

111TH CONGRESS
1ST SESSION

H. R. 2252

To improve the Federal infrastructure for health care quality improvement
in the United States.

IN THE HOUSE OF REPRESENTATIVES

MAY 5, 2009

Ms. DEGETTE introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To improve the Federal infrastructure for health care quality
improvement in the United States.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “National Health Care
5 Quality Act”.

6 **SEC. 2. DEFINITIONS.**

7 In this Act:

8 (1) **HEALTH CARE QUALITY.**—The term “health
9 care quality” means the degree to which health serv-

1 ices for individuals and populations increase the like-
2 lihood of desired health outcomes and are consistent
3 with current professional knowledge, based upon the
4 following criteria:

5 (A) EFFECTIVENESS.—Health care serv-
6 ices should be provided based upon scientific
7 knowledge of all who could benefit.

8 (B) EFFICIENCY.—Waste, including waste
9 of equipment, supplies, ideas, and energies,
10 should be avoided.

11 (C) EQUITY.—The provision of health care
12 should not vary in quality because of personal
13 characteristics of the individuals involved.

14 (D) PATIENT-CENTEREDNESS.—Health
15 care should be responsive to, and respectful of,
16 individual patient preferences.

17 (E) SAFETY.—Injuries to patients from
18 the health care that is supposed to help them
19 should be avoided.

20 (F) TIMELINESS.—Waiting times and
21 harmful delays in providing health care should
22 be reduced.

23 (2) HEALTH CARE QUALITY MEASURE.—The
24 term “health care quality measure” means a na-
25 tional consensus standard for measuring the per-

1 formance and improvement of population health or
2 of institutional providers of services, physicians, and
3 other clinicians in the delivery of health care serv-
4 ices, consistent with the health care quality criteria
5 described in paragraph (1).

6 (3) MULTI-STAKEHOLDER GROUP.—The term
7 “multi-stakeholder group” means, with respect to a
8 health care quality measure, a voluntary collabo-
9 rative of public and private organizations rep-
10 resenting persons interested in, or affected by, the
11 use of such health care quality measure, including—

12 (A) health care providers and practitioners,
13 including providers and practitioners primarily
14 serving children and those with long-term
15 health care needs;

16 (B) health care quality entities;

17 (C) health plans;

18 (D) patient advocates and consumer
19 groups;

20 (E) employers;

21 (F) public and private purchasers of health
22 care items and services;

23 (G) labor organizations;

24 (H) relevant departments or agencies of
25 the United States;

1 (I) biopharmaceutical companies and man-
2 ufacturers of medical devices; and

3 (J) licensing, credentialing, and accrediting
4 bodies.

5 **SEC. 3. DEPARTMENT AND AGENCY QUALITY REVIEW.**

6 Each relevant department and agency of the Federal
7 Government shall review the statutory authority of such
8 department or agency, effective on the date of enactment
9 of this Act, administrative regulations, and policies and
10 procedures for the purpose of determining whether there
11 are any deficiencies or inconsistencies therein which pro-
12 hibit full compliance with the purposes and provisions of
13 this Act. Each department and agency shall, not later than
14 July 1, 2010, propose to the President such measures as
15 may be necessary to bring the authority and policies and
16 procedures of such department or agency into conformity
17 with the intent, purposes, and provisions set forth in this
18 Act.

19 **SEC. 4. NATIONAL HEALTH CARE QUALITY PRIORITIES.**

20 (a) ESTABLISHMENT OF THE OFFICE OF NATIONAL
21 HEALTH CARE QUALITY IMPROVEMENT.—There is estab-
22 lished within the Executive Office of the President an Of-
23 fice of National Health Care Quality Improvement
24 (“NHCQI”) (referred to in this section as the “Office”).
25 The Office shall be headed by a Director of National

1 Health Care Quality (referred to in this section as the
2 “Director”) who shall be appointed by the President and
3 shall report directly to the President.

