PUBLIC HEALTH SERVICE ACT

[As Amended Through P.L. 118–86, Enacted September 27, 2024]

[Currency: This publication is a compilation of the text of title XII of Chapter 373 of the 78th Congress. It was last amended by the public law listed in the As Amended Through note above and below at the bottom of each page of the pdf version and reflects current law through the date of the enactment of the public law listed at https://www.govinfo.gov/app/collection/comps/]

[Note: While this publication does not represent an official version of any Federal statute, substantial efforts have been made to ensure the accuracy of its contents. The official version of Federal law is found in the United States Statutes at Large and in the United States Code. The legal effect to be given to the Statutes at Large and the United States Code is established by statute (1 U.S.C. 112, 204).]

[References in brackets [] are to title 42, United States Code]

TITLE XII—TRAUMA CARE

PART A—GENERAL AUTHORITY AND DUTIES OF SECRETARY

SEC. 1201. [300d] 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, analyze, 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 and medically underserved 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; and

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

(b) TRAUMA CARE READINESS AND COORDINATION.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall support the efforts of States and consortia of States to coordinate and improve emergency medical services and trauma care during a public health emergency declared by the Secretary pursuant to section 319 or a major disaster or emergency declared by the President under section 401 or 501, respectively, of

the Robert T. Stafford Disaster Relief and Emergency Assistance Act. Such support may include—

(1) developing, issuing, and updating guidance, as appropriate, to support the coordinated medical triage and evacuation to appropriate medical institutions based on patient medical need, taking into account regionalized systems of care;

(2) disseminating, as appropriate, information on evidence-based or evidence-informed trauma care practices, taking into consideration emergency medical services and trauma care systems, including such practices identified through activities conducted under subsection (a) and which may include the identification and dissemination of performance metrics, as applicable and appropriate; and

(3) other activities, as appropriate, to optimize a coordinated and flexible approach to the emergency response and medical surge capacity of hospitals, other health care facilities, critical care, and emergency medical systems.

(c) 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. [300d–3] GRANTS TO IMPROVE TRAUMA CARE IN RURAL AREAS.

(a) IN GENERAL.—The Secretary shall award grants to eligible entities for the purpose of carrying out research and demonstration projects to support the improvement of emergency medical services and trauma care in rural areas through the development of innovative uses of technology, training and education, transportation of seriously injured patients for the purposes of receiving such emergency medical services, access to prehospital care, evaluation of protocols for the purposes of improvement of outcomes and dissemination of any related best practices, activities to facilitate clinical research, as applicable and appropriate, and increasing communication and coordination with applicable State or Tribal trauma systems.

(b) ELIGIBLE ENTITIES.—

(1) IN GENERAL.—To be eligible to receive a grant under this section, an entity shall be a public or private entity that provides trauma care in a rural area.

(2) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to eligible entities 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.

(d) REPORTS.—An entity that receives a grant under this section shall submit to the Secretary such reports as the Secretary may require to inform administration of the program under this section.

SEC. 1203. [300d–5] COMPETITIVE GRANTS FOR TRAUMA SYSTEMS FOR THE IMPROVEMENT OF TRAUMA CARE.

(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, 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. 1204. [300d–6] COMPETITIVE GRANTS FOR TRAUMA CENTERS.

(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support pilot projects to design, implement, and evaluate new or existing innovative models of regionalized, comprehensive, and accountable emergency medical and trauma systems, and improve access to trauma care within such systems.

(b) ELIGIBLE ENTITY; REGION.—In this section:

(1) ELIGIBLE ENTITY.—The term "eligible entity" means—

(A) a State or consortia of States;

(B) an Indian Tribe or Tribal organization (as defined in section 4 of the Indian Self-Determination and Education Assistance Act);

(C) a consortium of level I, II, or III trauma centers designated by applicable State or local agencies within an applicable State or region, and, as applicable, other emergency services providers; or

(D) a consortium or partnership of nonprofit Indian Health Service, Indian Tribal, and urban Indian trauma centers.

(2) REGION.—The term "region" means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

(3) EMERGENCY SERVICES.—The term "emergency services" includes acute, prehospital, and trauma care.

(c) PILOT PROJECTS.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity to design, implement, and evaluate a new or existing emergency medical and trauma system. Such eligible entity shall use amounts awarded under this subsection to carry out 2 or more of the following activities:

(1) Strengthening coordination and communication with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop approaches to improve situational awareness and emergency medical and trauma system access.

(2) Providing a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region to support patient movement to ensure that the patient is taken to the medically appropriate facility (whether an initial facility or a higher-level facility) in a timely fashion.

(3) Improving the tracking of prehospital and hospital resources, including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions.

(4) Supporting a consistent region-wide prehospital, hospital, and interfacility data management system that—

(A) submits data to the National EMS Information System, the National Trauma Data Bank, and others;

(B) reports data to appropriate Federal and State databanks and registries; and

(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant health outcomes of hospital care.

(5) Establishing, implementing, and disseminating, or utilizing existing, as applicable, evidence-based or evidence-informed practices across facilities within such emergency medical and trauma system to improve health outcomes, including such practices related to management of injuries, and the ability of such facilities to surge.

(6) Conducting activities to facilitate clinical research, as applicable and appropriate.

(d) APPLICATION.—

(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

(2) APPLICATION INFORMATION.—Each application shall include—

(A) an assurance from the eligible entity that the applicable emergency medical and trauma system system—

(i) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office or Tribal entity);

(ii) includes consistent indirect and direct medical oversight of prehospital, hospital, and interfacility transport throughout the region;

(iii) coordinates prehospital treatment and triage, hospital destination, and interfacility transport throughout the region;

(iv) includes a categorization or designation system for special medical facilities throughout the region that is integrated with transport and destination protocols;

(v) includes a regional medical direction, patient tracking, and resource allocation system that supports day-to-day emergency care and surge capacity and is integrated with other components of the national and State emergency preparedness system; and

(vi) addresses pediatric concerns related to integration, planning, preparedness, and coordination of emergency medical services for infants, children and adolescents;

(B) for eligible entities described in subparagraph (C) or (D) of subsection (b)(1), a description of, and evidence of, coordination with the applicable State Office of Emergency Medical Services (or equivalent State Office) or applicable such office for a Tribe or Tribal organization; and

(C) such other information as the Secretary may require.

(e) REQUIREMENT OF MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant was made, to make available non-Federal contributions (in cash or in kind under paragraph (2)) toward such costs in an amount equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

(2) NON-FEDERAL CONTRIBUTIONS.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the Federal

Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(3) EFFECTIVE DATE.—The matching requirement described in paragraph (1) shall take effect on October 1, 2025.

(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a medically underserved population (as defined in section 330(b)(3)).

(g) REPORT.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

(2) opportunities for improvement, including recommendations for how to improve the effectiveness and efficiency of the program (or lack thereof);

(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;

(4) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers;

(5) recommendations on the utilization of available funding for future regionalization efforts; and

(6) any evidence-based or evidence-informed strategies developed or utilized pursuant to subsection (c)(5).

(h) DISSEMINATION OF FINDINGS.—Not later than 1 year after the completion of the final project under subsection (a), the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report describing the information contained in each report submitted pursuant to subsection (g) and any additional actions planned by the Secretary related to regionalized emergency care and trauma systems.

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

SEC. 1211. [300d–11] ESTABLISHMENT OF PROGRAM.

