

TRAUMA CARE SYSTEMS PLANNING AND DEVELOPMENT
ACT OF 2007

MARCH 27, 2007.—Committed to the Committee of the Whole House on the State
of the Union and ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce,
submitted the following

R E P O R T

[To accompany H.R. 727]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred
the bill (H.R. 727) to amend the Public Health Service Act to add
requirements regarding trauma care, and for other purposes, hav-
ing considered the same, report favorably thereon with an amend-
ment and recommend that the bill as amended do pass.

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AMENDMENT

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Trauma Care Systems Planning and Development Act of 2007”.

SEC. 2. ESTABLISHMENT.

Section 1201 of the Public Health Service Act (42 U.S.C. 300d) is amended to read as follows:

“SEC. 1201. ESTABLISHMENT.

“(a) **IN GENERAL.**—The Secretary shall, with respect to trauma care—

“(1) conduct and support research, training, evaluations, and demonstration projects;

“(2) foster the development of appropriate, modern systems of such care through the sharing of information among agencies and individuals involved in the study and provision of such care;

“(3) collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing trauma care and emergency medical services and, in so doing, give special consideration to the unique needs of rural areas;

“(4) provide to State and local agencies technical assistance to enhance each State’s capability to develop, implement, and sustain the trauma care component of each State’s plan for the provision of emergency medical services;

“(5) sponsor workshops and conferences; and

“(6) promote the collection and categorization of trauma data in a consistent and standardized manner.

“(b) **GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.**—The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).”.

SEC. 3. CLEARINGHOUSE ON TRAUMA CARE AND EMERGENCY MEDICAL SERVICES.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended—

(1) by striking section 1202; and

(2) by redesignating section 1203 as section 1202.

SEC. 4. ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.

Section 1202 of the Public Health Service Act, as redesignated by section 3(2), is amended to read as follows:

“SEC. 1202. ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.

“(a) **IN GENERAL.**—The Secretary may make grants to public and nonprofit private entities for the purpose of carrying out research and demonstration projects with respect to improving the availability and quality of emergency medical services in rural areas—

“(1) by developing innovative uses of communications technologies and the use of new communications technology;

“(2) by developing model curricula, such as advanced trauma life support, for training emergency medical services personnel, including first responders, emergency medical technicians, emergency nurses and physicians, and paramedics—

“(A) in the assessment, stabilization, treatment, preparation for transport, and resuscitation of seriously injured patients, with special attention to problems that arise during long transports and to methods of minimizing delays in transport to the appropriate facility; and

“(B) in the management of the operation of the emergency medical services system;

“(3) by making training for original certification, and continuing education, in the provision and management of emergency medical services more accessible to emergency medical personnel in rural areas through telecommunications, home studies, providing teachers and training at locations accessible to such personnel, and other methods;

“(4) by developing innovative protocols and agreements to increase access to prehospital care and equipment necessary for the transportation of seriously injured patients to the appropriate facilities;

“(5) by evaluating the effectiveness of protocols with respect to emergency medical services and systems; and

“(6) by increasing communication and coordination with State trauma systems.

“(b) **SPECIAL CONSIDERATION FOR CERTAIN RURAL AREAS.**—In making grants under subsection (a), the Secretary shall give special consideration to any applicant

for the grant that will provide services under the grant in any rural area identified by a State under section 1214(d)(1).

“(c) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.”.

SEC. 5. COMPETITIVE GRANTS.

Part A of title XII of the Public Health Service Act, as amended by section 3, is amended by adding at the end the following:

“SEC. 1203. COMPETITIVE GRANTS FOR THE IMPROVEMENT OF TRAUMA CARE.

“(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to States, political subdivisions, or consortia of States or political subdivisions for the purpose of improving access to and enhancing the development of trauma care systems.

“(b) USE OF FUNDS.—The Secretary may make a grant under this section only if the applicant agrees to use the grant—

“(1) to integrate and broaden the reach of a trauma care system, such as by developing innovative protocols to increase access to prehospital care;

“(2) to strengthen, develop, and improve an existing trauma care system;

“(3) to expand communications between the trauma care system and emergency medical services through improved equipment or a telemedicine system;

“(4) to improve data collection and retention; or

“(5) to increase education, training, and technical assistance opportunities, such as training and continuing education in the management of emergency medical services accessible to emergency medical personnel in rural areas through telehealth, home studies, and other methods.

“(c) PREFERENCE.—In selecting among States, political subdivisions, and consortia of States or political subdivisions for purposes of making grants under this section, the Secretary shall give preference to applicants that—

“(1) have developed a process, using national standards, for designating trauma centers;

“(2) recognize protocols for the delivery of seriously injured patients to trauma centers;

“(3) implement a process for evaluating the performance of the trauma system; and

“(4) agree to participate in information systems described in section 1202 by collecting, providing, and sharing information.

“(d) PRIORITY.—In making grants under this section, the Secretary shall give priority to applicants that will use the grants to focus on improving access to trauma care systems.

“(e) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary shall give special consideration to projects that demonstrate strong State or local support, including availability of non-Federal contributions.”.

SEC. 6. REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.

Section 1212 of the Public Health Service Act (42 U.S.C. 300d–12) is amended to read as follows:

“SEC. 1212. REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.

“(a) NON-FEDERAL CONTRIBUTIONS.—

“(1) IN GENERAL.—The Secretary may not make payments under section 1211(a) unless the State involved agrees, with respect to the costs described in paragraph (2), to make available non-Federal contributions (in cash or in kind under subsection (b)(1)) toward such costs in an amount that—

“(A) for the second and third fiscal years of such payments to the State, is not less than \$1 for each \$1 of Federal funds provided in such payments for such fiscal years; and

“(B) for the fourth and subsequent fiscal years of such payments to the State, is not less than \$2 for each \$1 of Federal funds provided in such payments for such fiscal years.

“(2) PROGRAM COSTS.—The costs referred to in paragraph (1) are—

“(A) the costs to be incurred by the State in carrying out the purpose described in section 1211(b); or

“(B) the costs of improving the quality and availability of emergency medical services in rural areas of the State.

“(3) INITIAL YEAR OF PAYMENTS.—The Secretary may not require a State to make non-Federal contributions as a condition of receiving payments under section 1211(a) for the first fiscal year of such payments to the State.

“(b) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—With respect to compliance with subsection (a) as a condition of receiving payments under section 1211(a)—

“(1) a State may make the non-Federal contributions required in such subsection in cash or in kind, fairly evaluated, including plant, equipment, or services; and

“(2) the Secretary may not, in making a determination of the amount of non-Federal contributions, include amounts provided by the Federal Government or services assisted or subsidized to any significant extent by the Federal Government.”.

