



National Association of State EMS Officials
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**Position Statement of the
National Association of State Emergency Medical Services Officials
In Support of HR 978
“Helicopter Medical Services
Patient Safety, Protection, and Coordination Act”**

The National Association of State Emergency Medical Services Officials

The National Association of State Emergency Medical Services Officials (NASEMSO) is the lead national organization for emergency medical services (EMS) in the 56 states and territories and a respected voice for national EMS policy. 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.

Position Statement

The Association believes that air medical services (AMS) are fundamentally medical resources that require effective integration into the EMS system and regulation by state EMS officials. It recognizes the safety issues involved in AMS operations and respects the expertise and authority of federal agencies in addressing these. Therefore, NASEMSO endorses passage of HR 978, the “Helicopter Medical Services Patient Safety, Protection, and Coordination Act”, and its call for shared authority between state and federal agencies over the air transport and medical services that constitute AMS.

Rationale

From the early 1970’s, when civilian air medical services 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. The slow growth of these programs was largely because air medical services were expensive to operate and were not well reimbursed by health insurance. 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 and more favorable reimbursement formula for air medical services. This allowed AMS to operate in areas where it may have been needed but previously unaffordable. The change in reimbursement was followed by extraordinary growth in the number of AMS helicopter services throughout the country. The predominant model changed to private, for-profit operators of independently based helicopters instead of non-profit hospital-based or governmental helicopters. Consolidation of these private, for-profit services into large, national or regional companies has also been noted. The growth of the for-profit, consolidator model has created medical necessity and system integration questions in many areas. It is the unprecedented growth in the numbers of aircraft in general, as well as challenges to efforts at integration, that have strained state EMS systems nationwide.

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. 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 other evaluative evidence.

Since 2000, however, the rapid injection of hundreds of new emergency medical aircraft responders into existing EMS systems has created coordination and confusion issues. 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. Adding to this challenge is the apparent strong desire of at least some AMS operators to avoid state integration and regulatory processes. There have been several successful court challenges by AMS operators to state emergency system planning and implementation processes.

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.

The difference, however, 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, they provide sophisticated emergency medical care that must be overseen by physicians and coordinated within the EMS systems.

Second, while airline passengers can choose their mode of transport and airline, EMS patients and their families generally cannot. Patients need protection as medical consumers.

Third, unlike typical air services, AMS providers must act together with another system – the healthcare system – in order to operate. Air medical; service providers are one 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.

Air medical services are, first and foremost, 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. However, air medical services are also air transport resources and possess certain aspects that must continue to be regulated by federal agencies.

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 federal government and the states should coordinate their oversight of AMS operations in a manner that will ensure effective integration in emergency care systems and appropriate use in meeting patient needs. The federal government authority should be clarified to reserve to the states the oversight of the medical aspects of AMS operations. The “Helicopter Medical Services Patient Safety, Protection, and Coordination Act”, HR 978, leads the way in this direction.

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