(a) REQUIREMENT OF ALLOTMENTS FOR STATES.—The Secretary shall for each fiscal year make an allotment for each State in an amount determined in accordance with section 1218. The Secretary shall make payments, as grants, each fiscal year to each State from the allotment for the State if the Secretary approves for the fiscal year involved an application submitted by the State pursuant to section 1217.

(b) PURPOSE.—Except as provided in section 1233, the Secretary may not make payments under this part for a fiscal year unless the State involved agrees that, with respect to the trauma care component of the State plan for the provision of emergency medical services, the payments will be expended only for the purpose of de-

veloping, implementing, and monitoring the modifications to such component described in section 1213.

SEC. 1212. [300d–12] 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. [300d–13] 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. [300d–14] 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. [300d–15] 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.

SEC. 1217. [300d–17] REQUIREMENT OF SUBMISSION OF APPLICATION CONTAINING CERTAIN AGREEMENTS AND ASSURANCES.

The Secretary may not make payments under section 1211(a) to a State for a fiscal year unless—

(1) the State submits to the Secretary an application for the payments containing agreements in accordance with this part;

(2) the agreements are made through certification from the chief executive officer of the State;

(3) with respect to such agreements, the application provides assurances of compliance satisfactory to the Secretary;

(4) the application contains the plan provisions and the information required to be submitted to the Secretary pursuant to section 1214; and

(5) the application otherwise 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 part.

SEC. 1218. [300d–18] DETERMINATION OF AMOUNT OF ALLOTMENT.

(a) MINIMUM ALLOTMENT.—Subject to the extent of amounts made available in appropriations Acts, the amount of an allotment under section 1211(a) for a State for a fiscal year shall be the greater of—

(1) the amount determined under subsection (b)(1); and

(2) $250,000 in the case of each of the several States, the District of Columbia, and the Commonwealth of Puerto Rico, and $50,000 in the case of each of the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(b) DETERMINATION UNDER FORMULA.—

(1) IN GENERAL.—The amount referred to in subsection (a)(1) for a State for a fiscal year is the sum of—

(A) an amount determined under paragraph (2); and

(B) an amount determined under paragraph (3).

(2) AMOUNT RELATING TO POPULATION.—The amount referred to in subparagraph (A) of paragraph (1) for a State for a fiscal year is the product of—

(A) an amount equal to 80 percent of the amounts appropriated under section 1232(a) for the fiscal year and available for allotment under section 1211(a); and

(B) a percentage equal to the quotient of—

(i) an amount equal to the population of the State; divided by

(ii) an amount equal to the population of all States.

(3) AMOUNT RELATING TO SQUARE MILEAGE.—The amount referred to in subparagraph (B) of paragraph (1) for a State for a fiscal year is the product of—

(A) an amount equal to 20 percent of the amounts appropriated under section 1232(a) for the fiscal year and available for allotment under section 1211(a); and

(B) a percentage equal to the quotient of—

(i) an amount equal to the lesser of 266,807 and the amount of the square mileage of the State; divided by

(ii) an amount equal to the sum of the respective amounts determined for the States under clause (i).

(c) DISPOSITION OF CERTAIN FUNDS APPROPRIATED FOR ALLOTMENTS.—

(1) IN GENERAL.—Amounts described in paragraph (2) shall, in accordance with paragraph (3), be allotted by the Secretary to States receiving payments under section 1211(a) for the fiscal year (other than any State referred to in paragraph (2)(C)).

(2) TYPE OF AMOUNTS.—The amounts referred to in paragraph (1) are any amounts made available pursuant to 1232(b)(3) that are not paid under section 1211(a) to a State as a result of—

(A) the failure of the State to submit an application under section 1217;

(B) the failure, in the determination of the Secretary, of the State to prepare within a reasonable period of time such application in compliance with such section; or

(C) the State informing the Secretary that the State does not intend to expend the full amount of the allotment made for the State.

(3) AMOUNT.—The amount of an allotment under paragraph (1) for a State for a fiscal year shall be an amount equal to the product of—

(A) an amount equal to the amount described in paragraph (2) for the fiscal year involved; and

(B) the percentage determined under subsection (b)(2) for the State.

SEC. 1219. [300d–19] FAILURE TO COMPLY WITH AGREEMENTS.

(a) REPAYMENT OF PAYMENTS.—

(1) REQUIREMENT.—The Secretary may, in accordance with subsection (b), require a State to repay any payments received by the State pursuant to section 1211(a) that the Secretary determines were not expended by the State in accordance with the agreements required to be made by the State as a condition of the receipt of payments under such section.

(2) OFFSET OF AMOUNTS.—If a State fails to make a repayment required in paragraph (1), the Secretary may offset the amount of the repayment against any amount due to be paid to the State under section 1211(a).

(b) OPPORTUNITY FOR A HEARING.—Before requiring repayment of payments under subsection (a)(1), the Secretary shall provide to the State an opportunity for a hearing.

SEC. 1220. [300d–20] PROHIBITION AGAINST CERTAIN FALSE STATEMENTS.

(a) IN GENERAL.—

(1) FALSE STATEMENTS OR REPRESENTATIONS.—A person may not knowingly and willfully make or cause to be made any false statement or representation of a material fact in connection with the furnishing of items or services for which payments may be made by a State from amounts paid to the State under section 1211(a).

(2) CONCEALING OR FAILING TO DISCLOSE INFORMATION.—A person with knowledge of the occurrence of any event affecting the right of the person to receive any payments from amounts paid to the State under section 1211(a) may not conceal or fail to disclose any such event with the intent of fraudulently securing such amount.

(b) CRIMINAL PENALTY FOR VIOLATION OF PROHIBITION.—Any person who violates a prohibition established in subsection (a) may for each violation be fined in accordance with title 18, United States Code, or imprisoned for not more than 5 years, or both.

SEC. 1221. [300d–21] TECHNICAL ASSISTANCE AND PROVISION BY SECRETARY OF SUPPLIES AND SERVICES IN LIEU OF GRANT FUNDS.

(a) TECHNICAL ASSISTANCE.—The Secretary shall, without charge to a State receiving payments under section 1211(a), provide to the State (or to any public or nonprofit private entity des-

ignated by the State) technical assistance with respect to the planning, development, and operation of any program carried out pursuant to section 1211(b). The Secretary may provide such technical assistance directly, through contract, or through grants.

(b) PROVISION BY SECRETARY OF SUPPLIES AND SERVICES IN LIEU OF GRANT FUNDS.—

(1) IN GENERAL.—Upon the request of a State receiving payments under section 1211(a), the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the State in carrying out section 1211(b) and, for such purpose, may detail to the State any officer or employee of the Department of Health and Human Services.

(2) REDUCTION IN PAYMENTS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of payments to the State under section 1211(a) by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Secretary. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

SEC. 1222. [300d–22] 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.

PART C—GENERAL PROVISIONS REGARDING PARTS A AND B

SEC. 1231. [300d–31] DEFINITIONS.

For purposes of this part and parts A and B:

(1) DESIGNATED TRAUMA CENTER.—The term "designated trauma center" means a trauma center designated in accordance with the modifications to the State plan described in section 1213.

(2) STATE PLAN REGARDING EMERGENCY MEDICAL SERVICES.—The term "State plan", with respect to the provision of emergency medical services, means a plan for a comprehensive, organized system to provide for the access, response, triage, field stabilization, transport, hospital stabilization, definitive care, and rehabilitation of patients of all ages with respect to emergency medical services.

(3) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(4) TRAUMA.—The term "trauma" means an injury resulting from exposure to—

(A) a mechanical force; or

(B) another extrinsic agent, including an extrinsic agent that is thermal, electrical, chemical, or radioactive.

