

112TH CONGRESS
1ST SESSION

H. R. 3144

To provide for improvement of field emergency medical services, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 7, 2011

Mr. WALZ of Minnesota (for himself and Mrs. MYRICK) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for improvement of field emergency medical services, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Field EMS Quality, Innovation, and Cost Effectiveness
6 Improvements Act of 2011”.

7 (b) TABLE OF CONTENTS.—The table of contents of
8 this Act is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings.
- Sec. 3. Definitions.
- Sec. 4. Recognition of HHS as primary Federal agency for emergency medical services and trauma care.
- Sec. 5. Field EMS Excellence, Quality, Universal Access, Innovation, and Preparedness.
- Sec. 6. Field EMS System Performance, Integration, and Accountability.
- Sec. 7. Field EMS quality.
- Sec. 8. Field EMS education grants.
- Sec. 9. Evaluating innovative models for access and delivery of field EMS for patients.
- Sec. 10. Enhancing research in field EMS.
- Sec. 11. Emergency Medical Services Trust Fund.
- Sec. 12. Authorization of appropriations.

1 **SEC. 2. FINDINGS.**

2 The Congress finds the following:

3 (1) All persons throughout the country should
4 have access to and receive high-quality emergency
5 medical care as part of a coordinated emergency
6 medical services system.

7 (2) Properly functioning emergency medical
8 services (EMS) systems, 24 hours per day, 7 days
9 per week, are essential to ensure access to emer-
10 gency medical care and transport for all patients
11 with emergency medical conditions. Such coordi-
12 nated EMS systems are also necessary for response
13 to catastrophic incidents.

14 (3) Ensuring high-quality and cost-effective
15 EMS systems requires readiness, preparedness, med-
16 ical direction, oversight, and innovation throughout
17 the continuum of emergency medical care through
18 Federal, State, and local multijurisdictional collabo-

1 ration and sufficient resources for EMS agencies
2 and providers.

3 (4) At the Federal level, EMS responsibilities
4 and resources of several Federal agencies consistent
5 with their expertise and authority must emphasize
6 the critical importance of Federal agency collabora-
7 tion and coordination for all emergency medical serv-
8 ices.

9 (5) At the State and local level, EMS systems
10 and agencies require the coordination and improved
11 capabilities of multiple and diverse stakeholders.

12 (6) Emergency medical services encompass the
13 provision of care provided to patients with emer-
14 gency medical conditions throughout the continuum,
15 including emergency medical care and trauma care
16 provided in the field, hospital, and rehabilitation set-
17 tings.

18 (7) Field EMS comprises essential emergency
19 medical services, including medical care or medical
20 transport provided to patients prior to or outside
21 medical facilities and other clinical settings. The pri-
22 mary purpose of field emergency medical services is
23 to ensure that emergency medical patients receive
24 the right care at the right place in the right amount
25 of time.

1 (8) Coordinated and high-quality field EMS is
2 essential to the Nation’s security. Field EMS is an
3 essential public service provided by governmental
4 and nongovernmental agencies and practitioners 24
5 hours a day, 7 days a week, and during catastrophic
6 incidents. To ensure disaster and all-hazards pre-
7 paredness for EMS operations as part of the Na-
8 tion’s comprehensive disaster preparedness, Federal
9 funding for preparedness activities, including cata-
10 strophic training and drills, must be provided to gov-
11 ernmental and nongovernmental EMS agencies so as
12 to ensure a greater capability within each of these
13 areas.

14 (9) Numerous recommendations from several
15 significant national reports and documents have
16 demonstrated the need in multiple areas for substan-
17 tial improvement of emergency medical services pro-
18 vided in the field, including recommendations in the
19 EMS Agenda for the Future, the Institute of Medi-
20 cine report “The Future of Emergency Care in the
21 United Health System”, and the National EMS
22 Education Agenda for the Future: A Systems Ap-
23 proach and recommendations by the National EMS
24 Workforce Injury and Illness Surveillance Program,
25 the Department of Transportation’s National EMS

1 Advisory Council (NEMSAC), and the Federal
2 Interagency Committee on Emergency Medical Serv-
3 ices (FICEMS).

4 (10) To substantially improve field EMS, ad-
5 vancements must be made in several essential areas
6 including readiness, innovation, preparedness, edu-
7 cation and workforce development, safety, financing,
8 quality, standards, and research.

9 (11) The recognition of a primary pro-
10 grammatic Federal agency for emergency medical
11 services within the Department of Health and
12 Human Services was recommended by the Institute
13 of Medicine and is necessary to provide a more
14 streamlined, cost-efficient, and comprehensive ap-
15 proach for field EMS and a focal point for practi-
16 tioners and agencies to interface with the Federal
17 Government.

18 (12) The essential role of field EMS in disaster
19 preparedness and response must be incorporated
20 into the national preparedness and response strategy
21 and implementation as provided and overseen by the
22 Department of Homeland Security and the Depart-
23 ment of Health and Human Services pursuant to
24 their respective jurisdictions.

1 (13) The essential role of NHTSA in the con-
2 tinued development of NEMSIS and in overseeing
3 transportation issues related to field EMS such as
4 EMS and ambulance vehicle safety standards should
5 be maintained.

6 (14) FICEEMS must continue in its essential
7 role in coordinating the Federal activities related to
8 the full spectrum of EMS.

9 **SEC. 3. DEFINITIONS.**

10 In this Act:

11 (1) The term “ambulance diversion” means the
12 practice by hospitals of denying access to an incom-
13 ing ambulance by requesting it to proceed to another
14 facility due to a stated lack of capacity at the initial
15 facility, resulting in delayed access to definitive care.

16 (2) The term “EMS” means emergency medical
17 services.

18 (3) The term “FICEEMS” means the Federal
19 Interagency Committee on Emergency Medical Serv-
20 ices.

21 (4) The term “field EMS” means emergency
22 medical services provided to patients (including
23 transport by ground, air, or otherwise) prior to or
24 outside a medical facility or other clinical setting.

1 (5) The term “field EMS agency” means an or-
2 ganization providing field EMS, regardless of—

3 (A) whether such organization is govern-
4 mental, nongovernmental, or volunteer; and

5 (B) whether such organization provides
6 field EMS by ground, air, or otherwise.

7 (6) The term “emergency medical services” or
8 “EMS” means emergency medical care, trauma
9 care, and related services provided to patients at any
10 point in the continuum of health care services, in-
11 cluding emergency medical dispatch and emergency
12 medical care, trauma care, and related services pro-
13 vided in the field, during transport, or in a medical
14 facility or other clinical setting.

15 (7) The term “field EMS patient care reports”
16 means the information that a field EMS agency
17 typically creates regarding a patient’s medical condi-
18 tion and treatment in the course of providing emer-
19 gency medical services to that patient.

20 (8) The term “medical oversight” means the
21 supervision by a physician of the medical aspects of
22 an EMS system or agency and its providers includ-
23 ing prospective, concurrent, and respective compo-
24 nents of field EMS and the education of EMS pro-
25 viders.

1 (9) The term “NEMSAC” means the National
2 Emergency Medical Services Advisory Council.

3 (10) The term “NEMSIS” means the National
4 EMS Information System.

5 (11) The term “NHTSA” means the National
6 Highway Traffic Safety Administration.

7 (12) The term “patient parking” means the
8 practice by hospitals of refusing to accept transfer
9 of a patient’s care from an ambulance crew until a
10 regular emergency department bed is available, re-
11 quiring the crew to continue to provide patient care
12 on the ambulance stretcher other than a patient bed
13 in the hospital until hospital staff will accept the
14 transfer of care, resulting in delayed access to defini-
15 tive care.

16 (13) The term “State EMS Office” means an
17 office designated by the State with primary responsi-
18 bility for oversight of the State’s EMS system, such
19 as responsibility for oversight of EMS coordination,
20 licensing or certifying EMS practitioners, and EMS
21 system improvement.

22 (14) The term “STEMI” means ST–Segment
23 Elevation Myocardial Infarction.

1 **SEC. 4. RECOGNITION OF HHS AS PRIMARY FEDERAL**
2 **AGENCY FOR EMERGENCY MEDICAL SERV-**
3 **ICES AND TRAUMA CARE.**

4 (a) PRIMARY FEDERAL AGENCY.—The Department
5 of Health and Human Services shall serve as the primary
6 Federal agency with responsibility for programs and ac-
7 tivities relating to emergency medical services and trauma
8 care.

9 (b) OFFICE OF EMS AND TRAUMA.—

10 (1) ESTABLISHMENT.—There is established an
11 Office of Emergency Medical Services and Trauma,
12 to be known as the Office of EMS and Trauma,
13 within the Department of Health and Human Serv-
14 ices. The Office of EMS and Trauma shall be head-
15 ed by a director appointed by the Secretary of
16 Health and Human Services.

17 (2) ROLE OF OFFICE WITHIN HHS.—

18 (A) IN GENERAL.—The Office of EMS and
19 Trauma shall have—

20 (i) the responsibilities delegated to the
21 Office of EMS and Trauma pursuant to
22 paragraph (3);

23 (ii) the responsibilities and authorities
24 vested in the Office of EMS and Trauma
25 by other provisions of this Act; and

1 (iii) such responsibilities and authori-
2 ties as may be delegated or transferred to
3 the Office of EMS and Trauma pursuant
4 to subparagraph (B).

5 (B) ADDITIONAL RESPONSIBILITIES AND
6 AUTHORITIES.—In addition to the responsibil-
7 ities and authorities specified in clauses (i) and
8 (ii) of subparagraph (A), the Secretary of
9 Health and Human Services may delegate or
10 transfer to the Office of EMS and Trauma any
11 other responsibility or authority of the Depart-
12 ment of Health and Human Services relating to
13 emergency medical services and trauma care,
14 including such services and care relating to—

15 (i) the full continuum of emergency
16 medical services, including field EMS and
17 trauma and hospital emergency medical
18 care; or

19 (ii) improving the quality, innovation,
20 or cost effectiveness of emergency medical
21 services.

22 (C) LOCATION OF OFFICE IN HHS.—The
23 Secretary shall locate the Office of EMS and
24 Trauma within the organizational structure of

1 the Department of Health and Human Services
2 in a manner that achieves each of the following:

3 (i) Recognition of the importance and
4 unique life-saving services associated with
5 field EMS, trauma care, and hospital
6 emergency care as a significant Federal
7 priority.

8 (ii) Integration of these essential serv-
9 ices with the larger health care system and
10 within the disaster preparedness system,
11 including through regionalization of such
12 services and by enhancing daily readiness
13 capabilities to ensure adequate disaster
14 readiness capabilities, consistent with the
15 National Health Security Strategy.

16 (iii) Consolidation, co-location, and
17 cost efficiencies in administering programs
18 and activities related to field EMS, trauma
19 care, and hospital emergency medical care.

20 (iv) Establishment of a Federal focal
21 point for leadership and improved coordi-
22 nation, support, and oversight of field
23 EMS, trauma care and hospital emergency
24 medical care.

1 (v) Sufficient level and stature such
2 that—

3 (I) such Office is able to fulfill its
4 role, responsibilities, and authorities;
5 and

6 (II) the Director of such Office
7 reports directly to the Secretary or an
8 official within the Department who re-
9 ports directly to the Secretary.

10 (vi) Establishment of a visible and
11 identifiable point of contact with which the
12 public; EMS agencies and practitioners;
13 State and local government agencies; EMS
14 educational institutions; EMS, trauma,
15 and hospital emergency care professional
16 associations; and all other parties may
17 interact.

18 (3) RESPONSIBILITIES.—The Secretary of
19 Health and Human Services shall, at a minimum,
20 delegate responsibility to the Office of EMS and
21 Trauma to carry out—

22 (A) sections 5 and 6 (relating to the
23 EQUIP and SPLA grant programs, respec-
24 tively); and

1 (B) section 330J of the Public Health
2 Service Act (42 U.S.C. 254e–15; relating to
3 rural emergency service training and equipment
4 assistance program);

5 (C) part A (42 U.S.C. 300d et seq.), part
6 B (42 U.S.C. 300d–11 et seq.), part C (42
7 U.S.C. 300d–31 et seq.), part D (42 U.S.C.
8 300d–41 et seq.), and part H (42 U.S.C. 300d–
9 81 et seq.) of title XII of the Public Health
10 Service Act (relating to trauma care);

11 (D) section 8 (relating to the field EMS
12 education grant program); and

13 (E) section 9 (relating to evaluating inno-
14 vative models for access and delivery of field
15 EMS for patients).

16 (c) NATIONAL EMS STRATEGY.—The Secretary of
17 Health and Human Services, acting through the Director
18 of the Office of EMS and Trauma, and in consultation
19 with the Assistant Secretary for Preparedness and Re-
20 sponse and the Administrator of the Health Resources and
21 Services Administration, shall develop and implement a
22 cohesive national EMS strategy to strengthen the develop-
23 ment of the full continuum of EMS at the Federal, State,
24 and local levels. In establishing such a strategy, the Sec-
25 retary shall—

1 (1) solicit and consider the recommendations of
2 the NEMSAC as well as relevant stakeholders;

3 (2) consult and collaborate with FICEMS to
4 ensure consistency of such national EMS strategy
5 within the larger Federal strategy regarding all of
6 emergency medical services and national prepared-
7 ness and response;

8 (3) address issues related to EMS patient and
9 practitioner safety, standardization of EMS practi-
10 tioner licensing and credentialing, field EMS quality
11 and medical oversight, regionalization of field EMS
12 and trauma and emergency care services, availability
13 of field EMS and trauma care and emergency med-
14 ical services throughout the Nation, and integration
15 of field EMS practitioners into the broader health
16 care system, including—

17 (A) promotion of the adoption by States of
18 the education standards identified in the
19 “Emergency Medical Services Education Agen-
20 da for the Future: A Systems Approach” and
21 any revisions thereto, including the standardiza-
22 tion of licensing and credentialing of field EMS
23 practitioners and standards of care, based on
24 best practices and evidence-based medicine, in-
25 cluding by—

1 (i) the identification of differences in
2 the levels of care, scope of practice, and li-
3 censure and credentialing requirements
4 among the States; and

5 (ii) the adoption by the States of na-
6 tional standards for such levels of care,
7 scope of practice and licensure and
8 credentialing requirements;

9 (B) promotion of a culture of safety, in-
10 cluding—

11 (i) the adoption of an anonymous
12 error reporting system designed to identify
13 systemic problems in field EMS patient
14 and practitioner safety and ensure a single
15 means of collecting and reporting relevant
16 error data by field EMS agencies and
17 States;

18 (ii) the establishment of field EMS
19 patient and practitioner safety goals and
20 the specific means to improve field EMS
21 practitioner and patient safety to achieve
22 such goals; and

23 (iii) the adoption of more uniform na-
24 tional ambulance vehicle safety and manu-
25 facturing standards as developed by the

1 National Fire Protection Administration or
2 coordinated by NHTSA;

3 (C) the integration and utilization of field
4 EMS practitioners as part of the larger health
5 care system including—

6 (i) the potential utilization of field
7 EMS practitioners for the provision of care
8 to patients with nonemergent medical con-
9 ditions; and

10 (ii) strategies to implement the rec-
11 ommendations provided by the National
12 Health Care Workforce Commission, pur-
13 suant to section 5101(d)(2) of the Patient
14 Protection and Affordable Care Act (42
15 U.S.C. 294q(d)(2); and

16 (D) such other issues as the Secretary con-
17 siders appropriate;

18 (4) incorporate into such strategy the prepared-
19 ness and response objectives identified by the Sec-
20 retary of Homeland Security and the Assistant Sec-
21 retary for Preparedness and Response in order—

22 (A) to ensure the capability and capacity
23 of the full spectrum of EMS to respond to ter-
24 rorist attacks, disasters, catastrophic events,
25 and mass casualty events; and

1 (B) to coordinate with the Secretary of
2 Homeland Security accordingly;

3 (5) complete the development of such strategy
4 not later than 18 months after the date of enact-
5 ment of this Act;

6 (6) communicate such strategy to the relevant
7 congressional committees of jurisdiction;

8 (7) implement such strategy to the extent prac-
9 tical not later than 3 years after the date of enact-
10 ment of this Act; and

11 (8) update such strategy not less than every 3
12 years.

13 (d) STATUTORY CONSTRUCTION.—Nothing in this
14 Act shall be construed to supercede any statutory author-
15 ity of any Federal agency that is not within the Depart-
16 ment of Health and Human Services.

17 **SEC. 5. FIELD EMS EXCELLENCE, QUALITY, UNIVERSAL AC-**
18 **CESS, INNOVATION, AND PREPAREDNESS.**

19 (a) IN GENERAL.—The Director of the Office of
20 EMS and Trauma (in this section referred to as the “Di-
21 rector”), shall establish the EQUIP grant program—

22 (1) to promote excellence in all aspects of the
23 provision of field EMS by field EMS agencies;

24 (2) to enhance the quality of emergency medical
25 care provided to patients by field EMS practitioners

1 through evidence-based, medically directed field
2 emergency care;

3 (3) to promote universal access to and avail-
4 ability of high-quality field EMS in all geographic lo-
5 cations of the Nation;

6 (4) to spur innovation in the delivery of field
7 EMS; and

8 (5) to improve EMS agency readiness and pre-
9 paredness for day-to-day emergency medical re-
10 sponse.

11 (b) APPLICATION.—

12 (1) IN GENERAL.—To be eligible to receive a
13 grant under this section, an eligible entity shall sub-
14 mit an application to the Director in such form and
15 manner, that contains such agreements, assurances,
16 and information as the Director determines to be
17 reasonably necessary to carry out this section.

18 (2) SIMPLE FORM.—The Director shall ensure
19 that grant application requirements are not unduly
20 burdensome to smaller and volunteer field EMS
21 agencies or other agencies with limited resources.

22 (3) CONSISTENCY WITH PREPARATION
23 GOALS.—The Director shall ensure that grant appli-
24 cations are consistent with national and relevant
25 State preparedness plans and goals.

1 (c) USE OF FUNDS.—Grants may be used by eligible
2 entities to—

3 (1) sustain field EMS practitioners to ensure
4 24 hours a day, 7 days a week readiness and pre-
5 paredness at the local level;

6 (2) develop and implement initiatives related to
7 delivery of medical services, including—

8 (A) innovative clinical practices to improve
9 the cost effectiveness and quality of care deliv-
10 ered to emergency patients in the field that re-
11 sults in improved patient outcomes and cost
12 savings to the health system, including for high
13 prevalence emergency medical conditions such
14 as sudden cardiac arrest, STEMI, stroke, and
15 trauma; and

16 (B) delivery systems to improve patient
17 outcomes, which may include implementing evi-
18 dence-based protocols, interventions, systems,
19 and technologies to reduce clinically meaningful
20 response times;

21 (3) purchase and implement—

22 (A) medical equipment and training for
23 using such equipment;

1 (B) communication systems to ensure
2 seamless and interoperable communications
3 with other first responders; and

4 (C) information systems to comply with
5 NEMSIS data collection and integrate field
6 emergency care with electronic medical records;

7 (4) participate in federally sponsored field EMS
8 research;

9 (5) establish or enhance comprehensive medical
10 oversight and quality assurance programs that in-
11 clude the active participation by medical directors in
12 field EMS medical direction and educational pro-
13 grams; and

14 (6) such other uses as the Director may estab-
15 lish.

16 (d) ADMINISTRATION OF GRANTS.—In establishing
17 and administering the EQUIP grant program, the Direc-
18 tor—

19 (1) shall establish a grantmaking process that
20 includes—

21 (A) prioritization for the awarding of
22 grants to eligible entities and consideration of
23 the factors in reviewing grant applications by
24 eligible entities including—

- 1 (i) demonstrated financial need for
2 funding;
- 3 (ii) utilization of public and private
4 partnerships;
- 5 (iii) enhanced access to high-quality
6 field EMS in under served geographic
7 areas;
- 8 (iv) unique needs of volunteer and
9 rural field EMS agencies;
- 10 (v) distribution among a variety of ge-
11 ographic areas, including urban, suburban,
12 and rural;
- 13 (vi) distribution of funds among types
14 of EMS agencies, including governmental,
15 nongovernmental and volunteer;
- 16 (vii) implementation of evidence-based
17 interventions that improve quality of care,
18 patient outcomes, efficiency, or cost effec-
19 tiveness; and
- 20 (viii) such other factors as the Direc-
21 tor considers necessary;
- 22 (B) a peer-reviewed process to recommend
23 grant allocations in accordance with the
24 prioritization established by the Director except

1 that final award determinations shall be made
2 by the Director; and

3 (C) the provision of grant awards to eligi-
4 ble entities on an annual basis, except that the
5 Director may reserve not more than 25 percent
6 of the available appropriations for multiyear
7 grants and no grant award may exceed a 2-year
8 period;

9 (2) shall consult with and take into consider-
10 ation the recommendations of the Assistant Sec-
11 retary for Preparedness and Response, FICEMS,
12 NEMSAC and relevant stakeholders;

13 (3) shall ensure that funds used for day-to-day
14 preparedness activities are consistent and aligned
15 with Federal preparedness priorities; and

16 (4) may contract with an independent, third-
17 party, nonprofit organization to administer the grant
18 program if the Director establishes conflict-of-inter-
19 est requirements as part of any such contractual re-
20 lationship.

21 (e) ELIGIBILITY.—Eligible grant recipients are field
22 EMS agencies that—

23 (1) are licensed by or otherwise authorized in
24 the State in which they operate; and

1 (2) have medical oversight and quality improve-
2 ment programs as defined by the Director.

3 (f) ANNUAL REPORT.—The Director shall submit an
4 annual report on the EQUIP grant program under this
5 section to the Congress.

6 **SEC. 6. FIELD EMS SYSTEM PERFORMANCE, INTEGRATION,**
7 **AND ACCOUNTABILITY.**

8 (a) IN GENERAL.—The Director of the Office of
9 EMS and Trauma (in this section referred to as the “Di-
10 rector”) shall establish the SPIA grant program—

11 (1) to improve field EMS system performance,
12 integration and accountability;

13 (2) to ensure preparedness for field EMS at the
14 State and local levels;

15 (3) to enhance physician medical oversight of
16 field EMS systems;

17 (4) to improve coordination between regional
18 field EMS systems and integration of such regional
19 field EMS systems into the larger health care sys-
20 tem;

21 (5) to enhance data collection and analysis to
22 improve, on a continuing basis, the field EMS sys-
23 tem; and

1 (6) to promote standardization of national EMS
2 certification of emergency medical technicians and
3 paramedics.

4 (b) USE OF FUNDS.—Grants may be used by eligible
5 entities—

6 (1) to enhance EMS system readiness and pre-
7 paredness for day-to-day emergency medical re-
8 sponse;

9 (2) to improve cross-border collaboration and
10 planning among States; and

11 (3) to collect data with regard to—

12 (A) NEMSIS;

13 (B) field EMS education;

14 (C) field EMS workforce;

15 (D) cardiac events, including STEMI and
16 sudden cardiac arrest;

17 (E) stroke;

18 (F) disasters, including injuries and ill-
19 nesses;

20 (G) ambulance diversion and patient park-
21 ing;

22 (H) trauma (in a manner that is com-
23 plementary and not duplicative of other trauma
24 data collection such as the National Trauma
25 Data Bank);

1 (I) data determined necessary by the State
2 office of EMS for oversight and coordination of
3 the State field EMS system; and

4 (J) any other such data that the Director
5 specifies;

6 (4) to implement and evaluate system-wide
7 quality improvement initiatives, including medical di-
8 rection at the State, local, and regional levels;

9 (5) to integrate field EMS with other health
10 care services as part of a coordinated system of care
11 provided to patients with emergency medical condi-
12 tions to help ensure the right patient receives the
13 right care by the right crew in the right vehicle and
14 at the right medical facility in the right amount of
15 time, including by enhancing regional emergency
16 medical dispatch;

17 (6) to incorporate national EMS certification
18 for all levels of emergency medical technicians and
19 paramedics;

20 (7) to improve the State's planning for ensuring
21 a consistent, available EMS workforce;

22 (8) to fund EMS regional and local oversight
23 and planning organizations or develop regional sys-
24 tems of emergency medical care within the State to

1 further enhance coordination and systemic develop-
2 ment throughout the State; and

3 (9) for such other uses as the Director may es-
4 tablish.

5 (c) ADMINISTRATION OF GRANTS.—In establishing
6 and administering the SPIA grant program, the Director
7 shall—

8 (1) establish State EMS system performance
9 standards to serve as guidance to States in improv-
10 ing their EMS systems and in applying for grants
11 under this subsection. In establishing such stand-
12 ards, the Director shall—

13 (A) take into the consideration the rec-
14 ommendations of the Assistant Secretary for
15 Preparedness and Response, FICEMS,
16 NEMSAC, and relevant stakeholders;

17 (B) include national, evidence-based guide-
18 lines; and

19 (C) take into account the needs and re-
20 source limitations of volunteer, smaller agen-
21 cies, and agencies in rural areas.

22 (2) provide technical assistance to State EMS
23 offices in conducting comprehensive EMS planning
24 with regard to evidence-based workforce and devel-
25 opment competencies for field EMS management;

1 (3) allocate, within the available funds, SPIA
2 grants to a maximum of one grant per applicant ac-
3 cording to a formula based on population and geo-
4 graphic area, as determined by the Director, for a
5 period not to exceed 2 years; and

6 (4) require that States allocate a portion of
7 their grant funds to regional and local oversight and
8 planning EMS organizations within the State for the
9 purpose of field EMS system development, mainte-
10 nance, and improvement of coordination among re-
11 gional organizations.

12 (d) APPLICATION.—To be eligible to receive a grant
13 under this section, an eligible entity shall submit an appli-
14 cation to the Director in such form and manner, that con-
15 tains such agreements, assurances, and information as the
16 Director determines to be reasonably necessary to carry
17 out this section.

18 (e) ELIGIBILITY.—The eligible entities for a grant
19 under this section are the State EMS office in each of
20 the several States, tribes, and territories.

21 (f) ANNUAL REPORT.—The Director shall submit an
22 annual report on the SPIA grant program under this sec-
23 tion to the Congress.

24 **SEC. 7. FIELD EMS QUALITY.**

25 (a) MEDICAL OVERSIGHT.—

1 (1) IN GENERAL.—To improve medical over-
2 sight of field EMS and ensure continuity and quality
3 for such medical oversight, the Director of the Office
4 of EMS and Trauma (in this section referred to as
5 the “Director”) shall—

6 (A) promote high-quality and comprehen-
7 sive medical oversight of—

8 (i) all medical care provided by field
9 EMS practitioners; and

10 (ii) the education and training of field
11 EMS practitioners;

12 (B) promote the development, adoption,
13 and utilization of national guidelines for the
14 roles of physicians who provide medical over-
15 sight for field EMS and other health care pro-
16 viders who support physicians in this role;

17 (C) support efforts of relevant physician
18 stakeholders in developing and disseminating
19 guidelines for use by EMS medical directors
20 and field EMS practitioners on a national basis;
21 and

22 (D) convene a Field EMS Medical Over-
23 sight Advisory Committee, comprised of rep-
24 resentatives of relevant physician stakeholders,
25 to advise the Director on ways and means to

1 advance and support development and mainte-
2 nance of quality medical oversight throughout
3 the Nation's systems for field EMS.

4 (2) ADDITIONAL CONSIDERATIONS.—In car-
5 rying out subparagraphs (B) and (C) of paragraph
6 (1) (relating to supporting guidelines), the Director
7 shall take into consideration—

8 (A) existing guidelines developed by na-
9 tional professional physician associations,
10 States, and other relevant governmental or non-
11 governmental entities;

12 (B) the input of other relevant stake-
13 holders, including health care providers who
14 support physicians who provide medical over-
15 sight for field EMS; and

16 (C) the unique needs associated with med-
17 ical oversight of provision of field EMS in rural
18 areas or by volunteers.

19 (3) FLEXIBILITY.—The guidelines promoted
20 under subparagraphs (B) and (C) of paragraph (1)
21 shall ensure high-quality training, credentialing, and
22 direction in connection with medical oversight of
23 field EMS at the State, regional, and local levels
24 while providing sufficient flexibility to account for

1 historical and legitimate differences in field EMS
2 among States, regions, and localities.

3 (4) REQUIRED USE OF GUIDELINES.—As a con-
4 dition on receipt of a grant under section 5 or 6, the
5 Director shall require the grant recipient to adopt
6 and implement (to the extent applicable) the guide-
7 lines promoted under subparagraphs (B) and (C) of
8 paragraph (1).

9 (b) GAO STUDY AND REPORT.—

10 (1) IN GENERAL.—The Comptroller General of
11 the United States shall complete a study on—

12 (A) medical and administrative liability
13 issues that may impede—

14 (i) medical direction provided by phy-
15 sicians directly regarding specific patients
16 or medical oversight provided by physicians
17 in establishing medical protocols, proce-
18 dures, and other activities related to the
19 provision of emergency medical care in
20 field EMS; or

21 (ii) the highest quality emergency
22 medical care in field EMS provided by per-
23 sonnel other than physicians such as emer-
24 gency medical technicians and paramedics;

1 (B) reimbursement for any component of
2 medical oversight; and

3 (C) such other issues as the Comptroller
4 General deems appropriate relating to improv-
5 ing the quality and medical oversight of emer-
6 gency medical care in field EMS.

7 (2) REPORT TO CONGRESS.—Not later than 18
8 months after the date of the enactment of this Act,
9 the Comptroller General shall complete the study
10 under paragraph (1) and submit a report to the
11 Congress on the results of such study, including any
12 recommendations.

13 (c) DATA COLLECTION AND EXCHANGE.—

14 (1) NATIONAL EMS INFORMATION SYSTEM.—

15 (A) IN GENERAL.—The Administrator of
16 NHTSA may maintain, improve, and expand
17 the National EMS Information System, includ-
18 ing the National EMS Database.

19 (B) CONSULTATION.—The Administrator
20 of NHTSA shall carry out this paragraph in
21 consultation with the Director.

22 (C) STANDARDIZATION.—In carrying out
23 subparagraph (A), the Administrator of
24 NHTSA shall promote the collection and re-

1 porting of data on field EMS in a standardized
2 manner.

3 (D) AVAILABILITY OF DATA.—The Admin-
4 istrator of NHTSA shall ensure that informa-
5 tion in the National EMS Database (other than
6 individually identifiable information) is available
7 to Federal and State policymakers, EMS stake-
8 holders, and researchers.

9 (E) TECHNICAL ASSISTANCE.—In carrying
10 out subparagraph (A), the Administrator of
11 NHTSA may provide technical assistance to
12 State and local agencies, field EMS agencies,
13 and other entities deemed appropriate by the
14 Administrator to assist in the collection, anal-
15 ysis, and reporting of data.

16 (2) REPORT ON DATA GAPS.—

17 (A) IN GENERAL.—Not later than 12
18 months after the date of the enactment of this
19 Act, the Secretary of Health and Human Serv-
20 ices, acting through the Director, in consulta-
21 tion with the Administrator of NHTSA, shall
22 submit to the Congress a report that—

23 (i) identifies gaps in the collection of
24 data related to the provision of field EMS;
25 and

1 (ii) includes recommendations for im-
2 proving the collection, reporting, and anal-
3 ysis of such data.

4 (B) RECOMMENDATIONS.—The rec-
5 ommendations required by subparagraph (A)(ii)
6 shall—

7 (i) take into consideration the rec-
8 ommendations of FICEMS and NEMSAC
9 and relevant stakeholders;

10 (ii) recommend methods for improving
11 data collection and reporting and analysis
12 without unduly burdening reporting enti-
13 ties and without duplicating existing data
14 sources (such as data collected by the Na-
15 tional Trauma Data Bank);

16 (iii) address the quality and avail-
17 ability of data, and linkages with existing
18 patient registries, related to the provision
19 of field EMS and utilization of field EMS
20 with respect to a variety of illnesses and
21 injuries (in both the everyday provision of
22 field EMS and catastrophic or disaster re-
23 sponse) including—

- 1 (I) cardiac events such as chest
2 pain, sudden cardiac arrest, and
3 STEMI;
- 4 (II) stroke;
- 5 (III) trauma;
- 6 (IV) disaster and catastrophic in-
7 cidents, such as incidents related to
8 terrorism or natural or manmade dis-
9 asters; and
- 10 (V) ambulance diversion and pa-
11 tient parking; and
- 12 (iv) include an analysis of the variety
13 of services provided by field EMS agencies.
- 14 (3) REPORT ON DATA INTEGRATION TO PRO-
15 MOTE QUALITY OF CARE.—Not later than 18
16 months after the date of the enactment of this Act,
17 the Secretary of Health and Human Services, acting
18 through the head of the Office of the National Coor-
19 dinator for Health Information Technology, in col-
20 laboration with the Director of the Office of EMS
21 and Trauma, FICEMS, and the Administrator of
22 NHTSA as appropriate, and taking into consider-
23 ation input from relevant stakeholders, shall submit
24 a report (including recommendations) on issues, im-

1 pediments, and potential solutions pertaining to the
2 following objectives:

3 (A) Incorporation of field EMS patient
4 care reports into patient electronic health
5 records, taking into consideration—

6 (i) the extent to which field EMS pa-
7 tient care reports are presently created in
8 electronic format and the potential for ele-
9 ments of such reports to be incorporated
10 into patient electronic health records;

11 (ii) the data elements of field EMS
12 patient care reports that would promote
13 quality and efficiency of care if incor-
14 porated into patient electronic health
15 records;

16 (iii) potential modifications to the
17 Medicare and Medicaid programs under ti-
18 tles XVIII and XIX, respectively, of the
19 Social Security Act or other Federal health
20 programs (including potential modifica-
21 tions to the HITECH Act (title XIII of di-
22 vision A of Public Law 111–5) including
23 modifications to the entities included as el-
24 igible for incentive payments under section
25 1848(o), 1853(l) (to the extent that such

1 section 1848(o) is applied), or 1903(t) of
2 the Social Security Act, criteria for cer-
3 tified EHR technology for purposes of
4 such sections, and objectives and measures
5 for determining meaningful use of such
6 technology for purposes of such sections)
7 to provide appropriate reimbursement and
8 financial incentives for EMS agencies—

9 (I) to maintain field EMS patient
10 care reports in a structured electronic
11 format; and

12 (II) to otherwise adopt and use
13 electronic health records; and

14 (iv) potential modifications to the
15 HITECH Act to provide incentives to eligi-
16 ble hospitals under section 1886(n),
17 1853(m) (to the extent that such section
18 1886(n) is applied), or section 1814(l)(3)
19 of the Social Security Act to incorporate
20 appropriate data elements of field EMS
21 patient care reports into patient electronic
22 health records.

23 (B) Incorporation of patient health infor-
24 mation created subsequent to the receipt of

1 field EMS emergency care into NEMESIS, tak-
2 ing into consideration—

3 (i) what types of medical information
4 created subsequent to the receipt of field
5 EMS emergency care (such as outcomes
6 information or information regarding sub-
7 sequent care and treatment) would, if in-
8 cluded in NEMESIS, be potentially useful in
9 evaluating and improving the quality of
10 EMS care;

11 (ii) how best to integrate such infor-
12 mation into NEMESIS;

13 (iii) potential modifications to the
14 HITECH Act to require eligible hospitals,
15 as defined in section 1886(n)(6)(B) of the
16 Social Security Act, for purposes of incen-
17 tive payments under 1886(b)(3)(B)(ix) and
18 1886(n) of such Act, to develop or report
19 relevant data to NEMESIS or other appro-
20 priate State or private registries; and

21 (iv) potential modifications to the
22 Medicare and Medicaid programs under ti-
23 tles XVIII and XIX, respectively, of the
24 Social Security Act or other Federal health
25 programs to provide appropriate reim-

1 bursement and financial incentives for field
2 EMS agencies to develop or report relevant
3 data to NEMESIS or other appropriate
4 State or private registries.

5 (d) CLARIFICATION OF HIPAA.—

6 (1) EXCHANGE OF INFORMATION RELATED TO
7 THE TREATMENT OF PATIENTS.—

8 (A) IN GENERAL.—Nothing in HIPAA pri-
9 vacy and security law (as defined in section
10 3009(a)(2) of the Public Health Service Act (42
11 U.S.C. 300jj–19(a)(2)) shall be construed as
12 prohibiting the exchange of information between
13 field EMS practitioners treating an individual
14 and personnel of a hospital to which the indi-
15 vidual is transported for the purposes of relat-
16 ing information on the medical history, treat-
17 ment, care, and outcome of such individual (in-
18 cluding any health care personnel safety issues
19 such as infectious disease).

20 (B) GUIDELINES.—The Secretary of
21 Health and Human Services shall establish
22 guidelines for exchanges of information between
23 field EMS practitioners treating an individual
24 and personnel of a hospital to which the indi-
25 vidual is transported to protect the privacy of

1 the individual while ensuring the ability of such
2 EMS practitioners and hospital personnel to
3 communicate effectively to further the con-
4 tinuity and quality of emergency medical care
5 provided to such individual.

6 (2) NEMSIS DATA.—Nothing in HIPAA pri-
7 vacy and security law (as defined in section
8 3009(a)(2) of the Public Health Service Act (42
9 U.S.C. 300jj–19(a)(2)) shall be construed as prohib-
10 iting—

11 (A) a field EMS agency from submitting
12 EMS data to the State EMS Office for the pur-
13 pose of quality improvement and data collection
14 by the State for submission to NEMSIS; or

15 (B) the State EMS Office from submitting
16 aggregated nonindividually identifiable EMS
17 data to the National EMS Database maintained
18 by NHTSA.

19 **SEC. 8. FIELD EMS EDUCATION GRANTS.**

20 (a) IN GENERAL.—For the purpose of promoting
21 field EMS as a health profession and ensuring the avail-
22 ability, quality, and capability of field EMS educators,
23 practitioners, and medical directors, the Director of the
24 Office of EMS and Trauma (in this section referred to
25 as the “Director”) may make grants to eligible entities

1 for the development, availability, and dissemination of
2 field EMS education programs and courses that improve
3 the quality and capability of field EMS personnel. In car-
4 rying out this section, the Director shall take into consid-
5 eration input from the Administrator of NHTSA,
6 FICEEMS, NEMSAC, the National Health Care Workforce
7 Commission established under section 5101 of the Patient
8 Protection and Affordable Care Act (42 U.S.C. 294q), and
9 relevant stakeholders.

10 (b) ELIGIBILITY.—In this section, the term “eligible
11 entity” means an educational organization, an educational
12 institution, a professional association, and any other entity
13 involved with the education of field EMS practitioners.

14 (c) USE OF FUNDS.—The Director may award a
15 grant to an eligible entity under paragraph (1) only if the
16 entity agrees to use the grant to—

17 (1) develop and implement education programs
18 that—

19 (A) train field EMS trainers and promote
20 the adoption and implementation of the edu-
21 cation standards identified in the “Emergency
22 Medical Services Education Agenda for the Fu-
23 ture: A Systems Approach” including any revi-
24 sions thereto;

1 (B) bridge the gap in knowledge and skills
2 in field EMS and among field EMS and other
3 allied health professions to develop a larger
4 cadre of educational instructors and build a
5 stronger and more flexible field EMS practi-
6 tioner corps; or

7 (C) provide training and retraining pro-
8 grams to provide displaced workers the oppor-
9 tunity to enter a field EMS profession;

10 (2) develop and implement educational courses
11 pertaining to—

12 (A) instructor courses;

13 (B) provision of medical direction of field
14 EMS;

15 (C) field EMS practitioners, including phy-
16 sicians, emergency medical technicians, para-
17 medics, nurses, and other relevant clinicians
18 providing emergency medical care in the field;

19 (D) field EMS educational and clinical re-
20 search;

21 (E) bridge programs among field EMS,
22 nursing, and other allied health professions;

23 (F) field EMS management;

24 (G) national, evidence-based guidelines;

25 and

1 (H) translation of the lessons learned in
2 military medicine to field EMS;

3 (3) evaluate education and training courses and
4 methodologies to identify optimal educational modal-
5 ities for field EMS practitioners;

6 (4) improve the field EMS education infrastruc-
7 ture by increasing the number of field EMS instruc-
8 tors and the quality of their preparation by improv-
9 ing, enhancing, and modernizing the dissemination
10 of EMS education, including distance learning, and
11 by establishing quality improvement for EMS edu-
12 cation programs;

13 (5) enhance the opportunity for medical direc-
14 tion training and for promoting appropriate medical
15 oversight of field emergency medical care;

16 (6) improve systems to design, implement, and
17 evaluate education for prospective and current field
18 EMS providers; or

19 (7) carrying out such other activities as the Di-
20 rector may identify.

21 (d) PRIORITY.—The Director, in consultation with
22 NHTSA and relevant stakeholders, and taking into con-
23 sideration the recommendations of FICEMS and
24 NEMSAC, shall establish a system of prioritization in
25 awarding grants under this section to eligible entities.

1 (e) DURATION OF GRANTS.—Grants under this sec-
2 tion shall be for a period of 1 to 3 years.

3 (f) APPLICATION.—The Director may not award a
4 grant to an eligible entity under this section unless the
5 entity submits an application to the Director in such form,
6 in such manner, and containing such agreements, assur-
7 ances, and information as the Director may require. The
8 Director shall ensure that the requirements for submitting
9 an application under this section are not unduly burden-
10 some.

11 **SEC. 9. EVALUATING INNOVATIVE MODELS FOR ACCESS**
12 **AND DELIVERY OF FIELD EMS FOR PATIENTS.**

13 (a) EVALUATION.—

14 (1) IN GENERAL.—Not later than 1 year after
15 the date of the enactment of this Act, the Director
16 of the Office of EMS and Trauma, in consultation
17 with the Administrator of the Centers for Medicare
18 & Medicaid Services (in this section referred to as
19 the “Director”), and taking into consideration the
20 recommendations of NEMSAC and FICEMS, shall
21 complete an evaluation of—

22 (A) the provision of and reimbursement for
23 alternative delivery models for medical care
24 through field EMS; and

1 (B) the integration of field EMS patients
2 with other medical providers and facilities as
3 medically appropriate.

4 (2) SPECIFIC ISSUES.—The evaluation under
5 paragraph (1) shall consider each of the following:

6 (A) Alternative dispositions of patients, in-
7 cluding—

8 (i) transporting patients by ambulance
9 to destinations other than a hospital such
10 as the office of the patient’s physician, an
11 urgent care center, or the facilities of an-
12 other health care provider;

13 (ii) when medically necessary, the
14 evaluation, treatment, or referral of pa-
15 tients to other medically appropriate health
16 care providers; and

17 (iii) the funding of the provision of
18 medical care regardless of the decision to
19 transport such as reimbursement models
20 based on readiness rather than transport
21 and shared savings.

22 (B) Issues related to medical liability and
23 the requirements of section 1867 of the Social
24 Security Act (42 U.S.C. 1395dd; commonly re-
25 ferred to as “EMTALA”) associated with

1 transport to destinations other than a hospital
2 emergency department.

3 (C) Necessary protections to ensure that
4 patients receive timely and appropriate care in
5 the appropriate setting.

6 (D) Whether there are any barriers to pro-
7 viding alternate dispositions to patients who are
8 not in need of care in hospital emergency de-
9 partments.

10 (E) Other issues determined by the Direc-
11 tor, including, when possible, issues rec-
12 ommended by FICEMS or NEMSAC for eval-
13 uation under this subsection.

14 (b) DEMONSTRATION PROJECTS.—

15 (1) IN GENERAL.—Beginning not later than 1
16 year after the date of the enactment of this Act, the
17 Director shall conduct or support at least 10 dem-
18 onstration projects to—

19 (A) evaluate the implementation and reim-
20 bursement of alternative dispositions of field
21 EMS patients, including—

22 (i) transporting patients by ambulance
23 to alternate destinations when medically
24 appropriate and in the patients' best inter-
25 ests; and

1 (ii) when medically necessary, evalu-
2 ating, treating, or referring patients to
3 other medically appropriate providers;

4 (B) evaluate the implementation of reim-
5 bursement models based on readiness rather
6 than transport or shared savings; and

7 (C) determine whether such alternative dis-
8 positions and reimbursement models—

9 (i) improve the safety, effectiveness,
10 timeliness, and efficiency of EMS; and

11 (ii) reduce overall utilization and ex-
12 penditures under the Medicare program
13 under title XVIII of the Social Security
14 Act.

15 (2) EVIDENCE-BASED PROTOCOLS.—The Direc-
16 tor shall ensure that at least one demonstration
17 project under paragraph (1) evaluates evidence-
18 based protocols that give guidance on selection of
19 the destination to which patients are transported.

20 (3) DURATION.—The period of a demonstration
21 project under paragraph (1) shall not exceed 36
22 months.

23 (4) RESEARCH.—If the Director determines
24 that further research is necessary prior to or in con-
25 junction with the demonstration projects under this

1 subsection in order to evaluate the implementation
2 of alternative dispositions of field EMS patients, the
3 Director shall conduct or support such research.

4 (5) AUTHORIZATION OF APPROPRIATIONS.—Of
5 the amount made available to carry out section
6 1115A of the Social Security Act (42 U.S.C. 1315a)
7 for a fiscal year, there are authorized to be appro-
8 priated such sums as may be necessary to carry out
9 this subsection.

10 (c) REPORT TO CONGRESS.—Not later than 1 year
11 after the completion of all demonstration projects under
12 subsection (b), the Director shall submit to the Congress
13 a report on the results of activities under this section, in-
14 cluding recommendations on the efficacy of alternative dis-
15 positions of field EMS patients.

16 **SEC. 10. ENHANCING RESEARCH IN FIELD EMS.**

17 (a) MODELS TO BE TESTED BY CENTER FOR MEDI-
18 CARE AND MEDICAID INNOVATION.—Section
19 1115A(b)(2)(B) of title XI of the Social Security Act (42
20 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end
21 the following:

22 “(xxi) Enhancing health outcomes for
23 patients receiving field emergency medical
24 services and improving timely and efficient

1 delivery of high-quality field emergency
2 medical services, such as through—

3 “(I) regionalization of emergency
4 care;

5 “(II) medical transport to alter-
6 nate destinations; or

7 “(III) when medically necessary,
8 the evaluation, treatment, or referral
9 of patients to other medically appro-
10 priate health providers.”.

11 (b) EMERGENCY MEDICAL RESEARCH.—Section
12 498D of the Public Health Service Act (42 U.S.C. 289g-
13 4) is amended—

14 (1) by redesignating subsections (c) and (d) as
15 subsections (d) and (e), respectively; and

16 (2) by inserting after subsection (b) the fol-
17 lowing:

18 “(c) FIELD EMS EMERGENCY MEDICAL RE-
19 SEARCH.—The Secretary shall conduct research and eval-
20 uation relating to field EMS through the Agency for
21 Healthcare Research and Quality and the Center for Medi-
22 care and Medicaid Innovation.”.

23 (c) FIELD EMS PRACTICE CENTER.—Subpart II of
24 part D of title IX of the Public Health Service Act (42

1 U.S.C. 299b–33 et seq.) is amended by adding at the end
2 the following:

3 **“SEC. 938. FIELD EMS PRACTICE CENTER.**

4 “(a) ESTABLISHMENT.—For the purpose described
5 in subsection (b), the Director shall establish within the
6 Office of Research and Evaluation a Field EMS Evidence-
7 Based Practice Center.

8 “(b) PURPOSE.—The purpose of the Center is to con-
9 duct or support research to promote the highest quality
10 of emergency medical care in field EMS and the most ef-
11 fective delivery system for the provision of such care. Re-
12 search conducted or supported pursuant to the preceding
13 sentence shall include—

14 “(1) comparative safety and effectiveness re-
15 search;

16 “(2) other appropriate clinical or systems re-
17 search; and

18 “(3) research addressing—

19 “(A) critical care transport;

20 “(B) off-shore operations;

21 “(C) tactical emergency medical services;

22 “(D) air medical services; and

23 “(E) the application of lessons learned in
24 military field medicine in the delivery of emer-
25 gency medical care in field EMS.

1 “(c) DEFINITION.—In this section:

2 “(1) The term ‘Center’ means the Field EMS
3 Evidence-Based Practice Center established under
4 subsection (a).

5 “(2) The term ‘field EMS’ has the meaning
6 given to such term in section 3 of the Field EMS
7 Quality, Innovation, and Cost Effectiveness Improve-
8 ments Act of 2011.”.

9 (d) LIMITATIONS ON CERTAIN USES OF RE-
10 SEARCH.—Section 1182 of the Social Security Act (42
11 U.S.C. 1320e–1) is amended by striking “section 1181”
12 each place it appears and inserting “section 1181 of this
13 Act or section 498D(c) or 938 of the Public Health Serv-
14 ice Act”.

15 (e) REGULATORY BARRIERS.—For the purposes of
16 research conducted pursuant to this section or any other
17 research funded by the Department of Health and Human
18 Services related to emergency medical services in the field
19 in which informed consent is required but may not be at-
20 tainable, the Secretary of Health and Human Services
21 shall—

22 (1) evaluate and consider the patient and re-
23 search issues involved; and

24 (2) address regulatory barriers to such research
25 related to the need for informed consent in a man-

1 ner that ensures adequate patient safety and notifi-
 2 cation, and submit recommendations to Congress for
 3 any changes to Federal statutes necessary to ad-
 4 dress such barriers.

5 **SEC. 11. EMERGENCY MEDICAL SERVICES TRUST FUND.**

6 (a) DESIGNATION OF INCOME TAX OVERPAYMENTS
 7 AND ADDITIONAL CONTRIBUTIONS FOR EMERGENCY
 8 MEDICAL SERVICES.—Subchapter A of chapter 61 of the
 9 Internal Revenue Code of 1986 (relating to returns and
 10 records) is amended by adding at the end the following
 11 new part:

12 **“PART IX—DESIGNATION OF INCOME TAX OVER-**
 13 **PAYMENTS AND ADDITIONAL CONTRIBU-**
 14 **TIONS FOR EMERGENCY MEDICAL SERVICES**
 15 **“SEC. 6097. DESIGNATION BY INDIVIDUALS.**

16 “(a) IN GENERAL.—Every individual (other than a
 17 nonresident alien)—

18 “(1) may designate that a specified portion of
 19 any overpayment of tax for a taxable year, and

20 “(2) may designate that an amount in addition
 21 to any payment of tax for such taxable year and any
 22 designation under paragraph (1),

23 shall be used to fund the Emergency Medical Services
 24 Trust Fund. Designations under the preceding sentence
 25 shall be in an amount not less than \$1 and the Secretary

1 shall provide for elections in amounts of \$1, \$5, \$10, or
2 such other amount as the taxpayer designates.

3 “(b) ADJUSTED INCOME TAX LIABILITY.—For pur-
4 poses of this section, the term ‘adjusted income tax liabil-
5 ity’ means income tax liability (as defined in section
6 6096(b)) reduced by any amount designated under section
7 6096 (relating to designation of income tax payments to
8 Presidential Election Campaign Fund).

9 “(c) OVERPAYMENTS TREATED AS REFUNDED.—For
10 purposes of this title, any portion of an overpayment of
11 tax designated under subsection (a) shall be treated as—

12 “(1) being refunded to the taxpayer as of the
13 last date prescribed for filing the return of tax im-
14 posed by chapter 1 (determined without regard to
15 extensions) or, if later, the date the return is filed,
16 and

17 “(2) a contribution made by such taxpayer on
18 such date to the United States.

19 “(d) MANNER AND TIME OF DESIGNATION.—A des-
20 ignation under subsection (a) may be made with respect
21 to any taxable year—

22 “(1) at the time of filing the return of the tax
23 imposed by chapter 1 for such taxable year, or

24 “(2) at any other time (after the time of filing
25 the return of the tax imposed by chapter 1 for such

1 taxable year) specified in regulations prescribed by
2 the Secretary.

3 Such designation shall be made in such manner as the
4 Secretary prescribes by regulations except that, if such
5 designation is made at the time of filing the return of the
6 tax imposed by chapter 1 for such taxable year, such des-
7 ignation shall be made either on the first page of the re-
8 turn or on the page bearing the signature of the tax-
9 payer.”.

10 (b) EMERGENCY MEDICAL SERVICES TRUST
11 FUND.—Subchapter A of chapter 98 of the Internal Rev-
12 enue Code of 1986 is amended by adding at the end the
13 following new section:

14 **“SEC. 9512. EMERGENCY MEDICAL SERVICES TRUST FUND.**

15 “(a) CREATION OF TRUST FUND.—There is estab-
16 lished in the Treasury of the United States a trust fund
17 to be known as the ‘Emergency Medical Services Trust
18 Fund’, consisting of such amounts as may be credited or
19 paid to such trust fund as provided in section 6097.

20 “(b) TRANSFERS TO TRUST FUND.—There are here-
21 by appropriated to the Emergency Medical Services Trust
22 Fund amounts equivalent to the amounts of the overpay-
23 ments of tax to which designations under section 6097
24 apply.

1 “(c) EXPENDITURES FROM TRUST FUND.—Amounts
 2 in the Emergency Medical Services Trust Fund shall be
 3 available, as provided in appropriation Acts, only for car-
 4 rying out the provisions for which amounts are authorized
 5 to be appropriated under subsections (a) and (b) of section
 6 12 of the Field EMS Quality, Innovation, and Cost Effec-
 7 tiveness Improvements Act of 2011.”.

8 (c) CLERICAL AMENDMENTS.—

9 (1) CLERICAL AMENDMENT.—The table of
 10 parts for subchapter A of chapter 61 of the Internal
 11 Revenue Code of 1986 is amended by adding at the
 12 end the following new item:

“PART IX. DESIGNATION OF INCOME TAX OVERPAYMENTS AND ADDITIONAL
 CONTRIBUTIONS FOR EMERGENCY MEDICAL SERVICES.”.

13 (2) The table of sections for subchapter A of
 14 chapter 98 of such Code is amended by adding at
 15 the end the following new item:

“Sec. 9512. Emergency Medical Services Trust Fund.”.

16 (d) EFFECTIVE DATE.—The amendments made by
 17 this section shall apply to taxable years beginning after
 18 December 31, 2011.

19 **SEC. 12. AUTHORIZATION OF APPROPRIATIONS.**

20 (a) IN GENERAL.—Out of amounts in the Emergency
 21 Medical Services Trust Fund, there are authorized to be
 22 appropriated—

1 (1) \$12,000,000 shall be for carrying out sec-
2 tions 4 (excluding the provisions of law listed in sub-
3 section (b)(3) of such section), 7, 9(a), 9(c), and 11
4 of this Act for each of fiscal years 2013 through
5 2016;

6 (2) \$200,000,000 shall be for carrying out sec-
7 tion 5 of this Act for each of fiscal years 2013
8 through 2016;

9 (3) \$50,000,000 shall be for carrying out sec-
10 tion 6 of this Act for each of fiscal years 2013
11 through 2016;

12 (4) \$4,000,000 shall be for carrying out section
13 7(c)(1) of this Act for each of fiscal years 2013
14 through 2016;

15 (5) \$15,000,000 shall be for carrying out sec-
16 tion 8 of this Act for each of fiscal years 2013
17 through 2016; and

18 (6) \$40,000,000 shall be for carrying out sec-
19 tions 498D(c) and 938 of the Public Health Service
20 Act, as added by subsections (b) and (c) of section
21 10 of this Act, for each of fiscal years 2013 through
22 2016.

23 (b) EXCESS AMOUNTS.—If, for any fiscal year,
24 amounts in the Emergency Medical Services Trust Fund
25 exceed the maximum amount authorized to be appro-

1 priated under subsection (a), such excess amounts are au-
2 thorized to be appropriated to carry out section 330J, sec-
3 tion 498D, and parts A, B, C, D, and H of title XII of
4 the Public Health Service Act (42 U.S.C. 254c–15, 289g–
5 4, 300d et seq., 300d–11 et seq., 300d–31 et seq., and
6 300d–81 et seq.).

7 (c) START-UP FUNDING.—

8 (1) IN GENERAL.—Out of the discretionary
9 funds available to the Secretary of Health and
10 Human Services for each of fiscal years 2012
11 through 2013, \$40,000,000 shall be for carrying out
12 the provisions listed in subsection (a) or (b).

13 (2) RELATION TO OTHER FUNDS.—The amount
14 of discretionary funds allocated under paragraph (1)
15 for the purpose of carrying out the provisions listed
16 in subsection (a) or (b) shall be in addition to, not
17 in lieu of, the amount of discretionary funds that
18 would otherwise be available for such purpose.

19 (d) ADMINISTRATIVE EXPENSES.—Of the amounts
20 made available under subsection (a), (b), or (c) to carry
21 out each of the provisions listed in subsection (a), not
22 more than 5 percent of each such amount may be used
23 for Federal administrative expenses.

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