SEC. 7. REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

Section 1213 of the Public Health Service Act (42 U.S.C. 300d–13) is amended to read as follows:

“SEC. 1213. REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

“(a) TRAUMA CARE MODIFICATIONS TO STATE PLAN FOR EMERGENCY MEDICAL SERVICES.—With respect to the trauma care component of a State plan for the provision of emergency medical services, the modifications referred to in section 1211(b) are such modifications to the State plan as may be necessary for the State involved to ensure that the plan provides for access to the highest possible quality of trauma care, and that the plan—

“(1) specifies that the modifications required pursuant to paragraphs (2) through (11) will be implemented by the principal State agency with respect to emergency medical services or by the designee of such agency;

“(2) specifies a public or private entity that will designate trauma care regions and trauma centers in the State;

“(3) subject to subsection (b), contains national standards and requirements of the American College of Surgeons or another appropriate entity for the designation of level I and level II trauma centers, and in the case of rural areas level III trauma centers (including trauma centers with specified capabilities and expertise in the care of pediatric trauma patients), by such entity, including standards and requirements for—

“(A) the number and types of trauma patients for whom such centers must provide care in order to ensure that such centers will have sufficient experience and expertise to be able to provide quality care for victims of injury;

“(B) the resources and equipment needed by such centers; and

“(C) the availability of rehabilitation services for trauma patients;

“(4) contains standards and requirements for the implementation of regional trauma care systems, including standards and guidelines (consistent with the provisions of section 1867 of the Social Security Act) for medically directed triage and transportation of trauma patients (including patients injured in rural areas) prior to care in designated trauma centers;

“(5) subject to subsection (b), contains national standards and requirements, including those of the American Academy of Pediatrics and the American College of Emergency Physicians, for medically directed triage and transport of severely injured children to designated trauma centers with specified capabilities and expertise in the care of pediatric trauma patients;

“(6) utilizes a program with procedures for the evaluation of designated trauma centers (including trauma centers described in paragraph (5)) and trauma care systems;

“(7) provides for the establishment and collection of data in accordance with data collection requirements developed in consultation with surgical, medical, and nursing specialty groups, State and local emergency medical services directors, and other trained professionals in trauma care, from each designated trauma center in the State of a central data reporting and analysis system—

“(A) to identify the number of severely injured trauma patients and the number of deaths from trauma within trauma care systems in the State;

“(B) to identify the cause of the injury and any factors contributing to the injury;

“(C) to identify the nature and severity of the injury;

“(D) to monitor trauma patient care (including prehospital care) in each designated trauma center within regional trauma care systems in the State (including relevant emergency-department discharges and rehabilitation information) for the purpose of evaluating the diagnosis, treatment, and treatment outcome of such trauma patients;

“(E) to identify the total amount of uncompensated trauma care expenditures for each fiscal year by each designated trauma center in the State; and

“(F) to identify patients transferred within a regional trauma system, including reasons for such transfer and the outcomes of such patients;

“(8) provides for the use of procedures by paramedics and emergency medical technicians to assess the severity of the injuries incurred by trauma patients;

“(9) provides for appropriate transportation and transfer policies to ensure the delivery of patients to designated trauma centers and other facilities within and outside of the jurisdiction of such system, including policies to ensure that only individuals appropriately identified as trauma patients are transferred to designated trauma centers, and to provide periodic reviews of the transfers and the auditing of such transfers that are determined to be appropriate;

“(10) conducts public education activities concerning injury prevention and obtaining access to trauma care;

“(11) coordinates planning for trauma systems with State disaster emergency planning and bioterrorism hospital preparedness planning; and

“(12) with respect to the requirements established in this subsection, provides for coordination and cooperation between the State and any other State with which the State shares any standard metropolitan statistical area.

“(b) CERTAIN STANDARDS WITH RESPECT TO TRAUMA CARE CENTERS AND SYSTEMS.—

“(1) IN GENERAL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees that, in carrying out paragraphs (3) through (5) of subsection (a), the State will adopt standards for the designation of trauma centers, and for triage, transfer, and transportation policies, and that the State will, in adopting such standards—

“(A) take into account national standards that outline resources for optimal care of injured patients;

“(B) consult with medical, surgical, and nursing speciality groups, hospital associations, emergency medical services State and local directors, concerned advocates, and other interested parties;

“(C) conduct hearings on the proposed standards after providing adequate notice to the public concerning such hearing; and

“(D) beginning in fiscal year 2008, take into account the model plan described in subsection (c).

“(2) QUALITY OF TRAUMA CARE.—The highest quality of trauma care shall be the primary goal of State standards adopted under this subsection.

“(3) APPROVAL BY THE SECRETARY.—The Secretary may not make payments under section 1211(a) to a State if the Secretary determines that—

“(A) in the case of payments for fiscal year 2008 and subsequent fiscal years, the State has not taken into account national standards, including those of the American College of Surgeons, the American College of Emergency Physicians, and the American Academy of Pediatrics, in adopting standards under this subsection; or

“(B) in the case of payments for fiscal year 2008 and subsequent fiscal years, the State has not, in adopting such standards, taken into account the model plan developed under subsection (c).

“(c) MODEL TRAUMA CARE PLAN.—

“(1) IN GENERAL.—Not later than 1 year after the date of the enactment of the Trauma Care Systems Planning and Development Act of 2007, the Secretary shall update the model plan for the designation of trauma centers and for triage, transfer, and transportation policies that may be adopted for guidance by the State. Such plan shall—

“(A) take into account national standards, including those of the American College of Surgeons, American College of Emergency Physicians, and the American Academy of Pediatrics;

“(B) take into account existing State plans;

“(C) be developed in consultation with medical, surgical, and nursing speciality groups, hospital associations, emergency medical services State directors and associations, and other interested parties; and

“(D) include standards for the designation of rural health facilities and hospitals best able to receive, stabilize, and transfer trauma patients to the nearest appropriate designated trauma center, and for triage, transfer, and transportation policies as they relate to rural areas.

“(2) APPLICABILITY.—Standards described in paragraph (1)(D) shall be applicable to all rural areas in the State, including both non-metropolitan areas and frontier areas that have populations of less than 6,000 per square mile.

“(d) **RULE OF CONSTRUCTION WITH RESPECT TO NUMBER OF DESIGNATED TRAUMA CENTERS.**—With respect to compliance with subsection (a) as a condition of the receipt of a grant under section 1211(a), such subsection may not be construed to specify the number of trauma care centers designated pursuant to such subsection.”.

SEC. 8. REQUIREMENT OF SUBMISSION TO SECRETARY OF TRAUMA PLAN AND CERTAIN INFORMATION.

Section 1214 of the Public Health Service Act (42 U.S.C. 300d–14) is amended to read as follows:

“SEC. 1214. REQUIREMENT OF SUBMISSION TO SECRETARY OF TRAUMA PLAN AND CERTAIN INFORMATION.

“(a) **IN GENERAL.**—For each fiscal year, the Secretary may not make payments to a State under section 1211(a) unless, subject to subsection (b), the State submits to the Secretary the trauma care component of the State plan for the provision of emergency medical services, including any changes to the trauma care component and any plans to address deficiencies in the trauma care component.

“(b) **INTERIM PLAN OR DESCRIPTION OF EFFORTS.**—For each fiscal year, if a State has not completed the trauma care component of the State plan described in subsection (a), the State may provide, in lieu of such completed component, an interim component or a description of efforts made toward the completion of the component.

“(c) **INFORMATION RECEIVED BY STATE REPORTING AND ANALYSIS SYSTEM.**—The Secretary may not make payments to a State under section 1211(a) unless the State agrees that the State will, not less than once each year, provide to the Secretary the information received by the State pursuant to section 1213(a)(7).

“(d) **AVAILABILITY OF EMERGENCY MEDICAL SERVICES IN RURAL AREAS.**—The Secretary may not make payments to a State under section 1211(a) unless—

“(1) the State identifies any rural area in the State for which—

“(A) there is no system of access to emergency medical services through the telephone number 911;

“(B) there is no basic life-support system; or

“(C) there is no advanced life-support system; and

“(2) the State submits to the Secretary a list of rural areas identified pursuant to paragraph (1) or, if there are no such areas, a statement that there are no such areas.”.

SEC. 9. RESTRICTIONS ON USE OF PAYMENTS.

Section 1215 of the Public Health Service Act (42 U.S.C. 300d–15) is amended to read as follows:

“SEC. 1215. RESTRICTIONS ON USE OF PAYMENTS.

“(a) **IN GENERAL.**—The Secretary may not, except as provided in subsection (b), make payments under section 1211(a) for a fiscal year unless the State involved agrees that the payments will not be expended—

“(1) for any purpose other than developing, implementing, and monitoring the modifications required by section 1211(b) to be made to the State plan for the provision of emergency medical services;

“(2) to make cash payments to intended recipients of services provided pursuant to this section;

“(3) to purchase or improve real property (other than minor remodeling of existing improvements to real property);

“(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

“(5) to provide financial assistance to any entity other than a public or non-profit private entity.

