I

114TH CONGRESS
1ST SESSION

H. R. 2366

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

IN THE HOUSE OF REPRESENTATIVES

MAY 15, 2015

Mr. BUCSHON 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

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Field EMS Modernization and Innovation Act''.

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

SEC. 2. FINDINGS.

Congress finds the following:

(1) Patients with emergency medical conditions depend upon field emergency medical services (referred to in this section as ''EMS'') for essential life-saving or unscheduled medical care. All people in the United States should have access to and receive high-quality emergency medical care as part of a coordinated EMS system.

(2) The Institute of Medicine, in its 2006 report ''Emergency Medical Services at the Crossroads'', outlined its vision of a 21st century emergency care system that is integrated, regionalized, accountable, and prepared for both routine emergency medical care and public health emergencies. Such a modernized system would be characterized by a highly trained and capable field EMS practitioner workforce that delivers high-quality, evidence-based, innovative, value-based, and patient-centered emer-

gency care in the field and across the emergency care continuum.

(3) In such 2006 report, the Institute of Medicine also outlined systemic problems plaguing field EMS that impede achievement of a 21st century emergency care system, including insufficient coordination, disparate response times, uncertain quality of care, lack of readiness for disasters, divided professional identity of field EMS practitioners, and a limited evidence base for the emergency medical care provided in the field.

(4) To modernize the field EMS system, the Institute of Medicine recommended that advancements be made in several priority areas, including readiness, innovation, preparedness, education and workforce development, safety, financing, quality, standards, and research. The Institutes of Medicine also recommended recognition of a lead programmatic Federal agency for emergency medical services within the Department of Health and Human Services to provide a more streamlined, cost-efficient, and comprehensive approach for field EMS, and a focal point for practitioners and agencies to interface with the Federal Government.

(5) Under an amendment made by the Pandemic and All-Hazards Preparedness Act (Public Law 109–417), the Secretary of Health and Human Services is already established as the lead of all Federal public health and medical response for public health emergencies and incidents. Preparedness and capability to deliver routine emergency medical care is a prerequisite for preparedness and capability to respond to public health emergencies and incidents.

(6) In 2007, the Homeland Security Presidential Directive HSPD–21 called for the establishment within the Department of Health and Human Services of an Office for Emergency Medical Care to lead an enterprise to promote and fund research in emergency medicine and trauma care; promote regional partnerships and more effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients; and promote local, regional, and State emergency medical systems' preparedness for and response to public health events. Under the Directive, the Office would address the full spectrum of issues that have an impact on care in hospital emergency departments, including the entire continuum

of patient care from prehospital to disposition from emergency or trauma care.

(7) Properly functioning EMS systems encompass fully mobile resources that are able to address patient needs 24 hours per day, 7 days per week, 365 days a year. Field EMS serves as an essential health care safety net by providing emergency, urgent, and mobile medical care throughout the health care continuum, including medical and trauma care provided in the field, hospital, rehabilitation, and other settings. Ensuring high-quality and cost-effective emergency medical services systems requires readiness, preparedness, medical oversight, and innovation throughout the continuum of emergency medical care through Federal, State, and local multi-jurisdictional collaboration and sufficient resources for EMS agencies and practitioners.

(8) Field EMS is the delivery of health care, not simply a transportation benefit having evolved from a patient transport model to a health care service delivery model that provides a variety of targeted medical services to meet the specific needs of their communities. This includes the development of community paramedicine as a health care service provided by field EMS agencies and mobile integrated

health care as a health care service provided collaboratively by a group of health care providers in a community, including local field EMS agencies. These new delivery models are filling gaps in patient care identified by a community's health care providers, including preventing recurrent medical episodes through reliable post-discharge follow up and chronic disease management. Facilitating reimbursement for such services, including under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), is necessary to the continued development and sustainability of such services.

(9) Field EMS is uniquely positioned to support the transformation of health care to a value and outcomes based model to improve the patient experience and the health of populations, and to reduce the per capita cost of health care. Field EMS provides highly reliable patient assessment and intervention at any hour of any day in response to urgent or unscheduled episodes of illness or injury and effectively navigates patients to ensure they receive the right care, in the right place, and at the right time. Field EMS helps contain health care costs by navigating the patient down a cost-effective pathway that is evidence-based.

(10) Coordinated and high-quality field EMS is essential to the Nation's security. Field EMS is an essential public service provided by governmental and nongovernmental agencies and practitioners every day and during catastrophic incidents. To ensure disaster and all-hazards preparedness for field EMS operations as part of the Nation's comprehensive disaster preparedness, Federal funding for preparedness activities, including catastrophic training and exercises, must be provided to governmental and nongovernmental field EMS agencies to ensure a greater capability within each of these areas.

(11) The essential role of field EMS in disaster preparedness and response must be incorporated into the national preparedness and response strategy and implementation as provided and overseen by the Department of Homeland Security and the Department of Health and Human Services, pursuant to their respective jurisdictions. Field EMS agencies must be capable of meeting the routine emergency care needs of patients to be capable of meeting the extraordinary medical needs during a catastrophic event.

SEC. 3. ALIGNING AMBULANCE REIMBURSEMENT WITH VALUE-BASED AND HIGH-QUALITY FIELD EMS.

(a) FIELD EMS MEDICARE DEMONSTRATION PROGRAM.—Section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

(1) in the last sentence of subparagraph (A), by inserting ", and shall include the model described in subparagraph (D)" before the period at the end; and

(2) by adding at the end the following new subparagraph:

"(D) DEMONSTRATION PROJECTS.—

"(i) IN GENERAL.—The model described in this subparagraph is a demonstration program under title XVIII. Beginning not later than 2 years after the date of the enactment of the Field EMS Modernization and Innovation Act, the CMI shall conduct not less than 10 demonstration projects to—

"(I) evaluate the implementation and reimbursement of alternative dispositions of field EMS patients, including—

"(aa) transporting individuals by ambulance to alternate

destinations when medically appropriate and in the individual's best interests;

"(bb) when medically necessary, evaluating, treating, or referring individuals to other medically appropriate providers; and

"(cc) when medically appropriate, treating individuals through community paramedicine or mobile integrated healthcare services;

"(II) evaluate the implementation of alternative reimbursement models, including models based on readiness rather than transport or shared savings; and

"(III) determine whether such alternative dispositions and reimbursement models—

"(aa) improve the safety, effectiveness, timeliness, and efficiency of emergency medical services; and

''(bb) reduce overall utilization and expenditures under title XVIII.

''(ii) EVIDENCE-BASED PROTOCOLS.—The CMI shall ensure that at least one demonstration project under this subparagraph evaluates evidence-based protocols that give guidance on selection of the destination to which individuals are transported.

''(iii) DURATION.—The duration of a demonstration project under this subparagraph shall not exceed 3 years.

