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

(4) provide to State and local agencies technical assistance to enhance each State’s capability to develop, implement, and sustain the trauma care component of each State’s plan.
for the provision of emergency medical services;
(5) sponsor workshops and conferences; and
(6) promote the collection and categorization of trauma data in a consistent and standardized manner.

(b) Grants, cooperative agreements, and contracts

The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).

(7) The Secretary may make grants, and enter into cooperative agreements and contracts, for the purpose of carrying out subsection (a).

(Prior Provisions


Amendments

2007—Pub. L. 110–23 amended section generally. Prior to amendment, section required the Secretary to provide support to trauma care, authorized the Secretary to make grants and enter into agreements for such support, and required the Administrator of the Health Resources and Services Administration to ensure that the Division of Trauma and Emergency Medical Systems administered this subchapter.

Effective date of 1996 amendment


Congressional statement of findings

Section 2 of Pub. L. 101–590 provided that: “The Congress finds that—

‘‘(1) the Federal Government and the governments of the States have established a history of cooperation in the development, implementation, and monitoring of integrated, comprehensive systems for the provision of emergency medical services throughout the United States;

‘‘(2) physical trauma is the leading cause of death of Americans between the ages of 1 and 44 and is the third leading cause of death in the general population of the United States;

‘‘(3) physical trauma in the United States results in an aggregate annual cost of $120,000,000,000 in medical expenses, insurance, lost wages, and property damage;

‘‘(4) barriers to the provision of prompt and appropriate emergency medical services exist in many areas of the United States;

‘‘(5) few States and communities have developed and implemented trauma care systems;

‘‘(6) many trauma centers have incurred substantial uncompensated costs in providing trauma care, and such costs have caused many such centers to cease participation in trauma care systems; and

‘‘(7) the number of incidents of physical trauma in the United States is a serious medical and social problem, and the number of deaths resulting from such incidents can be substantially reduced by improving the trauma-care components of the systems for the provision of emergency medical services in the United States.’’


Section, act July 1, 1944, ch. 373, title XII, §1202, as added Nov. 16, 1990, Pub. L. 101–690, §5, 104 Stat. 2916, provided for establishment, membership, duties, etc., of Advisory Council on Trauma Care Systems.


Section, act July 1, 1944, ch. 373, title XII, §1203, as added Nov. 16, 1990, Pub. L. 101–690, §5, 104 Stat. 2916, provided for establishment, membership, duties, etc., of Advisory Council on Trauma Care Systems.


§300d–3. Establishment of programs for improving trauma care in rural areas

(a) In general

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

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

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

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

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

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

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

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

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

(b) Special consideration for certain rural areas

In making grants under subsection (a), the Secretary shall give special consideration to any applicant for the grant that will provide services under the grant in any rural area identified by a State under section 300d–14(d)(1) of this title.

(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.


§300d–4. Emergency medical services

(a) 1 Federal Interagency Committee on Emergency Medical Services

(1) Establishment

The Secretary of Transportation, the Secretary of Health and Human Services, and the Secretary of Homeland Security, acting through the Under Secretary for Emergency Preparedness and Response, shall establish a Federal Interagency Committee on Emergency Medical Services.

(2) Membership

The Interagency Committee shall consist of the following officials, or their designees:


(B) The Director, Preparedness Division, Directorate of Emergency Preparedness and Response of the Department of Homeland Security.

(C) The Administrator, Health Resources and Services Administration, Department of Health and Human Services.

(D) The Director, Centers for Disease Control and Prevention, Department of Health and Human Services.


(F) The Administrator, Centers for Medicare and Medicaid Services, Department of Health and Human Services.

(G) The Under Secretary of Defense for Personnel and Readiness.

(H) The Director, Indian Health Service, Department of Health and Human Services.


(J) A representative of any other Federal agency appointed by the Secretary of Transportation or the Secretary of Homeland Security through the Under Secretary for Emergency Preparedness and Response, in consultation with the Secretary of Health and Human Services, as having a significant role in relation to the purposes of the Interagency Committee.

(K) A State emergency medical services director appointed by the Secretary.

Prior to amendment, section provided for establishment of programs for improving trauma care in rural areas.


1993—Subsec. (c), Pub. L. 103–183, §601(f)(1), as amended by Pub. L. 103–392, §401(a)(1)(B), inserted “determines to be necessary to carry out this section” before period at end.

