revoke any certificate, temporary certificate, or license if he or she finds the existence of any grounds which would justify the denial of an application for the certificate, temporary certificate, or license if application were then being made for it.

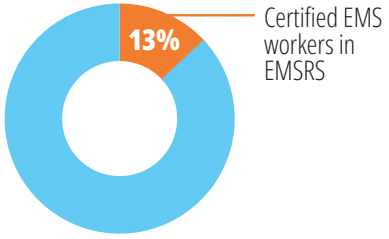
(l) The Office of Emergency Medical Services shall, after notice and opportunity for hearing, publish on its website any actions taken to suspend or revoke the certification of EMS personnel for any violation of this article or any rule promulgated pursuant to this article. The information published shall be limited to the individuals first and last name, certification number, city and state of residence, if the certification was revoked or suspended and date of action. This section does not require the Office of Emergency Medical Services to publish any information otherwise protected under this code.

NOTE: The purpose of this bill is to reduce the certification periods for EMS personnel from four years to two years to align certification periods with those of the National Registry of Emergency Medical Technicians and to reduce the certification renewal fees to correspond with the shorter certification period and to require the Office of Emergency Medical Services to publish disciplinary actions taken against certified EMS personnel on its website.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.

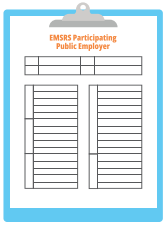
Expand the EMS Retirement System to include more Paramedics and EMTs

Most EMS personnel are ineligible for WV's EMS Retirement System (EMSRS) due to restrictions contained in the state code.



Less than 13% of certified EMS workers are in the EMSRS. WV has 5,021 Paramedics. AEMTs and EMTs. As of July 2022, the plan had 637 active members.

The EMSRS is fully funded and **there is zero cost to the state** to expand eligibility to more EMS workers.



Currently, an agency must be a "participating public employer" defined as a county commission or political subdivision, that has elected to cover its EMS officers in the EMSRS.

Many wrongfully assume all EMS agencies are a part of local government and can participate because they are named after a county or city.

The WV EMS Coalition estimates that **less than 25% of all EMS agencies** are organized in a structure that is eligible for the EMSRS.

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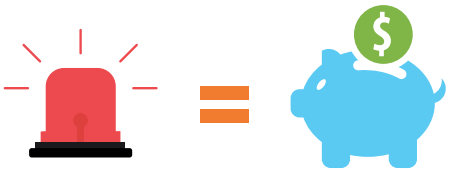
Counties have a legal duty to make EMS available but are not required to fund the service. Many designate a non-profit or other entity to provide EMS rather than establishing their own ambulance service.



EMS workers who **provide an essential public service should have equal access to retirement benefits** if delivering emergency response. All employees of EMS agencies designated by counties to respond to 911 dispatches should be eligible.

Expanding the EMSRS would:

- ✓ Boost recruitment and retention by **providing a 20-year retirement** for more paramedics and EMTS.
- ✓ **Have no fiscal impact** on the State. EMS agencies and personnel are fully responsible for the contributions.
- ✓ Provide EMTs and paramedics with the ability to **retain and grow their benefits** when working for multiple agencies or changing jobs.
- ✓ **Strengthen the plan** by increasing the number of participants.
- ✓ **Maintain balance** between EMS and Dispatch Centers when hiring employees. Continuing to exclude EMS could result in having more people to answer 911 calls but no one to send to the patients.

The Legislature has expanded EMSRS to include emergency managers, 911 dispatchers and county firefighters. It is time to add the excluded EMS agencies and personnel.

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