''(iv) RESEARCH.—The Secretary shall conduct or support further research that the Secretary determines to be necessary prior to, or in conjunction with, the demonstration projects under this subparagraph in order to evaluate the implementation of alternative dispositions of, and reimbursement models for transport of, field EMS patients.

''(v) REPORT TO CONGRESS.—Not later than 1 year after the completion of all demonstration projects under this sub-

paragraph, the Secretary shall include in the annual report to Congress required under subsection (g) a report on the results of the projects conducted under this subparagraph, including information about the efficacy of alternative disposition of, and reimbursement models for transport of, field EMS patients.

''(vi) DEFINITION OF FIELD EMS.—In this subparagraph, the terms 'community paramedicine', 'field EMS', 'mobile integrated healthcare', and 'readiness' shall have the meanings given such terms in section 1291 of the Public Health Service Act.''.

(b) FIELD EMS ALTERNATIVE DELIVERY PROGRAM.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) is amended by adding at the end the following new paragraph:

''(16) FIELD EMS ALTERNATIVE DELIVERY PROGRAM.—

''(A) IN GENERAL.—Not later than 3 years after the date of the enactment of this paragraph, the Secretary shall establish the Field EMS Alternative Delivery Program to establish

and promote the utilization of innovative payment models, including the models described in subparagraph (D), on a shared savings and voluntary basis, taking into consideration the results of the evaluation of models under subparagraph (G) and the demonstration projects conducted under section 1115A(b)(2)(D). To the extent that the Secretary ascertains that an innovative payment model has been sufficiently demonstrated through the private sector or through the Center for Medicare and Medicaid Innovation under section 1115A and does not need to be evaluated under subparagraph (G), the Secretary may establish such innovative payment model on a shared savings and budget neutral basis pursuant to this subparagraph.

''(B) VOLUNTARY NATURE OF PARTICIPATION.—Providers and suppliers of ground ambulance services may voluntarily opt to utilize innovative payment models under the Field EMS Alternative Delivery Program. Nothing in this subparagraph shall be construed as authorizing the Secretary to require participation in any innovative payment model under the Program.

"(C) BUDGET NEUTRALITY.—The Secretary shall implement the innovative payment models under this subparagraph in a budget neutral manner such that the cost of implementation of such models shall not exceed the amount that otherwise would have been provided in reimbursement under this title if such models had not been implemented.

"(D) TYPES OF MODELS.—The following models are described in this clause:

"(i) Community paramedicine that allows for payment for health care assessment and prevention services, or other care management services.

"(ii) Mobile integrated healthcare services that allow for health care assessment and prevention services, or other care management services within an integrated program of patient care.

"(iii) Alternate patient dispositions regardless of transport to the hospital, including transport to alternate destinations and other patient dispositions such as treating and referring patients to appropriate follow up care. Such alternate dis-

positions, including alternate destinations and treat and refer dispositions, would be subject to the discretion of the physician medical director responsible for providing medical oversight.

''(iv) The provision of field EMS and reimbursement on a population health basis, such as through global capitation.

''(v) Prevention-based models, such as injury prevention through home evaluations for fall prevention or infection control.

''(vi) Critical care models, particularly in geographic areas without proximate access to hospital-based critical care, and including a model that enables patient stabilization by critical care transport teams with telemedicine support for maintaining the patient in the patient's community.

''(vii) Any other innovative shared savings model the Secretary determines relevant pursuant to subparagraph (G).

''(E) QUALITY REPORTING.—As a condition of participation in the Field EMS Alternative Delivery Program, providers and sup-

pliers of ground ambulance services shall participate in the Ambulance Quality Incentive Program described in paragraph (17).

"(F) MEDICAL OVERSIGHT.—The Secretary shall specify and require appropriate medical oversight with regard to the development, demonstration, and implementation of innovative payment models under this paragraph to ensure high-quality care and patient safety.

"(G) DEVELOPMENT AND EVALUATION OF MODELS.—

"(i) IN GENERAL.—The Secretary, in consultation with the Assistant Secretary for Preparedness and Response and taking into consideration the recommendations of the National EMS Advisory Council and the Federal Interagency Committee on EMS, shall undertake the development and evaluation of innovative models of field EMS delivery and reimbursement.

"(ii) EVALUATION OF INNOVATIVE MODEL OPTIONS.—

"(I) IN GENERAL.—Not later than 1 year after the date of the enactment of the Field EMS Moderniza-

tion and Innovation Act, the Secretary shall complete an evaluation of—

"(aa) the provision of and reimbursement for alternative delivery models for medical care through field EMS; and

"(bb) the integration of field EMS patients with other medical providers and facilities as medically appropriate.

"(II) CONSIDERATIONS.—In completing the evaluation under subclause (I), the Secretary shall consider the following:

"(aa) Alternative dispositions of patients, including—

"(AA) transporting individuals by ambulance to destinations other than a hospital, such as the office of the physician of the individual, an urgent care center, or the facility of another health care provider;

"(BB) when medically necessary, the evaluation, treatment, or referral of individuals to other medically appropriate health care providers;

"(CC) the provision of medical care regardless of the decision to transport, such as reimbursement models based on readiness rather than transport and shared savings; and

"(DD) the provision of health care using patient-centered mobile resources in the out-of-hospital environment, such as community paramedicine and mobile-integrated health care services.

"(bb) Issues related to medical liability and the requirements of section 1867 (commonly referred to as 'EMTALA') associ-

ated with transport to destinations other than a hospital emergency department.

''(cc) Necessary protections to ensure that patients receive timely and appropriate care in the appropriate setting, including ongoing quality improvement and appropriate physician medical oversight.

''(dd) Whether there are any barriers to providing alternate dispositions to individuals who are not in need of hospital-based care.

''(ee) Other reimbursement related issues that span multiple delivery models including the cost of demonstrated evidence-based care, such as 12-lead electrocardiograms and continuous positive airway pressure, early recognition of time dependent diseases, such as stroke and sepsis, and trauma, and providing high-

quality appropriate physician medical oversight.

"(ff) Other issues, as determined by the Secretary, including, when practicable, issues recommended by the Assistant Secretary for Preparedness and Response, the National EMS Advisory Council, and the Federal Interagency Committee on EMS for evaluation under this subparagraph.

"(H) DEFINITIONS.—In this paragraph, the terms 'community paramedicine', 'field EMS', 'medical oversight', and 'mobile integrated healthcare' have the meanings given such terms in section 1291 of the Public Health Service Act.".

(c) AMBULANCE QUALITY INCENTIVE PROGRAM.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

"(17) AMBULANCE QUALITY INCENTIVE PROGRAM.—

"(A) IN GENERAL.—Not later than January 1 of the first fiscal year that begins on or after the date that is 3 years after the date of the enactment of this paragraph, the Secretary shall establish an Ambulance Quality Incentive Program under which providers and suppliers of ground ambulance services under this subsection may receive incentive payments from the amount made available under subparagraph (F) for reporting on the quality measures identified by the Secretary under subparagraph (B).