Effective Date of 1998 Amendment

Amendment by Pub. L. 105–392 deemed to have taken effect immediately after enactment of Pub. L. 103–183, see section 401(e) of Pub. L. 105–392, set out as a note under section 242m of this title.

(b) Special consideration for certain rural areas

In making grants under subsection (a), the Secretary shall give special consideration to any applicant for the grant that will provide services under the grant in any rural area identified by a State under section 300d–14(d)(1) of this title.

(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.

(Prior Provisions

(3) Purposes

The purposes of the Interagency Committee are as follows:

(A) To ensure coordination among the Federal agencies involved with State, local, tribal, or regional emergency medical services and 9–11 systems.

(B) To identify State, local, tribal, or regional emergency medical services and 9–11 needs.

(C) To recommend new or expanded programs, including grant programs, for improving State, local, tribal, or regional emergency medical services and implementing improved emergency medical services communications technologies, including wireless 9–1–1.

(D) To identify ways to streamline the process through which Federal agencies support State, local, tribal or regional emergency medical services.

(E) To assist State, local, tribal or regional emergency medical services in setting priorities based on identified needs.

(F) To advise, consult, and make recommendations on matters relating to the implementation of the coordinated State emergency medical services programs.

(4) Administration

The Administrator of the National Highway Traffic Safety Administration, in cooperation with the Administrator of the Health Resources and Services Administration of the Department of Health and Human Services and the Director of the Preparedness Division, Directorate of Emergency Preparedness and Response of the Department of Homeland Security, shall provide administrative support to the Interagency Committee, including scheduling meetings, setting agendas, keeping minutes and records, and producing reports.

(5) Leadership

The members of the Interagency Committee shall select a chairperson of the Committee each year.

(6) Meetings

The Interagency Committee shall meet as frequently as is determined necessary by the chairperson of the Committee.

(7) Annual reports

The Interagency Committee shall prepare an annual report to Congress regarding the Committee’s activities, actions, and recommendations.


Cross References

Section was enacted as part of the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users or SAFETEA-LU, and not as part of the Public Health Service Act which comprises this chapter.

Prior Provisions


§ 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 300d–3 of this title 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.

PRIOR PROVISIONS

A prior section 1203 of act July 1, 1994, was renumbered section 1202 and is classified to section 300d–3 of this title.

Another prior section 1203 of act July 1, 1994, was renumbered section 1202 and was classified to section 300d–2 of this title prior to repeal by Pub. L. 110–23.

AMENDMENTS
2010—Pub. L. 111–148 inserted “for trauma systems” after “grants” in section catchline and substituted “Assistant Secretary for Preparedness and Response” for “Administrator of the Health Resources and Services Administration” in subsec. (a).

§ 300d–6. Competitive grants for regionalized systems for emergency care response
(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 that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

(b) Eligible entity; region
In this section:
(1) Eligible entity
The term “eligible entity” means—
(A) a State or a partnership of 1 or more States and 1 or more local governments; or
(B) an Indian tribe (as defined in section 1603 of title 25) or a partnership of 1 or more Indian tribes.

(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 multi-county 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 that proposes a pilot project to design, implement, and evaluate an emergency medical and trauma system that—
(1) coordinates with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;
(2) includes a mechanism, such as a regional medical direction or transport communications system, that operates throughout the region 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) allows for 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; and
(4) includes 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.

(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 proposed system—
(1) has been coordinated with the applicable State Office of Emergency Medical Services (or equivalent State office); (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; and

(B) 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.

(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 population in a medically underserved area (as defined in section 254b(b)(3) of this title).

(g) Report

Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in subsection (a) to any eligible entity that serves a population in a medically underserved area (as defined in section 254b(b)(3) of this title).

Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in subsection (a) 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) the system characteristics that contribute to 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 State and local legislation necessary to implement and to maintain the system;

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

(6) recommendations on the utilization of available funding for future regionalization efforts.

(h) Dissemination of findings

The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g).

(July 1, 1944, ch. 373, title XII, §1204, as added Pub. L. 93–154, §2(a), 87 Stat. 602; amended Oct. 21, 1976, Pub. L. 94–573, §1, 90 Stat. 2715; set forth provisions relating to administration of emergency medical services administrative unit.