(5) TRAUMA CARE COMPONENT OF STATE PLAN.—The term "trauma care component", with respect to components of the State plan for the provision of emergency medical services, means a plan for a comprehensive health care system, within rural and urban areas of the State, for the prompt recognition, prehospital care, emergency medical care, acute surgical and medical care, rehabilitation, and outcome evaluation of seriously injured patients.

SEC. 1232. [300d–32] 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 $24,000,000 for each of fiscal years 2023 through 2027.

(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.

(d) AUTHORITY.—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall transfer authority in administering grants and related authorities under such parts from the Administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.

PART D—TRAUMA CENTERS OPERATING IN AREAS SEVERELY AFFECTED BY DRUG-RELATED VIOLENCE

SEC. 1241. [300d–41] GRANTS FOR CERTAIN TRAUMA CENTERS.

(a) IN GENERAL.—The Secretary shall establish 3 programs to award grants to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers—

(1) to assist in defraying substantial uncompensated care costs;

(2) to further the core missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination with local and regional trauma systems, essential personnel and other fixed costs, and expenses associated with employee and non-employee physician services; and

(3) to provide emergency relief to ensure the continued and future availability of trauma services.

(b) MINIMUM QUALIFICATIONS OF TRAUMA CENTERS.—

(1) PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTAIN PROFESSIONAL GUIDELINES.—Except as provided in paragraph (2), the Secretary may not award a grant to a trauma center under subsection (a) unless the trauma center is a participant in a trauma system that substantially complies with section 1213.

(2) EXEMPTION.—Paragraph (1) shall not apply to trauma centers that are located in States with no existing trauma care system.

(3) QUALIFICATION FOR SUBSTANTIAL UNCOMPENSATED CARE COSTS.—The Secretary shall award substantial uncompensated care grants under subsection (a)(1) only to trauma centers meeting at least 1 of the criteria in 1 of the following 3 categories:

(A) CATEGORY A.—The criteria for category A are as follows:

(i) At least 40 percent of the visits in the emergency department of the hospital in which the trauma center is located were charity or self-pay patients.

(ii) At least 50 percent of the visits in such emergency department were Medicaid (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) and charity and self-pay patients combined.

(B) CATEGORY B.—The criteria for category B are as follows:

(i) At least 35 percent of the visits in the emergency department were charity or self-pay patients.

(ii) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

(C) CATEGORY C.—The criteria for category C are as follows:

(i) At least 20 percent of the visits in the emergency department were charity or self-pay patients.

(ii) At least 30 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

(4) TRAUMA CENTERS IN 1115 WAIVER STATES.—Notwithstanding paragraph (3), the Secretary may award a substantial uncompensated care grant to a trauma center under subsection (a)(1) if the trauma center qualifies for funds under a Low Income Pool or Safety Net Care Pool established through a waiver approved under section 1115 of the Social Security Act (42 U.S.C. 1315).

(5) DESIGNATION.—The Secretary may not award a grant to a trauma center unless such trauma center is verified by the American College of Surgeons or designated by an equivalent State or local agency.

(c) ADDITIONAL REQUIREMENTS.—The Secretary may not award a grant to a trauma center under subsection (a)(1) unless such trauma center—

(1) submits to the Secretary a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay; and

(2) has policies in place to assist patients who cannot pay for part or all of the care they receive, including a sliding fee scale, and to ensure fair billing and collection practices.

SEC. 1242. [300d–42] PREFERENCES IN MAKING GRANTS.

(a) SUBSTANTIAL UNCOMPENSATED CARE AWARDS.—

(1) IN GENERAL.—The Secretary shall establish an award basis for each eligible trauma center for grants under section 1241(a)(1) according to the percentage described in paragraph (2), subject to the requirements of section 1241(b)(3).

(2) PERCENTAGES.—The applicable percentages are as follows:

(A) With respect to a category A trauma center, 100 percent of the uncompensated care costs.

(B) With respect to a category B trauma center, not more than 75 percent of the uncompensated care costs.

(C) With respect to a category C trauma center, not more than 50 percent of the uncompensated care costs.

(b)[1] CORE MISSION AWARDS.—

(1) IN GENERAL.—In awarding grants under section 1241(a)(2), the Secretary shall—

(A) reserve 25 percent of the amount allocated for core mission awards for Level III and Level IV trauma centers; and

(B) reserve 25 percent of the amount allocated for core mission awards for large urban Level I and II trauma centers—

(i) that have at least 1 graduate medical education fellowship in trauma or trauma related specialties for which demand is exceeding supply;

(ii) for which—

(I) annual uncompensated care costs exceed $10,000,000; or

(II) at least 20 percent of emergency department visits are charity or self-pay or Medicaid patients; and

(iii) that are not eligible for substantial uncompensated care awards under section 1241(a)(1).

(c) EMERGENCY AWARDS.—In awarding grants under section 1241(a)(3), the Secretary shall—

(1) give preference to any application submitted by a trauma center that provides trauma care in a geographic area in which the availability of trauma care has significantly decreased or will significantly decrease if the center is forced to close or downgrade service or growth in demand for trauma services exceeds capacity; and

(2) reallocate any emergency awards funds not obligated due to insufficient, or a lack of qualified, applications to the significant uncompensated care award program.

[1] So in law. Subsection (b) includes a paragraph (1) but does not include subsequent paragaraphs.

SEC. 1243. [300d–43] CERTAIN AGREEMENTS.

(a) MAINTENANCE OF FINANCIAL SUPPORT.—The Secretary may require a trauma center receiving a grant under section 1241(a) to maintain access to trauma services at comparable levels to the prior year during the grant period.

(b) TRAUMA CARE REGISTRY.—The Secretary may require the trauma center receiving a grant under section 1241(a) to provide data to a national and centralized registry of trauma cases, in accordance with guidelines developed by the American College of Surgeons, and as the Secretary may otherwise require.

SEC. 1244. [300d–44] GENERAL PROVISIONS.

(a) APPLICATION.—The Secretary may not award a grant to a trauma center under section 1241(a) unless such center submits an application for the grant 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 part.

(b) LIMITATION ON DURATION OF SUPPORT.—The period during which a trauma center receives payments under a grant under section 1241(a)(3) shall be for 3 fiscal years, except that the Secretary may waive such requirement for a center and authorize such center to receive such payments for 1 additional fiscal year.

(c) LIMITATION ON AMOUNT OF GRANT.—Notwithstanding section 1242(a), a grant under section 1241 may not be made in an amount exceeding $2,000,000 for each fiscal year.

(d) ELIGIBILITY.—Except as provided in section 1242(b)(1)(B)(iii), acquisition of, or eligibility for, a grant under section 1241(a) shall not preclude a trauma center from being eligible for other grants described in such section.

(e) FUNDING DISTRIBUTION.—Of the total amount appropriated for a fiscal year under section 1245, 70 percent shall be used for substantial uncompensated care awards under section 1241(a)(1), 20 percent shall be used for core mission awards under section 1241(a)(2), and 10 percent shall be used for emergency awards under section 1241(a)(3).

(f) MINIMUM ALLOWANCE.—Notwithstanding subsection (e), if the amount appropriated for a fiscal year under section 1245 is less than $25,000,000, all available funding for such fiscal year shall be used for substantial uncompensated care awards under section 1241(a)(1).

