Docket No. SA-530

Exhibit No. 5-H

NATIONAL TRANSPORTATION SAFETY BOARD

Washington, D.C.

Summary Position Statement of NASEMSO on the Need for Shared State and Federal Regulation of Air Medical Services

(6 Pages)

The **National Association of State Emergency Medical Services Officials (NASEMSO)** hereby submits the following summary position statement and the attached article, *Air Medical Services: Future Development as an Integrated Component of the Emergency Medical Services (EMS) System - A Guidance Document by the Air Medical Task Force of the National Association of State EMS Officials, the National Association of EMS Physicians, and the Association of Air Medical Services* for consideration as Exhibits for the February 3rd to 5th National Transportation Safety Board Hearings. The Association intends to submit a detailed position statement for the Hearing Docket.

Summary Position Statement of NASEMSO on the Need for Shared State and Federal Regulation of Air Medical Services

The National Association of State Emergency Medical Services Officials

The National Association of State Emergency Medical Services Officials (NASEMSO or " the Association") is the lead national organization for emergency medical services (EMS) and a respected voice for national EMS policy. The Association is committed to the development of effective, consistent, integrated, community-based, and universally available EMS systems. Its vision is a seamless nationwide network of coordinated and accountable state, regional and local emergency care systems that employ public health principles, data and evidence as a basis for safe and effective care in day-to-day operations as well as during catastrophic events.

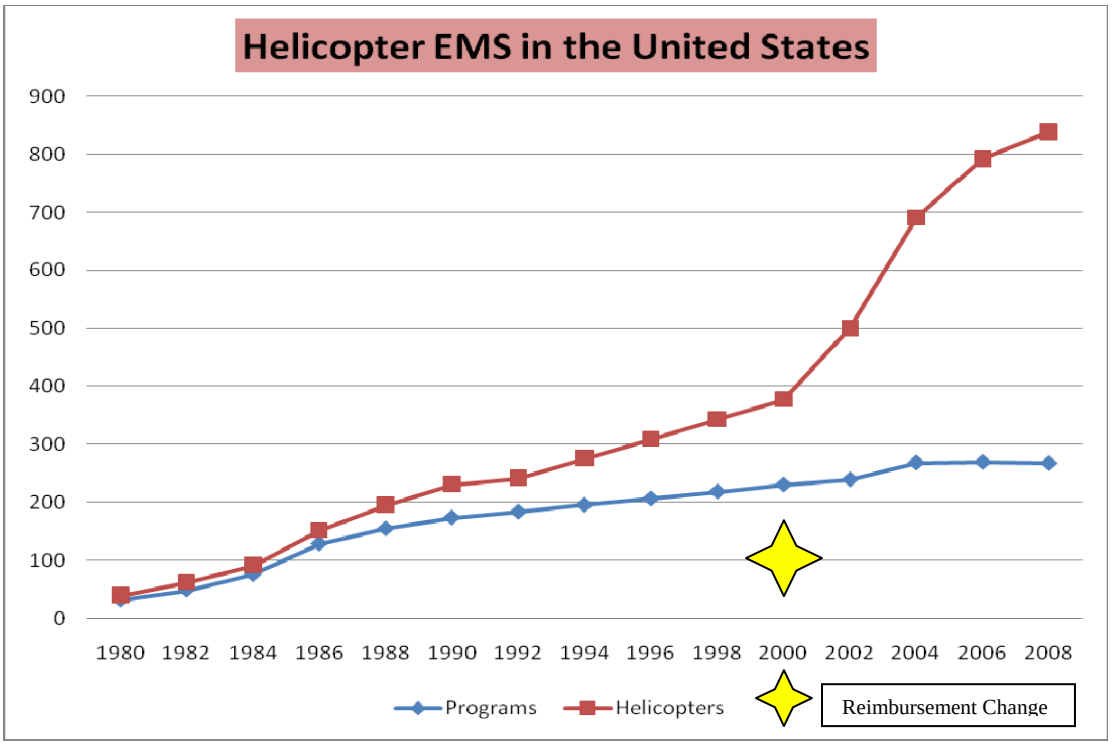
The members of NASEMSO include state EMS directors, medical directors, trauma managers, and other officials charged with building, leading, and regulating their statewide systems of emergency medical response. They typically lead EMS system development, and license the agencies (ambulance and non-transporting first responder) and personnel (first responders, emergency medical technicians or EMTs, and paramedics) that provide emergency patient care and transportation. They may also license ambulances and other EMS vehicles.