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

§300d–11. Establishment of program

(a) Requirement of allotments for States

The Secretary shall make payments, as grants, each fiscal year to each State from the 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.

(b) Purpose

Except as provided in section 300d–33 of this title, 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 developing, implementing, and monitoring the modifications to such component described in section 300d–13 of this title.

(Rule of Construction


REFERENCE IN TEXT


1 See References in Text note below.

1 See References in Text note below.
§ 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 300d–11(a) of this title 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 300d–11(b) of this title; 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 300d–11(a) of this title 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 300d–11(a) of this title—

(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.

(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 300d–11(a) of this title 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, 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 specialty groups, hospital associations, emergency medical services State and local directors, concerned advocates, 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) 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 300d–11(a) of this title 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 May 3, 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 specialty 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 300d–11(a) of this title, such subsection may not be construed to specify the number of trauma care centers designated pursuant to such subsection.

(71)
§ 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 300d–11(a) of this title 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 300d–11(a) of this title unless the State agrees that the Secretary will, not less than once each year, provide to the Secretary the information received by the State pursuant to section 300d–13(a)(7) of this title.

(d) Availability of emergency medical services in rural areas

The Secretary may not make payments to a State under section 300d–11(a) of this title 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.

(Amendments)

Effective Date of 1998 Amendment
Amendment by Pub. L. 105–392 deemed to have taken effect immediately after enactment of Pub. L. 103–183, see section 401(e) of Pub. L. 105–392, set out as a note under section 242m of this title.

§ 300d–15. Restrictions on use of payments

(a) In general
The Secretary may not, except as provided in subsection (b), make payments under section 300d–11(a) of this title 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 300d–11(b) of this title 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 300d–14(a) of this title by the State involved cannot otherwise be carried out.


(Amendments)


§ 300d–17. Requirement of submission of application containing certain agreements and assurances

The Secretary may not make payments under section 300d–11(a) of this title 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;
§ 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 300d–11(a) of this title for a State for a fiscal year shall be the greater of—

(1) the amount determined under subsection (b)(1) of this section; 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) of this section 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 300d–32(a) of this title for the fiscal year and available for allotment under section 300d–11(a) of this title; 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 300d–32(a) of this title for the fiscal year and available for allotment under section 300d–11(a) of this title; 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 300d–11(a) of this title 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 section 300d–32(b)(3) of this title that are not paid under section 300d–11(a) of this title to a State as a result of—

(A) the failure of the State to submit an application under section 300d–17 of this title;

(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) of this section for the State.

(§ 300d–19. Failure to comply with agreements

(a) Repayment of payments

(1) Requirement

The Secretary may, in accordance with subsection (b) of this section, require a State to repay any payments received by the State pursuant to 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 300d–11(a) of this title.

(b) Opportunity for hearing

Before requiring repayment of payments under subsection (a)(1) of this section, the Secretary shall provide to the State an opportunity for a hearing.

(§ 300d–20. Preservation of funds

The Secretary shall carry out this part in such manner, and contain such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(July 1, 1944, ch. 373, title XII, § 1217, as added Pub. L. 101–590, § 3, Nov. 16, 1990, 104 Stat. 2924.)
§ 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 300d–11(a) of this title.

(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 300d–11(a) of this title 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) of this section may, for each violation, be fined in accordance with title 18, or imprisoned for not more than 5 years, or both.


§ 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 300d–11(a) of this title, provide to the State (or to any public or nonprofit private entity designated by the State) technical assistance with respect to the planning, development, and operation of any program carried out pursuant to section 300d–11(b) of this title. 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 300d–11(a) of this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the State in carrying out section 300d–11(b) of this title 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 300d–11(a) of this title 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.

(July 1, 1944, ch. 373, title XII, § 1221, as added Pub. L. 101–590, § 3, Nov. 16, 1990, 104 Stat. 2926.)

§ 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 300d–11 of this title. 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.


AMENDMENTS


1993—Pub. L. 103–183 substituted “1995” for “1992” and inserted after first sentence “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.”

PART C—GENERAL PROVISIONS REGARDING PARTS A AND B

§ 300d–31. Definitions

For purposes of this part and parts A and B of this subchapter:

(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 300d–13 of this title.

(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 mechanical force.

(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.


AMENDMENTS


1992—Pub. L. 102–321 substituted “this part and parts A and B of this subchapter” for “this subchapter” in introductory provisions.