"(B) QUALITY MEASURES.—

"(i) IN GENERAL.—The Secretary shall, by regulation, identify quality measures that have been endorsed by the entity with a contract under section 1890(a). Such measures shall include outcome and patient safety measures and be relevant to the provision of field emergency medical response and mobile medical care.

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract

under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(iii) REVISING QUALITY MEASURES.—Subject to clause (iv), the Secretary may, by regulation, revise quality measures identified under this paragraph on an annual basis.

''(iv) TIMEFRAME.—The Secretary shall publish the quality measures that will apply to a fiscal year not later than January 1 of the preceding fiscal year.

''(C) VOLUNTARY NATURE OF REPORTING.—Participation in the Ambulance Quality Incentive Program is voluntary for providers and suppliers electing not to participate in the Field EMS Alternative Delivery Program.

''(D) CONSULTATION.—In carrying out the provisions of this paragraph (including in developing and revising the quality measures identified in subparagraph (B)), the Secretary shall—

"(i) solicit the input of relevant stakeholders;

"(ii) use the notice and comment procedures provided in section 553 of title 5, United States Code; and

"(iii) take into account prior investments in technology systems to enable participation in the program with minimal additional capital investments.

"(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under this paragraph available to the public on the website of the Centers for Medicare & Medicaid Services. Such procedures shall ensure that a supplier or provider has the opportunity to review the data that is to be made public with respect to the supplier or provider prior to such data being made public.

"(F) BUDGET NEUTRAL FUNDING.—

"(i) IN GENERAL.—The amount available for making payments under this paragraph for any fiscal year shall be equal to the amount of savings for the preceding fiscal year resulting from the Field EMS

Alternative Delivery Program described in paragraph (16), as determined by the Secretary.

''(ii) PRIORITY FOR PARTICIPANTS IN FIELD EMS ALTERNATIVE DELIVERY PROGRAM.—To the extent that funds are available for making payments under this paragraph for a fiscal year, the Secretary shall ensure that—

''(I) providers and suppliers who participated in the program established under paragraph (16) in the preceding fiscal year are paid before other providers and suppliers; and

''(II) providers and suppliers who did not participate in the program established under paragraph (16) in the preceding fiscal year may only receive payments if there are any funds remaining after the application of subclause (I).''.

SEC. 4. FIELD EMERGENCY MEDICAL SERVICES.

(a) IN GENERAL.—Title XII of the Public Health Service Act (42 U.S.C. 300d et seq.) is amended by adding at the end the following:

"PART I—FIELD EMERGENCY MEDICAL SERVICES

"SEC. 1291. DEFINITIONS.

''In this part:

''(1) The term 'ambulance diversion' means the practice of hospitals denying access to an incoming ambulance and requesting that the ambulance proceed to another facility due to a stated lack of capacity at the initial facility, resulting in delayed access to definitive care.

''(2) The term 'community paramedicine' means a health care service provided by a field EMS agency for the provision of cost-effective health care assessment and prevention services to fill gaps in the local health care system.

''(3) The term 'emergency medical response' means—

''(A) medical care provided to patients with emergency medical conditions prior to or outside a medical facility;

''(B) emergency medical dispatch, rapid response, and urgent or unscheduled patient assessment and intervention;

''(C) emergency, critical care, and inter-facility and air medical transport; or

''(D) telephone consultation to 911 callers as an alternative to ambulance dispatch, or

other requests through a public safety answering point.

''(4) The term 'emergency medical services' means emergency medical care, trauma care, and related services provided to patients at any point in the continuum of health care services, including emergency medical dispatch and emergency medical care, trauma care, and related services provided in the field, during transport, or in a medical facility or other clinical setting.

''(5) The term 'FICEMS' means the Federal Interagency Committee on Emergency Medical Services.

''(6) The term 'field EMS' means emergency medical response and mobile medical services provided prior to or outside a medical facility.

''(7) The term 'field EMS agency' means an organization providing field EMS, including—

''(A) governmental (including fire-based agencies), nongovernmental (including hospital based or private agencies), and volunteer organizations; and

''(B) organizations that provide field EMS by ground, air, or otherwise.

''(8) The term 'field EMS practitioner' means an individual licensed and credentialed to provide emergency and mobile medical care to patients within the scope of such individual's practice.

''(9) The term 'medical oversight' means the supervision by a physician of the medical aspects of a field EMS system or agency and its practitioners, including prospective, concurrent, and respective components of field EMS and the education of field EMS practitioners.

''(10) The term 'mobile integrated health care' means a health care service that is undertaken collaboratively by a group of health care providers, including the local field EMS agency, in a community, for the provision of medical care to fill gaps in the local health care system.

''(11) The term 'mobile medical services' means preventive medical assessment and care, chronic disease assessment and management support, post-discharge follow-up assessment and management support, and post-assessment patient transport, arranged transportation, or referral to other community health or social service resources.

''(12) The term 'NEMSAC' means the National Emergency Medical Services Advisory Council.

''(13) The term 'NEMSIS' means the National EMS Information System.

''(14) The term 'NHTSA' means the National Highway Traffic Safety Administration.

''(15) The term 'patient parking' means the practice by hospitals of refusing to accept transfer of a patient's care from an ambulance crew until a regular emergency department bed is available, requiring the crew to continue to provide patient care on the ambulance stretcher rather than in a patient bed in the hospital, until hospital staff will accept the transfer of care, resulting in delayed access to definitive care for the patient and denied access to emergency care for the community served by the field EMS Agency.

''(16) The term 'readiness' means the standby costs of preparedness to respond to a health care need, 24 hours a day, 7 days a week, 365 days a year.

''(17) The term 'State EMS Office' means an office designated by the State with primary responsibility for oversight of the State's emergency medical services system, such as responsibility for oversight of field EMS coordination, licensing or certifying

field EMS practitioners, and emergency medical services system improvement.

"SEC. 1292. FIELD EMS PREPAREDNESS FOR PUBLIC HEALTH EMERGENCIES AND OTHER INCIDENTS.

''(a) IN GENERAL.—The Assistant Secretary for Preparedness and Response shall establish the Field EMS Preparedness Program to be administered by the Office of Emergency Medical Care for the purpose of improving field EMS agency all-hazards readiness and preparedness and public health emergencies and incidents.

''(b) APPLICATION.—

''(1) IN GENERAL.—To be eligible to receive a grant under this section, an eligible entity shall submit an application to the Assistant Secretary for Preparedness and Response in such form and manner, and containing such agreements, assurances, and information as such Assistant Secretary requires.

''(2) SIMPLE FORM.—The Assistant Secretary for Preparedness and Response shall ensure that grant application requirements are not unduly burdensome to smaller and volunteer field EMS agencies or other agencies with limited resources.