“(b) **WAIVER.**—The Secretary may waive a restriction under subsection (a) only if the Secretary determines that the activities outlined by the State plan submitted under section 1214(a) by the State involved cannot otherwise be carried out.”.

SEC. 10. REQUIREMENTS OF REPORTS BY STATES.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by striking section 1216.

SEC. 11. REPORT BY SECRETARY.

Section 1222 of the Public Health Service Act (42 U.S.C. 300d–22) is amended to read as follows:

“SEC. 1222. REPORT BY SECRETARY.

“Not later than October 1, 2008, the Secretary shall report to the appropriate committees of Congress on the activities of the States carried out pursuant to section 1211. Such report shall include an assessment of the extent to which Federal and State efforts to develop systems of trauma care and to designate trauma centers

have reduced the incidence of mortality, and the incidence of permanent disability, resulting from trauma. Such report may include any recommendations of the Secretary for appropriate administrative and legislative initiatives with respect to trauma care.”

SEC. 12. FUNDING.

Section 1232 of the Public Health Service Act (42 U.S.C. 300d–32) is amended to read as follows:

“SEC. 1232. FUNDING.

“(a) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out parts A and B, subject to subsections (b) and (c), there are authorized to be appropriated \$12,000,000 for fiscal year 2008, \$10,000,000 for fiscal year 2009, and \$8,000,000 for each of the fiscal years 2010 through 2012.

“(b) **RESERVATION OF FUNDS.**—If the amount appropriated under subsection (a) for a fiscal year is equal to or less than \$1,000,000, such appropriation is available only for the purpose of carrying out part A. If the amount so appropriated is greater than \$1,000,000, 50 percent of such appropriation shall be made available for the purpose of carrying out part A and 50 percent shall be made available for the purpose of carrying out part B.

“(c) **ALLOCATION OF PART A FUNDS.**—Of the amounts appropriated under subsection (a) for a fiscal year to carry out part A—

“(1) 10 percent of such amounts for such year shall be allocated for administrative purposes; and

“(2) 10 percent of such amounts for such year shall be allocated for the purpose of carrying out section 1202.”

SEC. 13. RESIDENCY TRAINING PROGRAMS IN EMERGENCY MEDICINE.

Section 1251 of the Public Health Service Act (42 U.S.C. 300d–51) is amended to read as follows:

“SEC. 1251. RESIDENCY TRAINING PROGRAMS IN EMERGENCY MEDICINE.

“(a) **IN GENERAL.**—The Secretary may make grants to public and nonprofit private entities for the purpose of planning and developing approved residency training programs in emergency medicine.

“(b) **IDENTIFICATION AND REFERRAL OF DOMESTIC VIOLENCE.**—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that the training programs under subsection (a) will provide education and training in identifying and referring cases of domestic violence.

“(c) **AUTHORIZATION OF APPROPRIATIONS.**—For the purpose of carrying out this section, there is authorized to be appropriated \$400,000 for each of the fiscal years 2008 through 2012.”

SEC. 14. STATE GRANTS FOR CERTAIN PROJECTS.

Section 1252 of the Public Health Service Act (42 U.S.C. 300d–52) is amended in the section heading by striking “**DEMONSTRATION**”.

PURPOSE AND SUMMARY

The purpose of H.R. 727, the Trauma Care Systems Planning and Development Act of 2007, is to amend the Public Health Service Act to add requirements regarding trauma care, and for other purposes. The legislation would reauthorize title XII of the Public Health Service Act for a period of 5 years to establish formula and competitive grants for the purpose of planning, implementing, and developing statewide trauma care systems.

BACKGROUND AND NEED FOR LEGISLATION

Traumatic injury is one of the most important public health problems facing the United States. Each year more than 150,000 Americans die from traumatic injuries, another two million people are seriously injured. Trauma and injury are leading causes of death and disability of Americans between the ages of 1 and 44 years, the third leading cause of death in the general population of the United States. Most traumatic injury is due to motor vehicle collisions, violence, and falls.

A trauma care system is an organized approach to facilitating and coordinating a response to traumatic injury for severely injured patients. This multidisciplinary approach includes injury prevention, emergency transport, emergency department care, surgical intervention, hospital care, rehabilitative services and social services that enable the patient to return to society at the most productive level. Adequate and timely trauma care is life sustaining for the severely injured patients.

Both death and disability for severely injured patients are reduced drastically when definitive, timely trauma care is provided. Inadequate systems of trauma care at both the community and hospital levels, as well as inequities in access to prehospital and hospital emergency services contribute to high rates of death and disability, particularly in rural and medically underserved areas. According to a 2004 study of the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention, as many as 35 percent of trauma patients' deaths could have been prevented if optimal acute care had been available.

Trauma care systems are vital to our Nation's public health and emergency preparedness infrastructure. Strengthening title XII programs governing trauma care system planning and development will help to enhance disaster preparedness and reduce death and disability for those experiencing traumatic injury.

HEARINGS

The Committee on Energy and Commerce has not held hearings on the legislation.

COMMITTEE CONSIDERATION

On Tuesday, March 13, 2007, the Subcommittee on Health met in open markup session and approved H.R. 727 for full Committee consideration, amended, by voice vote. On Thursday, March 15, 2007, the full Committee met in open markup session and ordered H.R. 727 favorably reported to the House, as amended, by voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken on amendments or in connection with ordering H.R. 727 reported. A motion by Mr. Dingell to order H.R. 727 favorably reported to the House, amended, was agreed to by voice vote.

COMMITTEE OVERSIGHT FINDINGS

Regarding clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this legislation.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goals and objectives of H.R. 727 are to improve emergency medical services to ensure that severely injured patients receive

prompt trauma care, thereby reducing the rates of lifelong traumatic injuries and death. Particular emphasis is placed on improving trauma care systems in rural areas, which disproportionately experience challenges in communication and coordination with State trauma systems.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX
EXPENDITURES

Regarding compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 727 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARKS AND TAX AND TARIFF BENEFITS

Regarding compliance with clause 9 of rule XXI of the Rules of the House of Representatives, H.R. 727 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e), or 9(f) of rule XXI.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 19, 2007.

Hon. JOHN D. DINGELL,
*Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 727, the Trauma Care Systems Planning and Development Act of 2007.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Camile Williams.

Sincerely,

PETER R. ORSZAG,
Director.

Enclosure.

*H.R. 727—Trauma Care Systems Planning and Development Act of
2007*

Summary: H.R. 727 would amend the Public Health Service Act to authorize several emergency services and trauma care programs administered by the Health Resources and Services Administration (HRSA). The trauma care programs include grants and cooperative agreements to assist states in the improvement and development

of trauma care systems and emergency care residency training programs.

Assuming that the specified amounts are appropriated for fiscal years 2008 through 2012, CBO estimates that implementing H.R. 727 would cost \$40 million over the 2008–2012 period. The legislation would not affect direct spending or receipts.

H.R. 727 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would benefit states. The bill would authorize grant programs designed to improve the quality of trauma care systems. States that choose to apply for those grants would have to provide matching funds, but any costs they face would be incurred voluntarily.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 727 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year in millions of dollars—				
	2008	2009	2010	2011	2012
CHANGES IN SPENDING SUBJECT TO APPROPRIATION					
Authorization Level	12	10	8	8	8
Estimated Outlays	5	10	9	8	8

Basis of estimate: H.R. 727 would authorize the appropriation of \$12 million in fiscal year 2008, \$10 million in 2009, and \$8 million in each of fiscal years 2010 through 2012 for trauma-related grant programs. The bill also would authorize the appropriation of \$400,000 a year for grants to plan and develop residency programs in emergency medicine. Based on spending patterns for similar grant programs (which were funded through 2006, and assuming authorization of specified amounts, CBO estimates that implementing H.R. 727 would cost \$5 million in 2008 and \$40 million over the 2008–2012 period.