Rapid Growth in the Number of Medical Aircraft

From the early 1970's, when civilian air medical services (AMS) began in the United States, through the year 2000, there was a slow but steady growth of fixed and rotor wing air medical services. They were generally non-profit, hospital-based or governmentally-sponsored helicopter programs, with the occasional emergency fixed wing service in remote areas and fixed wing commercial services for non-emergency transports. The slow growth of these programs was largely because air medical services were expensive to operate and were not well reimbursed by health insurance. As a result, these programs were typically operated by large hospital systems or by governments that had other sources of funding to subsidize AMS losses. The slow growth allowed EMS system leaders and regulators, and AMS operators, to integrate these services into the complex emergency response systems in individual states.

In 2000, however, reimbursement for AMS dramatically changed. The Centers for Medicare and Medicaid Services (CMS) issued a new reimbursement formula for air medical services that emerged from a "negotiated rule-making process." That reimbursement formula recognized the costs of operating AMS under the hospital-based and governmental models with their added indirect and other costs of the support provided by those organizations.

The change in reimbursement was followed by extraordinary growth in the number of AMS helicopter services throughout the country. As a result, the number of medical helicopters then more than doubled from under 400 in 2000 to over 830 today (see figure below). Further, the predominant model has changed to private, for-profit operators of independently based helicopters instead of non-profit hospital-based or governmental helicopters.

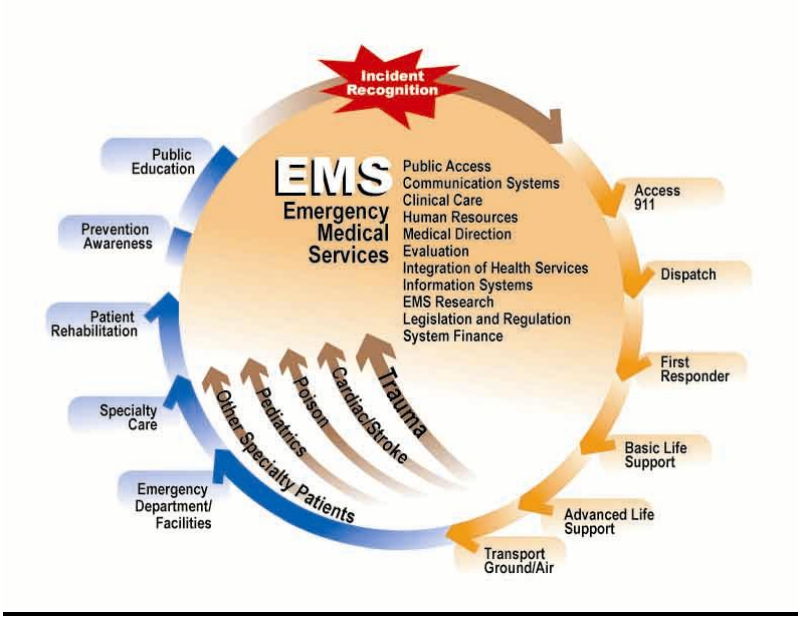


A review of the emergency medical system literature fails to identify any sudden need for rapid additional medical aircraft growth around 2000. The Association has concluded, therefore, that the both the growth in the number of AMS aircraft, and the trend toward for-profit operations resulted not from medical necessity but from the increase in reimbursement.

Problems for Emergency Care Systems Resulting from Uncontrolled Growth

Modern emergency medical services were born as a "system" in the early 1970's. As such, response to a 9-1-1 call for help results in a complex choreography of dispatchers, responders, and hospital personnel and resources. The figure below depicts that

complexity. Such an interweaving of varied personnel, equipment, and facility resources requires careful coordination in order to meet the needs of the critically ill or injured patient.



Changes in this system must also be carefully planned and implemented, and undertaken only after the need for such change is demonstrated by medical studies or science evidence. To implement any change typically requires new protocols and procedures, the training of hundreds or thousands of personnel, and the establishment of ways to monitor the effect of the change on EMS response, patient care, and patient outcome.

Since 2000, however, the rapid injection of hundreds of new emergency medical aircraft responders into an existing system has created coordination and confusion issues for EMS systems. In some areas, there are more aircraft capabilities than necessary to transport those relatively few patients who need to be transported by air. There is often pressure to transport more and more patients by air who do not require this method of transport, unnecessarily increasing health costs for all and potentially exposing greater numbers of patients to unnecessary risks of flying. New AMS operators beginning operation in a particular geographic area without effective coordination by state EMS regulatory entities has been problematic for EMS system response when state officials are unable to set standards for accessing, dispatching, and coordinating these services. As just one example, NASEMSO members frequently report instances when multiple air medical services respond unnecessarily to one car crash in an uncoordinated fashion and when they have not been asked to respond by a public safety dispatch agency. This is similar to 1970's era "call-jumping" by ground ambulance services, which EMS systems effectively put to an end long ago.