4 (b) DIRECTOR.—

5 (1) RESPONSIBILITIES.—The Director shall
6 perform the duties of the Office, described in para-
7 graph (3), in a manner consistent with the develop-
8 ment of a nationwide health care quality infrastruc-
9 ture that—

10 (A) coordinates and implements health
11 care quality research, measurement, and data
12 collection and reporting across all Federal agen-
13 cies involved in purchasing, providing, studying,
14 or regulating health care services;

15 (B) incorporates proven public and private
16 quality improvement best practices;

17 (C) includes public and private quality im-
18 provement strategies to address activities other
19 than health care quality measurement, such as
20 provider payment models, alternative care mod-
21 els, licensing, professional certification, medical
22 education, alternative staffing models, and pub-
23 lic reporting; and

24 (D) leads to improved health care out-
25 comes for patients across the United States.

1 (2) QUALIFICATIONS.—The President shall, by
2 and with the advice and consent of the Senate, ap-
3 point a Director. The President shall select an indi-
4 vidual who has—

5 (A) national recognition for expertise in
6 health care quality improvement;

7 (B) experience addressing health care qual-
8 ity improvement in more than one health care
9 setting, such as inpatient care, outpatient care,
10 long-term care, public programs, and private
11 programs; and

12 (C) experience addressing health care qual-
13 ity as it applies to vulnerable populations, in-
14 cluding children, underserved populations, rural
15 populations, individuals with disabilities, the el-
16 derly, and racial and ethnic minorities.

17 (3) DUTIES OF THE DIRECTOR.—The Director
18 shall—

19 (A) advise the President on the quality of
20 health care in the United States, including pri-
21 orities and goals for the future;

22 (B) in coordination with public and private
23 stakeholders, determine national priorities for
24 improving health care quality, in accordance
25 with subsection (c);

1 (C) establish annual benchmarks for each
2 relevant Federal department and agency to
3 achieve national priorities for health care qual-
4 ity improvement;

5 (D) develop an annual report card on the
6 state of the Nation's health as it relates to
7 health care quality;

8 (E) in coordination with the heads of other
9 relevant agencies and as part of the annual
10 budget request of Congress, submit funding re-
11 quirements, in accordance with subsection (d);

12 (F) serve as the chairperson of the Quality
13 Interagency Coordinating Council (QuICC), es-
14 tablished under section 4; and

15 (G) in consultation with the National Coor-
16 dinator of Health Information Technology, de-
17 velop an open source framework for Federal
18 quality communication to create and maintain a
19 standardized, electronic language or interface
20 that enables all relevant Federal entities to
21 communicate information or make requests re-
22 garding quality research, definitions, activities,
23 or regulations, or to provide any other
24 functionality, as the Director determines.

1 (c) NATIONAL PRIORITIES FOR HEALTH CARE
2 QUALITY IMPROVEMENT.—

3 (1) IN GENERAL.—Not later than January 1,
4 2010 and at least every 5 years thereafter, the Di-
5 rector, in coordination with public and private stake-
6 holders, shall establish national priorities for health
7 care quality improvement.

8 (2) DEVELOPMENT OF PRIORITIES.—In estab-
9 lishing the national priorities for health care quality
10 improvement under paragraph (1), the Director shall
11 consider—

12 (A) health care outcomes in the United
13 States in comparison to health outcomes in
14 other World Health Organization member coun-
15 tries;

16 (B) the burden of disease, including the
17 prevalence, incidence, and cost of disease to the
18 United States;

19 (C) demographics;

20 (D) variability in practice norms;

21 (E) potential to eliminate harm to pa-
22 tients;

23 (F) improvements with the potential for
24 the greatest impact on morbidity, mortality,
25 performance, and a focus on the patient;

1 (G) quality measures that may be coordi-
2 nated across different health care settings, in-
3 cluding inpatient and outpatient measures, pri-
4 mary care, and specialty care;

5 (H) the specific quality improvement needs
6 and challenges of rural areas; and

7 (I) the unique quality improvement needs
8 disparities and challenges of vulnerable popu-
9 lations, including children, the elderly, individ-
10 uals with disabilities, individuals near the end
11 of life, and racial and ethnic minorities.

12 (3) INITIAL PRIORITIES.—The first set of na-
13 tional priorities established under this subsection
14 shall include as a priority pediatric health care qual-
15 ity improvement, for children up to age 21.

16 (4) COLLABORATION WITH MULTI-STAKE-
17 HOLDER GROUPS.—

18 (A) IN GENERAL.—The Director shall con-
19 vene and collaborate with multi-stakeholder
20 groups in establishing and updating the na-
21 tional priorities under paragraph (1).

22 (B) TRANSPARENCY.—All collaboration be-
23 tween the Director and multi-stakeholder
24 groups shall be conducted through an open and
25 transparent process.

1 (C) STATUTORY CONSTRUCTION.—Not-
2 withstanding any other provision in this para-
3 graph, the Director shall have the final author-
4 ity to decide whether to accept the rec-
5 ommendations provided by such multi-stake-
6 holder groups.

7 (5) AGENCY- AND DEPARTMENT-SPECIFIC
8 STRATEGIC PLANS.—Not later than October 1,
9 2010, and annually thereafter, the Director, in con-
10 sultation with the heads of relevant Federal agencies
11 and departments, shall develop agency- and depart-
12 ment-specific strategic plans for health care quality
13 improvement to achieve national priorities, including
14 annual benchmarks.

15 (d) ANNUAL BUDGET REQUEST FOR RESOURCES.—
16 As part of the annual budget request made by the Presi-
17 dent to Congress, beginning with such budget request
18 made in calendar year 2011, the Director, in consultation
19 with the heads of relevant Federal departments and agen-
20 cies, shall include—

21 (1) a description of the agency- and depart-
22 ment-specific strategic plans for health care quality
23 improvement; and

1 (2) the level of Federal funding required for im-
2 plementing or maintaining the quality improvement
3 strategic plans described under paragraph (1).

4 (e) MONITORING.—

5 (1) IN GENERAL.—The Director shall institute
6 mechanisms for monitoring the progress on achiev-
7 ing national health care quality priorities under sub-
8 section (c)(1) as well as department- and agency-
9 specific strategic plans under subsection (c)(5), in-
10 cluding objectives, metrics, and benchmarks for the
11 following:

12 (A) The benefits and drawbacks of specific
13 quality improvement efforts for public programs
14 and for the health care system at large.

15 (B) Coordination and communication of ef-
16 forts to achieve interagency goals, including in-
17 formation exchange.

18 (C) Interagency coordination progress for
19 national quality efforts.

20 (D) Methods for ensuring awareness and
21 recognition among health care providers and
22 the public at large of the significance of health
23 care quality improvement.

24 (2) REPORTING.—

1 (A) REPORTING.—Not later than Decem-
2 ber 31, 2011, and by the end of each calendar
3 year thereafter, the Director shall submit to the
4 President and to Congress a report regarding
5 the progress of Federal agencies in achieving
6 the quality improvement priorities under para-
7 graphs (1) and (5) of subsection (c), and shall
8 make such report publicly available through the
9 Internet.

10 (B) ANNUAL NATIONAL HEALTH CARE
11 QUALITY REPORT CARD.—Not later than Janu-
12 ary 31, 2011, and annually thereafter, the Di-
13 rector shall publish a national health care qual-
14 ity report card, which shall include—

15 (i) the considerations for national
16 health care quality priorities described in
17 subsection (c)(2);

18 (ii) an analysis of the progress of the
19 department- and agency-specific strategic
20 plans under subsection (c)(5) in achieving
21 the national health care quality priorities
22 established under subsection (c)(1), and
23 any gaps in such strategic plans;

1 (iii) the extent to which private sector
2 strategies have informed Federal quality
3 improvement efforts; and

4 (iv) a summary of consumer feedback
5 regarding how well current quality im-
6 provement practices work for such con-
7 sumers and additional ways to improve
8 health care quality.

9 (f) WEBSITE.—Not later than July 1, 2010, the Di-
10 rector shall create a website to make public information
11 regarding—

12 (1) the national priorities for health care qual-
13 ity improvement established under subsection (c)(1);

14 (2) the department- and agency-specific stra-
15 tegic plans for health care quality described in sub-
16 section (c)(5);

17 (3) the annual national health care quality re-
18 port card described in subsection (e)(2)(B);

19 (4) ongoing health care quality research efforts;

20 (5) new and innovative health care quality im-
21 provement practices in the public and private sec-
22 tors;

23 (6) a consumer feedback mechanism; and

24 (7) other information, as the Director deter-
25 mines to be appropriate.

1 (g) STAFF; EXPERTS AND CONSULTANTS; VOL-
2 UNTARY AND UNCOMPENSATED SERVICE.—

3 (1) STAFF.—The Director may employ such of-
4 ficers and employees as may be necessary to enable
5 the Office to carry out its functions under this Act,
6 and may employ and fix the compensation of such
7 officers and employees as may be necessary to carry
8 out its functions under this Act.

9 (2) EXPERTS AND CONSULTANTS.—The Direc-
10 tor may employ and fix the compensation of such ex-
11 perts and consultants as may be necessary for the
12 carrying out of its functions under this Act, in ac-
13 cordance with section 3109 of title 5, United States
14 Code (without regard to the last sentence).

15 (3) VOLUNTARY AND UNCOMPENSATED SERV-
16 ICE.—Notwithstanding section 1342 of title 31,
17 United States Code, the Office may accept and use
18 voluntary and uncompensated services, as the Direc-
19 tor determines necessary.

20 (h) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to carry out this section \$50,000,000 for
22 fiscal years 2010 through 2014.

23 **SEC. 5. NATIONAL HEALTH CARE QUALITY COORDINATION.**

24 (a) ESTABLISHMENT.—As of the date of enactment
25 of this Act, there is established within the Office of Na-

1 tional Health Care Quality Improvement, the Quality
2 Interagency Coordinating Council (referred to in this sec-
3 tion as the “QuICC”).

4 (b) PURPOSE.—The purpose of the QuICC is to co-
5 ordinate health care quality improvement efforts across all
6 Federal agencies involved in purchasing, providing, study-
7 ing, or regulating health care services in order to achieve
8 the common goal of improving patient health outcomes.

9 (c) ORGANIZATION OF THE QUICC.—

10 (1) CO-CHAIRPERSONS.—The Director of Na-
11 tional Health Care Quality (referred to in this sec-
12 tion as the “Director”) and the Secretary of Health
13 and Human Services shall serve as co-chairpersons
14 of the QuICC, and the Director shall manage day-
15 to-day operations of the QuICC.

16 (2) FEDERAL MEMBERS.—The Federal mem-
17 bers of the QuICC, each of whom shall have equal
18 standing in the QuICC, shall include—

19 (A) the Administrator of the Centers for
20 Medicare & Medicaid Services;

21 (B) the Director of the National Institutes
22 of Health;

23 (C) the Director of the Centers for Disease
24 Control and Prevention;

25 (D) the Commissioner of Food and Drugs;

1 (E) the Administrator of the Health Re-
2 sources and Services Administration;

3 (F) the Director of the Agency for
4 Healthcare Research and Quality;

5 (G) the Assistant Secretary of the Admin-
6 istration for Children and Families;

7 (H) the Secretary of Labor;

8 (I) the Secretary of Defense;

9 (J) the Secretary of Veterans Affairs;

10 (K) the Under Secretary for Health of the
11 Veterans Health Administration;

12 (L) the Secretary of Commerce;

13 (M) the Director of the Office of Personnel
14 Management;

15 (N) the Director of the Office of Manage-
16 ment and Budget;

17 (O) the Commandant of the United States
18 Coast Guard;

19 (P) the Director of the Federal Bureau of
20 Prisons;

21 (Q) the Administrator of the National
22 Highway Traffic Safety Administration;

23 (R) the Chairman of the Federal Trade
24 Commission; and

1 (S) the Commissioner of the Social Secu-
2 rity Administration.

3 (d) GOALS.—The goals of the QuICC shall be to
4 achieve the following:

5 (1) Collaboration between Federal departments
6 and agencies with respect to developing goals, mod-
7 els, and timetables that are consistent with—

8 (A) reducing the underlying causes of ill-
9 ness, injury, and disability;

10 (B) reducing health care errors;

11 (C) ensuring the appropriate use of health
12 care services;

13 (D) expanding research on effectiveness of
14 treatments;

15 (E) addressing over-supply and under-sup-
16 ply of health care resources; and

17 (F) increasing patient participation in
18 their care.