The bill would authorize HRSA to make grants to states for the planning, development, and improvement of trauma care centers and systems. H.R. 727 also would authorize HRSA to make grants to public and private nonprofit entities to improve access to trauma care and to conduct research and demonstration projects to improve the availability and quality of emergency medical services in rural areas.

The planning grant part of the program provides federal matching payments to funds spent by states. The federal government would provide \$1 for every \$1 of state spending in the second and third year and \$1 for every \$2 of state spending in the fourth and subsequent years. The grants to public or provide nonprofit agencies would not require matching payment by those agencies. CBO estimates that implementing the grant program would cost \$5 million in 2008 and \$38 million over the 2008–2012 period, assuming the appropriation of the specified amounts.

The grants for residency training programs in emergency medicine would provide funding to public and private nonprofit entities to develop residency program with an emphasis on treatment and referral of domestic violence cases. CBO estimates that implementing this provision would cost \$2 million over the 2008–2012 period.

Intergovernmental and private-sector impact: The bill contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments. The bill would authorize grant programs designed to improve the quality of trauma care systems. States that choose to apply for those grants would have to provide matching funds, but any costs they face would be incurred voluntarily.

Estimate prepared by: Federal Costs: Camile Williams. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Paige Shevlin.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in the provisions of Article I, section 8, clause 1 that relate to expending funds to provide for the general welfare of the United States.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 establishes the short title as the “Trauma Care Systems Planning and Development Act of 2007.”

Section 2. Establishment

Section 2 amends the Public Health Service Act to direct the Secretary of Health and Human Services, either directly or through cooperative agreement and contract, to promote and enhance a State’s capacity with respect to trauma care through information sharing, technical assistance, data collection, and workshops and conferences.

Section 3. Clearinghouse on Trauma Care and Emergency Medical Services

Section 3 strikes the section that relates to the National Clearinghouse on Trauma Care and Emergency Medical Services.

Section 4. Establishment of programs for improving trauma care in rural areas

Section 4 allows the Secretary to make grants to entities to carry out demonstration projects to improve emergency medical services in rural areas by increasing communication and coordination with state trauma systems.

Section 5. Competitive grants

Section 5 allows the Secretary, acting through the Administrator of the Health Resources and Services Administration, to make grants to States, political subdivisions, or consortia of States or political subdivisions to improve access to and enhance the development of trauma care system.

Section 6. Requirements of matching funds for fiscal years subsequent to first fiscal year of payments

Section 6 revises the matching requirements for States to be eligible for grants so that a State increases its share of non-Federal contribution (in cash and in kind), in subsequent fiscal years.

Section 7. Requirements with respect to carrying out purpose of allotments

Section 7 revises the requirement of trauma care modifications to the State plan to ensure that the plan provides for access to the highest possible quality of trauma care.

The section prohibits the Secretary from making trauma care grants to a State unless the State's emergency medical services plan coordinates planning for trauma systems with state disaster emergency planning and bioterrorism hospital preparedness planning.

The section directs the Secretary to update the model trauma care plan to update policies that may be adopted by the State.

Section 8. Requirement of submission to Secretary of trauma plan and certain information

Section 8 prohibits the Secretary from making trauma care grants to a State unless the State submits to the Secretary the trauma care component of the State plan, including any changes to the trauma care component together with any deficiencies, an interim component, or description of effort toward the completion of the component. States must evaluate the availability of emergency medical services in rural areas.

The section directs the Secretary to update the model plan for the designation of trauma centers and for triage, transfer, and transportation policies.

Section 9. Restrictions on use of payments

Section 9 revises the restrictions on use of payments and modifies the waiver authority of the Secretary over such restrictions.

Section 10. Requirements of reports by States

Section 10 strikes section 1216, which requires annual reports by States.

Section 11. Report by Secretary

Section 11 requires the Secretary to report to Congress on Federal and State efforts to develop systems of trauma care no later than October 1, 2008.

Section 12. Funding

Section 12 extends the authorization of appropriations for parts A and B for five fiscal years through fiscal year 2012. The section clarifies that the amount authorized to be appropriated for carrying out part A (program and competitive grant funding) and part B (State formula funding) is for the purposes of carrying out each part, which may include administrative and technical assistance. Clarifies that under part A, 10 percent is allocated to each for administrative purposes and 10 percent is allocated for the purpose of carrying out rural trauma improvement under section 1202.

Section 13. Residency training programs in emergency medicine

Section 13 extends the authorization of appropriations for section 1251 for five fiscal years through fiscal year 2012.

Section 14. State grants for certain projects

Section 14 amends the section heading of section 1252 so that it reads “State Grants for Projects Regarding Traumatic Brain Injury.”

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE XII—TRAUMA CARE

PART A—GENERAL AUTHORITY AND DUTIES OF SECRETARY

[SEC. 1201. ESTABLISHMENT.

[(a) IN GENERAL.—The Secretary shall, with respect to trauma care—

[(1) conduct and support research, training, evaluations, and demonstration projects;

[(2) foster the development of appropriate, modern systems of such care through the sharing of information among agencies and individuals involved in the study and provision of such care;

[(3) provide to State and local agencies technical assistance; and

[(4) sponsor workshops and conferences.

[(b) GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.—The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).

[(c) ADMINISTRATION.—The Administrator of the Health Resources and Services Administration shall ensure that this title is administered by the Division of Trauma and Emergency Medical Systems within such Administration. Such Division shall be headed by a director appointed by the Secretary from among individuals who are knowledgeable by training or experience in the development and operation of trauma and emergency medical systems.

[SEC. 1202. CLEARINGHOUSE ON TRAUMA CARE AND EMERGENCY MEDICAL SERVICES.

[(a) ESTABLISHMENT.—The Secretary shall by contract provide for the establishment and operation of a National Clearinghouse on Trauma Care and Emergency Medical Services (hereafter in this section referred to as the “Clearinghouse”).

[(b) DUTIES.—The Clearinghouse shall—

[(1) foster the development of appropriate, modern trauma care and emergency medical services (including the development of policies for the notification of family members of individuals involved in medical emergencies) through the sharing of information among agencies and individuals involved in planning, furnishing, and studying such services and care;

[(2) collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing trauma care and emergency medical services and, in so doing, give special consideration of the unique needs of rural areas;

[(3) provide technical assistance relating to trauma care and emergency medical services to State and local agencies; and

[(4) sponsor workshops and conferences on trauma care and emergency medical services.

[(c) FEES AND ASSESSMENTS.—A contract entered into by the Secretary under this section may provide that the Clearinghouse charge fees or assessments in order to defray, and beginning with fiscal year 1992, to cover, the costs of operating the Clearinghouse.

[SEC. 1203. ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.

[(a) IN GENERAL.—The Secretary may make grants to public and nonprofit private entities for the purpose of carrying out research and demonstration projects with respect to improving the availability and quality of emergency medical services in rural areas—

[(1) by developing innovative uses of communications technologies and the use of new communications technology;

[(2) by developing model curricula for training emergency medical services personnel, including first responders, emergency medical technicians, emergency nurses and physicians, and paramedics—

[(A) in the assessment, stabilization, treatment, preparation for transport, and resuscitation of seriously injured patients, with special attention to problems that arise during long transports and to methods of minimizing delays in transport to the appropriate facility; and

[(B) in the management of the operation of the emergency medical services system;

[(3) by making training for original certification, and continuing education, in the provision and management of emergency medical services more accessible to emergency medical

personnel in rural areas through telecommunications, home studies, providing teachers and training at locations accessible to such personnel, and other methods;

[(4) by developing innovative protocols and agreements to increase access to prehospital care and equipment necessary for the transportation of seriously injured patients to the appropriate facilities; and

[(5) by evaluating the effectiveness of protocols with respect to emergency medical services and systems.