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by Pub. L. 102–321 effective July 10, 1992, with provision for programs providing financial assistance, see section 801(b), (d) of Pub. L. 102–321, set out as a note under section 236 of this title.

§ 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 2010 through 2014.

(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 300d–3 of this title.

(d) Authority

For the purpose of carrying out parts A through C, beginning on March 23, 2010, 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.


AMENDMENTS

2007—Subsec. (a). Pub. L. 111–148, §3504(a)(3)(A), substituted “$24,000,000 for each of fiscal years 2010 through 2014” for “$12,000,000 for fiscal year 2006, $10,000,000 for fiscal year 2009, and $8,000,000 for each of the fiscal years 2010 through 2012”.


1993—Subsec. (a). Pub. L. 103–183, as amended by Pub. L. 105–392, §401(a)(2), substituted “For the purpose of carrying out parts A and B of this subchapter, there are authorized to be appropriated $6,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 and 1996” for “For the purpose of carrying out parts A and B of this subchapter, there are authorized to be appropriated $60,000,000 for fiscal year 1991 and such sums as may be necessary for each of the fiscal years 1992 and 1993”.

1992—Subsec. (a). Pub. L. 102–321 substituted “parts A and B of this subchapter” for “this subchapter”.

EFFECTIVE DATE OF 1992 AMENDMENT

Amendment by section 401(a)(2) of Pub. L. 105–392 deemed to have taken effect immediately after enactment of Pub. L. 103–183, see section 401(e) of Pub. L. 105–392, set out as a note under section 242m of this title.

EFFECTIVE DATE OF 1998 AMENDMENT

Amendment by section 401(a)(2) of Pub. L. 105–392 effective July 10, 1992, with provision for programs providing financial assistance, see section 801(b), (d) of Pub. L. 102–321, set out as a note under section 236 of this title.


Section, act July 1, 1944, ch. 373, title XII, §1233, as added Nov. 16, 1990, Pub. L. 101–590, §3, 104 Stat. 2727, related to waiver of requirement regarding purpose of grants.

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

§ 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; and

(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)(1) unless the trauma center is a participant in a trauma system that substantially complies with section 300d–13 of this title.

(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.


References in Text


Amendments

2010—Pub. L. 111–148 added subsecs. (a) to (c) and struck out former subsecs. (a) and (b) which related to grants for trauma centers in geographic areas with a significant incidence of violence arising from illicit trafficking in drugs and set forth minimum qualifications of such centers.

Effective Date

Part effective July 10, 1992, with programs making awards providing financial assistance in fiscal year 1993 and subsequent years effective for awards made on or after Oct. 1, 1992, see section 901(b), (d)(1) of Pub. L. 102–321, set out as an Effective Date of 1992 Amendment note under section 236 of this title.

§ 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 300d–41(a)(1) of this title according to the percentage described in paragraph (2), subject to the requirements of section 300d–41(b)(3) of this title.

(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) Core mission awards

(1) In general

In awarding grants under section 300d–41(a)(2) of this title, the Secretary shall—

1 So in original. No par. (2) has been enacted.
(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 300d–41(a)(1) of this title.

(c) Emergency awards
In awarding grants under section 300d–41(a)(3) of this title, 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.


AMENDMENTS
2010—Pub. L. 111–148 added subssecs. (a) to (c) and struck out former subssecs. (a) and (b) which related to preferences in making grants and preferences for certain applications.

§ 300d–43. Certain agreements
(a) Maintenance of financial support
The Secretary may require a trauma center receiving a grant under section 300d–41(a) of this title 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 300d–41(a) of this title 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.


AMENDMENTS
2010—Pub. L. 111–148 added subssecs. (a) and (b) and struck out former subssecs. (a) to (c) which related to commitment regarding continued participation in trauma care system, maintenance of financial support, and trauma care registry.

§ 300d–44. General provisions
(a) Application
The Secretary may not award a grant to a trauma center under section 300d–41(a) of this title 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 300d–41(a) of this title 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 300d–42(a) of this title, a grant under section 300d–41 of this title may not be made in an amount exceeding $2,000,000 for each fiscal year.