(g) SUBSTANTIAL UNCOMPENSATED CARE AWARD DISTRIBUTION AND PROPORTIONAL SHARE.—Notwithstanding section 1242(a), of the amount appropriated for substantial uncompensated care grants for a fiscal year, the Secretary shall—

(1) make available—

(A) 50 percent of such funds for category A trauma center grantees;

(B) 35 percent of such funds for category B trauma center grantees; and

(C) 15 percent of such funds for category C trauma center grantees; and

(2) provide available funds within each category in a manner proportional to the award basis specified in section 1242(a)(2) to each eligible trauma center.

(h) REPORT.—Beginning 2 years after the date of enactment of the Patient Protection and Affordable Care Act, and every 2 years thereafter, the Secretary shall biennially report to Congress regarding the status of the grants made under section 1241 and on the overall financial stability of trauma centers.

SEC. 1245. [300d–45] AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out this part, there are authorized to be appropriated $100,000,000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2015. Such authorization of appropriations is in addition to any other authorization of appropriations or amounts that are available for such purpose.

SEC. 1246. [300d–46] DEFINITION.

In this part, the term "uncompensated care costs" means unreimbursed costs from serving self-pay, charity, or Medicaid patients, without regard to payment under section 1923 of the Social Security Act, all of which are attributable to emergency care and trauma care, including costs related to subsequent inpatient admissions to the hospital.

Part E—Miscellaneous Programs

SEC. 1251. [300d–51] 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 though 2012.

SEC. 1252. [300d–52] STATE GRANTS FOR PROJECTS REGARDING TRAUMATIC BRAIN INJURY.

(a) IN GENERAL.—The Secretary, acting through the Administrator for the Administration for Community Living, may make grants to States and American Indian consortia for the purpose of carrying out projects to improve access to rehabilitation and other services regarding traumatic brain injury.

(b) STATE ADVISORY BOARD.—

(1) IN GENERAL.—The Secretary may make a grant under subsection (a) only if the State or American Indian consortium involved agrees to establish an advisory board within the appropriate health department of the State or American Indian consortium or within another department as designated by the chief executive officer of the State or American Indian consortium.

(2) FUNCTIONS.—An advisory board established under paragraph (1) shall advise and make recommendations to the

State or American Indian consortium on ways to improve services coordination regarding traumatic brain injury. Such advisory boards shall encourage citizen participation through the establishment of public hearings and other types of community outreach programs. In developing recommendations under this paragraph, such boards shall consult with Federal, State, and local governmental agencies and with citizens groups and other private entities.

(3) COMPOSITION.—An advisory board established under paragraph (1) shall be composed of—

(A) representatives of—

(i) the corresponding State or American Indian consortium agencies involved;

(ii) public and nonprofit private health related organizations;

(iii) other disability advisory or planning groups within the State or American Indian consortium;

(iv) members of an organization or foundation representing individuals with traumatic brain injury in that State or American Indian consortium; and

(v) injury control programs at the State or local level if such programs exist; and

(B) a substantial number of individuals with traumatic brain injury, or the family members of such individuals.

(c) MATCHING FUNDS.—

(1) IN GENERAL.—With respect to the costs to be incurred by a State or American Indian consortium in carrying out the purpose described in subsection (a), the Secretary may make a grant under such subsection only if the State or American Indian consortium agrees to make available non-Federal contributions toward such costs in an amount that is not less than $1 for each $2 of Federal funds provided under the grant.

(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) APPLICATION FOR GRANT.—The Secretary may make a grant under subsection (a) only if 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.

(e) USE OF STATE AND AMERICAN INDIAN CONSORTIUM GRANTS.—

(1) COMMUNITY SERVICES AND SUPPORTS.—A State or American Indian consortium shall (directly or through awards of contracts to nonprofit private entities) use amounts received under a grant under this section for the following:

(A) To develop, change, or enhance community-based service delivery systems that include timely access to com-

prehensive appropriate services and supports. Such service and supports—

(i) shall promote full participation by individuals with traumatic brain injury and their families in decision making regarding the services and supports; and

(ii) shall be designed for children, youth, and adults with traumatic brain injury.

(B) To focus on outreach to underserved and inappropriately served individuals, such as individuals in institutional settings, individuals with low socioeconomic resources, individuals in rural communities, and individuals in culturally and linguistically diverse communities.

(C) To award contracts to nonprofit entities for consumer or family service access training, consumer support, peer mentoring, and parent to parent programs.

(D) To develop individual and family service coordination or case management systems.

(E) To support other needs identified by the advisory board under subsection (b) for the State or American Indian consortium involved.

(2) BEST PRACTICES.—

(A) IN GENERAL.—State or American Indian consortium services and supports provided under a grant under this section shall reflect the best practices in the field of traumatic brain injury, shall be in compliance with title II of the Americans with Disabilities Act of 1990, and shall be supported by quality assurance measures as well as state-of-the-art health care and integrated community supports, regardless of the severity of injury.

(B) DEMONSTRATION BY STATE AGENCY.—The State or American Indian consortium agency responsible for administering amounts received under a grant under this section shall demonstrate that it has obtained knowledge and expertise of traumatic brain injury and the unique needs associated with traumatic brain injury.

(3) STATE CAPACITY BUILDING.—A State or American Indian consortium may use amounts received under a grant under this section to—

(A) educate consumers and families;

(B) train professionals in public and private sector financing (such as third party payers, State agencies, community-based providers, schools, and educators);

(C) develop or improve case management or service coordination systems;

(D) develop best practices in areas such as family or consumer support, return to work, housing or supportive living personal assistance services, assistive technology and devices, behavioral health services, substance abuse services, and traumatic brain injury treatment and rehabilitation;

(E) tailor existing State or American Indian consortium systems to provide accommodations to the needs of individuals with traumatic brain injury (including systems administered by the State or American Indian consortium

departments responsible for health, mental health, labor/employment, education, intellectual disabilities or developmental disorders, transportation, and correctional systems);

(F) improve data sets coordinated across systems and other needs identified by a State or American Indian consortium plan supported by its advisory council; and

(G) develop capacity within targeted communities.

(f) COORDINATION OF ACTIVITIES.—The Secretary shall ensure that activities under this section are coordinated as appropriate with other Federal agencies that carry out activities regarding traumatic brain injury.

(g) REPORT.—Not less than biennially, the Secretary shall submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Health, Education, Labor, and Pensions of the Senate, a report describing the findings and results of the programs established under this section and section 1253, including measures of outcomes and consumer and surrogate satisfaction.

(h) DEFINITIONS.—For purposes of this section:

(1) The terms "American Indian consortium" and "State" have the meanings given to those terms in section 1253.

(2) The term "traumatic brain injury" means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to trauma. The Secretary may revise the definition of such term as the Secretary determines necessary, after consultation with States and other appropriate public or nonprofit private entities.

(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $7,321,000 for each of fiscal years 2020 through 2024.

SEC. 1253. [300d–53] STATE GRANTS FOR PROTECTION AND ADVOCACY SERVICES.

(a) IN GENERAL.—The Secretary, acting through the Administrator for the Administration for Community Living, shall make grants to protection and advocacy systems for the purpose of enabling such systems to provide services to individuals with traumatic brain injury.

(b) SERVICES PROVIDED.—Services provided under this section may include the provision of—

(1) information, referrals, and advice;

(2) individual and family advocacy;

(3) legal representation; and

(4) specific assistance in self-advocacy.

(c) APPLICATION.—To be eligible to receive a grant under this section, a protection and advocacy system shall submit an application to the Secretary at such time, in such form and manner, and accompanied by such information and assurances as the Secretary may require.