[(b) SPECIAL CONSIDERATION FOR CERTAIN RURAL AREAS.—In making grants under subsection (a), the Secretary shall give special consideration to any applicant for the grant that will provide services under the grant in any rural area identified by a State under section 1214(c)(1).

[(c) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.]

SEC. 1201. ESTABLISHMENT.

(a) *IN GENERAL.*—*The Secretary shall, with respect to trauma care—*

(1) *conduct and support research, training, evaluations, and demonstration projects;*

(2) *foster the development of appropriate, modern systems of such care through the sharing of information among agencies and individuals involved in the study and provision of such care;*

(3) *collect, compile, and disseminate information on the achievements of, and problems experienced by, State and local agencies and private entities in providing trauma care and emergency medical services and, in so doing, give special consideration to the unique needs of rural areas;*

(4) *provide to State and local agencies technical assistance to enhance each State's capability to develop, implement, and sustain the trauma care component of each State's plan for the provision of emergency medical services;*

(5) *sponsor workshops and conferences; and*

(6) *promote the collection and categorization of trauma data in a consistent and standardized manner.*

(b) *GRANTS, COOPERATIVE AGREEMENTS, AND CONTRACTS.*—*The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).*

SEC. 1202. ESTABLISHMENT OF PROGRAMS FOR IMPROVING TRAUMA CARE IN RURAL AREAS.

(a) *IN GENERAL.*—*The Secretary may make grants to public and nonprofit private entities for the purpose of carrying out research and demonstration projects with respect to improving the availability and quality of emergency medical services in rural areas—*

(1) *by developing innovative uses of communications technologies and the use of new communications technology;*

(2) *by developing model curricula, such as advanced trauma life support, for training emergency medical services personnel,*

including first responders, emergency medical technicians, emergency nurses and physicians, and paramedics—

(A) in the assessment, stabilization, treatment, preparation for transport, and resuscitation of seriously injured patients, with special attention to problems that arise during long transports and to methods of minimizing delays in transport to the appropriate facility; and

(B) in the management of the operation of the emergency medical services system;

(3) by making training for original certification, and continuing education, in the provision and management of emergency medical services more accessible to emergency medical personnel in rural areas through telecommunications, home studies, providing teachers and training at locations accessible to such personnel, and other methods;

(4) by developing innovative protocols and agreements to increase access to prehospital care and equipment necessary for the transportation of seriously injured patients to the appropriate facilities;

(5) by evaluating the effectiveness of protocols with respect to emergency medical services and systems; and

(6) by increasing communication and coordination with State trauma systems.

(b) **SPECIAL CONSIDERATION FOR CERTAIN RURAL AREAS.**—In making grants under subsection (a), the Secretary shall give special consideration to any applicant for the grant that will provide services under the grant in any rural area identified by a State under section 1214(d)(1).

(c) **REQUIREMENT OF APPLICATION.**—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

SEC. 1203. COMPETITIVE GRANTS FOR THE IMPROVEMENT OF TRAUMA CARE.

(a) **IN GENERAL.**—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants to States, political subdivisions, or consortia of States or political subdivisions for the purpose of improving access to and enhancing the development of trauma care systems.

(b) **USE OF FUNDS.**—The Secretary may make a grant under this section only if the applicant agrees to use the grant—

(1) to integrate and broaden the reach of a trauma care system, such as by developing innovative protocols to increase access to prehospital care;

(2) to strengthen, develop, and improve an existing trauma care system;

(3) to expand communications between the trauma care system and emergency medical services through improved equipment or a telemedicine system;

(4) to improve data collection and retention; or

(5) to increase education, training, and technical assistance opportunities, such as training and continuing education in the management of emergency medical services accessible to emer-

gency medical personnel in rural areas through telehealth, home studies, and other methods.

(c) PREFERENCE.—In selecting among States, political subdivisions, and consortia of States or political subdivisions for purposes of making grants under this section, the Secretary shall give preference to applicants that—

(1) have developed a process, using national standards, for designating trauma centers;

(2) recognize protocols for the delivery of seriously injured patients to trauma centers;

(3) implement a process for evaluating the performance of the trauma system; and

(4) agree to participate in information systems described in section 1202 by collecting, providing, and sharing information.

(d) PRIORITY.—In making grants under this section, the Secretary shall give priority to applicants that will use the grants to focus on improving access to trauma care systems.

(e) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary shall give special consideration to projects that demonstrate strong State or local support, including availability of non-Federal contributions.

PART B—FORMULA GRANTS WITH RESPECT TO MODIFICATIONS OF STATE PLANS

* * * * *

[(SEC. 1212 REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.

[(a) NON-FEDERAL CONTRIBUTIONS.—

[(1) IN GENERAL.—The Secretary may not make payments under section 1211(a) unless the State involved agrees, with respect to the costs described in paragraph (2), to make available non-Federal contributions (in cash or in kind under subsection (b)(1)) toward such costs in an amount equal to—

[(A) for the second fiscal year of such payments to the State, not less than \$1 for each \$1 of Federal funds provided in such payments for such fiscal year; and

[(B) for any subsequent fiscal year of such payments to the State, not less than \$3 for each \$1 of Federal funds provided in such payments for such fiscal year.

[(2) PROGRAM COSTS.—The costs referred to in paragraph (1) are—

[(A) the costs to be incurred by the State in carrying out the purpose described in section 1211(b); or

[(B) the costs of improving the quality and availability of emergency medical services in rural areas of the State.

[(3) INITIAL YEAR OF PAYMENTS.—The Secretary may not require a State to make non-Federal contributions as a condition of receiving payments under section 1211(a) for the first fiscal year of such payments to the State.

[(b) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—With respect to compliance with subsection (a) as a condition of receiving payments under section 1211(a)—

[(1) a State may make the non-Federal contributions required in such subsection in cash or in kind, fairly evaluated, including plant, equipment, or services;

[(2) the Secretary may not, in making a determination of the amount of non-Federal contributions, include amounts provided by the Federal Government or services assisted or subsidized to any significant extent by the Federal Government; and

[(3) the Secretary shall, in making such a determination, include only non-Federal contributions in excess of the amount of non-Federal contributions made by the State during fiscal year 1990 toward—

[(A) the costs of providing trauma care in the State; and

[(B) the costs of improving the quality and availability of emergency medical services in rural areas of the State.

[SEC. 1213. REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

[(a) TRAUMA CARE MODIFICATIONS TO STATE PLAN FOR EMERGENCY MEDICAL SERVICES.—With respect to the trauma care component of a State plan for the provision of emergency medical services, the modifications referred to in section 1211(b) are such modifications to the State plan as may be necessary for the State involved to ensure that the plan provides for access to the highest possible quality of trauma care, and that the plan—

[(1) specifies that the modifications required pursuant to paragraphs (2) through (10) will be implemented by the principal State agency with respect to emergency medical services or by the designee of such agency;

[(2) specifies any public or private entity that will designate trauma care regions and trauma centers in the State;

[(3) subject to subsection (b), contains standards and requirements for the designation of level I and level II trauma centers, and in the case of rural areas level III trauma centers (including trauma centers with specified capabilities and expertise in the care of the pediatric trauma patient), by such entity, including standards and requirements for—

[(A) the number and types of trauma patients for whom such centers must provide care in order to ensure that such centers will have sufficient experience and expertise to be able to provide quality care for victims of injury;

[(B) the resources and equipment needed by such centers; and

[(C) the availability of rehabilitation services for trauma patients;

[(4) subject to subsection (b), contains standards and requirements for the implementation of regional trauma care systems, including standards and guidelines (consistent with the provisions of section 1867 of the Social Security Act) for medically directed triage and transportation of trauma patients (including patients injured in rural areas) prior to care in designated trauma centers;