(d) Eligibility
Except as provided in section 300d–42(b)(1)(B)(iii) of this title, acquisition of, or eligibility for, a grant under section 300d–41(a) of this title 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 300d–45 of this title, 70 percent shall be used for substantial uncompensated care awards under section 300d–41(a)(1) of this title, 20 percent shall be used for core mission awards under section 300d–41(a)(2) of this title, and 10 percent shall be used for emergency awards under section 300d–41(a)(3) of this title.

(f) Minimum allowance
Notwithstanding subsection (e), if the amount appropriated for a fiscal year under section 300d–45 of this title is less than $25,000,000, all available funding for such fiscal year shall be used for substantial uncompensated care awards under section 300d–41(a)(1) of this title.

(g) Substantial uncompensated care award distribution and proportional share
Notwithstanding section 300d–42(a) of this title, 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 300d–42(a)(2) of this title to each eligible trauma center.
(h) Report

Beginning 2 years after March 23, 2010, and every 2 years thereafter, the Secretary shall biennially report to Congress regarding the status of the grants made under section 300d–41 of this title and on the overall financial stability of trauma centers.

(July 1, 1944, ch. 373, title XII, §1245, as added Pub. L. 111–148, title III, §3505(a)(6), Mar. 23, 2010, 124 Stat. 525.)

AMENDMENTS 2010—Pub. L. 111–148 added subsec. (h) and struck out former subsec. (a) which related to application for grant, limitation on duration of support, and limitation on amount of grant.

§ 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.


AMENDMENTS 2010—Pub. L. 111–148 added subsections (a) to (h) and struck out former subsection (a) which related to application for grant, limitation on duration of support, and limitation on amount of grant.

§ 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 1396r–4 of this title, all of which are attributable to emergency care and trauma care, including costs related to subsequent inpatient admissions to the hospital.


§ 300d–47. Authorization of appropriations

For the purpose of carrying out this section, there is authorized to be appropriated $400,000 for each of the fiscal years 2008 through 2012.


§ 300d–52. State grants for projects regarding traumatic brain injury

(a) In general

The Secretary, acting through the Administrator of the Health Resources and Services Administration, 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) of this section 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.
§ 300d–52

(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) of this section, 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) of this section 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) Continuation of previously awarded demonstration projects

A State or American Indian consortium that received a grant under this section prior to April 28, 2008, may complete the activities funded by the grant.

(f) 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 comprehensive appropriate services and supports. Such service and supports—

(i) shall promote full participation by individuals with 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) of this section 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 [42 U.S.C. 12131 et seq.], 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 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.

(g) 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.

(h) Report

Not less than biennially, the Secretary shall submit to the Committee on Energy and Com-
merce 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 300d–53 of this title including measures of outcomes and consumer and surrogate satisfaction.

(i) Definitions

For purposes of this section:

(1) The terms “American Indian consortium” and “State” have the meanings given to those terms in section 300d–53 of this title.

(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.

(j) 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.

(j).


Subsec. (h). Pub. L. 110–206, §6(a)(6), substituted “Not less than biennially, the Secretary” for “Not later than 2 years after July 29, 1996, the Secretary” and “Energy and Commerce of the House of Representatives, and to the Committee on Health, Education, Labor, and Pensions” for “Commerce of the House of Representatives, and to the Committee on Labor and Human Resources” and inserted “and section 300d–53 of this title” after “programs established under this section.”.

Subsec. (i). Pub. L. 110–206, §6(a)(7), amended subsec. (i) generally. Prior to amendment, text read as follows: “For purposes of this section, 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.”

Subsec. (j). Pub. L. 110–206, §6(a)(8), inserted “, and such sums as may be necessary for each of the fiscal years 2009 through 2012” before period at end.


Subsec. (c)(2). Pub. L. 110–310, §1304(4)(B), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: “In determining the amount of non-Federal contributions in cash that a State has provided pursuant to paragraph (1), the Secretary may not include any amounts provided to the State by the Federal Government.”

Subsecs. (e), (f). Pub. L. 110–310, §1304(6), added subsecs. (e) and (f). Former subsecs. (e) and (f) redesignated (g) and (h), respectively.

Subsec. (g). Pub. L. 110–310, §1304(5), redesignated subsec. (e) as (g) and substituted “Federal agencies” for “agencies of the Public Health Service”. Former subsec. (g) redesignated (i).