''(3) CONSISTENCY WITH PREPARATION GOALS.—The Assistant Secretary for Preparedness and Response shall ensure that grant applications are consistent with national and relevant State preparedness plans and goals.

''(c) USE OF FUNDS.—Grants may be used by eligible entities to achieve the preparedness goals described under paragraphs (1), (3), (4), (5), (6), and (8) of section 2802(b) with respect to all-hazards, including chemical, biological, radiological, or nuclear threats, including the purchase of equipment, training, and supplies.

''(d) ADMINISTRATION OF GRANTS.—In carrying out this section, the Assistant Secretary for Preparedness and Response—

''(1) shall establish a grantmaking process that includes—

''(A) prioritization for the awarding of grants to eligible entities and consideration of the factors in reviewing grant applications by eligible entities, including—

''(i) demonstrated financial need for funding;

''(ii) utilization of public and private partnerships;

"(iii) improving the availability of field EMS in underserved regions to enhance the capability for medical response to public health emergencies and incidents;

"(iv) unique needs of volunteer and rural field EMS agencies;

"(v) distribution among a variety of geographic areas, including urban, suburban, and rural;

"(vi) distribution of funds among types of field EMS agencies, including governmental, nongovernmental, and volunteer agencies;

"(vii) implementation of regionalized systems of medical response to public health emergencies and incidents; and

"(viii) such other factors as the Assistant Secretary for Preparedness and Response determines necessary;

"(B) a peer-reviewed process to recommend grant allocations in accordance with the prioritization established under subparagraph (A), except that final award determinations shall be made by the Assistant Secretary for Preparedness and Response; and

''(C) the provision of grant awards to eligible entities on an annual basis, except that the Assistant Secretary for Preparedness and Response may reserve not more than 25 percent of the available appropriations for multiyear grants and no grant award may exceed a 2-year period; and

''(2) shall consult with and take into consideration the recommendations of the FICEMS, NEMSAC, and relevant stakeholders.

''(e) ELIGIBILITY.—To be eligible to receive a grant under this section, an entity shall be a field EMS agency that—

''(1) is licensed by or otherwise authorized in the State in which it operates; and

''(2) has medical oversight and quality improvement programs, as determined by the Assistant Secretary for Preparedness and Response.

''(f) REQUIRED USE OF MEDICAL OVERSIGHT GUIDELINES.—As a condition on receipt of a grant under this section, the Assistant Secretary for Preparedness and Response shall require each grant recipient to adopt and implement (to the extent applicable) the guidelines promoted, developed, and disseminated under subparagraphs

(B) and (C) of subsection (a)(1) of section 1293 with regard to medical oversight.

''(g) ANNUAL REPORT.—The Assistant Secretary for Preparedness and Response shall submit an annual report on the Field EMS Preparedness Program under this section to Congress.

''SEC. 1293. FIELD EMS QUALITY IMPROVEMENT.

''(a) ENHANCING PHYSICIAN MEDICAL OVERSIGHT.—

''(1) IN GENERAL.—To improve medical oversight of field EMS and ensure continuity and quality for such medical oversight, the Assistant Secretary for Preparedness and Response shall—

''(A) promote high-quality and comprehensive medical oversight of—

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

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

''(B) promote the development, adoption, and utilization of national guidelines for the role of physicians who provide medical oversight for field EMS and other health care providers who support physicians in such role;

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

"(D) convene a Field EMS Medical Oversight Advisory Committee, comprised of representatives of relevant physician stakeholders, to advise the Assistant Secretary for Preparedness and Response on ways and means to advance and support development and maintenance of quality medical oversight throughout the Nation's systems for field EMS.

"(2) ADDITIONAL CONSIDERATIONS.—In carrying out subparagraphs (B) and (C) of paragraph (1), the Assistant Secretary for Preparedness and Response shall take into consideration—

"(A) existing guidelines developed by national professional physician associations, States, and other relevant governmental or nongovernmental entities;

"(B) the input of other relevant stakeholders, including health care providers who support physicians who provide medical oversight for field EMS; and

''(C) the unique needs associated with medical oversight of provision of field EMS in rural areas or by volunteers.

''(3) FLEXIBILITY.—The guidelines promoted, developed, and disseminated under subparagraphs (B) and (C) of paragraph (1) shall ensure high-quality training, credentialing, and direction in connection with medical oversight of field EMS at the State, regional, and local levels while providing sufficient flexibility to account for historical and legitimate differences in field EMS among States, regions, and localities.

''(b) PATIENT SAFETY IMPROVEMENT.—Field EMS agencies and practitioners shall be eligible to participate in the activities of patient safety organizations for the purpose of improving patient safety and the quality of health care delivery.

''(c) ANALYSIS OF DATA GAPS THAT HINDER HIGH-QUALITY FIELD EMS CARE.—

''(1) IN GENERAL.—Not later than 1 year after the date of the enactment of the Field EMS Modernization and Innovation Act, the Secretary, acting through the Assistant Secretary for Preparedness and Response, shall submit to Congress a report that—

"(A) identifies gaps in the collection of data related to the provision of field EMS; and

"(B) includes recommendations for improving the collection, reporting, and analysis of such data, and integration of such data with other health care data.

"(2) RECOMMENDATIONS.—The recommendations included in the report in accordance with paragraph (1)(B) shall—

"(A) take into consideration the recommendations of FICEMS, NEMSAC, and relevant stakeholders;

"(B) recommend methods for improving data collection, reporting, and analysis without unduly burdening reporting entities and without duplicating existing data sources (such as data collected by the National Trauma Data Bank);

"(C) address the quality and availability of data, and linkages with existing patient registries, related to the provision of field EMS and utilization of field EMS with respect to a variety of illnesses and injuries (in both the everyday provision of field EMS and catastrophic or disaster response), including—

''(i) cardiac events such as chest pain, sudden cardiac arrest, and ST-segment elevation myocardial infarction;

''(ii) stroke;

''(iii) trauma;

''(iv) disaster and catastrophic incidents, such as incidents related to terrorism or natural or manmade disasters; and

''(v) ambulance diversion and patient parking;

''(D) include an analysis of the variety of services provided by field EMS agencies; and

''(E) any recommendations that require statutory authorization from Congress.

''(3) IMPLEMENTATION OF RECOMMENDATIONS WITH EXISTING STATUTORY AUTHORITY.—The Secretary, acting through the Office of the National Coordinator for Health Information Technology, shall implement such recommendations for data collection to the extent that such authority exists and does not require further statutory authorization from Congress.

"SEC. 1294. ACCOUNTABILITY FOR FIELD EMS SYSTEM PERFORMANCE.