[(5) subject to subsection (b), contains standards and requirements for medically directed triage and transport of severely injured children to designated trauma centers with specified capabilities and expertise in the care of the pediatric trauma patient;

[(6) specifies procedures for the evaluation of designated trauma centers (including trauma centers described in paragraph (5)) and trauma care systems;

[(7) provides for the establishment and collection of data from each designated trauma center in the State of a central data reporting and analysis system—

[(A) to identify the number of severely injured trauma patients within regional trauma care systems in the State;

[(B) to identify the cause of the injury and any factors contributing to the injury;

[(C) to identify the nature and severity of the injury;

[(D) to monitor trauma patient care (including prehospital care) in each designated trauma center within regional trauma care systems in the State (including relevant emergency-department discharges and rehabilitation information) for the purpose of evaluating the diagnosis, treatment and treatment outcome of such trauma patients;

[(E) to identify the total amount of uncompensated trauma care expenditures for each fiscal year by each designated trauma center in the State; and

[(F) to identify patients transferred within a regional trauma system, including reasons for such transfer;

[(8) provides for the use of procedures by paramedics and emergency medical technicians to assess the severity of the injuries incurred by trauma patients;

[(9) provides for appropriate transportation and transfer policies to ensure the delivery of patients to designated trauma centers and other facilities within and outside of the jurisdiction of such system, including policies to ensure that only individuals appropriately identified as trauma patients are transferred to designated trauma centers, and to provide periodic reviews of the transfers and the auditing of such transfers that are determined to be appropriate;

[(10) conducts public education activities concerning injury prevention and obtaining access to trauma care; and

[(11) with respect to the requirements established in this subsection, provides for coordination and cooperation between the State and any other State with which the State shares any standard metropolitan statistical area.

[(b) CERTAIN STANDARDS WITH RESPECT TO TRAUMA CARE CENTERS AND SYSTEMS.—

[(1) IN GENERAL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees that, in carrying out paragraphs (3) through (5) of subsection (a), the State will adopt standards for the designation of trauma centers, and for triage, transfer, and transportation policies, and that the State will, in adopting such standards—

[(A) take into account national standards concerning such;

[(B) consult with medical, surgical, and nursing speciality groups, hospital associations, emergency medical services State and local directors, concerned advocates and other interested parties;

[(C) conduct hearings on the proposed standards after providing adequate notice to the public concerning such hearing; and

[(D) beginning in fiscal year 1992, take into account the model plan described in subsection (c).

[(2) QUALITY OF TRAUMA CARE.—The highest quality of trauma care shall be the primary goal of State standards adopted under this subsection.

[(3) APPROVAL BY SECRETARY.—The Secretary may not make payments under section 1211(a) to a State if the Secretary determines that—

[(A) in the case of payments for fiscal year 1991 and subsequent fiscal years, the State has not taken into account national standards, including those of the American College of Surgeons, the American College of Emergency Physicians and the American Academy of Pediatrics, in adopting standards under this subsection; or

[(B) in the case of payments for fiscal year 1992 and subsequent fiscal years, the State has not, in adopting such standards, taken into account the model plan developed under subsection (c) .

[(c) MODEL TRAUMA CARE PLAN.—Not later than 1 year after the date of the enactment of the Trauma Care Systems Planning and Development Act of 1990, the Secretary shall develop a model plan for the designation of trauma centers and for triage, transfer and transportation policies that may be adopted for guidance by the State. Such plan shall—

[(1) take into account national standards, including those of the American College of Surgeons, American College of Emergency Physicians and the American Academy of Pediatrics;

[(2) take into account existing State plans;

[(3) be developed in consultation with medical, surgical, and nursing speciality groups, hospital associations, emergency medical services State directors and associations, and other interested parties; and

[(4) include standards for the designation of rural health facilities and hospitals best able to receive, stabilize, and transfer trauma patients to the nearest appropriate designated trauma center, and for triage, transfer, and transportation policies as they relate to rural areas.

Standards described in paragraph (4) shall be applicable to all rural areas in the State, including both non-metropolitan areas and frontier areas that have populations of less than 6,000 per square mile.

[(d) RULE OF CONSTRUCTION WITH RESPECT TO NUMBER OF DESIGNATED TRAUMA CENTERS.—With respect to compliance with subsection (a) as a condition of the receipt of a grant under section 1211(a), such subsection may not be construed to specify the number of trauma care centers designated pursuant to such subsection.

[SEC. 1214. REQUIREMENT OF SUBMISSION TO SECRETARY OF TRAUMA PLAN AND CERTAIN INFORMATION.

[(a) TRAUMA PLAN.—

[(1) IN GENERAL.—For fiscal year 1991 and subsequent fiscal years, the Secretary may not make payments under section 1211(a) unless, subject to paragraph (2), the State involved

submits to the Secretary the trauma care component of the State plan for the provision of emergency medical services.

[(2) INTERIM PLAN OR DESCRIPTION OF EFFORTS.—For fiscal year 1991, if a State has not completed the trauma care component of the State plan described in paragraph (1), the State may provide, in lieu of a completed such component, an interim component or a description of efforts made toward the completion of the component.

[(b) INFORMATION RECEIVED BY STATE REPORTING AND ANALYSIS SYSTEM.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees that the State will, not less than once each year, provide to the Secretary the information received by the State pursuant to section 1213(a)(7).

[(c) AVAILABILITY OF EMERGENCY MEDICAL SERVICES IN RURAL AREAS.—The Secretary may not make payments under section 1211(a) for a fiscal year unless—

[(1) the State involved identifies any rural area in the State for which—

[(A) there is no system of access to emergency medical services through the telephone number 911;

[(B) there is no basic life-support system; or

[(C) there is no advanced life-support system; and

[(2) the State submits to the Secretary a list of rural areas identified pursuant to paragraph (1) or, if there are no such areas, a statement that there are no such areas.

[SEC. 1215. RESTRICTIONS ON USE OF PAYMENTS.

[(a) IN GENERAL.—The Secretary may not, except as provided in subsection (b), make payments under section 1211(a) for a fiscal year unless the State involved agrees that the payments will not be expended—

[(1) subject to section 1233, for any purpose other than developing, implementing, and monitoring the modifications required by section 1211(b) to be made to the State plan for the provision of emergency medical services.

[(2) to make cash payments to intended recipients of services provided pursuant to such section;

[(3) to purchase or improve real property (other than minor remodeling of existing improvements to real property) or to purchase major medical or communication equipment, ambulances, or aircraft;

[(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;

or

[(5) to provide financial assistance to any entity other than a public or nonprofit private entity.

[(b) EXCEPTION.—If the Secretary finds that the purpose described in section 1211(b) cannot otherwise be carried out, the Secretary may, with respect to an otherwise qualified State, waive the restriction established in subsection (a)(3).

[SEC. 1216. REQUIREMENT OF REPORTS BY STATES.

[(a) IN GENERAL.—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees to prepare and submit to the Secretary an annual report in such form

and containing such information as the Secretary determines (after consultation with the States) to be necessary for—

【(1) securing a record and a description of the purposes for which payments received by the State pursuant to such section were expended and of the recipients of such payments; and

【(2) determining whether the payments were expended in accordance with the purpose of the program involved.

【(b) AVAILABILITY TO PUBLIC OF REPORTS.—The Secretary may not make payments under section 1211(a) unless the State involved agrees that the State will make copies of the report described in subsection (a) available for public inspection.

【(c) EVALUATIONS BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall evaluate the expenditures by States of payments under section 1211(a) in order to assure that expenditures are consistent with the provisions of this part, and not later than December 1, 1994, prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report concerning such evaluation.】

SEC. 1212. REQUIREMENT OF MATCHING FUNDS FOR FISCAL YEARS SUBSEQUENT TO FIRST FISCAL YEAR OF PAYMENTS.