Subsec. (i). Pub. L. 110–310, §1304(5), redesignated subsec. (g) as (i), substituted “anoxia due to trauma” for “anoxia due to near drowning” in second sentence, and inserted before period at end “, after consultation with States and other appropriate public or nonprofit private entities.”

Subsec. (j). Pub. L. 110–310, §1304(9), reenacted heading without change and amended text generally. Prior to amendment, text read as follows: “For the purpose of carrying out this section, there is authorized to be appropriated $5,000,000 for each of the fiscal years 1997 through 1999.”

DEFINITIONS

For meaning of references to an intellectual disability and to individuals with intellectual disabilities in provisions amended by section 2 of Pub. L. 111–256, see section 2(k) of Pub. L. 111–256, set out as a note under section 1460 of Title 20, Education.

§ 300d–53. State grants for protection and advocacy services

(a) In general

The Secretary, acting through the Administrator of the Health Resources and Services Administration (referred to in this section as the "Administrator"), 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 Administrator at such time, in such form and manner, and accompanied by such information and assurances as the Administrator 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) of this section to carry out this section is less than $2,700,000, the Administrator 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) of this section.

(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) of this section to carry out this section is $2,700,000 or more, the Administrator 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) of this section 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 grant1 to 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) of this section 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 Administrator 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) of this section 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 Administrator 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) Annual report

Each protection and advocacy system that receives a payment under this section shall submit an annual report to the Administrator concerning the services provided to individuals with traumatic brain injury by such system.

(i) Data collection

The Administrator of the Health Resources and Services Administration and the Commissioner of the Administration on Developmental Disabilities shall enter into an agreement to coordinate the collection of data by the Administrator and the Commissioner 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

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1 So in original. Probably should be followed by "to".
§ 300d-61 TITL E 42—THE PUBLIC HEALTH AND WELFARE Page 936

$5,000,000 or greater, the Administrator 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 the Developmental Disabilities Assistance and Bill of Rights Act of 2000 [42 U.S.C. 1594I et seq.].

(l) Authorization of appropriations

There are authorized to be appropriated to carry out this section $5,000,000 for fiscal year 2001, and such sums as may be necessary for each fiscal year 2002 through 2012.

(m) Definitions

In this section:

(1) American Indian consortium

The term “American Indian consortium” means a consortium established under part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6042 et seq.).

(2) Protection and advocacy system

The term “protection and advocacy system” means a protection and advocacy system established under part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6042 et seq.).

(3) State

The term “State”, unless otherwise specified, means a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and the Commonwealth of the Northern Marianas Islands.

Part F—Interagency Program for Trauma Research

§ 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) of this section, shall establish and implement a plan for carrying out the activities of the Program, including the activities described in subsection (d) of this section. 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 grants of awards 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, that arrest further deterioration 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) of this section, 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) of this section (including the activities described in subsection (d) of this section).

(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) of this section, 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 300d–31(1) of this title.

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

(3) The term “trauma” means any serious injury that could result in loss of life or in significant disability and that would meet pre-hospital triage criteria for transport to a designated trauma center.

(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.

executed because the phrase “acute injury” does not appear in text.
Subsec. (h)(4). Pub. L. 106–310, § 1303(b), substituted “anoxia due to trauma” for “anoxia due to near drowning” in second sentence and inserted before period at end “; after consultation with States and other appropriate public or nonprofit private entities”.
Subsec. (i). Pub. L. 106–310, § 1303(d), added subsec. (i).
Subsec. (i). Pub. L. 106–310, § 1303(d), added subsec. (i).

CHANGE OF NAME

Committee on Energy and Commerce of House of Representatives treated as referring to Committee on Commerce of House of Representatives by section 1(a) of Pub. L. 108–194, as amended by Pub. L. 109–163, div. A, title XIII, § 1302, Oct. 17, 2000, 114 Stat. 1338, required the Secretary of Health and Human Services to conduct a study of traumatic brain injuries, to submit a report to Congress within 18 months of July 29, 1996 on the findings of such study and a report within 3 years of that date on certain therapeutic interventions and guidelines developed in the study, and to conduct a national consensus conference on managing traumatic brain injury and related rehabilitation concerns.

PART G—POISON CONTROL

§ 300d–71. Maintenance of the national toll-free number

(a) In general

The Secretary shall provide coordination and assistance to poison control centers for the establishment of a nationwide toll-free phone number, and the maintenance of such number, to be used to access such centers.

