

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

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 Modernization and Innovation Act”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

Sec. 3. Aligning ambulance reimbursement with value-based and high-quality field EMS.

- Sec. 4. Field emergency medical services.
- Sec. 5. Integration of field EMS into the National Health Information Infrastructure.
- Sec. 6. Clarification of leadership responsibility for routine emergency medical care.
- Sec. 7. Enhancing evidence-based care in field EMS.
- Sec. 8. Emergency medical services trust fund.
- Sec. 9. GAO study to identify impediments to quality improvement in field EMS.
- Sec. 10. Funding.
- Sec. 11. Statutory construction.

1 **SEC. 2. FINDINGS.**

2 Congress finds the following:

3 (1) Patients with emergency medical conditions
4 depend upon field emergency medical services (re-
5 ferred to in this section as “EMS”) for essential life-
6 saving or unscheduled medical care. All people in the
7 United States should have access to and receive
8 high-quality emergency medical care as part of a co-
9 ordinated EMS system.

10 (2) The Institute of Medicine, in its 2006 re-
11 port “Emergency Medical Services at the Cross-
12 roads”, outlined its vision of a 21st century emer-
13 gency care system that is integrated, regionalized,
14 accountable, and prepared for both routine emer-
15 gency medical care and public health emergencies.
16 Such a modernized system would be characterized by
17 a highly trained and capable field EMS practitioner
18 workforce that delivers high-quality, evidence-based,
19 innovative, value-based, and patient-centered emer-

1 agency care in the field and across the emergency
2 care continuum.

3 (3) In such 2006 report, the Institute of Medi-
4 cine also outlined systemic problems plaguing field
5 EMS that impede achievement of a 21st century
6 emergency care system, including insufficient coordi-
7 nation, disparate response times, uncertain quality
8 of care, lack of readiness for disasters, divided pro-
9 fessional identity of field EMS practitioners, and a
10 limited evidence base for the emergency medical care
11 provided in the field.

12 (4) To modernize the field EMS system, the In-
13 stitute of Medicine recommended that advancements
14 be made in several priority areas, including readi-
15 ness, innovation, preparedness, education and work-
16 force development, safety, financing, quality, stand-
17 ards, and research. The Institutes of Medicine also
18 recommended recognition of a lead programmatic
19 Federal agency for emergency medical services with-
20 in the Department of Health and Human Services to
21 provide a more streamlined, cost-efficient, and com-
22 prehensive approach for field EMS, and a focal point
23 for practitioners and agencies to interface with the
24 Federal Government.

1 (5) Under an amendment made by the Pan-
2 demic and All-Hazards Preparedness Act (Public
3 Law 109–417), the Secretary of Health and Human
4 Services is already established as the lead of all Fed-
5 eral public health and medical response for public
6 health emergencies and incidents. Preparedness and
7 capability to deliver routine emergency medical care
8 is a prerequisite for preparedness and capability to
9 respond to public health emergencies and incidents.

10 (6) In 2007, the Homeland Security Presi-
11 dential Directive HSPD–21 called for the establish-
12 ment within the Department of Health and Human
13 Services of an Office for Emergency Medical Care to
14 lead an enterprise to promote and fund research in
15 emergency medicine and trauma care; promote re-
16 gional partnerships and more effective emergency
17 medical systems in order to enhance appropriate
18 triage, distribution, and care of routine community
19 patients; and promote local, regional, and State
20 emergency medical systems’ preparedness for and
21 response to public health events. Under the Direc-
22 tive, the Office would address the full spectrum of
23 issues that have an impact on care in hospital emer-
24 gency departments, including the entire continuum

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

3 (7) Properly functioning EMS systems encom-
4 pass fully mobile resources that are able to address
5 patient needs 24 hours per day, 7 days per week,
6 365 days a year. Field EMS serves as an essential
7 health care safety net by providing emergency, ur-
8 gent, and mobile medical care throughout the health
9 care continuum, including medical and trauma care
10 provided in the field, hospital, rehabilitation, and
11 other settings. Ensuring high-quality and cost-effec-
12 tive emergency medical services systems requires
13 readiness, preparedness, medical oversight, and inno-
14 vation throughout the continuum of emergency med-
15 ical care through Federal, State, and local multi-ju-
16 risdictional collaboration and sufficient resources for
17 EMS agencies and practitioners.

18 (8) Field EMS is the delivery of health care,
19 not simply a transportation benefit having evolved
20 from a patient transport model to a health care serv-
21 ice delivery model that provides a variety of targeted
22 medical services to meet the specific needs of their
23 communities. This includes the development of com-
24 munity paramedicine as a health care service pro-
25 vided by field EMS agencies and mobile integrated

1 health care as a health care service provided collabo-
2 ratively by a group of health care providers in a
3 community, including local field EMS agencies.
4 These new delivery models are filling gaps in patient
5 care identified by a community's health care pro-
6 viders, including preventing recurrent medical epi-
7 sodes through reliable post-discharge follow up and
8 chronic disease management. Facilitating reimburse-
9 ment for such services, including under the Medicare
10 program under title XVIII of the Social Security Act
11 (42 U.S.C. 1395 et seq.), is necessary to the contin-
12 ued development and sustainability of such services.

13 (9) Field EMS is uniquely positioned to support
14 the transformation of health care to a value and out-
15 comes based model to improve the patient experience
16 and the health of populations, and to reduce the per
17 capita cost of health care. Field EMS provides high-
18 ly reliable patient assessment and intervention at
19 any hour of any day in response to urgent or un-
20 scheduled episodes of illness or injury and effectively
21 navigates patients to ensure they receive the right
22 care, in the right place, and at the right time. Field
23 EMS helps contain health care costs by navigating
24 the patient down a cost-effective pathway that is evi-
25 dence-based.

1 (10) 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
5 every day and during catastrophic incidents. To en-
6 sure disaster and all-hazards preparedness for field
7 EMS operations as part of the Nation’s comprehen-
8 sive disaster preparedness, Federal funding for pre-
9 paredness activities, including catastrophic training
10 and exercises, must be provided to governmental and
11 nongovernmental field EMS agencies to ensure a
12 greater capability within each of these areas.

13 (11) The essential role of field EMS in disaster
14 preparedness and response must be incorporated
15 into the national preparedness and response strategy
16 and implementation as provided and overseen by the
17 Department of Homeland Security and the Depart-
18 ment of Health and Human Services, pursuant to
19 their respective jurisdictions. Field EMS agencies
20 must be capable of meeting the routine emergency
21 care needs of patients to be capable of meeting the
22 extraordinary medical needs during a catastrophic
23 event.