(a) *NON-FEDERAL CONTRIBUTIONS.*—

(1) *IN GENERAL.*—*The Secretary may not make payments under section 1211(a) unless the State involved agrees, with respect to the costs described in paragraph (2), to make available non-Federal contributions (in cash or in kind under subsection (b)(1)) toward such costs in an amount that—*

(A) *for the second and third fiscal years of such payments to the State, is not less than \$1 for each \$1 of Federal funds provided in such payments for such fiscal years; and*

(B) *for the fourth and subsequent fiscal years of such payments to the State, is not less than \$2 for each \$1 of Federal funds provided in such payments for such fiscal years.*

(2) *PROGRAM COSTS.*—*The costs referred to in paragraph (1) are—*

(A) *the costs to be incurred by the State in carrying out the purpose described in section 1211(b); or*

(B) *the costs of improving the quality and availability of emergency medical services in rural areas of the State.*

(3) *INITIAL YEAR OF PAYMENTS.*—*The Secretary may not require a State to make non-Federal contributions as a condition of receiving payments under section 1211(a) for the first fiscal year of such payments to the State.*

(b) *DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.*—*With respect to compliance with subsection (a) as a condition of receiving payments under section 1211(a)—*

(1) *a State may make the non-Federal contributions required in such subsection in cash or in kind, fairly evaluated, including plant, equipment, or services; and*

(2) *the Secretary may not, in making a determination of the amount of non-Federal contributions, include amounts provided by the Federal Government or services assisted or subsidized to any significant extent by the Federal Government.*

SEC. 1213. REQUIREMENTS WITH RESPECT TO CARRYING OUT PURPOSE OF ALLOTMENTS.

(a) **TRAUMA CARE MODIFICATIONS TO STATE PLAN FOR EMERGENCY MEDICAL SERVICES.**—With respect to the trauma care component of a State plan for the provision of emergency medical services, the modifications referred to in section 1211(b) are such modifications to the State plan as may be necessary for the State involved to ensure that the plan provides for access to the highest possible quality of trauma care, and that the plan—

(1) specifies that the modifications required pursuant to paragraphs (2) through (11) will be implemented by the principal State agency with respect to emergency medical services or by the designee of such agency;

(2) specifies a public or private entity that will designate trauma care regions and trauma centers in the State;

(3) subject to subsection (b), contains national standards and requirements of the American College of Surgeons or another appropriate entity for the designation of level I and level II trauma centers, and in the case of rural areas level III trauma centers (including trauma centers with specified capabilities and expertise in the care of pediatric trauma patients), by such entity, including standards and requirements for—

(A) the number and types of trauma patients for whom such centers must provide care in order to ensure that such centers will have sufficient experience and expertise to be able to provide quality care for victims of injury;

(B) the resources and equipment needed by such centers;

and

(C) the availability of rehabilitation services for trauma patients;

(4) contains standards and requirements for the implementation of regional trauma care systems, including standards and guidelines (consistent with the provisions of section 1867 of the Social Security Act) for medically directed triage and transportation of trauma patients (including patients injured in rural areas) prior to care in designated trauma centers;

(5) subject to subsection (b), contains national standards and requirements, including those of the American Academy of Pediatrics and the American College of Emergency Physicians, for medically directed triage and transport of severely injured children to designated trauma centers with specified capabilities and expertise in the care of pediatric trauma patients;

(6) utilizes a program with procedures for the evaluation of designated trauma centers (including trauma centers described in paragraph (5)) and trauma care systems;

(7) provides for the establishment and collection of data in accordance with data collection requirements developed in consultation with surgical, medical, and nursing specialty groups, State and local emergency medical services directors, and other trained professionals in trauma care, from each designated trauma center in the State of a central data reporting and analysis system—

(A) to identify the number of severely injured trauma patients and the number of deaths from trauma within trauma care systems in the State;

- (B) to identify the cause of the injury and any factors contributing to the injury;
- (C) to identify the nature and severity of the injury;
- (D) to monitor trauma patient care (including prehospital care) in each designated trauma center within regional trauma care systems in the State (including relevant emergency-department discharges and rehabilitation information) for the purpose of evaluating the diagnosis, treatment, and treatment outcome of such trauma patients;
- (E) to identify the total amount of uncompensated trauma care expenditures for each fiscal year by each designated trauma center in the State; and
- (F) to identify patients transferred within a regional trauma system, including reasons for such transfer and the outcomes of such patients;
- (8) provides for the use of procedures by paramedics and emergency medical technicians to assess the severity of the injuries incurred by trauma patients;
- (9) provides for appropriate transportation and transfer policies to ensure the delivery of patients to designated trauma centers and other facilities within and outside of the jurisdiction of such system, including policies to ensure that only individuals appropriately identified as trauma patients are transferred to designated trauma centers, and to provide periodic reviews of the transfers and the auditing of such transfers that are determined to be appropriate;
- (10) conducts public education activities concerning injury prevention and obtaining access to trauma care;
- (11) coordinates planning for trauma systems with State disaster emergency planning and bioterrorism hospital preparedness planning; and
- (12) with respect to the requirements established in this subsection, provides for coordination and cooperation between the State and any other State with which the State shares any standard metropolitan statistical area.
- (b) **CERTAIN STANDARDS WITH RESPECT TO TRAUMA CARE CENTERS AND SYSTEMS.**—
- (1) **IN GENERAL.**—The Secretary may not make payments under section 1211(a) for a fiscal year unless the State involved agrees that, in carrying out paragraphs (3) through (5) of subsection (a), the State will adopt standards for the designation of trauma centers, and for triage, transfer, and transportation policies, and that the State will, in adopting such standards—
- (A) take into account national standards that outline resources for optimal care of injured patients;
- (B) consult with medical, surgical, and nursing speciality groups, hospital associations, emergency medical services State and local directors, concerned advocates, and other interested parties;
- (C) conduct hearings on the proposed standards after providing adequate notice to the public concerning such hearing; and
- (D) beginning in fiscal year 2008, take into account the model plan described in subsection (c).

(2) *QUALITY OF TRAUMA CARE.*—*The highest quality of trauma care shall be the primary goal of State standards adopted under this subsection.*

(3) *APPROVAL BY THE SECRETARY.*—*The Secretary may not make payments under section 1211(a) to a State if the Secretary determines that—*

(A) in the case of payments for fiscal year 2008 and subsequent fiscal years, the State has not taken into account national standards, including those of the American College of Surgeons, the American College of Emergency Physicians, and the American Academy of Pediatrics, in adopting standards under this subsection; or

(B) in the case of payments for fiscal year 2008 and subsequent fiscal years, the State has not, in adopting such standards, taken into account the model plan developed under subsection (c).

(c) *MODEL TRAUMA CARE PLAN.*—

(1) IN GENERAL.—*Not later than 1 year after the date of the enactment of the Trauma Care Systems Planning and Development Act of 2007, the Secretary shall update the model plan for the designation of trauma centers and for triage, transfer, and transportation policies that may be adopted for guidance by the State. Such plan shall—*

(A) take into account national standards, including those of the American College of Surgeons, American College of Emergency Physicians, and the American Academy of Pediatrics;

(B) take into account existing State plans;

(C) be developed in consultation with medical, surgical, and nursing speciality groups, hospital associations, emergency medical services State directors and associations, and other interested parties; and

(D) include standards for the designation of rural health facilities and hospitals best able to receive, stabilize, and transfer trauma patients to the nearest appropriate designated trauma center, and for triage, transfer, and transportation policies as they relate to rural areas.

(2) APPLICABILITY.—*Standards described in paragraph (1)(D) shall be applicable to all rural areas in the State, including both non-metropolitan areas and frontier areas that have populations of less than 6,000 per square mile.*

(d) RULE OF CONSTRUCTION WITH RESPECT TO NUMBER OF DESIGNATED TRAUMA CENTERS.—*With respect to compliance with subsection (a) as a condition of the receipt of a grant under section 1211(a), such subsection may not be construed to specify the number of trauma care centers designated pursuant to such subsection.*

SEC. 1214. REQUIREMENT OF SUBMISSION TO SECRETARY OF TRAUMA PLAN AND CERTAIN INFORMATION.

(a) IN GENERAL.—*For each fiscal year, the Secretary may not make payments to a State under section 1211(a) unless, subject to subsection (b), the State submits to the Secretary the trauma care component of the State plan for the provision of emergency medical services, including any changes to the trauma care component and any plans to address deficiencies in the trauma care component.*

(b) *INTERIM PLAN OR DESCRIPTION OF EFFORTS.*—For each fiscal year, if a State has not completed the trauma care component of the State plan described in subsection (a), the State may provide, in lieu of such completed component, an interim component or a description of efforts made toward the completion of the component.

(c) *INFORMATION RECEIVED BY STATE REPORTING AND ANALYSIS SYSTEM.*—The Secretary may not make payments to a State under section 1211(a) unless the State agrees that the State will, not less than once each year, provide to the Secretary the information received by the State pursuant to section 1213(a)(7).

(d) *AVAILABILITY OF EMERGENCY MEDICAL SERVICES IN RURAL AREAS.*—The Secretary may not make payments to a State under section 1211(a) unless—

(1) the State identifies any rural area in the State for which—

(A) there is no system of access to emergency medical services through the telephone number 911;

(B) there is no basic life-support system; or

(C) there is no advanced life-support system; and

(2) the State submits to the Secretary a list of rural areas identified pursuant to paragraph (1) or, if there are no such areas, a statement that there are no such areas.

SEC. 1215. RESTRICTIONS ON USE OF PAYMENTS.

(a) *IN GENERAL.*—The Secretary may not, except as provided in subsection (b), make payments under section 1211(a) for a fiscal year unless the State involved agrees that the payments will not be expended—

(1) for any purpose other than developing, implementing, and monitoring the modifications required by section 1211(b) to be made to the State plan for the provision of emergency medical services;

(2) to make cash payments to intended recipients of services provided pursuant to this section;

(3) to purchase or improve real property (other than minor remodeling of existing improvements to real property);

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit private entity.

(b) *WAIVER.*—The Secretary may waive a restriction under subsection (a) only if the Secretary determines that the activities outlined by the State plan submitted under section 1214(a) by the State involved cannot otherwise be carried out.

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[SEC. 1222. REPORT BY SECRETARY.

[Not later than October 1, 1995, the Secretary shall report to the appropriate committees of Congress on the activities of the States carried out pursuant to section 1211. Such report shall include an assessment of the extent to which Federal and State efforts to develop systems of trauma care and to designate trauma centers have reduced the incidence of mortality, and the incidence of permanent disability, resulting from trauma. Such report may include any recommendations of the Secretary for appropriate administrative and legislative initiatives with respect to trauma care.]

SEC. 1222. REPORT BY SECRETARY.

Not later than October 1, 2008, the Secretary shall report to the appropriate committees of Congress on the activities of the States carried out pursuant to section 1211. Such report shall include an assessment of the extent to which Federal and State efforts to develop systems of trauma care and to designate trauma centers have reduced the incidence of mortality, and the incidence of permanent disability, resulting from trauma. Such report may include any recommendations of the Secretary for appropriate administrative and legislative initiatives with respect to trauma care.

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PART C—GENERAL PROVISIONS REGARDING PARTS A AND B

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[SEC. 1232. FUNDING.

[(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out parts A and B, there are authorized to be appropriated \$6,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 through 2002.

[(b) ALLOCATION OF FUNDS BY SECRETARY.—

[(1) GENERAL AUTHORITY.—For the purpose of carrying out part A, the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under subsection (a).

[(2) RURAL GRANTS.—For the purpose of carrying out section 1204, the Secretary shall make available 10 percent of the amounts appropriated for a fiscal year under subsection (a).

[(3) FORMULA GRANTS.—

[(A) For the purpose of making allotments under section 1211(a), the Secretary shall, subject to subsection (c), make available 80 percent of the amounts appropriated for a fiscal year pursuant to subsection (a).

[(B) Amounts paid to a State under section 1211(a) for a fiscal year shall, for the purposes for which the amounts were paid, remain available for obligation until the end of the fiscal year immediately following the fiscal year for which the amounts were paid.

[(c) EFFECT OF INSUFFICIENT APPROPRIATIONS FOR MINIMUM ALLOTMENTS.—

[(1) IN GENERAL.—If the amounts made available under subsection (b)(3)(A) for a fiscal year are insufficient for providing each State with an allotment under section 1211(a) of not less than the applicable amount under section 1218(a)(2), the Secretary shall, from such amounts as are made available under subsection (b)(3)(A), make grants to States described in paragraph (2) for carrying out part B.

[(2) ELIGIBLE STATES.—The States referred to in paragraph (1) are States that—

[(A) have the greatest need to develop, implement, and maintain trauma care systems; and

[(B) demonstrate in their applications under section 1217 the greatest commitment to establishing and maintaining such systems.

[(3) RULE OF CONSTRUCTION.—Paragraph (1) may not be construed to require the Secretary to make a grant under such paragraph to each State.]

SEC. 1232. FUNDING.

(a) *AUTHORIZATION OF APPROPRIATIONS.*—For the purpose of carrying out parts A and B, subject to subsections (b) and (c), there are authorized to be appropriated \$12,000,000 for fiscal year 2008, \$10,000,000 for fiscal year 2009, and \$8,000,000 for each of the fiscal years 2010 through 2012.

(b) *RESERVATION OF FUNDS.*—If the amount appropriated under subsection (a) for a fiscal year is equal to or less than \$1,000,000, such appropriation is available only for the purpose of carrying out part A. If the amount so appropriated is greater than \$1,000,000, 50 percent of such appropriation shall be made available for the purpose of carrying out part A and 50 percent shall be made available for the purpose of carrying out part B.

(c) *ALLOCATION OF PART A FUNDS.*—Of the amounts appropriated under subsection (a) for a fiscal year to carry out part A—

(1) 10 percent of such amounts for such year shall be allocated for administrative purposes; and

(2) 10 percent of such amounts for such year shall be allocated for the purpose of carrying out section 1202.

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Part E—Miscellaneous Programs

[SEC. 1251. RESIDENCY TRAINING PROGRAMS IN EMERGENCY MEDICINE.

[(a) *IN GENERAL.*—The Secretary may make grants to public and nonprofit private entities for the purpose of planning and developing approved residency training programs in emergency medicine.

[(b) *IDENTIFICATION AND REFERRAL OF DOMESTIC VIOLENCE.*—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that training programs under subsection (a) will provide education and training in identifying and referring cases of domestic violence.

[(c) *AUTHORIZATION OF APPROPRIATIONS.*—For the purpose of carrying out this section, there is authorized to be appropriated \$400,000 for each of the fiscal years 1993 through 1995.]

SEC. 1251. RESIDENCY TRAINING PROGRAMS IN EMERGENCY MEDICINE.

(a) *IN GENERAL.*—The Secretary may make grants to public and nonprofit private entities for the purpose of planning and developing approved residency training programs in emergency medicine.

(b) *IDENTIFICATION AND REFERRAL OF DOMESTIC VIOLENCE.*—The Secretary may make a grant under subsection (a) only if the applicant involved agrees that the training programs under subsection (a) will provide education and training in identifying and referring cases of domestic violence.

(c) *AUTHORIZATION OF APPROPRIATIONS.*—For the purpose of carrying out this section, there is authorized to be appropriated \$400,000 for each of the fiscal years 2008 through 2012.

SEC. 1252. STATE GRANTS FOR [DEMONSTRATION] PROJECTS REGARDING TRAUMATIC BRAIN INJURY.

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