(b) Authorization of appropriations

There is authorized to be appropriated $2,000,000 for fiscal year 2009 to carry out this section, and $700,000 for each of fiscal years 2010 through 2014 for the maintenance of the nationwide toll free phone number under subsection (a).


AMENDMENTS

2008—Pub. L. 110–377 amended section generally. Prior to amendment, section required the Secretary to coordinate and assist in establishment of nationwide poison control center toll-free phone number, allowed for establishment and continued operation of privately funded nationwide toll-free numbers, and authorized appropriations for fiscal years 2000 through 2009.

FININGS

Pub. L. 110–377, § 2, Oct. 8, 2008, 122 Stat. 4065, provided that: “Congress makes the following findings:

(1) Poison control centers are the primary defense of the United States against injury and deaths from poisoning. Twenty-four hours a day, the general public as well as health care practitioners contact their local poison control centers for help in diagnosing and treating victims of poisoning. In 2007, more than 4,000,000 calls were managed by poison control centers providing ready and direct access for all people of the United States, including many underserved populations in the United States, with vital emergency public health information and response.

(2) Poisoning is the second most common form of unintentional death in the United States. In any given year, there will be between 3,000,000 and 5,000,000 poison exposures. Sixty percent of these exposures will involve children under the age of 6 who are exposed to toxins in their home. Poisoning accounts for 285,000 hospitalizations, 1,200,000 days of acute hospital care, and more than 26,000 fatalities in 2005.

(3) In 2008, the Harvard Injury Control Research Center reported that poisonings from accidents and unknown circumstances more than tripled in rate since 1990. In 2005, the last year for which data are available, 28,858 people died from accidental or unknown poisonings. This represents an increase of 20,000 since 1990 and an increase of 2,400 between 2004 and 2005. Fatalities from poisoning are increasing in the United States in near epidemic proportions. The funding of programs to reverse this trend is needed now more than ever.

(4) In 2004, The Institute of Medicine of the National Academy of Sciences recommended that Congress should amend the current Poison Control Center Enhancement and Awareness Act Amendments of 2003 [Pub. L. 108–194, see Short Title of 2003 Amendments note set out under section 301 of this title] to provide sufficient funding to support the proposed Poison Prevention and Control System with its national network of poison centers. Support for the core activities at the current level of service is estimated to require more than $100 million annually.

(5) Sustaining the funding structure and increasing accessibility to poison control centers will promote the utilization of poison control centers and reduce the inappropriate use of emergency medical services and other more costly health care services. The 2004 Institute of Medicine Report to Congress determined that for every $1 invested in the Nation’s poison control centers $7 of health care costs are saved. In 2005, direct Federal health care program savings totaled in excess of $525,000,000 as the result of poison control center public health services.

(6) More than 30 percent of the cost savings and financial benefits of the Nation’s network of poison control centers are realized annually by Federal health care programs (estimated to be more than $1,000,000,000), yet Federal funding support (as demonstrated by the annual authorization of $30,100,000 in Public Law 108–194) comprises less than 11 percent of the annual network expenditures of poison centers.

(7) Real-time data collected from the Nation’s certified poison control centers can be an important source of information for the detection, monitoring, and response for contamination of the air, water, pharmaceutical, or food supply.

(8) In the event of a terrorist event, poison control centers will be relied upon as a critical source for accurate medical information and public health emergency response concerning the treatment of patients who have had an exposure to a chemical, radiological, or biological agent.”
§ 300d–72. Nationwide media campaign to promote poison control center utilization

(a) In general

The Secretary shall carry out, and expand upon, a national media campaign to educate the public and health care providers about poison prevention and the availability of poison control center resources in local communities and to conduct advertising campaigns concerning the nationwide toll-free number established under section 300d–71(a) of this title.

(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 poison prevention and poison control center awareness campaign, which may include:

(1) the development and distribution of poison prevention 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) Evaluation

The Secretary shall—

(1) establish baseline measures and benchmarks to quantitatively evaluate the impact of the nationwide media campaign carried out under this section; and

(2) on an annual basis, prepare and submit to the appropriate committees of Congress, an evaluation of the nationwide media campaign.

(d) Authorization of appropriations

There is authorized to be appropriated to carry out this section, such sums as may be necessary for fiscal year 2009, and $800,000 for each of fiscal years 2010 through 2014.