The sudden expansion of air medical assets has been a formidable challenge for state EMS systems and to state EMS offices throughout the U.S. Adding to this challenge is the often strong desire of AMS operators to forego state integration and regulatory processes involved in favor of rapidly ramping-up new operations to provide more

helicopter flights. As a result, there have been several court challenges by AMS operators to state emergency system planning and implementation processes.

Air Medical Services Cannot be Regulated as Simple Air Carriers

The Airline Deregulation Act of 1978 (ADA) has been frequently cited as the major factor preempting state EMS offices from regulating fixed and rotor wing AMS as they do other emergency medical services in their jurisdictions. It is argued that the U.S. Department of Transportation (USDOT) is solely authorized to regulate these air services, and that, under the ADA, states are precluded from regulations that would affect "rates, routes, and services" of AMS programs.

When the ADA was passed, however, civilian air medical services had existed for only a few years, and state EMS agencies were only beginning to regulate EMS. How air medical services fit into EMS systems and might be regulated by them had not been well developed and was not considered when the ADA was enacted. Further, provisions for AMS regulation beyond the same general air safety and other requirements placed on any air carrier and flight crew were not considered. Finally, the types and levels of medical care that are now provided by AMS services did not even exist when the ADA was enacted.

The difference between aircraft operations transporting passengers that are typically regulated solely by the ADA and AMS operations are important.

First, unlike typical air carriers, AMS providers do not simply transport patients between two points. While one of the benefits of AMS is certainly speed of transport, equally or more important is the high level medical care that can be provided at the scene and while the patient is en route during transport. This is sophisticated medical care that must be overseen by physicians and coordinated as part of the overall medical response to the patient.

Second, while private and commercial passengers can choose their mode of transport and also choose among providers of air services, EMS patients and their families generally do not have this same choice with AMS services. Patients need protection as medical consumers of services about which they, under emergency circumstances, do not have the ability to make informed decisions.

Third, unlike typical air services, AMS providers must act together with another system – the healthcare system – in order to operate. AMS providers are <u>one</u> component of a state's health and EMS system and must routinely interact with a variety of emergency, public safety, and health care personnel and operations in order to provide services. These include 9-1-1 dispatchers, first responders and paramedics, police and fire who respond to an incident, as well as the hospitals, physicians and nurses who participate in that system. For an EMS system to be successful, there must be a high degree of coordination among all components and state oversight is required to assure that this coordination is effective. Consequently, AMS providers should be subject to the same

coordination requirements as are all other components of the EMS and health care systems.

State EMS Agencies Should Team With Federal Agencies to Provide Effective Oversight of AMS Providers

First and foremost, air medical services are medical resources that are used within EMS systems to provide patient care. State EMS agencies have the necessary experience and authority in planning, coordinating, integrating, and regulating the medical resources that are components of EMS systems to provide appropriate oversight of the medical aspects of AMS operations. Recently, Federal Aviation Administration officials have been quoted as stating that Congress had not intended the ADA to apply to the medical operations of AMS[1]. Indeed, in 2006, the national Institute of Medicine called upon state EMS agencies to regulate the medical aspects of AMS[1].

At the same time, however, air medical services are also air transport resources and possess certain aspects that must continue to be regulated by federal agencies; these aspects include air transport safety and air system integration and operation.

The Association believes that clearly defined areas of federal and state responsibilities can be delineated in order to ensure effective oversight of air and medical operations of AMS services. The responsibilities sought for states include, but are not limited to:

- The determination of medical necessity for new AMS resources, and the medical appropriateness for the types of patients to be flown, the care and destinations selected for them, and the medical equipment utilized.
- The qualifications of medical flight crew;
- Approval and coordination of hours of availability, basing, methods of emergency access by ground responders and hospitals, and dispatch arrangements;
- Licensing of AMS providers as medical resources;
- Requirements for AMS medical oversight and medical quality improvement.

Conclusion

An unprecedented growth in the number of emergency medical aircraft has resulted from increases in reimbursement, not from proven medical necessity. Uncontrolled insertion of new AMS providers in an EMS system has been disruptive to states attempting to provide effective EMS system response and patient care. The federal government and the states should coordinate their oversight of AMS operations in a manner that will ensure effective AMS use in state EMS and health care systems and appropriate use in meeting patient care needs. The federal government authority should be clarified to permit states to provide for the oversight of the medical aspects of AMS operations.

1 - McGinnis KK, Judge T, Nemitz B, et al *Air Medical Services: Future Development as an Integrated Component of the Emergency Medical Services (EMS) System - A Guidance Document by the Air Medical Task Force of the National Association of State EMS Officials, the National Association of EMS Physicians, and the Association of Air Medical Services*; Prehospital Emergency Care; 2007;11:357–358