(d) APPROPRIATIONS LESS THAN $2,700,000.—

(1) IN GENERAL.—With respect to any fiscal year in which the amount appropriated under subsection (l) to carry out this

section is less than $2,700,000, the Secretary shall make grants from such amount to individual protection and advocacy systems within States to enable such systems to plan for, develop outreach strategies for, and carry out services authorized under this section for individuals with traumatic brain injury.

(2) AMOUNT.—The amount of each grant provided under paragraph (1) shall be determined as set forth in paragraphs (2) and (3) of subsection (e).

(e) APPROPRIATIONS OF $2,700,000 OR MORE.—

(1) POPULATION BASIS.—Except as provided in paragraph (2), with respect to each fiscal year in which the amount appropriated under subsection (l) to carry out this section is $2,700,000 or more, the Secretary shall make a grant to a protection and advocacy system within each State.

(2) AMOUNT.—The amount of a grant provided to a system under paragraph (1) shall be equal to an amount bearing the same ratio to the total amount appropriated for the fiscal year involved under subsection (l) as the population of the State in which the grantee is located bears to the population of all States.

(3) MINIMUMS.—Subject to the availability of appropriations, the amount of a grant a protection and advocacy system under paragraph (1) for a fiscal year shall—

(A) in the case of a protection and advocacy system located in American Samoa, Guam, the United States Virgin Islands, or the Commonwealth of the Northern Mariana Islands, and the protection and advocacy system serving the American Indian consortium, not be less than $20,000; and

(B) in the case of a protection and advocacy system in a State not described in subparagraph (A), not be less than $50,000.

(4) INFLATION ADJUSTMENT.—For each fiscal year in which the total amount appropriated under subsection (l) to carry out this section is $5,000,000 or more, and such appropriated amount exceeds the total amount appropriated to carry out this section in the preceding fiscal year, the Secretary shall increase each of the minimum grants amount described in subparagraphs (A) and (B) of paragraph (3) by a percentage equal to the percentage increase in the total amount appropriated under subsection (l) to carry out this section between the preceding fiscal year and the fiscal year involved.

(f) CARRYOVER.—Any amount paid to a protection and advocacy system that serves a State or the American Indian consortium for a fiscal year under this section that remains unobligated at the end of such fiscal year shall remain available to such system for obligation during the next fiscal year for the purposes for which such amount was originally provided.

(g) DIRECT PAYMENT.—Notwithstanding any other provision of law, each fiscal year not later than October 1, the Secretary shall pay directly to any protection and advocacy system that complies with the provisions of this section, the total amount of the grant for such system, unless the system provides otherwise for such payment.

(h) REPORTING.—[2]

(1) REPORTS BY SYSTEMS.—Each protection and advocacy system that receives a payment under this section shall submit an annual report to the Secretary concerning the services provided to individuals with traumatic brain injury by such system.

(2) REPORT BY SECRETARY.—Not later than 1 year after the date of enactment of the Traumatic Brain Injury Reauthorization Act of 2014, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the services and activities carried out under this section during the period for which the report is being prepared.

(i) DATA COLLECTION.—The Secretary shall facilitate agreements to coordinate the collection of data by agencies within the Department of Health and Human Services regarding protection and advocacy services.

(j) TRAINING AND TECHNICAL ASSISTANCE.—

(1) GRANTS.—For any fiscal year for which the amount appropriated to carry out this section is $6,000,000 or greater, the Secretary shall use 2 percent of such amount to make a grant to an eligible national association for providing for training and technical assistance to protection and advocacy systems.

(2) DEFINITION.—In this subsection, the term "eligible national association" means a national association with demonstrated experience in providing training and technical assistance to protection and advocacy systems.

(k) SYSTEM AUTHORITY.—In providing services under this section, a protection and advocacy system shall have the same authorities, including access to records, as such system would have for purposes of providing services under subtitle C of title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15041 et seq.).

(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $4,000,000 for each of fiscal years 2020 through 2024.

(m) DEFINITIONS.—In this section:

(1) AMERICAN INDIAN CONSORTIUM.—The term "American Indian consortium" means a consortium established under subtitle C of title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15041 et seq.).

(2) PROTECTION AND ADVOCACY SYSTEM.—The term "protection and advocacy system" means a protection and advocacy system established under subtitle C of title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15041 et seq.).

(3) STATE.—The term "State", unless otherwise specified, means the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United

[2] The formatting of heading of subsection (h), as amended by section 4(3) of Public Law 113–196, reflects the probable intent of Congress. The matter being inserted should have appeared in light typeface with an initial cap and small caps letters. Also, a period and a dash should have been included at the end.

States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

SEC. 1254. [300d–54] STOP, OBSERVE, ASK, AND RESPOND TO HEALTH AND WELLNESS TRAINING PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a program to be known as the Stop, Observe, Ask, and Respond to Health and Wellness Training Program or the SOAR to Health and Wellness Training Program (in this section referred to as the "Program") to provide training to health care and social service providers on human trafficking in accordance with this section.

(b) ACTIVITIES.—

(1) IN GENERAL.—The Program shall include the Stop, Observe, Ask, and Respond to Health and Wellness Training Program's activities existing on the day before the date of enactment of this section and the authorized initiatives described in paragraph (2).

(2) AUTHORIZED INITIATIVES.—The authorized initiatives of the Program shall include—

(A) engaging stakeholders, including victims of human trafficking and Federal, State, local, and tribal partners, to develop a flexible training module—

(i) for supporting activities under subsection (c); and

(ii) that adapts to changing needs, settings, health care providers, and social service providers;

(B) providing technical assistance to grantees related to implementing activities described in subsection (c) and reporting on any best practices identified by the grantees;

(C) developing a reliable methodology for collecting data, and reporting such data, on the number of human trafficking victims identified and served by grantees in a manner that, at a minimum, prevents disclosure of individually identifiable information consistent with all applicable privacy laws and regulations; and

(D) integrating, as appropriate, the training described in paragraphs (1) through (4) of subsection (c) with training programs, in effect on the date of enactment of this section, for health care and social service providers for victims of intimate partner violence, sexual assault, stalking, child abuse, child neglect, child maltreatment, and child sexual exploitation.

(c) GRANTS.—The Secretary may award grants to appropriate entities to train health care and social service providers to—

(1) identify potential human trafficking victims;

(2) implement best practices for working with law enforcement to report and facilitate communication with human trafficking victims, in accordance with all applicable Federal, State, local, and tribal laws, including legal confidentiality requirements for patients and health care and social service providers;

(3) implement best practices for referring such victims to appropriate health care, social, or victims service agencies or organizations; and

(4) provide such victims with coordinated, age-appropriate, culturally relevant, trauma-informed, patient-centered, and evidence-based care.

(d) CONSIDERATION IN AWARDING GRANTS.—The Secretary, in making awards under this section, shall give consideration to—

(1) geography;

(2) the demographics of the population to be served;

(3) the predominant types of human trafficking cases involved; and

(4) health care and social service provider profiles.

(e) DATA COLLECTION AND REPORTING.—

(1) IN GENERAL.—The Secretary shall collect data and report on the following:

(A) The total number of entities that received a grant under this section.

(B) The total number and geographic distribution of health care and social service providers trained through the Program.

(2) INITIAL REPORT.—In addition to the data required to be collected under paragraph (1), for purposes of the initial report to be submitted under paragraph (3), the Secretary shall collect data on the total number of facilities and health care professional organizations that were operating under, and the total number of health care and social service providers trained through, the Stop, Observe, Ask, and Respond to Health and Wellness Training Program existing prior to the establishment of the Program under this section.