''(a) DEVELOPMENT OF FIELD EMS QUALITY AND SYSTEM PERFORMANCE MEASURES.—The Assistant Secretary for Preparedness and Response shall support—

''(1) further development and refinement of measures to be utilized under the Ambulance Quality Incentive Program, as appropriate, including—

''(A) quality measures to improve accountability for patient outcomes in field EMS; and

''(B) performance measures to enhance the measurement of field EMS system performance; and

''(2) a technical assistance center to provide assistance and education to field EMS agencies, physician medical directors, and practitioners to participate effectively in quality and performance improvement programs.

''(b) CLARIFICATION OF HIPAA.—

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

''(A) IN GENERAL.—Nothing in HIPAA privacy and security law (as defined in section 3009(a)(2)) shall be construed as prohibiting the exchange of information between field EMS practitioners treating an individual and per-

sonnel of a hospital to which the individual has been treated for the purposes of relating information on the medical history, treatment, care, and outcome of such individual (including any health care personnel safety issues, such as infectious disease).

''(B) GUIDELINES.—The Secretary shall establish guidelines for exchanges of information between field EMS practitioners treating an individual and personnel of a hospital to which the individual has been treated to protect the privacy of the individual while ensuring the ability of such field EMS practitioners and hospital personnel to communicate effectively to further the continuity and quality of medical care provided to such individual.

''(2) NEMSIS DATA.—Nothing in HIPAA privacy and security law (as defined in section 3009(a)(2)) shall be construed as prohibiting the exchange of non-individually identifiable data between the field EMS agency, a State, and the Federal Government, including the exchange of information by—

''(A) a field EMS agency to the State EMS Office for the purpose of quality improve-

ment and data collection by the State for submission to NEMSIS; or

''(B) the State EMS Office to the National EMS Database maintained by Assistant Secretary for Preparedness and Response.

''SEC. 1295. FIELD EMS WORKFORCE DEVELOPMENT.

''(a) IN GENERAL.—For the purpose of promoting field EMS as a health profession and ensuring the availability, quality, and capability of field EMS educators, practitioners, managers, and medical directors, the Assistant Secretary for Preparedness and Response shall make grants to eligible entities for the development, availability, and dissemination of field EMS education programs and courses that improve the quality and capability of field EMS practitioners, educators, managers, and physician medical directors. In carrying out this section, the Assistant Secretary for Preparedness and Response shall take into consideration recommendations of FICEMS, NEMSAC, and relevant stakeholders.

''(b) ELIGIBILITY.—In this section, the term 'eligible entity' means an educational organization, an educational institution, a professional association, or any other entity involved in and experienced with the education of field EMS practitioners, physician medical directors, field EMS managers and administrators, and field EMS educators.

''(c) USE OF FUNDS.—The Assistant Secretary for Preparedness and Response may award a grant to an eligible entity under paragraph (1) only if the entity agrees to use the grant to—

''(1) develop and implement education programs to—

''(A) train field EMS instructors and promote the adoption and implementation of the education standards identified in the 'Emergency Medical Services Education Agenda for the Future: A Systems Approach', including any revisions thereto or successor standards;

''(B) provide training for information system workers, such as information security, forensic analysts, data analysts, network engineers, and similar roles to work in support of field EMS data systems; or

''(C) provide training and retraining programs that prepare displaced workers to enter a field EMS profession, including veterans and military EMS practitioners;

''(2) develop and implement educational courses pertaining to—

''(A) improving the provision of quality medical oversight of field EMS;

"(B) expanding the knowledge and skills of field EMS practitioners, including those needed to provide community paramedicine and mobile integrated health care;

"(C) undertaking field EMS educational and clinical research to develop investigators;

"(D) tactical training for field EMS; or

"(E) developing and expanding field EMS undergraduate and graduate programs;

"(3) evaluate education and training courses and methodologies to identify optimal educational modalities for field EMS practitioners;

"(4) enhance the opportunity for medical direction training and for promoting appropriate medical oversight of field emergency medical care; or

"(5) carry out such other activities as the Assistant Secretary for Preparedness and Response determines appropriate.

"(d) PRIORITY.—The Assistant Secretary for Preparedness and Response, in consultation with relevant stakeholders, and taking into consideration the recommendations of FICEMS and NEMSAC, shall establish a system of prioritization in awarding grants under this section to eligible entities.

''(e) DURATION OF GRANTS.—Grants under this section shall be for a period of 1 to 3 years.

''(f) APPLICATION.—The Assistant Secretary for Preparedness and Response may not award a grant to an eligible entity under this section unless the entity submits an application to such Assistant Secretary in such form, in such manner, and containing such agreements, assurances, and information as the Assistant Secretary may require. The Assistant Secretary for Preparedness and Response shall ensure that the requirements for submitting an application under this section are not unduly burdensome.

"SEC. 1296. NATIONAL EMERGENCY MEDICAL SERVICES STRATEGY.

''(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall develop and implement a cohesive national emergency medical services strategy to strengthen the development of field EMS and the full continuum of emergency medical care and systems at the Federal, State, and local levels to improve patient outcomes and access to high-quality care in the field and develop financing models that support the evolution of value-based emergency medical care. In establishing such a strategy, the Assistant Secretary for Preparedness and Response shall—

''(1) solicit and consider the 2007 and subsequent recommendations of the Institute of Medicine, the National EMS Advisory Council, and relevant stakeholders;

''(2) consult and collaborate with the Federal Interagency Committee on EMS to ensure consistency of such national emergency medical services strategy within the larger Federal strategy regarding national preparedness and response;

''(3) address issues related to emergency medical services system development, including—

''(A) the regionalization of field EMS, trauma, and emergency medical services, particularly for time sensitive conditions such as trauma, ST–Segment Elevation Myocardial Infarction, stroke, neonatal patients, and poisonings;

''(B) the availability of field EMS and trauma care and emergency medical services throughout the Nation;

''(C) the integration of emergency medical care from the perspective of patients across the emergency care continuum, and accountability for system performance; and

"(D) financing of field EMS agencies, including appropriate medical oversight;

"(4) promote the professional development of field EMS practitioners to deliver high-quality field EMS, including the adoption by States of the education standards identified in the National EMS Education Standards and any revisions thereto or successor standards, including the standardization of licensing of field EMS practitioners and standards of care in accordance with the National EMS Scope of Practice Model and based on best practices and evidence-based medicine, including by—

"(A) identifying differences in the levels of care, scope of practice, and licensure requirements among the States; and

"(B) encouraging States to adopt national minimum standards for such levels of care and licensure requirements;

"(5) promote a culture of safety, including through—

"(A) the establishment of field EMS patient and practitioner safety goals and the specific means to improve field EMS practitioner and patient safety to achieve such goals; and

"(B) the adoption of uniform national ambulance vehicle safety and manufacturing standards;

"(6) support the development of value-based reimbursement for new mobile resources and models of delivery that support the transformation of health care, including the full utilization of field EMS to deliver emergency medical response and mobile medical services including—