AMENDMENTS

2008—Pub. L. 110–377 amended section generally. Prior to amendment, section required the Secretary to establish a national media campaign to educate the public and health care providers about poison control and prevention and authorized appropriations for fiscal years 2000 through 2009.

EFFECTIVE DATE OF 2008 AMENDMENT

Pub. L. 110–377, §4(b), Oct. 8, 2008, 122 Stat. 4065, provided that: “The amendment made by this section [amending this section] shall be effective on the date of the enactment of this Act (Oct. 8, 2008) and shall apply to contracts entered into on or after January 1, 2009.”

§ 300d–73. Maintenance of the poison control center grant program

(a) Authorization of program

The Secretary shall award grants to poison control centers certified 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 complying with the operational requirements needed to sustain the certification of the center under subsection (c).

(b) Additional uses of funds

In addition to the purposes described in subsection (a), a poison control 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 establish and evaluate best practices in the United States for poison prevention, poison control center outreach, and emergency and preparedness 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 and the Centers for Disease Control and Prevention;
(4) 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;
(5) to develop initiatives to foster the enhanced public health utilization of national poison data collected by organizations described in paragraph (4);
(6) to support and expand the toxicologic expertise within poison control centers; and
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(7) to improve the capacity of poison control centers to answer high volumes of calls and respond during times of national crisis or other public health emergencies.

c) Certification

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 certified by a professional organization in the field of poison control, and the Secretary has approved the organization as having in effect standards for certification that reasonably provide for the protection of the public health with respect to poisoning; or

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

d) Waiver of certification requirements

(1) In general

The Secretary may grant a waiver of the certification requirements of subsection (c) with respect to a noncertified poison control center that applies for a grant under this section if such center can reasonably demonstrate that the center will obtain such a certification 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

In no case may the sum of the number of years for a waiver under paragraph (1) and a renewal under paragraph (2) exceed 5 years. The preceding sentence shall take effect as of October 8, 2008.

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

A poison control center, in utilizing the proceeds of a grant under this section, shall maintain the expenditures of the center for activities of the center 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, $27,500,000 for fiscal year 2000 through 2008, and $28,600,000 for each of fiscal years 2009, and $28,600,000 for each of fiscal years 2010 through 2014. The Secretary may utilize not to exceed 8 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 that do not include grants, contracts, or cooperative agreements under subsections (a) and (b), which are determined by the Secretary to be appropriate for carrying out the program under this section.


AMENDMENTS


EFFECTIVE DATE OF 2008 AMENDMENT
Pub. L. 110–377, § 5(b), Oct. 8, 2008, 122 Stat. 4067, provided that: “The amendment made by this section [amending this section] shall be effective as of the date of the enactment of this Act (Oct. 8, 2008) and shall apply to grants made on or after January 1, 2009.”

§ 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

§ 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 300d–41(b) of this title;

(ii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 300d–41(b) of this title; 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

1So in original. Probably should be “the”.

Amendments


Effective Date of 2008 Amendment

Pub. L. 110–377, § 5(b), Oct. 8, 2008, 122 Stat. 4067, provided that: “The amendment made by this section [amending this section] shall be effective as of the date of the enactment of this Act (Oct. 8, 2008) and shall apply to grants made on or after January 1, 2009.”
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 subparagraph (A) and (B) of section 300d-41(b)(3) of this title.

(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 300d-41(b)(3) of this title.

(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.

(July 1, 1944, ch. 373, title XII, § 1281, as added Pub. L. 111–148, title III, § 3505(b), Mar. 23, 2010, 124 Stat. 525.)

§ 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.

(July 1, 1944, ch. 373, title XII, § 1282, as added Pub. L. 111–148, title III, § 3505(b), Mar. 23, 2010, 124 Stat. 527.)

SUBCHAPTER XI—HEALTH MAINTENANCE ORGANIZATIONS

§ 300e. Requirements of health maintenance organizations

(a) “Health maintenance organization” defined

For purposes of this subchapter, the term “health maintenance organization” means a public or private entity which is organized under the laws of any State and which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b) of this section, and (2) is organized and operated in the manner prescribed by subsection (c) of this section.

(b) Manner of supplying basic and supplemental health services to members

A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this subchapter, basic and supplemental health services to its members in the following manner:

(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic...