



**TESTIMONY OF THOMAS JUDGE ON BEHALF OF
THE PATIENT FIRST AIR AMBULANCE ALLIANCE
BEFORE THE TRANSPORTATION AND INFRASTRUCTURE COMMITTEE AVIATION SUBCOMMITTEE
HEARING ON HELICOPTER MEDICAL SERVICES
APRIL 22, 2009**

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Good morning Chairman Costello, Ranking Member Petri, and Honorable Members of the Committee. I am Thomas Judge, and am testifying on behalf of The Patient First Air-Ambulance Alliance (PFAA), which represents more than 70 not-for profit and for profit air medical providers ranging from single aircraft to large national organizations, including several members of the Air Medical Operators Association. PFAA members operate bases in 37 states and work nationwide.

I currently serve as the Executive Director of LifeFlight of Maine, a small independent non-profit program, one of three air medical providers serving Maine. I am a member of the Joint Helicopter Safety Implementation Team of the IHST project, a joint industry and FAA initiative, served as a subject matter expert for the NTSB in recent hearings on medical helicopter safety, served as a member of the national expert review panel for the State of Maryland, and am a past president of the Association of Air Medical Services. In addition to professional roles in air medicine, I continue to serve as a volunteer paramedic in the local Fire/Rescue system of a small group of fishing villages and islands on the coast of Maine. I have practiced and worked in rural EMS systems for over 30 years. Assuring rural access to quality emergency healthcare is a personal imperative.

The PFAA was created quite simply to improve the accountability of the air medical system to patients and the public. Although the provision of helicopter medical services (HMS) is primarily performed by private organizations, HMS is a public endeavor. Helicopter medical services incorporate both scene transports directly to trauma centers and inter-hospital transport of critically ill and injured patients. To the extent that patients must be transported in a helicopter it is always an emergency. PFAA supports stronger federal and state regulations to ensure the safety and protection of patients and crews so that HMS are truly deserving of the public trust. PFAA endorses both HR 978 and HR 1201 to build a more accountable and safer system for patients.

It is extremely regrettable that HMS has ended up on the NTSB's "10 Most Wanted" list. While significant progress is slowly being made in improving aviation system safety, more must be done. HMS is an extremely complex arena that has drivers and influences that are significantly different than other sectors of transportation. Rather than a traditional aviation enterprise, it is more appropriate to view HMS as an essential emergency service—more akin to a public utility than an enterprise. The values and accountability of provider organizations, whether public, nonprofit or for profit, must assure the public of quality, safety, and coordination of medical services. The public and vulnerable patients must be assured of both medical and transportation safety. Our "passengers" are a unique population who generally lack a choice of carriage or carrier.

PFAA appreciates the Committee reviewing the entire HMS operating environment. PFAA believes that there are three sweeping and critical problems in the helicopter medical services arena that must be addressed -- aviation safety, patient safety, and the underlying economics of the industry which dis-incentivize safety.

PATIENTS MUST BE ABLE TO TRUST THE AIR MEDICAL SYSTEM -- UNACCOUNTABLE SYSTEMS PUT PATIENTS AT RISK

Public Perception Versus Reality. Patients and the public must be able to trust that each and every HMS provider is making decisions on their behalf strictly on the basis best medical and aviation practice. The medical helicopter tragedies are shocking as we see the pictures of the burned debris of a helicopter crash. We should also be shocked by the patients placed at risk and harmed daily in much less visible but all too real ways.

- The public believes that that all medical helicopters are the same with the same levels of performance and aviation safety technology. They are not.
- The public believes that if they or a loved one needs air medical transport, the helicopter that arrives to transport them will take them quickly and efficiently to the closest appropriate hospital—the right hospital, the right physician, at the right time. That may or may not be true depending on where they live.
- The public believes that the helicopter will be well staffed by similarly trained medical crews with the latest medical technology to provide them with the critical care needed to keep them alive. There is no such guarantee.

Real Example of Patient and Aviation Safety Risks to Patients. Air ambulance program Alpha was called to transport a patient from a scene after air ambulance program Beta turned down the flight due to weather conditions below industry standards for safe medical transport. Alpha launched despite the poor weather, with the only report being that "it came in as chest pain but the ground crew thinks it may have been a stroke." Alpha lifted off without sufficient information on the patient's condition or diagnosis, thus not knowing what the appropriate receiving hospital would be and without contacting the receiving hospital to coordinate and accept the transfer. After Alpha finally determined mid-flight the appropriate receiving hospital to be the nearest trauma center, the medical crew was unable to provide a complete patient report to the trauma center prior to arrival, as Alpha was on a radio frequency unknown to the trauma center. Based on limited information that the trauma center was finally able to receive, the Emergency Department thought the patient may be suffering from a stroke, and the trauma center activated the stroke team and prepared to accept the patient.

Amazingly, Alpha didn't land at the trauma center, it landed at a different hospital 5 miles away as they did not know the location of the trauma center. That hospital had no warning of the arrival, and had no medical or security team to meet the helicopter and patient. Alpha never notified Beta that it was flying in the same flight area to ensure coordination and avoid possible overlapping flight path, particularly given the poor weather. After Alpha sat on the wrong helipad for 10 minutes and determined it had the wrong coordinates and was at the wrong hospital, it lifted off again, and flew for another 10-15 minutes before returning and delivering the patient to the same wrong hospital. The patient was finally treated by that hospital 2 hours after the initial call. The patient did not have a stroke, the patient had a heart attack which symptoms are clinically distinguishable. Additionally, the weather conditions were so bad that Alpha was unable to return to its base after transporting the patient and was grounded at a local airport until conditions

improved. The problem list in this case is extensive -- here is a patient that suffered serious time delay in care and was exposed to unacceptable medical and aviation risks during transport.

Broken Air Medical System. Unfortunately, stories like these are now commonplace in many parts of the country in which state medical oversight is lacking, compromised, or has been outright dismantled. We do not find these stories in regulated markets regardless of few or many providers. We find these stories in unregulated markets, regardless of the number of providers, in which individual companies are setting their own standards of practice and have limited the ability of state health and EMS authorities to set and enforce a consistent standard of performance and accountability for licensed providers.

All too often, the system upon which patients rely in time of emergency is broken. If known, stories like the one above would generate headlines similar to a crash, but the problems and risk are unrecognized in an unaccountable system where individual provider organizations have chosen to create and set their own standards. When I was Association of Air Medical Services President, (AAMS) I believed industry could self-regulate. Today I am not convinced. To understand how we got here and how to solve the problem, we must first understand the underlying economic problems in the air medical industry.

A PERFECT STORM -- DRAMATIC GROWTH, PROBLEMATIC ECONOMICS OF HMS, AND ADA PREEMPTION OF STATE ECONOMIC REGULATION OF HMS

The rapid and dramatic growth in the number of HMS providers, underlying economic incentives and dis-incentives, and the use of the ADA economic preemption to strike down the states' ability to effectively regulate HMS have come together as the perfect storm impacting both aviation and patient safety.

Growth of HMS. Civilian “medevac” started in the early 1970’s. There have been three periods of rapid growth in the number of helicopters, each period with a corresponding rapid increase in the number of crashes and ongoing safety concerns. Growth has been dramatic with 21 medical programs in 1978 with about 30 helicopters extending to over 250 provider organizations operating 377 helicopters in 2000. Since 2000 the number of aircraft has more than doubled to a current fleet of around 850 helicopters.

While the increase in the number of helicopters has increased the availability of HMS and has provided new options for improving access and care to patients, the reasons for growth are multi-factorial. A major driver was the creation of the national Medicare Fee Schedule project that was started in 1997 with implementation in 2002. The Medicare Fee schedule for HMS has more than doubled the reimbursement to fee for service providers. While the final implementation beginning in 2002 used 5 year old cost data, the cost data used to develop the fee schedule were based on twin engine, hospital based helicopters, the predominant model at the time. With a close to cost based Medicare reimbursement establishing a “floor” for HMS, providers were able to leverage higher rates from private insurers significantly increasing the revenue flow into the air medical system.

While each period of growth was associated with increased crashes, reports by the NTSB, and work by industry on improving safety, actual safety standards have been only slowly adopted. The NTSB and industry identified imperatives such as mandating radar altimeters, improving training for inadvertent instrument meteorological condition recovery, night and IFR operations, stretching back to 1992 in many cases have yet to be adopted widely or fully. Unfortunately, the positive impacts of growth have come, often at tragic costs to the pilots, medical teams, and patients, Growth has however, had other costs as well. An unregulated system places patients at risk, and indirectly negatively impacts aviation safety.

The Economics Realities of HMS. The economic realities of HMS are important to understand, particularly in that they differ from other areas of aviation.

- HMS Providers are Paid Only Per Transport. HMS providers are paid only when they transport a patient rather than for readiness more seen in other public safety endeavors. There is significant economic incentive to transport patients.
- HMS Reimbursement is Divorced from Quality, Aircraft or Service Capability. Current regulatory schemes at both the state and federal level focus on minimum standards for operations. Other than CAMTS accreditation, there is no delineation of capability such as there is for ground ambulances and trauma centers. Medicare reimbursement follows a fixed fee schedule reimbursement that does not distinguish the level of vehicle or quality or level of medical capability. For example, a program operating an \$800,000 retrofitted helicopter coming off an oil rig is paid the same base amount per transport as an \$9 million helicopter fully equipped twin engine, dual pilot, state of the art aircraft with specialist critical care pediatric teams including physicians.
- HMS Has High Costs and Low Margins. HMS is a high unit cost service with significant fixed costs often constituting 80% of operating budgets. While costs are high and drive charges, charges are not necessarily related to costs. Lower operating costs do not equate to lower charges due to standardized reimbursement. Charges can be extensive and vary widely from \$6-20K per transport depending on locale.
- User, Chooser, Payor of HMS are Not One in the Same. The person who *uses* HMS (patient) is different from the person who *chooses* the service (requester) and is also different from the person who *pays* for the service (insurer). In commercial aviation, the consumer who uses an airline service, chooses a service based on certain factors (such as cost, service and quality) and pays for the same service are all one in the same.
- Limited Pool of Flight Volume Per Market. While the numbers of helicopters have increased, the number of patients served per helicopter has remained static or in the last year is declining due to significant reductions in numbers of vehicle miles travelled. There are only so many people in a given market that ever could or should be transported by medical helicopter.

Perverse Economic Incentives of HMS. The underlying economic challenges and underpinnings of HMS reimbursement, drive decision making which is all too often not in the best interests of aviation or patient safety.

- Base Location Where Profitable, Not Where Needed. Base locations are developed in markets with positive reimbursement rather than the markets with poor payer mixes, resulting in a geographic maldistribution of services and many markets with helicopters on top of helicopters. This can occur both at the state or regional level within a state.
- Maximize Flight Volume. To cover fixed costs, the economic incentive is to fly as much as possible. But if there are a finite number of patients in the market and many helicopters, there is an imperative for each to have enough volume to cover fixed costs impacting the safety of operations. Market saturation pushes air medical providers to make poor decisions and take unnecessary risks. The increased economic pressure to fly in highly competitive markets was recognized by the troubling testimony at the NTSB Hearings of the physicians, pilots, nurses, and paramedics. Examples of such risks that we see in unregulated markets include:
 - Flying below weather minimums -- operations in marginal or worse weather with risk to crew and patients is seen as a matter of course in unregulated markets
 - Stacking emergency flights with delays in care for economic and non patient care purposes
 - Inappropriate marketing to flight requestors.
 - Call jumping and self-dispatch. While publicly decried, there are constant reports that these practices are occurring.
 - Flying patients with minimal medical need which increased costs to the healthcare system without corresponding clinical benefit.
- Reduce Medical or Safety Expenses. Reducing fixed costs to whatever degree possible can dis-incentivize or prevent providers from investing in quality of medical care and aviation safety. Air medical programs are not incentivized to purchase expensive but more capable aircraft, improved patient care aircraft attributes, medical equipment, or maintain high quality medical personnel and training. They are not incentivized (nor reimbursed) to purchase night vision goggles, install HTAWS, or provide IFR operations.
- Raise Charges. Although Medicare payments are fixed and Medicaid payments vary by State, air medical programs can and do raise rates to cover fixed costs and generate margins where flight volume is insufficient to support them. Counterintuitive to traditional market economics, intense competition actually increases charges to private payors rather than decreases charges. **(SLIDE 1)**
- Pressures for Less Regulation, Oversight and Accountability. The economics and drive toward flight volume incentivizes providers to work outside of the EMS system, rather than as a part of a coordinated delivery of critical care air medical services.

Impact of Oversaturation of HMS in Some Markets. Oversaturation of a particular market results in reduced flight volume per program. Thus, too many helicopters in certain regions creates intense competition – not for the market, but for specific patients. While this may work well in general aviation, in HMS where the consumer is not making the choice of the service or paying for it directly, the current system organization of HMS based on competition for individual patients rather than markets doesn't work. Results of unregulated competition and inability of states to rationalize distribution of medical helicopters are exemplified below:

- Maldistribution of HMS. While some rural access has certainly and positively increased with the massive growth of medical helicopters, the majority of growth has been in better paying urban areas resulting in helicopters on top of helicopters. Arkansas has seen the addition new rural helicopters in the northwest part of the state where employers are more plentiful and patients are better insured; no helicopter bases have developed in the impoverished areas of southeastern Arkansas. An example of growth following finances is Kentucky which has increased Medicaid reimbursement. Helicopters have increased more than 100% in less than 5 years (ADAMS 2003:12 2008:27) with the greatest number of aircraft in the built up areas around the state capitol of Lexington.
- Flights of Patients with Minimal Medical Need. In oversaturated markets, competitive pressures result in flying patients who could be more appropriately be served by ground EMS units at much less cost to the patient and healthcare system. As an example, Houston has gone from 3 1/2 helicopters in mid 1990's to 16 in the current service area. Houston now has more medical helicopters in all of Canada or in all the states of New England. The hospital discharge rate in less than 24 hours in Houston increased 4 fold from 9 to 40%. The comparable rate in New England's discharge in less than 24 hours rate is under 10%. While a blunt tool for measuring medical necessity, a four fold increase in discharge rate cannot be explained other than a reduction in the acuity threshold for flight.
- Declining Ability to Invest in Quality and Safety. In 1996, Missouri's certificate of need law was invalidated for air ambulance services. The number of helicopters statewide has increased from 21 to 33 in 5 years with the overall concentration of aircraft in the urban areas. The original fleet in Kansas City was exclusively twin engine and now due to intense competition and the need to achieve bottom line performance system evolution has transitioned to predominantly single engine aircraft. The issue is not about single vs. dual engine aircraft but rather, the growth in the fleet is based on lowest operating costs not consistent with the current FAA goal of incentivizing IFR. In Missouri, medical care and equipment requirements are set by each individual program's medical director with minimal state standards, and enforcement has been limited for fear of another lawsuit.

Unintended Consequences of ADA Preemption in HMS. PFAA recognizes the benefits and value that the Airline Deregulation Act has brought to the interstate transportation of passengers and goods in the commercial aviation realm. We believe, however, the ADA has had unintended and negative consequences in the sphere of HMS and indeed the Congress in 1978 did not anticipate how the ADA would impact emergency medical aviation. The ability of states to regulate the "ambulance" aspect of HMS has been challenged in numerous areas leaving enormous gaps in oversight, lack of clarity over what states can and can't regulate, and a chilling effect on state regulators to strengthen or even enforce existing HMS regulations.

The ADA preemption provision prohibits the states from regulating the prices, routes or services of air carriers. Accordingly, States are currently prohibited by the ADA from fully regulating helicopter medical services in the way they regulate all other health care services within their borders. The result of the broadly preemptive nature of ADA in its applicability to medical

helicopters as air carriers is a major gap in HMS regulation because states are prohibited from effective state health planning and providing rationality to the location and distribution of HMS services throughout the state, regulating air ambulances as they do ground ambulances, ensuring patients have coordinated ground and air ambulance transport, and appropriately overseeing air ambulance access, availability, and delivery as part of their EMS and Trauma Systems. The FAA is not capable of providing system medical oversight as governance of health services is historically a state function.

Examples of Dismantled State Laws Governing Air Ambulance Services:

- Designating base of air ambulance operations and service areas to ensure coordinated response and prevent call-jumping (multiple air ambulances responding to same scene or hospital) and flight stacking (accepting flight request without an available aircraft rather than referring request to another provider)
- Requiring 24/7 availability, weather permitting, or defined response times
- Requiring demonstrable need for new or expanded air ambulances
- Limiting the number of air ambulances within a state or region thereof
- Requiring demonstration of least-cost alternative analysis and non-duplication of services
- Requiring affiliation with a trauma center as part of a trauma plan
- Licensure requirement requiring affiliation with EMS system or EMS Peer Review Committee

Current interpretation and court decisions have recognized that States may regulate the medical care and equipment provided aboard helicopters to some degree. PFAA appreciates the effort of DOT in its 2008 letter to the State of Texas¹ to recognize that medically related requirements such as rules on the adequacy of medical equipment, qualifications of medical personnel, and the need to maintain sanitary conditions are not preempted by the ADA. Unfortunately, the extent to which states may establish all medically necessary requirements related to patient safety is still limited or not clear due to a variety of interpretations around the issue of economic regulation or field preemption.

For example, as noted in a DOT letter the State of Hawaii,² the State's requirement for 24 hours emergency system operations were preempted as well as other criteria including "quality, accessibility, availability, and acceptability." The letter went on to note that Hawaii could regulate "trauma supplies, oxygen masks, blankets, and litters" but cautioned that state medical requirements related to supplies and equipment could indirectly and impermissibly constitute prohibited economic regulation.

"Of course, it is possible that a State medical program, ostensibly dealing with only medical equipment/supplies aboard aircraft, could be so pervasive or so constructed as to be indirectly regulating in the preempted economic area of air ambulance prices, routes, or

¹ Letter from D.J. Gribbin, General Counsel of the Department of Transportation to the Honorable Greg Abbott, Texas Attorney General, November 3, 2008 at 13.

² Letter from Rosalind Knapp, Acting General Counsel of the Department of Transportation to Gregory Walden, Counsel for Pacific Wings, LLC, April 23, 2007 at 5.

*services. While that has not been shown here, the parties are reminded of the breadth of the Federal express preemption provision, which extends to prohibit any State provision 'having the force and effect of law related to a price, route or service....'"*³

As another example, the recent ruling North Carolina was helpful in clarifying that state regulations serving primarily a patient care objective are properly within the states' regulatory objective.⁴ However, the North Carolina ruling struck down a State requirement for tail rotor illumination (not required by FAA), thus posing safety risks to patients and medical personnel during night time loading/unloading of patients in the rear of the aircraft where the tail rotor is not visible. This invalidated requirement relates to the aircraft but is essential for patient and medical crew safety.

STATE ECONOMIC REGULATION MUST BE ALLOWED TO SOLVE UNDERLYING INDUSTRY PROBLEMS LEADING TO BOTH PATIENT AND AVIATION SAFETY PROBLEMS

HMS is Different than Other Sectors of Aviation. Several years ago, I wrote the *Vision Zero* white paper, an initiative of the Association of Air Medical Services. It highlights the inter-related complexities of emergency care, critical care, and aviation medicine. A number of questions and replies at the recent NTSB Hearings focused on the question: is HMS different than other sectors of aviation, and if so why? While airworthiness, training, tasking, and operations of any aircraft should be consistent within the one system FAA safety regulations, there are a number of distinctions in the HMS operating environment that are vitally important to understand:

- Unlike other commuter operations or any other area of transportation, the passenger is in a unique circumstance and does not have a real or informed choice of carriage or carrier. A critically ill patient cannot be considered a rational consumer.
- Unlike other commuter operations, flight requests are always emergencies. While we do everything we can to isolate the specifics of the flight request from the pilot and medical crew, when the tone goes off with a flight request, it is not a request for a scheduled flight at some projected time in the future. It is always a time sensitive emergency, with limited planning time, requiring a much different system of operations and controls.
- Unlike other commuter operations, in which the vast majority of operations are conducted during daylight hours, this is a 24 hour business. In fact, due to other iatrogenic factors in the healthcare system, night operations are increasing.

As illustrated, unregulated markets and market economics that are benefits of the ADA in commercial aviation do not work for HMS. This mix of factors is a substantial regulatory challenge. Both patient safety in the medical system and aviation safety are affected. We believe the best efforts of the FAA will be unlikely to completely overcome all of the safety issues -- neither the FAA nor the DOT alone can address the underlying flaws in the current HMS system design and underlying economic model, and they are not capable of evaluating the medical aspect of HMS transporting a truly unique passenger. This must be a coordinated federal and state effort.

³ DOT letter to Hawaii, quoting 49 U.S.C. Section 41713(b)(1) at 5.

⁴ *Med-Trans v. Benton*, 581 F. Supp.2d 721 (E.D. NC 2008)

The Intersection of Federal and State Law Over HMS is Truly Unique. Medical helicopters are both ambulances and aircraft. While the Federal Aviation Administration has and must maintain complete governance over the aviation safety of medical helicopters as aircraft, equally, state EMS and health authorities must have complete governance of medical helicopters as ambulances, as long as states do not infringe on federal authority over aviation safety. HMS is the only area of aviation where the states have a role and legitimate interest because the individual being transported is not simply a passenger – the individual is a patient receiving health care services. HMS is the only area of health law in which states are limited or prevented from regulating as they do all other health care services within their borders.

BUILDING A BETTER AND SAFER HELICOPTER MEDICAL SERVICES SYSTEM

H.R. 978. PFAA is comprised of healthcare providers whose goal is to improve access to and the quality and safety of emergency medical care and strongly endorse HR 978 for that reason. PFAA in its advocacy for H.R. 978 strongly supports the single system aviation safety overseen by the FAA. We have greatly appreciated their thoughtful comments regarding the legislation.

HR 978 establishes a clear boundary between federal and state regulatory oversight. The current lack of clarity and gaps in state regulation over the HMS services does not benefit the public, critically ill patients, regulators, and air medical providers and operators. State regulation over "medical" is more than simply the medical care provided by medical crews inside a helicopter. State regulation must encompass the entirety of helicopter medical services, meaning the entirety of the system integration, coordination, and quality. This includes the ability of states to regulate competition and prevent oversaturation of markets that results in aviation and patient safety problems.

HR 978 will lead to a safer higher quality HMS system. It will enable states to regulate competition to level the playing field and make sure there is accountability for the medical interests and patient and public protection in a coordinated emergency care system. HR 978 will lead to more harmonized state regulation that is predictable for providers and operators establishing and maintaining their missions.

HR 978 does not limit access to needed services or prevent providers or operators from working in more than one state. HR978 only applies to intrastate point to point transport of patients by HMS. Indeed, cross state border operations occur daily throughout the country as part of regional trauma and specialty care system plans. This legislation will clarify where a State EMS or Health Authority has jurisdiction and the limitations on state regulation. To further illustrate:

- If a patient is transported by a HMS provider based in State A to State B, HR 978 is not applicable.
- If a HMS provider is based in State A, travels to State B to pick up a patient and returns to State A, HR 978 is not applicable.

- HR 978 is applicable when a HMS provider is transporting within a state, even it is based in a neighboring state. HMS providers can and do obtain medical licenses in multiple states all the time. **(SLIDE 2)**

HR978 will lead to long term improved access to HMS, especially for rural areas as planned deployment of resources improves access to service for all populations and areas. An unregulated market does not guarantee access to a needed emergency system. While critics of HR978 assert that the bill will limit access in rural areas, in fact most of the recent growth is in areas already served by helicopters leading to oversaturated markets in some areas as illustrated in comparing the 2003 and 2008 the national ADAMS database of air medical resources. **(SLIDES 3-4)** .

Healthcare planning for all EMS resources, including HMS, needs to occur at the state level. There is no simple metric to the needed number of helicopters, and more helicopters does not necessarily translate into improved outcomes for patients. Indeed the states of Massachusetts and Connecticut with the fewest number of helicopters have the best trauma preventable death outcomes in the country. Decisions about the location and number of medical helicopters should be made at the state level as part of the EMS system, not based on the free market, which when left unchecked, does not ensure the proper and appropriate distribution of services to assure access.

H.R. 1201. PFAA endorses HR 1201 as an essential means by which to improve aviation safety for patients and crews. This legislation takes a number of current guidance documents from the FAA and requires through rule making that the guidance becomes regulatory. Assuring the safety of the system requires a more formal regulatory effort as industry has not fully achieved the necessary changes on a voluntary basis, especially in assuring the safety standards of Part 135 operations, standardizing risk assessment, and dispatch procedures.

Specifically with regard to HR1201, we need to assure IFR operations within the current FAR's. The FAA has recognized the safety of IFR operations by providing for an exemption that allows a Part 135 Certificate Holder to conduct IFR operations to destinations without approved weather reporting at the destination. We recommend adding language preserve and acknowledge that existing exemption and allow for the continued operation of the safety benefits of IFR.

We also support the addition of flight monitoring devices for flight operations quality assurance and improving accident information for the NTSB. There has been tremendous progress in the development of this technology applicable to helicopters and this important technology needs to be incorporated into the system sooner rather than later.

Recognizing the fluidity of the legislative process, just as we believe there are opportunities to improve and clarify HR 978, so too do we believe that there are opportunities to improve and clarify specific language in HR 1201 and look forward to working with the Committee on both pieces of legislation.

CONCLUSION

Air medical helicopters are not simply air taxis and should not be considered as such. HMS is not an enterprise but an emergency public utility. We strongly believe a rebalancing and clarification of the lines of current conflicting regulatory authority are necessary if we are to effectively address both aviation and patient safety.

Investments in quality and safety can be achieved despite economic challenges. In Maine, although nearly forty (40%) of our patients are now uninsured and we have one of the highest rates of Medicaid and Medicare populations in the country, we are able to fly twin engine aircraft, IFR with night vision goggles as do a number of PFAA members. We make the choice to operate at the highest level of safety possible, within the current economics of HMS. We also recognize that some of our colleagues do not have that choice. In HMS oversaturated markets, the economics of multiple providers competing for patients force providers to make difficult choices regarding safety investments. This is why we need to improve and integrate the federal and state regulatory oversight of HMS.

In any complex, time critical, and high consequence system the additive effects of continued small mistakes rapidly multiply into the potential for catastrophe. Even more important, no matter the quality of caliber of the individuals engaged in delivering the system, the most motivated, ethical, and highly trained people cannot make a poorly designed system function at high performance on a continued basis. Consequently, it is essential to consider the elements of the medical system design to ensure both aviation and patient safety without losing the benefits of the ADA to commercial aviation. We believe this can be achieved without compromising the plenary and exclusive control of aviation safety overseen by the FAA but recognize that HMS is fundamentally different than other aviation sectors. Both HR 978 and HR 1201 should be enacted to ensure that both the federal and state governments may fulfill their obligation to protect the public and greatly improve the air medical transport system.