"(A) community paramedicine for the provision of cost-effective health care assessment and prevention services;

"(B) mobile integrated health care undertaken collaboratively by a group of providers in a community, including local field EMS agencies, to fill gaps in the local health care system;

"(C) integrated injury prevention strategies or programs; and

"(D) such other issues as the Secretary considers appropriate;

"(7) incorporate into such strategy preparedness and response objectives identified in the National Health Security Strategy under section 2802 in order—

''(A) to ensure the capability and capacity of the full spectrum of field EMS to respond to terrorist attacks, disasters, catastrophic events, and mass casualty events; and

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

''(8) promote research in emergency medical services and coordination across Federal agencies undertaking such research, taking into consideration the National EMS Research Agenda;

''(9) complete the development of such strategy not later than 18 months after the date of enactment of the Field EMS Modernization and Innovation Act;

''(10) communicate such strategy to the relevant congressional committees of jurisdiction;

''(11) implement such strategy, to the extent practicable, not later than 3 years after the date of enactment of the Field EMS Modernization and Innovation Act; and

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

''SEC. 1297. OFFICE OF EMERGENCY MEDICAL CARE.

''(a) ESTABLISHMENT OF OFFICE.—Pursuant to paragraph 41 of Homeland Security Presidential Directive

HSPD–21, dated October 18, 2007, the Secretary shall establish an Office of Emergency Medical Care under the direct authority of the Assistant Secretary for Preparedness and Response, to carry out all of the responsibilities described in such paragraph of such directive.

''(b) FUNCTIONS.—The Assistant Secretary for Preparedness and Response, acting through the Office of Emergency Medical Care, shall administer the emergency medical services activities and programs under this part and the trauma programs under parts A through D and H and shall—

''(1) promote and fund research in emergency medicine and trauma health care;

''(2) promote regional partnerships and effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients;

''(3) promote local, regional, and State emergency medical systems preparedness for and response to public health events;

''(4) address the full spectrum of issues that have an impact on care in emergency departments, including the entire continuum of patient care from prehospital to disposition from emergency or trauma care; and

''(5) coordinate with existing executive departments and agencies that perform functions related to emergency medical systems in order to ensure unified strategy, policy, and implementation.

''(c) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES, AND ADMINISTRATIVE ACTIONS.—All functions, personnel, assets, and liabilities of, and administrative actions applicable to, the Emergency Care Coordination Center, as in existence on the day before the date of the enactment of the Field EMS Modernization and Innovation Act, shall be transferred to the Office of Emergency Medical Care established under subsection (a).''.

(b) INCLUSION OF FIELD EMS IN PATIENT SAFETY IMPROVEMENT.—Section 921(8)(A) of the Public Health Service Act (42 U.S.C. 299b–21(8)(A)) is amended—

(1) in clause (i), by inserting ''field EMS agency (as defined in section 1291),'' after ''clinical laboratory,''; and

(2) in clause (ii), by inserting ''field EMS (as defined in section 1291) medical director, emergency medical technician,'' after ''pharmacist,''.

SEC. 5. INTEGRATION OF FIELD EMS INTO THE NATIONAL HEALTH INFORMATION INFRASTRUCTURE.

(a) NATIONAL EMS INFORMATION SYSTEM.—

(1) TRANSFER OF AUTHORITY.—The authority for the administration of the National EMS Information System, including the National EMS Database, shall be transferred from NHTSA to the National Coordinator for Health Information Technology.

(2) NATIONAL EMS INFORMATION SYSTEM.—Section 3001(c) of the Public Health Service Act (42 U.S.C. 300jj–11(c)) is amended by adding at the end the following:

''(9) NATIONAL EMS INFORMATION SYSTEM.—

''(A) STANDARDIZATION.—The National Coordinator shall promote the collection and reporting of data on field EMS (as defined in section 1291) in a standardized manner.

''(B) AVAILABILITY OF DATA.—The National Coordinator shall ensure that information in the National EMS Database (other than individually identifiable information) is available to Federal and State policymakers, EMS stakeholders, and researchers.

''(C) TECHNICAL ASSISTANCE.—In carrying out subparagraph (A), the National Coordinator may provide technical assistance to State and local agencies, field EMS agencies,

and other entities, as the National Coordinator determines appropriate, to assist in the collection, analysis, and reporting of data.''.

(b) ASSIMILATION OF PATIENT HEALTH INFORMATION ACROSS THE EMERGENCY CARE CONTINUUM.—Not later than 18 months after the date of enactment of this Act, taking into account the definition of ''health care provider'' under section 3000 of the Public Health Service Act (42 U.S.C. 300jj), the Secretary shall promulgate a regulation that specifically includes ''emergency medical service provider'' under the definition of ''health care provider'' for purposes of title XXX of the Public Health Service Act, to enable and facilitate the integration and assimilation of field EMS data systems as part of the electronic exchange and use of health information and the enterprise integration of such information.

(c) GAO EVALUATION.—

(1) IN GENERAL.—The Comptroller General of the United States, in consultation with the National Coordinator for Health Information Technology, the Assistant Secretary for Preparedness and Response, and the Federal Interagency Committee on Emergency Medical Services, as appropriate, and taking into consideration input from relevant stakeholders, shall undertake an evaluation of issues, impedi-

ments, and potential solutions pertaining to integration of field EMS into the National Health Information Infrastructure.

(2) REPORT.—The Comptroller General of the United States shall submit a report to Congress detailing the extent to which the Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') has authority to implement solutions to achieve such integration and the extent to which statutory changes are required to achieve such integration.

(3) CONTENTS.—The evaluation under paragraph (1) and report under paragraph (2) shall address—

(A) the integration of patient health information regarding care provided to patients in field EMS into each patient's electronic health care record;

(B) the bi-directional integration and data sharing among providers and entities providing patient care related to performance measures as part of quality initiatives;

(C) the means by which to achieve contemporaneous field EMS practitioner access to a patient's medical record without regard to phys-

ical location while preparing to provide or providing care to that patient in the field, for the purpose of enhancing care delivery and populating the electronic health care record in real time; and

(D) incorporation of patient health information created subsequent to the receipt of field EMS care into the National EMS Information System, taking into consideration—

(i) the types of medical information created subsequent to the receipt of field EMS emergency care (such as outcomes information or information regarding subsequent care and treatment) that would, if included in the National EMS Information System, be potentially useful in evaluating and improving the quality of EMS care;

(ii) how best to integrate such information into the National EMS Information System;

(iii) potential modifications to the Health Information Technology for Economic and Clinical Health Act (title XIII of division A and title IV of division B of Public Law 111–5) to require eligible hos-

pitals (as defined in section 1886(n)(6)(B) of the Social Security Act (42 U.S.C. 1395ww(n)(6)(B))) to develop or report relevant data to the National EMS Information System or other appropriate State or private registries for the purpose of determining whether such a hospital shall be—

(I) subject to a reduction in the applicable percentage increase otherwise applicable to such hospital under section 1886(b)(3)(B)(ix) of such Act; or

(II) eligible for an incentive payment under section 1886(n) of such Act;

(iv) potential modifications to the Medicare and Medicaid programs under titles XVIII and XIX, respectively, of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) or other Federal health programs to provide appropriate reimbursement and financial incentives for field EMS agencies to develop or report relevant data to the National EMS Information

System or other appropriate State or private registries; and

(v) any other changes to improve integration of patient health information across the continuum of emergency medical care and bidirectional integration and data sharing related to performance measures that the Secretary has authority to implement or that requires a statutory change by Congress to enable the Secretary such authority to implement.

SEC. 6. CLARIFICATION OF LEADERSHIP RESPONSIBILITY FOR ROUTINE EMERGENCY MEDICAL CARE.

(a) IN GENERAL.—Pursuant to the designation of the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') under section 2801 of the Public Health Service Act (42 U.S.C. 300hh) to lead all Federal public health and medical response to public health emergencies and incidents under the National Response Plan (developed pursuant to section 504(a)(6) of the Homeland Security Act of 2002), and pursuant to the Secretary's responsibility for administration of titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.; 1397aa et seq.), such leadership responsibilities shall be construed to include the

provision of routine emergency medical care across the full continuum of such care provided (including field EMS (as defined in section 1291 of the Public Health Service Act (as added by section 4)), trauma, and hospital emergency medical care) as a necessary prerequisite to ensure the adequacy of such response to public health emergencies and incidents under the National Response Plan and the integration and provision of emergency medical care provided to beneficiaries of such titles of the Social Security Act.

(b) EMERGENCY MEDICAL CARE SYSTEM.—In accordance with subsection (a), the Secretary shall be responsible for—

(1) improving the emergency medical care system providing routine emergency medical care to patients with emergency medical conditions to enhance the capacity of the existing public health and emergency medical system to prepare for and sustain such public health and medical response to public health emergencies and incidents; and

(2) the quality, innovation, and cost-effectiveness of field EMS, including such services provided to individuals who are beneficiaries of the Medicare, Medicaid or State Children's Health Insurance Program under titles XVIII, XIX, and XXI, respectively

of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.; 1397aa et seq.).

SEC. 7. ENHANCING EVIDENCE-BASED CARE IN FIELD EMS.

(a) FIELD EMS EMERGENCY MEDICAL RESEARCH.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall undertake a comprehensive evaluation of the extent to which research and evaluation relating to field EMS is conducted by the National Institutes of Health, the Agency for Healthcare Research Quality, the Center for Medicare & Medicaid Innovation, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Patient-Centered Outcomes Research Institute, and any other agencies or departments within the Department of Health and Human Services, as the Secretary determines appropriate.

(2) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that includes—

(A) information related to the extent of federally sponsored research in field EMS;

(B) identification of any impediments to enhancing research in emergency medicine to improve patient outcomes; and

(C) opportunities to enhance such research within existing funding levels.

(3) DEFINITION.—In this subsection, the term ''field EMS'' has the meaning given such term in section 1291 of the Public Health Service Act, as added by section 4.

(b) FIELD EMS CENTER OF EXCELLENCE.—Subpart II of part D of title IX of the Public Health Service Act (42 U.S.C. 299b–33 et seq.) is amended by adding at the end the following:

''SEC. 938. FIELD EMS CENTER OF EXCELLENCE.

''(a) ESTABLISHMENT.—The Director shall establish within the Office of Planning, Research & Evaluation a Field EMS Evidence-Based Center of Excellence (referred to in this section as the 'Center').

''(b) PURPOSE.—The purpose of the Center is to conduct or support research to promote the highest quality of emergency medical care in field EMS and the most effective delivery system for the provision of such care, including—

''(1) comparative safety and effectiveness research, especially with regard to the highest cost and

most prevalent emergency medical conditions with the greatest opportunity to improve patient outcomes and lower costs by care provided in the field;

''(2) other appropriate clinical or systems research on the effectiveness of existing and potential treatments provided in the field that translate into improved quality, outcomes, and patient satisfaction;

''(3) specific research topics designed to save lives, lower costs, and improve outcomes for patients with emergency medical conditions, including—

''(A) the clinical value and benefit of critical care ground and air transport, including the potential for bidirectional care that fills gaps in rural and other underserved geographic regions, especially where hospitals have closed;

''(B) the application of lessons learned in military field medicine in the delivery of emergency medical care in field EMS;

''(C) the ability to intervene clinically in the early onset of an emergency medical condition that will improve patient outcomes;

''(D) specific treatment modalities and protocols that are cost-effective and produce better outcomes, such as 12-lead electrocardiograms and continuous positive airway pressure; and

''(E) medical conditions most conducive to regionalization of emergency care that will be most effective in improving service delivery, outcomes, and cost-effectiveness; and

''(4) support research being conducted by academic medical centers, particularly those with centers of excellence formed around EMS research.

''(c) DEFINITION.—In this section, the term 'field EMS' has the meaning given such term in section 1291.''.

(c) LIMITATIONS ON CERTAIN USES OF RESEARCH.—Section 1182 of the Social Security Act (42 U.S.C. 1320e–1) is amended by striking ''section 1181'' each place it appears and inserting ''section 1181 of this Act, section 938 of the Public Health Service Act, or section 7(a) of the Field EMS Modernization and Innovation Act''.

(d) REGULATORY BARRIERS.—For the purposes of research conducted pursuant to section 1115A(b)(2)(D)(iv) of the Social Security Act (as added by section 3(a)(2)), subsection (a) of this section, section 938 of the Public Health Service Act (as added by subsection (b)), or any other research funded by the Department of Health and Human Services related to emergency medical services in the field in which informed consent is

required but may not be attainable, the Secretary of Health and Human Services shall—

(1) evaluate and consider the patient and research issues involved; and

(2) address regulatory barriers to such research related to the need for informed consent in a manner that ensures adequate patient safety and notification, and submit recommendations to Congress for any changes to Federal statutes necessary to address such barriers.

SEC. 8. EMERGENCY MEDICAL SERVICES TRUST FUND.

(a) DESIGNATION OF INCOME TAX OVERPAYMENTS AND ADDITIONAL CONTRIBUTIONS FOR EMERGENCY MEDICAL SERVICES.—Subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

"PART IX—DESIGNATION OF INCOME TAX OVERPAYMENTS AND ADDITIONAL CONTRIBUTIONS FOR EMERGENCY MEDICAL SERVICES

"Sec. 6097. Designation by individuals.

"SEC. 6097. DESIGNATION BY INDIVIDUALS.