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

4 (a) **FIELD EMS MEDICARE DEMONSTRATION PRO-**
5 **GRAM.**—Section 1115A(b)(2) of the Social Security Act
6 (42 U.S.C. 1315a(b)(2)) is amended—

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

10 (2) by adding at the end the following new sub-
11 paragraph:

12 “(D) **DEMONSTRATION PROJECTS.**—

13 “(i) **IN GENERAL.**—The model de-
14 scribed in this subparagraph is a dem-
15 onstration program under title XVIII. Be-
16 ginning not later than 2 years after the
17 date of the enactment of the Field EMS
18 Modernization and Innovation Act, the
19 CMI shall conduct not less than 10 dem-
20 onstration projects to—

21 “(I) evaluate the implementation
22 and reimbursement of alternative dis-
23 positions of field EMS patients, in-
24 cluding—

25 “(aa) transporting individ-
26 uals by ambulance to alternate

1 destinations when medically ap-
2 propriate and in the individual’s
3 best interests;

4 “(bb) when medically nec-
5 essary, evaluating, treating, or
6 referring individuals to other
7 medically appropriate providers;
8 and

9 “(cc) when medically appro-
10 priate, treating individuals
11 through community paramedicine
12 or mobile integrated healthcare
13 services;

14 “(II) evaluate the implementation
15 of alternative reimbursement models,
16 including models based on readiness
17 rather than transport or shared sav-
18 ings; and

19 “(III) determine whether such al-
20 ternative dispositions and reimburse-
21 ment models—

22 “(aa) improve the safety, ef-
23 fectiveness, timeliness, and effi-
24 ciency of emergency medical serv-
25 ices; and

1 “(bb) reduce overall utiliza-
2 tion and expenditures under title
3 XVIII.

4 “(ii) EVIDENCE-BASED PROTOCOLS.—
5 The CMI shall ensure that at least one
6 demonstration project under this subpara-
7 graph evaluates evidence-based protocols
8 that give guidance on selection of the des-
9 tination to which individuals are trans-
10 ported.

11 “(iii) DURATION.—The duration of a
12 demonstration project under this subpara-
13 graph shall not exceed 3 years.

14 “(iv) RESEARCH.—The Secretary
15 shall conduct or support further research
16 that the Secretary determines to be nec-
17 essary prior to, or in conjunction with, the
18 demonstration projects under this subpara-
19 graph in order to evaluate the implementa-
20 tion of alternative dispositions of, and re-
21 imbursement models for transport of, field
22 EMS patients.

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

1 paragraph, the Secretary shall include in
2 the annual report to Congress required
3 under subsection (g) a report on the re-
4 sults of the projects conducted under this
5 subparagraph, including information about
6 the efficacy of alternative disposition of,
7 and reimbursement models for transport
8 of, field EMS patients.

9 “(vi) DEFINITION OF FIELD EMS.—In
10 this subparagraph, the terms ‘community
11 paramedicine’, ‘field EMS’, ‘mobile inte-
12 grated healthcare’, and ‘readiness’ shall
13 have the meanings given such terms in sec-
14 tion 1291 of the Public Health Service
15 Act.”.

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

20 “(16) FIELD EMS ALTERNATIVE DELIVERY
21 PROGRAM.—

22 “(A) IN GENERAL.—Not later than 3 years
23 after the date of the enactment of this para-
24 graph, the Secretary shall establish the Field
25 EMS Alternative Delivery Program to establish

1 and promote the utilization of innovative pay-
2 ment models, including the models described in
3 subparagraph (D), on a shared savings and vol-
4 untary basis, taking into consideration the re-
5 sults of the evaluation of models under subpara-
6 graph (G) and the demonstration projects con-
7 ducted under section 1115A(b)(2)(D). To the
8 extent that the Secretary ascertains that an in-
9 novative payment model has been sufficiently
10 demonstrated through the private sector or
11 through the Center for Medicare and Medicaid
12 Innovation under section 1115A and does not
13 need to be evaluated under subparagraph (G),
14 the Secretary may establish such innovative
15 payment model on a shared savings and budget
16 neutral basis pursuant to this subparagraph.

17 “(B) VOLUNTARY NATURE OF PARTICIPA-
18 TION.—Providers and suppliers of ground am-
19 bulance services may voluntarily opt to utilize
20 innovative payment models under the Field
21 EMS Alternative Delivery Program. Nothing in
22 this subparagraph shall be construed as author-
23 izing the Secretary to require participation in
24 any innovative payment model under the Pro-
25 gram.

1 “(C) BUDGET NEUTRALITY.—The Sec-
2 retary shall implement the innovative payment
3 models under this subparagraph in a budget
4 neutral manner such that the cost of implemen-
5 tation of such models shall not exceed the
6 amount that otherwise would have been pro-
7 vided in reimbursement under this title if such
8 models had not been implemented.

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

11 “(i) Community paramedicine that al-
12 lows for payment for health care assess-
13 ment and prevention services, or other care
14 management services.

15 “(ii) Mobile integrated healthcare
16 services that allow for health care assess-
17 ment and prevention services, or other care
18 management services within an integrated
19 program of patient care.

20 “(iii) Alternate patient dispositions re-
21 gardless of transport to the hospital, in-
22 cluding transport to alternate destinations
23 and other patient dispositions such as
24 treating and referring patients to appro-
25 priate follow up care. Such alternate dis-

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

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

9 “(v) Prevention-based models, such as
10 injury prevention through home evalua-
11 tions for fall prevention or infection con-
12 trol.

13 “(vi) Critical care models, particularly
14 in geographic areas without proximate ac-
15 cess to hospital-based critical care, and in-
16 cluding a model that enables patient sta-
17 bilization by critical care transport teams
18 with telemedicine support for maintaining
19 the patient in the patient’s community.

20 “(vii) Any other innovative shared
21 savings model the Secretary determines
22 relevant pursuant to subparagraph (G).

23 “(E) QUALITY REPORTING.—As a condi-
24 tion of participation in the Field EMS Alter-
25 native Delivery Program, providers and sup-

1 pliers of ground ambulance services shall par-
2 ticipate in the Ambulance Quality Incentive
3 Program described in paragraph (17).

4 “(F) MEDICAL OVERSIGHT.—The Sec-
5 retary shall specify and require appropriate
6 medical oversight with regard to the develop-
7 ment, demonstration, and implementation of in-
8 novative payment models under this paragraph
9 to ensure high-quality care and patient safety.

10 “(G) DEVELOPMENT AND EVALUATION OF
11 MODELS.—

12 “(i) IN GENERAL.—The Secretary, in
13 consultation with the Assistant Secretary
14 for Preparedness and Response and taking
15 into consideration the recommendations of
16 the National EMS Advisory Council and
17 the Federal Interagency Committee on
18 EMS, shall undertake the development and
19 evaluation of innovative models of field
20 EMS delivery and reimbursement.

21 “(ii) EVALUATION OF INNOVATIVE
22 MODEL OPTIONS.—

23 “(I) IN GENERAL.—Not later
24 than 1 year after the date of the en-
25 actment of the Field EMS Moderniza-

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

3 “(aa) the provision of and
4 reimbursement for alternative de-
5 livery models for medical care
6 through field EMS; and

7 “(bb) the integration of field
8 EMS patients with other medical
9 providers and facilities as medi-
10 cally appropriate.

11 “(II) CONSIDERATIONS.—In
12 completing the evaluation under sub-
13 clause (I), the Secretary shall consider
14 the following:

15 “(aa) Alternative disposi-
16 tions of patients, including—

17 “(AA) transporting in-
18 dividuals by ambulance to
19 destinations other than a
20 hospital, such as the office
21 of the physician of the indi-
22 vidual, an urgent care cen-
23 ter, or the facility of another
24 health care provider;

1 “(BB) when medically
2 necessary, the evaluation,
3 treatment, or referral of in-
4 dividuals to other medically
5 appropriate health care pro-
6 viders;

7 “(CC) the provision of
8 medical care regardless of
9 the decision to transport,
10 such as reimbursement mod-
11 els based on readiness rath-
12 er than transport and
13 shared savings; and

14 “(DD) the provision of
15 health care using patient-
16 centered mobile resources in
17 the out-of-hospital environ-
18 ment, such as community
19 paramedicine and mobile-in-
20 tegrated health care serv-
21 ices.

22 “(bb) Issues related to med-
23 ical liability and the requirements
24 of section 1867 (commonly re-
25 ferred to as ‘EMTALA’) associ-

1 ated with transport to destina-
2 tions other than a hospital emer-
3 gency department.

4 “(cc) Necessary protections
5 to ensure that patients receive
6 timely and appropriate care in
7 the appropriate setting, including
8 ongoing quality improvement and
9 appropriate physician medical
10 oversight.

11 “(dd) Whether there are any
12 barriers to providing alternate
13 dispositions to individuals who
14 are not in need of hospital-based
15 care.

16 “(ee) Other reimbursement
17 related issues that span multiple
18 delivery models including the cost
19 of demonstrated evidence-based
20 care, such as 12-lead electro-
21 cardiograms and continuous posi-
22 tive airway pressure, early rec-
23 ognition of time dependent dis-
24 eases, such as stroke and sepsis,
25 and trauma, and providing high-

1 quality appropriate physician
2 medical oversight.

3 “(ff) Other issues, as deter-
4 mined by the Secretary, includ-
5 ing, when practicable, issues rec-
6 ommended by the Assistant Sec-
7 retary for Preparedness and Re-
8 sponse, the National EMS Advi-
9 sory Council, and the Federal
10 Interagency Committee on EMS
11 for evaluation under this sub-
12 paragraph.

13 “(H) DEFINITIONS.—In this paragraph,
14 the terms ‘community paramedicine’, ‘field
15 EMS’, ‘medical oversight’, and ‘mobile inte-
16 grated healthcare’ have the meanings given
17 such terms in section 1291 of the Public Health
18 Service Act.”.

19 (c) AMBULANCE QUALITY INCENTIVE PROGRAM.—
20 Section 1834(l) of the Social Security Act (42 U.S.C.
21 1395m(l)), as amended by subsection (a), is further
22 amended by adding at the end the following new para-
23 graph:

24 “(17) AMBULANCE QUALITY INCENTIVE PRO-
25 GRAM.—

1 “(A) IN GENERAL.—Not later than Janu-
2 ary 1 of the first fiscal year that begins on or
3 after the date that is 3 years after the date of
4 the enactment of this paragraph, the Secretary
5 shall establish an Ambulance Quality Incentive
6 Program under which providers and suppliers
7 of ground ambulance services under this sub-
8 section may receive incentive payments from the
9 amount made available under subparagraph (F)
10 for reporting on the quality measures identified
11 by the Secretary under subparagraph (B).

12 “(B) QUALITY MEASURES.—

13 “(i) IN GENERAL.—The Secretary
14 shall, by regulation, identify quality meas-
15 ures that have been endorsed by the entity
16 with a contract under section 1890(a).
17 Such measures shall include outcome and
18 patient safety measures and be relevant to
19 the provision of field emergency medical
20 response and mobile medical care.

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

1 under section 1890(a), the Secretary may
2 specify a measure that is not so endorsed
3 as long as due consideration is given to
4 measures that have been endorsed or
5 adopted by a consensus organization iden-
6 tified by the Secretary.

7 “(iii) REVISING QUALITY MEAS-
8 URES.—Subject to clause (iv), the Sec-
9 retary may, by regulation, revise quality
10 measures identified under this paragraph
11 on an annual basis.

12 “(iv) TIMEFRAME.—The Secretary
13 shall publish the quality measures that will
14 apply to a fiscal year not later than Janu-
15 ary 1 of the preceding fiscal year.

16 “(C) VOLUNTARY NATURE OF REPORT-
17 ING.—Participation in the Ambulance Quality
18 Incentive Program is voluntary for providers
19 and suppliers electing not to participate in the
20 Field EMS Alternative Delivery Program.

21 “(D) CONSULTATION.—In carrying out the
22 provisions of this paragraph (including in devel-
23 oping and revising the quality measures identi-
24 fied in subparagraph (B)), the Secretary
25 shall—

1 “(i) solicit the input of relevant stake-
2 holders;

3 “(ii) use the notice and comment pro-
4 cedures provided in section 553 of title 5,
5 United States Code; and

6 “(iii) take into account prior invest-
7 ments in technology systems to enable par-
8 ticipation in the program with minimal ad-
9 ditional capital investments.

10 “(E) PUBLIC AVAILABILITY OF DATA SUB-
11 MITTED.—The Secretary shall establish proce-
12 dures for making data submitted under this
13 paragraph available to the public on the website
14 of the Centers for Medicare & Medicaid Serv-
15 ices. Such procedures shall ensure that a sup-
16 plier or provider has the opportunity to review
17 the data that is to be made public with respect
18 to the supplier or provider prior to such data
19 being made public.

20 “(F) BUDGET NEUTRAL FUNDING.—

21 “(i) IN GENERAL.—The amount avail-
22 able for making payments under this para-
23 graph for any fiscal year shall be equal to
24 the amount of savings for the preceding
25 fiscal year resulting from the Field EMS

1 Alternative Delivery Program described in
2 paragraph (16), as determined by the Sec-
3 retary.

4 “(ii) PRIORITY FOR PARTICIPANTS IN
5 FIELD EMS ALTERNATIVE DELIVERY PRO-
6 GRAM.—To the extent that funds are avail-
7 able for making payments under this para-
8 graph for a fiscal year, the Secretary shall
9 ensure that—

10 “(I) providers and suppliers who
11 participated in the program estab-
12 lished under paragraph (16) in the
13 preceding fiscal year are paid before
14 other providers and suppliers; and

15 “(II) providers and suppliers who
16 did not participate in the program es-
17 tablished under paragraph (16) in the
18 preceding fiscal year may only receive
19 payments if there are any funds re-
20 maining after the application of sub-
21 clause (I).”.

22 **SEC. 4. FIELD EMERGENCY MEDICAL SERVICES.**

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

1 **“PART I—FIELD EMERGENCY MEDICAL SERVICES**

2 **“SEC. 1291. DEFINITIONS.**

3 “In this part:

4 “(1) The term ‘ambulance diversion’ means the
5 practice of hospitals denying access to an incoming
6 ambulance and requesting that the ambulance pro-
7 ceed to another facility due to a stated lack of ca-
8 pacity at the initial facility, resulting in delayed ac-
9 cess to definitive care.

10 “(2) The term ‘community paramedicine’ means
11 a health care service provided by a field EMS agency
12 for the provision of cost-effective health care assess-
13 ment and prevention services to fill gaps in the local
14 health care system.

15 “(3) The term ‘emergency medical response’
16 means—

17 “(A) medical care provided to patients with
18 emergency medical conditions prior to or out-
19 side a medical facility;

20 “(B) emergency medical dispatch, rapid re-
21 sponse, and urgent or unscheduled patient as-
22 sessment and intervention;

23 “(C) emergency, critical care, and inter-fa-
24 cility and air medical transport; or

25 “(D) telephone consultation to 911 callers
26 as an alternative to ambulance dispatch, or

1 other requests through a public safety answer-
2 ing point.

3 “(4) The term ‘emergency medical services’
4 means emergency medical care, trauma care, and re-
5 lated services provided to patients at any point in
6 the continuum of health care services, including
7 emergency medical dispatch and emergency medical
8 care, trauma care, and related services provided in
9 the field, during transport, or in a medical facility
10 or other clinical setting.

11 “(5) The term ‘FICEEMS’ means the Federal
12 Interagency Committee on Emergency Medical Serv-
13 ices.

14 “(6) The term ‘field EMS’ means emergency
15 medical response and mobile medical services pro-
16 vided prior to or outside a medical facility.

17 “(7) The term ‘field EMS agency’ means an or-
18 ganization providing field EMS, including—

19 “(A) governmental (including fire-based
20 agencies), nongovernmental (including hospital
21 based or private agencies), and volunteer orga-
22 nizations; and

23 “(B) organizations that provide field EMS
24 by ground, air, or otherwise.

1 “(8) The term ‘field EMS practitioner’ means
2 an individual licensed and credentialed to provide
3 emergency and mobile medical care to patients with-
4 in the scope of such individual’s practice.

5 “(9) The term ‘medical oversight’ means the
6 supervision by a physician of the medical aspects of
7 a field EMS system or agency and its practitioners,
8 including prospective, concurrent, and respective
9 components of field EMS and the education of field
10 EMS practitioners.

11 “(10) The term ‘mobile integrated health care’
12 means a health care service that is undertaken col-
13 laboratively by a group of health care providers, in-
14 cluding the local field EMS agency, in a community,
15 for the provision of medical care to fill gaps in the
16 local health care system.

17 “(11) The term ‘mobile medical services’ means
18 preventive medical assessment and care, chronic dis-
19 ease assessment and management support, post-dis-
20 charge follow-up assessment and management sup-
21 port, and post-assessment patient transport, ar-
22 ranged transportation, or referral to other commu-
23 nity health or social service resources.

24 “(12) The term ‘NEMSAC’ means the National
25 Emergency Medical Services Advisory Council.

1 “(13) The term ‘NEMESIS’ means the National
2 EMS Information System.

3 “(14) The term ‘NHTSA’ means the National
4 Highway Traffic Safety Administration.

5 “(15) The term ‘patient parking’ means the
6 practice by hospitals of refusing to accept transfer
7 of a patient’s care from an ambulance crew until a
8 regular emergency department bed is available, re-
9 quiring the crew to continue to provide patient care
10 on the ambulance stretcher rather than in a patient
11 bed in the hospital, until hospital staff will accept
12 the transfer of care, resulting in delayed access to
13 definitive care for the patient and denied access to
14 emergency care for the community served by the
15 field EMS Agency.

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

20 “(17) The term ‘State EMS Office’ means an
21 office designated by the State with primary responsi-
22 bility for oversight of the State’s emergency medical
23 services system, such as responsibility for oversight
24 of field EMS coordination, licensing or certifying

1 field EMS practitioners, and emergency medical
2 services system improvement.

3 **“SEC. 1292. FIELD EMS PREPAREDNESS FOR PUBLIC**
4 **HEALTH EMERGENCIES AND OTHER INCI-**
5 **DENTS.**

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

12 “(b) APPLICATION.—

13 “(1) IN GENERAL.—To be eligible to receive a
14 grant under this section, an eligible entity shall sub-
15 mit an application to the Assistant Secretary for
16 Preparedness and Response in such form and man-
17 ner, and containing such agreements, assurances,
18 and information as such Assistant Secretary re-
19 quires.

20 “(2) SIMPLE FORM.—The Assistant Secretary
21 for Preparedness and Response shall ensure that
22 grant application requirements are not unduly bur-
23 densome to smaller and volunteer field EMS agen-
24 cies or other agencies with limited resources.

1 “(3) CONSISTENCY WITH PREPARATION
2 GOALS.—The Assistant Secretary for Preparedness
3 and Response shall ensure that grant applications
4 are consistent with national and relevant State pre-
5 paredness plans and goals.

6 “(c) USE OF FUNDS.—Grants may be used by eligible
7 entities to achieve the preparedness goals described under
8 paragraphs (1), (3), (4), (5), (6), and (8) of section
9 2802(b) with respect to all-hazards, including chemical, bi-
10 ological, radiological, or nuclear threats, including the pur-
11 chase of equipment, training, and supplies.

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

15 “(1) shall establish a grantmaking process that
16 includes—

17 “(A) prioritization for the awarding of
18 grants to eligible entities and consideration of
19 the factors in reviewing grant applications by
20 eligible entities, including—

21 “(i) demonstrated financial need for
22 funding;

23 “(ii) utilization of public and private
24 partnerships;

1 “(iii) improving the availability of
2 field EMS in underserved regions to en-
3 hance the capability for medical response
4 to public health emergencies and incidents;

5 “(iv) unique needs of volunteer and
6 rural field EMS agencies;

7 “(v) distribution among a variety of
8 geographic areas, including urban, subur-
9 ban, and rural;

10 “(vi) distribution of funds among
11 types of field EMS agencies, including gov-
12 ernmental, nongovernmental, and volunteer
13 agencies;

14 “(vii) implementation of regionalized
15 systems of medical response to public
16 health emergencies and incidents; and

17 “(viii) such other factors as the As-
18 sistant Secretary for Preparedness and Re-
19 sponse determines necessary;

20 “(B) a peer-reviewed process to rec-
21 ommend grant allocations in accordance with
22 the prioritization established under subpara-
23 graph (A), except that final award determina-
24 tions shall be made by the Assistant Secretary
25 for Preparedness and Response; and

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

8 “(2) shall consult with and take into consider-
9 ation the recommendations of the FICEMS,
10 NEMSAC, and relevant stakeholders.

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

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

16 “(2) has medical oversight and quality improve-
17 ment programs, as determined by the Assistant Sec-
18 retary for Preparedness and Response.

19 “(f) REQUIRED USE OF MEDICAL OVERSIGHT
20 GUIDELINES.—As a condition on receipt of a grant under
21 this section, the Assistant Secretary for Preparedness and
22 Response shall require each grant recipient to adopt and
23 implement (to the extent applicable) the guidelines pro-
24 moted, developed, and disseminated under subparagraphs

1 (B) and (C) of subsection (a)(1) of section 1293 with re-
2 gard to medical oversight.

3 “(g) ANNUAL REPORT.—The Assistant Secretary for
4 Preparedness and Response shall submit an annual report
5 on the Field EMS Preparedness Program under this sec-
6 tion to Congress.

7 **“SEC. 1293. FIELD EMS QUALITY IMPROVEMENT.**

8 “(a) ENHANCING PHYSICIAN MEDICAL OVER-
9 SIGHT.—

10 “(1) IN GENERAL.—To improve medical over-
11 sight of field EMS and ensure continuity and quality
12 for such medical oversight, the Assistant Secretary
13 for Preparedness and Response shall—

14 “(A) promote high-quality and comprehen-
15 sive medical oversight of—

16 “(i) all medical care provided by field
17 EMS practitioners; and

18 “(ii) the education and training of
19 field EMS practitioners;

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

1 “(C) support efforts of relevant physician
2 stakeholders in developing and disseminating
3 guidelines for use by field EMS medical direc-
4 tors and field EMS practitioners on a national
5 basis; and

6 “(D) convene a Field EMS Medical Over-
7 sight Advisory Committee, comprised of rep-
8 resentatives of relevant physician stakeholders,
9 to advise the Assistant Secretary for Prepared-
10 ness and Response on ways and means to ad-
11 vance and support development and mainte-
12 nance of quality medical oversight throughout
13 the Nation’s systems for field EMS.

14 “(2) ADDITIONAL CONSIDERATIONS.—In car-
15 rying out subparagraphs (B) and (C) of paragraph
16 (1), the Assistant Secretary for Preparedness and
17 Response shall take into consideration—

18 “(A) existing guidelines developed by na-
19 tional professional physician associations,
20 States, and other relevant governmental or non-
21 governmental entities;

22 “(B) the input of other relevant stake-
23 holders, including health care providers who
24 support physicians who provide medical over-
25 sight for field EMS; and

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

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

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

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

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

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

3 “(B) includes recommendations for improv-
4 ing the collection, reporting, and analysis of
5 such data, and integration of such data with
6 other health care data.

7 “(2) RECOMMENDATIONS.—The recommenda-
8 tions included in the report in accordance with para-
9 graph (1)(B) shall—

10 “(A) take into consideration the rec-
11 ommendations of FICEEMS, NEMSAC, and rel-
12 evant stakeholders;

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

18 “(C) address the quality and availability of
19 data, and linkages with existing patient reg-
20 istries, related to the provision of field EMS
21 and utilization of field EMS with respect to a
22 variety of illnesses and injuries (in both the ev-
23 eryday provision of field EMS and catastrophic
24 or disaster response), including—

1 “(i) cardiac events such as chest pain,
2 sudden cardiac arrest, and ST-segment ele-
3 vation myocardial infarction;

4 “(ii) stroke;

5 “(iii) trauma;

6 “(iv) disaster and catastrophic inci-
7 dents, such as incidents related to ter-
8 rorism or natural or manmade disasters;
9 and

10 “(v) ambulance diversion and patient
11 parking;

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

14 “(E) any recommendations that require
15 statutory authorization from Congress.

16 “(3) IMPLEMENTATION OF RECOMMENDATIONS
17 WITH EXISTING STATUTORY AUTHORITY.—The Sec-
18 retary, acting through the Office of the National Co-
19 ordinator for Health Information Technology, shall
20 implement such recommendations for data collection
21 to the extent that such authority exists and does not
22 require further statutory authorization from Con-
23 gress.

1 **“SEC. 1294. ACCOUNTABILITY FOR FIELD EMS SYSTEM PER-**
2 **FORMANCE.**

3 “(a) DEVELOPMENT OF FIELD EMS QUALITY AND
4 SYSTEM PERFORMANCE MEASURES.—The Assistant Sec-
5 retary for Preparedness and Response shall support—

6 “(1) further development and refinement of
7 measures to be utilized under the Ambulance Qual-
8 ity Incentive Program, as appropriate, including—

9 “(A) quality measures to improve account-
10 ability for patient outcomes in field EMS; and

11 “(B) performance measures to enhance the
12 measurement of field EMS system performance;
13 and

14 “(2) a technical assistance center to provide as-
15 sistance and education to field EMS agencies, physi-
16 cian medical directors, and practitioners to partici-
17 pate effectively in quality and performance improve-
18 ment programs.

19 “(b) CLARIFICATION OF HIPAA.—

20 “(1) EXCHANGE OF INFORMATION RELATED TO
21 THE TREATMENT OF PATIENTS.—

22 “(A) IN GENERAL.—Nothing in HIPAA
23 privacy and security law (as defined in section
24 3009(a)(2)) shall be construed as prohibiting
25 the exchange of information between field EMS
26 practitioners treating an individual and per-

1 sonnel of a hospital to which the individual has
2 been treated for the purposes of relating infor-
3 mation on the medical history, treatment, care,
4 and outcome of such individual (including any
5 health care personnel safety issues, such as in-
6 fectious disease).

7 “(B) GUIDELINES.—The Secretary shall
8 establish guidelines for exchanges of informa-
9 tion between field EMS practitioners treating
10 an individual and personnel of a hospital to
11 which the individual has been treated to protect
12 the privacy of the individual while ensuring the
13 ability of such field EMS practitioners and hos-
14 pital personnel to communicate effectively to
15 further the continuity and quality of medical
16 care provided to such individual.

17 “(2) NEMESIS DATA.—Nothing in HIPAA pri-
18 vacy and security law (as defined in section
19 3009(a)(2)) shall be construed as prohibiting the ex-
20 change of non-individually identifiable data between
21 the field EMS agency, a State, and the Federal Gov-
22 ernment, including the exchange of information by—

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

1 ment and data collection by the State for sub-
2 mission to NEMESIS; or

3 “(B) the State EMS Office to the National
4 EMS Database maintained by Assistant Sec-
5 retary for Preparedness and Response.

6 **“SEC. 1295. FIELD EMS WORKFORCE DEVELOPMENT.**

7 “(a) IN GENERAL.—For the purpose of promoting
8 field EMS as a health profession and ensuring the avail-
9 ability, quality, and capability of field EMS educators,
10 practitioners, managers, and medical directors, the Assist-
11 ant Secretary for Preparedness and Response shall make
12 grants to eligible entities for the development, availability,
13 and dissemination of field EMS education programs and
14 courses that improve the quality and capability of field
15 EMS practitioners, educators, managers, and physician
16 medical directors. In carrying out this section, the Assist-
17 ant Secretary for Preparedness and Response shall take
18 into consideration recommendations of FICEMS,
19 NEMSAC, and relevant stakeholders.

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

1 “(c) USE OF FUNDS.—The Assistant Secretary for
2 Preparedness and Response may award a grant to an eligi-
3 ble entity under paragraph (1) only if the entity agrees
4 to use the grant to—

5 “(1) develop and implement education programs
6 to—

7 “(A) train field EMS instructors and pro-
8 mote the adoption and implementation of the
9 education standards identified in the ‘Emer-
10 gency Medical Services Education Agenda for
11 the Future: A Systems Approach’, including
12 any revisions thereto or successor standards;

13 “(B) provide training for information sys-
14 tem workers, such as information security, fo-
15 rensic analysts, data analysts, network engi-
16 neers, and similar roles to work in support of
17 field EMS data systems; or

18 “(C) provide training and retraining pro-
19 grams that prepare displaced workers to enter
20 a field EMS profession, including veterans and
21 military EMS practitioners;

22 “(2) develop and implement educational courses
23 pertaining to—

24 “(A) improving the provision of quality
25 medical oversight of field EMS;

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

5 “(C) undertaking field EMS educational
6 and clinical research to develop investigators;

7 “(D) tactical training for field EMS; or

8 “(E) developing and expanding field EMS
9 undergraduate and graduate programs;

10 “(3) evaluate education and training courses
11 and methodologies to identify optimal educational
12 modalities for field EMS practitioners;

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

16 “(5) carry out such other activities as the As-
17 sistant Secretary for Preparedness and Response de-
18 termines appropriate.

19 “(d) PRIORITY.—The Assistant Secretary for Pre-
20 paredness and Response, in consultation with relevant
21 stakeholders, and taking into consideration the rec-
22 ommendations of FICEMS and NEMSAC, shall establish
23 a system of prioritization in awarding grants under this
24 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 Assistant Secretary for Pre-
4 paredness and Response may not award a grant to an eli-
5 gible entity under this section unless the entity submits
6 an application to such Assistant Secretary in such form,
7 in such manner, and containing such agreements, assur-
8 ances, and information as the Assistant Secretary may re-
9 quire. The Assistant Secretary for Preparedness and Re-
10 sponse shall ensure that the requirements for submitting
11 an application under this section are not unduly burden-
12 some.

13 **“SEC. 1296. NATIONAL EMERGENCY MEDICAL SERVICES**
14 **STRATEGY.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Assistant Secretary for Preparedness and Response,
17 shall develop and implement a cohesive national emer-
18 gency medical services strategy to strengthen the develop-
19 ment of field EMS and the full continuum of emergency
20 medical care and systems at the Federal, State, and local
21 levels to improve patient outcomes and access to high-
22 quality care in the field and develop financing models that
23 support the evolution of value-based emergency medical
24 care. In establishing such a strategy, the Assistant Sec-
25 retary for Preparedness and Response shall—

1 “(1) solicit and consider the 2007 and subse-
2 quent recommendations of the Institute of Medicine,
3 the National EMS Advisory Council, and relevant
4 stakeholders;

5 “(2) consult and collaborate with the Federal
6 Interagency Committee on EMS to ensure consist-
7 ency of such national emergency medical services
8 strategy within the larger Federal strategy regarding
9 national preparedness and response;

10 “(3) address issues related to emergency med-
11 ical services system development, including—

12 “(A) the regionalization of field EMS,
13 trauma, and emergency medical services, par-
14 ticularly for time sensitive conditions such as
15 trauma, ST–Segment Elevation Myocardial In-
16 farction, stroke, neonatal patients, and
17 poisonings;

18 “(B) the availability of field EMS and
19 trauma care and emergency medical services
20 throughout the Nation;

21 “(C) the integration of emergency medical
22 care from the perspective of patients across the
23 emergency care continuum, and accountability
24 for system performance; and

1 “(D) financing of field EMS agencies, in-
2 cluding appropriate medical oversight;

3 “(4) promote the professional development of
4 field EMS practitioners to deliver high-quality field
5 EMS, including the adoption by States of the edu-
6 cation standards identified in the National EMS
7 Education Standards and any revisions thereto or
8 successor standards, including the standardization of
9 licensing of field EMS practitioners and standards
10 of care in accordance with the National EMS Scope
11 of Practice Model and based on best practices and
12 evidence-based medicine, including by—

13 “(A) identifying differences in the levels of
14 care, scope of practice, and licensure require-
15 ments among the States; and

16 “(B) encouraging States to adopt national
17 minimum standards for such levels of care and
18 licensure requirements;

19 “(5) promote a culture of safety, including
20 through—

21 “(A) the establishment of field EMS pa-
22 tient and practitioner safety goals and the spe-
23 cific means to improve field EMS practitioner
24 and patient safety to achieve such goals; and

1 “(B) the adoption of uniform national am-
2 bulance vehicle safety and manufacturing
3 standards;

4 “(6) support the development of value-based re-
5 imbursement for new mobile resources and models of
6 delivery that support the transformation of health
7 care, including the full utilization of field EMS to
8 deliver emergency medical response and mobile med-
9 ical services including—

10 “(A) community paramedicine for the pro-
11 vision of cost-effective health care assessment
12 and prevention services;

13 “(B) mobile integrated health care under-
14 taken collaboratively by a group of providers in
15 a community, including local field EMS agen-
16 cies, to fill gaps in the local health care system;

17 “(C) integrated injury prevention strate-
18 gies or programs; and

19 “(D) such other issues as the Secretary
20 considers appropriate;

21 “(7) incorporate into such strategy prepared-
22 ness and response objectives identified in the Na-
23 tional Health Security Strategy under section 2802
24 in order—

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

5 “(B) to coordinate with the Secretary of
6 Homeland Security accordingly;

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

11 “(9) complete the development of such strategy
12 not later than 18 months after the date of enact-
13 ment of the Field EMS Modernization and Innova-
14 tion Act;

15 “(10) communicate such strategy to the rel-
16 evant congressional committees of jurisdiction;

17 “(11) implement such strategy, to the extent
18 practicable, not later than 3 years after the date of
19 enactment of the Field EMS Modernization and In-
20 novation Act; and

21 “(12) update such strategy not less than every
22 3 years.

23 **“SEC. 1297. OFFICE OF EMERGENCY MEDICAL CARE.**

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

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

6 “(b) FUNCTIONS.—The Assistant Secretary for Pre-
7 paredness and Response, acting through the Office of
8 Emergency Medical Care, shall administer the emergency
9 medical services activities and programs under this part
10 and the trauma programs under parts A through D and
11 H and shall—

12 “(1) promote and fund research in emergency
13 medicine and trauma health care;

14 “(2) promote regional partnerships and effec-
15 tive emergency medical systems in order to enhance
16 appropriate triage, distribution, and care of routine
17 community patients;

18 “(3) promote local, regional, and State emer-
19 gency medical systems preparedness for and re-
20 sponse to public health events;

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

1 “(5) coordinate with existing executive depart-
2 ments and agencies that perform functions related
3 to emergency medical systems in order to ensure
4 unified strategy, policy, and implementation.

5 “(c) FUNCTIONS, PERSONNEL, ASSETS, LIABILITIES,
6 AND ADMINISTRATIVE ACTIONS.—All functions, per-
7 sonnel, assets, and liabilities of, and administrative actions
8 applicable to, the Emergency Care Coordination Center,
9 as in existence on the day before the date of the enactment
10 of the Field EMS Modernization and Innovation Act, shall
11 be transferred to the Office of Emergency Medical Care
12 established under subsection (a).”.

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

16 (1) in clause (i), by inserting “field EMS agen-
17 cy (as defined in section 1291),” after “clinical lab-
18 oratory,”; and

19 (2) in clause (ii), by inserting “field EMS (as
20 defined in section 1291) medical director, emergency
21 medical technician,” after “pharmacist,”.

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

24 (a) NATIONAL EMS INFORMATION SYSTEM.—

1 (1) TRANSFER OF AUTHORITY.—The authority
2 for the administration of the National EMS Infor-
3 mation System, including the National EMS Data-
4 base, shall be transferred from NHTSA to the Na-
5 tional Coordinator for Health Information Tech-
6 nology.

7 (2) NATIONAL EMS INFORMATION SYSTEM.—
8 Section 3001(c) of the Public Health Service Act
9 (42 U.S.C. 300jj–11(c)) is amended by adding at
10 the end the following:

11 “(9) NATIONAL EMS INFORMATION SYSTEM.—

12 “(A) STANDARDIZATION.—The National
13 Coordinator shall promote the collection and re-
14 porting of data on field EMS (as defined in sec-
15 tion 1291) in a standardized manner.

16 “(B) AVAILABILITY OF DATA.—The Na-
17 tional Coordinator shall ensure that information
18 in the National EMS Database (other than in-
19 dividually identifiable information) is available
20 to Federal and State policymakers, EMS stake-
21 holders, and researchers.

22 “(C) TECHNICAL ASSISTANCE.—In car-
23 rying out subparagraph (A), the National Coor-
24 dinator may provide technical assistance to
25 State and local agencies, field EMS agencies,

1 and other entities, as the National Coordinator
2 determines appropriate, to assist in the collec-
3 tion, analysis, and reporting of data.”.

4 (b) ASSIMILATION OF PATIENT HEALTH INFORMA-
5 TION ACROSS THE EMERGENCY CARE CONTINUUM.—Not
6 later than 18 months after the date of enactment of this
7 Act, taking into account the definition of “health care pro-
8 vider” under section 3000 of the Public Health Service
9 Act (42 U.S.C. 300jj), the Secretary shall promulgate a
10 regulation that specifically includes “emergency medical
11 service provider” under the definition of “health care pro-
12 vider” for purposes of title XXX of the Public Health
13 Service Act, to enable and facilitate the integration and
14 assimilation of field EMS data systems as part of the elec-
15 tronic exchange and use of health information and the en-
16 terprise integration of such information.

17 (c) GAO EVALUATION.—

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

1 ments, and potential solutions pertaining to integra-
2 tion of field EMS into the National Health Informa-
3 tion Infrastructure.

4 (2) REPORT.—The Comptroller General of the
5 United States shall submit a report to Congress de-
6 tailing the extent to which the Secretary of Health
7 and Human Services (referred to in this subsection
8 as the “Secretary”) has authority to implement solu-
9 tions to achieve such integration and the extent to
10 which statutory changes are required to achieve such
11 integration.

12 (3) CONTENTS.—The evaluation under para-
13 graph (1) and report under paragraph (2) shall ad-
14 dress—

15 (A) the integration of patient health infor-
16 mation regarding care provided to patients in
17 field EMS into each patient’s electronic health
18 care record;

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

23 (C) the means by which to achieve contem-
24 poraneous field EMS practitioner access to a
25 patient’s medical record without regard to phys-

1 ical location while preparing to provide or pro-
2 viding care to that patient in the field, for the
3 purpose of enhancing care delivery and
4 populating the electronic health care record in
5 real time; and

6 (D) incorporation of patient health infor-
7 mation created subsequent to the receipt of
8 field EMS care into the National EMS Infor-
9 mation System, taking into consideration—

10 (i) the types of medical information
11 created subsequent to the receipt of field
12 EMS emergency care (such as outcomes
13 information or information regarding sub-
14 sequent care and treatment) that would, if
15 included in the National EMS Information
16 System, be potentially useful in evaluating
17 and improving the quality of EMS care;

18 (ii) how best to integrate such infor-
19 mation into the National EMS Information
20 System;

21 (iii) potential modifications to the
22 Health Information Technology for Eco-
23 nomic and Clinical Health Act (title XIII
24 of division A and title IV of division B of
25 Public Law 111–5) to require eligible hos-

1 pitals (as defined in section 1886(n)(6)(B)
2 of the Social Security Act (42 U.S.C.
3 1395ww(n)(6)(B))) to develop or report
4 relevant data to the National EMS Infor-
5 mation System or other appropriate State
6 or private registries for the purpose of de-
7 termining whether such a hospital shall
8 be—

9 (I) subject to a reduction in the
10 applicable percentage increase other-
11 wise applicable to such hospital under
12 section 1886(b)(3)(B)(ix) of such Act;

13 or

14 (II) eligible for an incentive pay-
15 ment under section 1886(n) of such
16 Act;

17 (iv) potential modifications to the
18 Medicare and Medicaid programs under ti-
19 tles XVIII and XIX, respectively, of the
20 Social Security Act (42 U.S.C. 1395 et
21 seq.; 1396 et seq.) or other Federal health
22 programs to provide appropriate reim-
23 bursement and financial incentives for field
24 EMS agencies to develop or report relevant
25 data to the National EMS Information

1 System or other appropriate State or pri-
2 vate registries; and

3 (v) any other changes to improve inte-
4 gration of patient health information
5 across the continuum of emergency medical
6 care and bidirectional integration and data
7 sharing related to performance measures
8 that the Secretary has authority to imple-
9 ment or that requires a statutory change
10 by Congress to enable the Secretary such
11 authority to implement.

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

14 (a) IN GENERAL.—Pursuant to the designation of
15 the Secretary of Health and Human Services (referred to
16 in this section as the “Secretary”) under section 2801 of
17 the Public Health Service Act (42 U.S.C. 300hh) to lead
18 all Federal public health and medical response to public
19 health emergencies and incidents under the National Re-
20 sponse Plan (developed pursuant to section 504(a)(6) of
21 the Homeland Security Act of 2002), and pursuant to the
22 Secretary’s responsibility for administration of titles
23 XVIII, XIX, and XXI of the Social Security Act (42
24 U.S.C. 1395 et seq.; 1396 et seq.; 1397aa et seq.), such
25 leadership responsibilities shall be construed to include the

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

11 (b) EMERGENCY MEDICAL CARE SYSTEM.—In ac-
12 cordance with subsection (a), the Secretary shall be re-
13 sponsible for—

14 (1) improving the emergency medical care sys-
15 tem providing routine emergency medical care to pa-
16 tients with emergency medical conditions to enhance
17 the capacity of the existing public health and emer-
18 gency medical system to prepare for and sustain
19 such public health and medical response to public
20 health emergencies and incidents; and

21 (2) the quality, innovation, and cost-effective-
22 ness of field EMS, including such services provided
23 to individuals who are beneficiaries of the Medicare,
24 Medicaid or State Children’s Health Insurance Pro-
25 gram under titles XVIII, XIX, and XXI, respectively

1 of the Social Security Act (42 U.S.C. 1395 et seq.;
2 1396 et seq.; 1397aa et seq.).

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

4 (a) FIELD EMS EMERGENCY MEDICAL RE-
5 SEARCH.—

6 (1) IN GENERAL.—The Secretary of Health and
7 Human Services (referred to in this subsection as
8 the “Secretary”) shall undertake a comprehensive
9 evaluation of the extent to which research and eval-
10 uation relating to field EMS is conducted by the Na-
11 tional Institutes of Health, the Agency for
12 Healthcare Research Quality, the Center for Medi-
13 care & Medicaid Innovation, the Health Resources
14 and Services Administration, the Centers for Disease
15 Control and Prevention, and the Patient-Centered
16 Outcomes Research Institute, and any other agen-
17 cies or departments within the Department of
18 Health and Human Services, as the Secretary deter-
19 mines appropriate.

20 (2) REPORT TO CONGRESS.—Not later than 1
21 year after the date of enactment of this Act, the
22 Secretary shall submit to Congress a report that in-
23 cludes—

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

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

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

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

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

14 **“SEC. 938. FIELD EMS CENTER OF EXCELLENCE.**

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

19 “(b) PURPOSE.—The purpose of the Center is to con-
20 duct or support research to promote the highest quality
21 of emergency medical care in field EMS and the most ef-
22 fective delivery system for the provision of such care, in-
23 cluding—

24 “(1) comparative safety and effectiveness re-
25 search, especially with regard to the highest cost and

1 most prevalent emergency medical conditions with
2 the greatest opportunity to improve patient out-
3 comes and lower costs by care provided in the field;

4 “(2) other appropriate clinical or systems re-
5 search on the effectiveness of existing and potential
6 treatments provided in the field that translate into
7 improved quality, outcomes, and patient satisfaction;

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

11 “(A) the clinical value and benefit of crit-
12 ical care ground and air transport, including
13 the potential for bidirectional care that fills
14 gaps in rural and other underserved geographic
15 regions, especially where hospitals have closed;

16 “(B) the application of lessons learned in
17 military field medicine in the delivery of emer-
18 gency medical care in field EMS;

19 “(C) the ability to intervene clinically in
20 the early onset of an emergency medical condi-
21 tion that will improve patient outcomes;

22 “(D) specific treatment modalities and pro-
23 tocols that are cost-effective and produce better
24 outcomes, such as 12-lead electrocardiograms
25 and continuous positive airway pressure; and

1 “(E) medical conditions most conducive to
2 regionalization of emergency care that will be
3 most effective in improving service delivery, out-
4 comes, and cost-effectiveness; and

5 “(4) support research being conducted by aca-
6 demic medical centers, particularly those with cen-
7 ters of excellence formed around EMS research.

8 “(c) DEFINITION.—In this section, the term ‘field
9 EMS’ has the meaning given such term in section 1291.”.

10 (c) LIMITATIONS ON CERTAIN USES OF RE-
11 SEARCH.—Section 1182 of the Social Security Act (42
12 U.S.C. 1320e–1) is amended by striking “section 1181”
13 each place it appears and inserting “section 1181 of this
14 Act, section 938 of the Public Health Service Act, or sec-
15 tion 7(a) of the Field EMS Modernization and Innovation
16 Act”.

17 (d) REGULATORY BARRIERS.—For the purposes of
18 research conducted pursuant to section
19 1115A(b)(2)(D)(iv) of the Social Security Act (as added
20 by section 3(a)(2)), subsection (a) of this section, section
21 938 of the Public Health Service Act (as added by sub-
22 section (b)), or any other research funded by the Depart-
23 ment of Health and Human Services related to emergency
24 medical services in the field in which informed consent is

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

3 (1) evaluate and consider the patient and re-
4 search issues involved; and

5 (2) address regulatory barriers to such research
6 related to the need for informed consent in a man-
7 ner that ensures adequate patient safety and notifi-
8 cation, and submit recommendations to Congress for
9 any changes to Federal statutes necessary to ad-
10 dress such barriers.

11 **SEC. 8. EMERGENCY MEDICAL SERVICES TRUST FUND.**

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

17 **“PART IX—DESIGNATION OF INCOME TAX OVER-**
18 **PAYMENTS AND ADDITIONAL CONTRIBU-**
19 **TIONS FOR EMERGENCY MEDICAL SERVICES**

“Sec. 6097. Designation by individuals.

20 **“SEC. 6097. DESIGNATION BY INDIVIDUALS.**

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

23 “(1) a specified portion of any overpayment of
24 tax for a taxable year, and

1 “(2) any amount contributed in addition to any
2 payment of tax for such taxable year and any des-
3 ignation under paragraph (1),
4 shall be used to fund the Emergency Medical Services
5 Trust Fund. Designations under the preceding sentence
6 shall be in an amount not less than \$1, and the Secretary
7 shall provide for elections in amounts of \$1, \$5, \$10, or
8 such other amount as the taxpayer designates.

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

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

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

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

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

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

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

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

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

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

22 “(b) TRANSFERS TO TRUST FUND.—There are here-
23 by appropriated to the Emergency Medical Services Trust
24 Fund amounts equivalent to the amounts of the overpay-

1 ments of tax to which designations under section 6097
2 apply.

3 “(c) EXPENDITURES FROM TRUST FUND.—Amounts
4 in the Emergency Medical Services Trust Fund shall be
5 available, as provided in appropriation Acts, only for car-
6 rying out the provisions for which amounts are authorized
7 to be appropriated under subsections (a) and (b) of section
8 10 of the Field EMS Innovation Act.”.

9 (c) CLERICAL AMENDMENTS.—

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

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

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

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

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

20 **SEC. 9. GAO STUDY TO IDENTIFY IMPEDIMENTS TO QUAL-**
21 **ITY IMPROVEMENT IN FIELD EMS.**

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

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

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

6 (A) medical oversight provided by physi-
7 cians directly regarding specific patients and
8 medical oversight provided by physicians in es-
9 tablishing medical protocols, procedures, and
10 other activities related to the provision of emer-
11 gency medical care in field EMS; and

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

16 (2) the types and levels of reimbursement nec-
17 essary to ensure the highest quality of care overseen
18 by physician medical directors, including—

19 (A) the actual costs of all components of
20 medical oversight in high-performing EMS sys-
21 tems with demonstrated improvement in out-
22 comes, such as those evidenced by cardiac rates
23 and traumatic injury survival rates;

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

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

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

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

13 (A) issues affecting the direct patient care
14 provided by field EMS practitioners such as
15 personal and patient safety, fatigue, and train-
16 ing; and

17 (B) issues affecting the ability to recruit
18 and maintain a highly qualified field EMS prac-
19 titioner workforce such as salary, hours, and
20 benefits; and

21 (4) such other issues as the Comptroller Gen-
22 eral determines appropriate relating to improving
23 the quality and medical oversight of emergency med-
24 ical care in field EMS.

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

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

11 **SEC. 10. FUNDING.**

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

16 (1) \$12,000,000 for each of fiscal years 2016
17 through 2021, for the purpose of carrying out the
18 additional duties required under part I of the Public
19 Health Service Act (as added by section 4);

20 (2) \$200,000,000 for each of fiscal years 2016
21 through 2021, for the purpose of carrying out sec-
22 tion 1292 of the Public Health Service Act, as added
23 by section 4;

24 (3) \$15,000,000 for each of fiscal years 2016
25 through 2021, for the purpose of carrying out sec-

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

3 (4) \$40,000,000 for each of fiscal years 2016
4 through 2021, for the purpose of carrying out sec-
5 tion 7(a) of this Act and 938 of the Public Health
6 Service Act, as added by section 7(b); and

7 (5) \$4,000,000 for each of fiscal years 2016
8 through 2021, for the purpose of carrying out sec-
9 tion 3001(c)(9) of the Public Health Service Act
10 with respect to the National EMS Information Sys-
11 tem, as added by section 5(a)(2).

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

22 (c) START-UP FUNDING.—

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

1 2017, up to \$40,000,000 may be used for carrying
2 out the amendments made by sections 3 and 4.

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

8 (d) ADMINISTRATIVE EXPENSES.—Not more than 5
9 percent of each amount made available under paragraphs
10 (1) through (5) of subsection (a) may be used for adminis-
11 trative expenses.

12 **SEC. 11. STATUTORY CONSTRUCTION.**

13 Nothing in this Act, including the amendments made
14 by this Act, shall be construed to supersede any statutory
15 authority of any Federal agency that is not within the De-
16 partment of Health and Human Services.

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