(3) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this section, and annually thereafter, the Secretary shall submit an annual report to Congress on the data collected under this subsection in a manner that, at a minimum, prevents the disclosure of individually identifiable information consistent with all applicable privacy laws and regulations.

(f) SHARING BEST PRACTICES.—The Secretary shall make available, on the Internet website of the Department of Health and Human Services, a description of the best practices and procedures used by entities that receive a grant for carrying out activities under this section.

(g) DEFINITION.—In this section, the term "human trafficking" has the meaning given the term "severe forms of trafficking in persons" as defined in section 103 of the Trafficking Victims Protection Act of 2000.

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this Act, $4,000,000 for each of fiscal years 2020 through 2024.

PART F—INTERAGENCY PROGRAM FOR TRAUMA RESEARCH

SEC. 1261. [300d–61] ESTABLISHMENT OF PROGRAM.

(a) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health (in this section referred to as the "Director"), shall establish a comprehensive program of conducting basic and clinical research on trauma (in this section referred to as

the "Program"). The Program shall include research regarding the diagnosis, treatment, rehabilitation, and general management of trauma.

(b) PLAN FOR PROGRAM.—

(1) IN GENERAL.—The Director, in consultation with the Trauma Research Interagency Coordinating Committee established under subsection (g), shall establish and implement a plan for carrying out the activities of the Program, including the activities described in subsection (d). All such activities shall be carried out in accordance with the plan. The plan shall be periodically reviewed, and revised as appropriate.

(2) SUBMISSION TO CONGRESS.—Not later than December 1, 1993, the Director shall submit the plan required in paragraph (1) to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Health, Education, Labor, and Pensions of the Senate, together with an estimate of the funds needed for each of the fiscal years 1994 through 1996 to implement the plan.

(c) PARTICIPATING AGENCIES; COORDINATION AND COLLABORATION.—The Director—

(1) shall provide for the conduct of activities under the Program by the Directors of the agencies of the National Institutes of Health involved in research with respect to trauma;

(2) shall ensure that the activities of the Program are coordinated among such agencies; and

(3) shall, as appropriate, provide for collaboration among such agencies in carrying out such activities.

(d) CERTAIN ACTIVITIES OF PROGRAM.—The Program shall include—

(1) studies with respect to all phases of trauma care, including prehospital, resuscitation, surgical intervention, critical care, infection control, wound healing, nutritional care and support, and medical rehabilitation care;

(2) basic and clinical research regarding the response of the body to trauma and the acute treatment and medical rehabilitation of individuals who are the victims of trauma;

(3) basic and clinical research regarding trauma care for pediatric and geriatric patients; and

(4) the authority to make awards of grants or contracts to public or nonprofit private entities for the conduct of basic and applied research regarding traumatic brain injury, which research may include—

(A) the development of new methods and modalities for the more effective diagnosis, measurement of degree of brain injury, post-injury monitoring and prognostic assessment of head injury for acute, subacute and later phases of care;

(B) the development, modification and evaluation of therapies that retard, prevent or reverse brain damage after acute head injury[3], that arrest further deterioration

[3] Section 1303(a)(2) of Public Law 106–310 (114 Stat. 1138) provides that subparagraph (B) is amended by striking "acute injury" and inserting "acute brain injury". The amendment cannot

Continued

following injury and that provide the restitution of function for individuals with long-term injuries;

(C) the development of research on a continuum of care from acute care through rehabilitation, designed, to the extent practicable, to integrate rehabilitation and long-term outcome evaluation with acute care research;

(D) the development of programs that increase the participation of academic centers of excellence in brain injury treatment and rehabilitation research and training; and

(E) carrying out subparagraphs (A) through (D) with respect to cognitive disorders and neurobehavioral consequences arising from traumatic brain injury, including the development, modification, and evaluation of therapies and programs of rehabilitation toward reaching or restoring normal capabilities in areas such as reading, comprehension, speech, reasoning, and deduction.

(e) MECHANISMS OF SUPPORT.—In carrying out the Program, the Director, acting through the Directors of the agencies referred to in subsection (c)(1), may make grants to public and nonprofit entities, including designated trauma centers.

(f) RESOURCES.—The Director shall assure the availability of appropriate resources to carry out the Program, including the plan established under subsection (b) (including the activities described in subsection (d)).

(g) COORDINATING COMMITTEE.—

(1) IN GENERAL.—There shall be established a Trauma Research Interagency Coordinating Committee (in this section referred to as the "Coordinating Committee").

(2) DUTIES.—The Coordinating Committee shall make recommendations regarding—

(A) the activities of the Program to be carried out by each of the agencies represented on the Committee and the amount of funds needed by each of the agencies for such activities; and

(B) effective collaboration among the agencies in carrying out the activities.

(3) COMPOSITION.—The Coordinating Committee shall be composed of the Directors of each of the agencies that, under subsection (c), have responsibilities under the Program, and any other individuals who are practitioners in the trauma field as designated by the Director of the National Institutes of Health.

(h) DEFINITIONS.—For purposes of this section:

(1) The term "designated trauma center" has the meaning given such term in section 1231(1).

(2) The term "Director" means the Director of the National Institutes of Health.

(3) The term "trauma" means an injury resulting from exposure to—

(A) a mechanical force; or

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be executed because the term to be struck does not appear in subparagraph (B). (Compare "acute injury" and "acute head injury".)

(B) another extrinsic agent, including an extrinsic agent that is thermal, electrical, chemical, or radioactive.

(4) The term "traumatic brain injury" means an acquired injury to the brain. Such term does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma, but may include brain injuries caused by anoxia due to trauma. The Secretary may revise the definition of such term as the Secretary determines necessary, after consultation with States and other appropriate public or nonprofit private entities.

(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005, and such sums as may be necessary for each of the fiscal years 2009 through 2012.

PART G—POISON CONTROL

SEC. 1271. [300d–71] MAINTENANCE OF THE NATIONAL TOLL-FREE NUMBER AND OTHER COMMUNICATION CAPABILITIES.

(a) IN GENERAL.—The Secretary—

(1) shall provide coordination and assistance to poison control centers for the establishment and maintenance of a nationwide toll-free phone number, to be used to access such centers; and

(2) may provide coordination and assistance to poison control centers and consult with professional organizations for the establishment, implementation, and maintenance of other communication technologies to be used to access such centers.

(b) ROUTING CONTACTS WITH POISON CONTROL CENTERS.—Not later than 18 months after the date of enactment of this subsection, the Secretary shall coordinate with the Chairman of the Federal Communications Commission, to the extent technically and economically feasible, to ensure that communications with the national toll-free number are routed to the appropriate poison control center based on the physical location of the contact rather than the area code of the contact device.

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $700,000 for each of fiscal years 2025 through 2029 for the establishment, implementation, and maintenance activities carried out under subsections (a) and (b).

SEC. 1272. [300d–72] PROMOTING POISON CONTROL CENTER UTILIZATION.

(a) IN GENERAL.—The Secretary shall carry out, and expand upon, a national media campaign to educate and support outreach to the public and health care providers about poisoning and toxic exposure prevention and the availability of poison control center resources in local communities and to conduct advertising campaigns concerning the nationwide toll-free number and other available communication technologies established, implemented, or maintained under section 1271(a).

(b) CONTRACT WITH ENTITY.—The Secretary may carry out subsection (a) by entering into contracts with one or more public

or private entities, including nationally recognized organizations in the field of poison control and national media firms, for the development and implementation of a nationwide poisoning and toxic exposure prevention and poison control center awareness campaign, which may include—

(1) the development and distribution of poisoning and toxic exposure prevention awareness materials, applicable public health emergency preparedness and response information, and poison control center awareness materials;

(2) television, radio, Internet, and newspaper public service announcements; and

(3) other activities to provide for public and professional awareness and education.

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $800,000 for each of fiscal years 2025 through 2029.

SEC. 1273. [300d–73] MAINTENANCE OF THE POISON CONTROL CENTER GRANT PROGRAM.

(a) AUTHORIZATION OF PROGRAM.—The Secretary shall award grants to poison control centers accredited under subsection (c) (or granted a waiver under subsection (d)) and professional organizations in the field of poison control for the purposes of preventing, and providing treatment recommendations for, poisonings and toxic exposures and complying with the operational requirements needed to sustain the accreditation of the center under subsection (c).

(b) ADDITIONAL USES OF FUNDS.—In addition to the purposes described in subsection (a), a poison center or professional organization awarded a grant, contract, or cooperative agreement under such subsection may also use amounts received under such grant, contract, or cooperative agreement—

(1) to research, establish, implement, and evaluate best practices in the United States for poisoning and toxic exposure prevention, poison control center outreach, and emergency preparedness and response programs;

(2) to research, develop, implement, revise, and communicate standard patient management guidelines for commonly encountered toxic exposures;

(3) to improve national toxic exposure surveillance by enhancing cooperative activities between poison control centers in the United States, the Centers for Disease Control and Prevention, and other government agencies as determined to be appropriate and nonduplicative by the Secretary;

(4) to research, improve, and enhance the communications and response capability and capacity of the nation's network of poison control centers to facilitate increased access to the centers through the integration and modernization of the current poison control centers communications and data system, including enhancing the network's telephony, Internet, data and social networking technologies;

(5) to develop, support, and enhance technology and capabilities of professional organizations in the field of poison control to collect national poisoning, toxic occurrence, and related public health data;

(6) to develop initiatives to foster the enhanced public health utilization of national poison data collected by organizations described in paragraph (5);

(7) to support and expand the toxicologic expertise within poison control centers; and

(8) to improve the capacity of poison control centers to answer high volumes of contacts and Internet communications, and to sustain and enhance the poison control center's network capability to respond during times of national crisis or other public health emergencies.

(c) ACCREDITATION.—Except as provided in subsection (d), the Secretary may award a grant to a poison control center under subsection (a) only if—

(1) the center has been accredited by a professional organization in the field of poison control, and the Secretary has approved the organization as having in effect standards for accreditation that reasonably provide for the protection of the public health with respect to poisoning; or

(2) the center has been accredited by a State government, and the Secretary has approved the State government as having in effect standards for accreditation that reasonably provide for the protection of the public health with respect to poisoning.

(d) WAIVER OF ACCREDITATION REQUIREMENTS.—

(1) IN GENERAL.—The Secretary may grant a waiver of the accreditation requirements of subsection (c) with respect to a nonaccredited poison control center that applies for a grant under this section if such center can reasonably demonstrate that the center will obtain such an accreditation within a reasonable period of time as determined appropriate by the Secretary.

(2) RENEWAL.—The Secretary may renew a waiver under paragraph (1).

(3) LIMITATION.—

(A) IN GENERAL.—The sum of the number of years for a waiver under paragraph (1) and a renewal under paragraph (2) may not exceed 5 years.

(B) PUBLIC HEALTH EMERGENCY.—Notwithstanding any previous waivers, in the case of a poison control center whose accreditation is affected by a public health emergency declared pursuant to section 319, the Secretary may, as the circumstances of the emergency reasonably require, provide a waiver under paragraph (1) or a renewal under paragraph (2), not to exceed 2 years. The Secretary may require quarterly reports and other information related to such a waiver or renewal under this paragraph.

(e) SUPPLEMENT NOT SUPPLANT.—Amounts made available to a poison control center under this section shall be used to supplement and not supplant other Federal, State or local funds provided for such center.

(f) MAINTENANCE OF EFFORT.—With respect to activities for which a grant is awarded under this section, the Secretary may require that poison control centers agree to maintain the expenditures of the center for such activities at a level that is not less than

the level of expenditures maintained by the center for the fiscal year preceding the fiscal year for which the grant is received.

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $28,600,000 for each of fiscal years 2025 through 2029. The Secretary may utilize an amount not to exceed 6 percent of the amount appropriated under this preceding sentence in each fiscal year for coordination, dissemination, technical assistance, program evaluation, data activities, and other program administration functions, which are determined by the Secretary to be appropriate for carrying out the program under this section.

(h) BIENNIAL REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and Committee on Energy and Commerce of the House of Representatives a report concerning the operations of, and trends identified by, the Poison Control Network. Such report shall include—

(1) descriptions of the activities carried out pursuant to sections 1271, 1272, and 1273, and the alignment of such activities with the purposes provided under subsection (a);

(2) a description of trends in volume of contacts to poison control centers;

(3) a description of trends in poisonings and toxic exposures reported to poison control centers, as applicable and appropriate;

(4) an assessment of the impact of the public awareness campaign, including any geographic variations;

(5) a description of barriers, if any, preventing poison control centers from achieving the purposes and programs under this section and sections 1271 and 1272;

(6) a description of the standards for accreditation described in subsection (c), including any variations in those standards, and any efforts to create and maintain consistent standards across organizations that accredit poison control centers; and

(7) the number of and reason for any waivers provided under subsection (d).

SEC. 1274. [300d–74] RULE OF CONSTRUCTION.

Nothing in this part may be construed to ease any restriction in Federal law applicable to the amount or percentage of funds appropriated to carry out this part that may be used to prepare or submit a report.

PART H—TRAUMA SERVICE AVAILABILITY

SEC. 1281. [300d–81] GRANTS TO STATES.

(a) ESTABLISHMENT.—To promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties, the Secretary shall provide funding to States to enable such States to award grants to eligible entities for the purposes described in this section.

(b) AWARDING OF GRANTS BY STATES.—Each State may award grants to eligible entities within the State for the purposes described in subparagraph (d).

(c) ELIGIBILITY.—

(1) IN GENERAL.—To be eligible to receive a grant under subsection (b) an entity shall—

(A) be—

(i) a public or nonprofit trauma center or consortium thereof that meets that requirements of paragraphs (1), (2), and (5) of section 1241(b);

(ii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 1241(b); or

(iii) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services; and

(B) submit to the State an application at such time, in such manner, and containing such information as the State may require.

(2) LIMITATION.—A State shall use at least 40 percent of the amount available to the State under this part for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

(d) USE OF FUNDS.—The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b):

(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the region involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

(2) Providing for individual safety net trauma center fiscal stability and costs related to having service that is available 24 hours a day, 7 days a week, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

(3) Reducing trauma center overcrowding at specific trauma centers related to throughput of trauma patients.

(4) Establishing new trauma services in underserved areas as defined by the State.

(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

(7) Enhancing trauma surge capacity at specific trauma centers.

(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

(9) Enhancing interstate trauma center collaboration.

(e) LIMITATION.—

(1) IN GENERAL.—A State may use not more than 20 percent of the amount available to the State under this part for

a fiscal year for administrative costs associated with awarding grants and related costs.

(2) MAINTENANCE OF EFFORT.—The Secretary may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.

(f) DISTRIBUTION OF FUNDS.—The following shall apply with respect to grants provided in this part:

(1) LESS THAN $10,000,000.—If the amount of appropriations for this part in a fiscal year is less than $10,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3)(A).

(2) LESS THAN $20,000,000.—If the amount of appropriations in a fiscal year is less than $20,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under subparagraphs (A) and (B) of section 1241(b)(3).

(3) LESS THAN $30,000,000.—If the amount of appropriations for this part in a fiscal year is less than $30,000,000, the Secretary shall divide such funding evenly among only those States that have 1 or more trauma centers eligible for funding under section 1241(b)(3).

(4) $30,000,000 OR MORE.—If the amount of appropriations for this part in a fiscal year is $30,000,000 or more, the Secretary shall divide such funding evenly among all States.

SEC. 1282. [300d–82] AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out this part, there is authorized to be appropriated $100,000,000 for each of fiscal years 2010 through 2015.

PART I—MILITARY AND CIVILIAN PARTNERSHIP FOR TRAUMA READINESS GRANT PROGRAM

SEC. 1291. [300d–91] MILITARY AND CIVILIAN PARTNERSHIP FOR TRAUMA READINESS GRANT PROGRAM.

(a) MILITARY TRAUMA TEAM PLACEMENT PROGRAM.—

(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response and in consultation with the Secretary of Defense, shall award grants to not more than 20 eligible high-acuity trauma centers to enable military trauma teams to provide, on a full-time basis, trauma care and related acute care at such trauma centers.

(2) LIMITATIONS.—In the case of a grant awarded under paragraph (1) to an eligible high-acuity trauma center, such grant—

(A) shall be for a period of at least 3 years and not more than 5 years (and may be renewed at the end of such period); and

(B) shall be in an amount that does not exceed $1,000,000 per year.

(3) AVAILABILITY OF FUNDS.—Notwithstanding section 1552 of title 31, United States Code, or any other provision of law, funds available to the Secretary for obligation for a grant under this subsection shall remain available for expenditure for 100 days after the last day of the performance period of such grant.

(b) MILITARY TRAUMA CARE PROVIDER PLACEMENT PROGRAM.—

(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Preparedness and Response and in consultation with the Secretary of Defense, shall award grants to eligible trauma centers to enable military trauma care providers to provide trauma care and related acute care at such trauma centers.

(2) LIMITATIONS.—In the case of a grant awarded under paragraph (1) to an eligible trauma center, such grant—

(A) shall be for a period of at least 1 year and not more than 3 years (and may be renewed at the end of such period); and

(B) shall be in an amount that does not exceed, in a year—

(i) $100,000 for each military trauma care provider that is a physician at such eligible trauma center; and

(ii) $50,000 for each other military trauma care provider at such eligible trauma center.

(c) GRANT REQUIREMENTS.—

(1) DEPLOYMENT AND PUBLIC HEALTH EMERGENCIES.—As a condition of receipt of a grant under this section, a grant recipient shall agree to allow military trauma care providers providing care pursuant to such grant to—

(A) be deployed by the Secretary of Defense for military operations, for training, or for response to a mass casualty incident; and

(B) be deployed by the Secretary of Defense, in consultation with the Secretary of Health and Human Services, for response to a public health emergency pursuant to section 319.

(2) USE OF FUNDS.—Grants awarded under this section to an eligible trauma center may be used to train and incorporate military trauma care providers into such trauma center, including incorporation into operational exercises and training drills related to public health emergencies, expenditures for malpractice insurance, office space, information technology, specialty education and supervision, trauma programs, research, and applicable license fees for such military trauma care providers.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to affect any other provision of law that preempts State licensing requirements for health care professionals, including with respect to military trauma care providers.

(e) REPORTING REQUIREMENTS.—

(1) REPORT TO THE SECRETARY AND THE SECRETARY OF DEFENSE.—Each eligible trauma center or eligible high-acuity trauma center awarded a grant under subsection (a) or (b) for

a year shall submit to the Secretary and the Secretary of Defense a report for such year that includes information on—

(A) the number and types of trauma cases managed by military trauma teams or military trauma care providers pursuant to such grant during such year;

(B) the ability to maintain the integration of the military trauma providers or teams of providers as part of the trauma center, including the financial effect of such grant on the trauma center;

(C) the educational effect on resident trainees in centers where military trauma teams are assigned;

(D) any research conducted during such year supported by such grant; and

(E) any other information required by the Secretaries for the purpose of evaluating the effect of such grant.

(2) REPORT TO CONGRESS.—Not less than once every 2 years, the Secretary, in consultation with the Secretary of Defense, shall submit a report to the congressional committees of jurisdiction that includes information on the effect of placing military trauma care providers in trauma centers awarded grants under this section on—

(A) maintaining military trauma care providers' readiness and ability to respond to and treat battlefield injuries;

(B) providing health care to civilian trauma patients in urban and rural settings;

(C) the capability of trauma centers and military trauma care providers to increase medical surge capacity, including as a result of a large-scale event;

(D) the ability of grant recipients to maintain the integration of the military trauma providers or teams of providers as part of the trauma center;

(E) efforts to incorporate military trauma care providers into operational exercises and training and drills for public health emergencies; and

(F) the capability of military trauma care providers to participate as part of a medical response during or in advance of a public health emergency, as determined by the Secretary, or a mass casualty incident.

(f) DEFINITIONS.—For purposes of this part:

(1) ELIGIBLE HIGH-ACUITY TRAUMA CENTER.—The term "eligible high-acuity trauma center" means a Level I trauma center that satisfies each of the following:

(A) Such trauma center has an agreement with the Secretary of Defense to enable military trauma teams to provide trauma care and related acute care at such trauma center.

(B) At least 20 percent of patients treated at such trauma center in the most recent 3-month period for which data are available are treated for a major trauma at such trauma center.

(C) Such trauma center utilizes a risk-adjusted benchmarking system and metrics to measure performance, quality, and patient outcomes.

(D) Such trauma center is an academic training center—

(i) affiliated with a medical school;

(ii) that maintains residency programs and fellowships in critical trauma specialties and subspecialties, and provides education and supervision of military trauma team members according to those specialties and subspecialties; and

(iii) that undertakes research in the prevention and treatment of traumatic injury.

(E) Such trauma center serves as a medical and public health preparedness and response leader for its community, such as by participating in a partnership for State and regional hospital preparedness established under section 319C–2 or 319C–3.

(2) ELIGIBLE TRAUMA CENTER.—The term "eligible trauma center" means a Level I, II, or III trauma center that satisfies each of the following:

(A) Such trauma center has an agreement with the Secretary of Defense to enable military trauma care providers to provide trauma care and related acute care at such trauma center.

(B) Such trauma center utilizes a risk-adjusted benchmarking system and metrics to measure performance, quality, and patient outcomes.

(C) Such trauma center demonstrates a need for integrated military trauma care providers to maintain or improve the trauma clinical capability of such trauma center.

(3) MAJOR TRAUMA.—The term "major trauma" means an injury that is greater than or equal to 15 on the injury severity score.

(4) MILITARY TRAUMA TEAM.—The term "military trauma team" means a complete military trauma team consisting of military trauma care providers.

(5) MILITARY TRAUMA CARE PROVIDER.—The term "military trauma care provider" means a member of the Armed Forces who furnishes emergency, critical care, and other trauma acute care services (including a physician, surgeon, physician assistant, nurse, nurse practitioner, respiratory therapist, flight paramedic, combat medic, or enlisted medical technician) or other military trauma care provider as the Secretary determines appropriate.

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $11,500,000 for each of fiscal years 2019 through 2023.