"(a) IN GENERAL.—Every individual (other than a nonresident alien) may designate that—

"(1) a specified portion of any overpayment of tax for a taxable year, and

''(2) any amount contributed in addition to any payment of tax for such taxable year and any designation under paragraph (1),

shall be used to fund the Emergency Medical Services Trust Fund. Designations under the preceding sentence shall be in an amount not less than $1, and the Secretary shall provide for elections in amounts of $1, $5, $10, or such other amount as the taxpayer designates.

''(b) OVERPAYMENTS TREATED AS REFUNDED.—For purposes of this title, any portion of an overpayment of tax designated under subsection (a) shall be treated as—

''(1) being refunded to the taxpayer as of the last date prescribed for filing the return of tax imposed by chapter 1 (determined without regard to extensions) or, if later, the date the return is filed, and

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

''(c) MANNER AND TIME OF DESIGNATION.—A designation under subsection (a) may be made with respect to any taxable year—

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

''(2) at any other time (after the time of filing the return of the tax imposed by chapter 1 for such taxable year) specified in regulations prescribed by the Secretary.

Such designation shall be made in such manner as the Secretary prescribes by regulations except that, if such designation is made at the time of filing the return of the tax imposed by chapter 1 for such taxable year, such designation shall be made either on the first page of the return or on the page bearing the signature of the taxpayer.''.

(b) EMERGENCY MEDICAL SERVICES TRUST FUND.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

''SEC. 9512. EMERGENCY MEDICAL SERVICES TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Emergency Medical Services Trust Fund', consisting of such amounts as may be credited or paid to such trust fund as provided in subsection (b).

''(b) TRANSFERS TO TRUST FUND.—There are hereby appropriated to the Emergency Medical Services Trust Fund amounts equivalent to the amounts of the overpay-

ments of tax to which designations under section 6097 apply.

''(c) EXPENDITURES FROM TRUST FUND.—Amounts in the Emergency Medical Services Trust Fund shall be available, as provided in appropriation Acts, only for carrying out the provisions for which amounts are authorized to be appropriated under subsections (a) and (b) of section 10 of the Field EMS Innovation Act.''.

(c) CLERICAL AMENDMENTS.—

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

''PART IX. DESIGNATION OF INCOME TAX OVER-PAYMENTS AND ADDITIONAL CONTRIBUTIONS FOR EMERGENCY MEDICAL SERVICES''.

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

''Sec. 9512. Emergency Medical Services Trust Fund.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2015.

SEC. 9. GAO STUDY TO IDENTIFY IMPEDIMENTS TO QUALITY IMPROVEMENT IN FIELD EMS.

(a) IN GENERAL.—The Comptroller General of the United States shall complete a study on impediments to

the ability of field EMS practitioners, physician medical directors, and agencies to improve the quality of medical care provided to patients including—

(1) medical and administrative liability issues that may impede—

(A) medical oversight provided by physicians directly regarding specific patients and medical oversight provided by physicians in establishing medical protocols, procedures, and other activities related to the provision of emergency medical care in field EMS; and

(B) the highest quality emergency medical care in field EMS provided by personnel other than physicians, such as emergency medical technicians and paramedics;

(2) the types and levels of reimbursement necessary to ensure the highest quality of care overseen by physician medical directors, including—

(A) the actual costs of all components of medical oversight in high-performing EMS systems with demonstrated improvement in outcomes, such as those evidenced by cardiac rates and traumatic injury survival rates;

(B) the costs of medical oversight for part-time or volunteer medical directors;

(C) recommended payment model options for medical oversight that will enhance quality of care; and

(D) the sufficiency, or lack of sufficiency, of reimbursement under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to providers and suppliers of ambulance services to enable high-quality and appropriate medical oversight;

(3) issues that may adversely impact the ability of field EMS practitioners to deliver high-quality care including—

(A) issues affecting the direct patient care provided by field EMS practitioners such as personal and patient safety, fatigue, and training; and

(B) issues affecting the ability to recruit and maintain a highly qualified field EMS practitioner workforce such as salary, hours, and benefits; and

(4) such other issues as the Comptroller General determines appropriate relating to improving the quality and medical oversight of emergency medical care in field EMS.

(b) REPORT TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall complete the study under subsection (a) and submit a report to Congress on the results of such study, including any recommendations.

(c) DEFINITIONS.—In this subsection, the terms ''emergency medical care'' and ''field EMS'' have the meanings given such terms in section 1291 of the Public Health Service Act (as added by section 4).

SEC. 10. FUNDING.

(a) IN GENERAL.—Out of amounts in the Emergency Medical Services Trust Fund, there are authorized to be transferred to the Secretary of Health and Human Services—

(1) $12,000,000 for each of fiscal years 2016 through 2021, for the purpose of carrying out the additional duties required under part I of the Public Health Service Act (as added by section 4);

(2) $200,000,000 for each of fiscal years 2016 through 2021, for the purpose of carrying out section 1292 of the Public Health Service Act, as added by section 4;

(3) $15,000,000 for each of fiscal years 2016 through 2021, for the purpose of carrying out sec-

tion 1295 of the Public Health Service Act, as added by section 4;

(4) $40,000,000 for each of fiscal years 2016 through 2021, for the purpose of carrying out section 7(a) of this Act and 938 of the Public Health Service Act, as added by section 7(b); and

(5) $4,000,000 for each of fiscal years 2016 through 2021, for the purpose of carrying out section 3001(c)(9) of the Public Health Service Act with respect to the National EMS Information System, as added by section 5(a)(2).

(b) EXCESS AMOUNTS.—If, for any fiscal year, amounts in the Emergency Medical Services Trust Fund exceed the maximum amount authorized to be transferred under subsection (a), the Secretary of Health and Human Services may transfer such excess amounts for the purpose of carrying out section 330J, section 498D, section 7(a), and parts A, B, C, D, and H of title XII of the Public Health Service Act (42 U.S.C. 254c–15, 289g–4, 300d et seq., 300d–11 et seq., 300d–31 et seq., and 300d–81 et seq.).

(c) START-UP FUNDING.—

(1) IN GENERAL.—Out of the discretionary funds available to the Secretary of Health and Human Services for each of fiscal years 2016 and

2017, up to $40,000,000 may be used for carrying out the amendments made by sections 3 and 4.

(2) RELATION TO OTHER FUNDS.—The amount of discretionary funds allocated under paragraph (1) shall be in addition to, not in lieu of, the amount of discretionary funds that would otherwise be available for such purposes.

(d) ADMINISTRATIVE EXPENSES.—Not more than 5 percent of each amount made available under paragraphs (1) through (5) of subsection (a) may be used for administrative expenses.

SEC. 11. STATUTORY CONSTRUCTION.

Nothing in this Act, including the amendments made by this Act, shall be construed to supersede any statutory authority of any Federal agency that is not within the Department of Health and Human Services.

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