19 (2) Collaboration between Federal departments
20 and agencies with respect to the development and
21 utilization of quality improvement strategies, includ-
22 ing quality measurement, for public sector programs
23 that are flexible enough to respond to changing
24 health care needs, technology, and information, while

1 being sufficiently standardized to be comparably
2 measured.

3 (3) Cooperation between Federal departments
4 and agencies in the development and dissemination
5 of evidence-based health care information to help
6 guide practitioners' actions in ways that will improve
7 quality and potentially reduce costs.

8 (4) Cooperation between Federal departments
9 and agencies in the development and dissemination
10 of user-friendly information for both consumer and
11 business purchasers that facilitates meaningful com-
12 parisons of quality performances of health care
13 plans, facilities and practitioners.

14 (5) Consultation with multi-stakeholder groups,
15 where appropriate, in order to develop interdepart-
16 mental and interagency models for quality improve-
17 ment.

18 (6) Avoidance of inefficient duplication of ongo-
19 ing health care quality improvement efforts and re-
20 sources, where feasible and appropriate.

21 (7) Coordination and implementation by Fed-
22 eral departments and agencies of a streamlined proc-
23 ess for quality reporting and compliance require-
24 ments to reduce administrative burdens on private

1 entities who administer, oversee, or participate in
2 the Federal health programs.

3 (e) WORKGROUPS.—

4 (1) IN GENERAL.—Not later than 30 days after
5 the establishment of the QuICC, the Director shall
6 establish within the QuICC workgroups for each of
7 the national health care priorities established under
8 section 4(c)(1).

9 (2) PURPOSE.—Each such workgroup shall
10 focus on achieving the goals of the QuICC (described
11 in subsection (d)) for one such priority and shall—

12 (A) coordinate the implementation of such
13 priority across all relevant Federal agencies and
14 departments; and

15 (B) identify opportunities to improve the
16 process of implementing such health care pri-
17 ority.

18 (3) MEMBERSHIP.—

19 (A) LEADERSHIP.—Each workgroup shall
20 be led by 2 relevant Federal departments or
21 agencies, as determined by the Director.

22 (B) REPRESENTATION.—Each of the Fed-
23 eral members listed in subsection (c)(2) may
24 appoint 1 or more representatives to each
25 workgroup.

1 (4) REPORTING.—

2 (A) REPORT.—Not later than December
3 31, 2010, and annually thereafter, the co-chair-
4 persons of the QuICC shall submit a report to
5 the relevant committees of Congress describ-
6 ing—

7 (i) the QuICC’s progress in meeting
8 the goals described in subsection (d);

9 (ii) recommendations for legislation to
10 improve the processes of health care qual-
11 ity coordination and prioritization; and

12 (iii) recommendations for new and in-
13 novative quality initiatives.

14 (B) PUBLICATION.—Not later than De-
15 cember 31, 2010, and annually thereafter, the
16 co-chairpersons shall publish the report de-
17 scribed in subparagraph (A) on the website of
18 the Office of National Health Care Quality Im-
19 provement.

20 (f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 \$5,000,000 for fiscal years 2011 through 2014.

1 **SEC. 6. INCREASED AUTHORITY OF THE AGENCY FOR**
2 **HEALTHCARE RESEARCH AND QUALITY**
3 **WITHIN THE DEPARTMENT OF HEALTH AND**
4 **HUMAN SERVICES.**

5 (a) DIRECTOR OF THE AGENCY FOR HEALTHCARE
6 RESEARCH AND QUALITY.—Section 901(a) of the Public
7 Health Service Act (42 U.S.C. 299(a)) is amended by
8 striking “by the Secretary” and inserting “by the Presi-
9 dent, by and with the advice and consent of the Senate”.

10 (b) NATIONAL HEALTH CARE QUALITY PRIOR-
11 ITIES.—Title IX of the Public Health Service Act (42
12 U.S.C. 299 et seq.) is amended by adding at the end the
13 following:

14 **“PART E—NATIONAL HEALTH CARE QUALITY**
15 **PRIORITIES**

16 **“SEC. 940. DEFINITIONS.**

17 “In this part:

18 “(1) HEALTH CARE QUALITY.—The term
19 ‘health care quality’ means the degree to which
20 health services for individuals and populations in-
21 crease the likelihood of desired health outcomes and
22 are consistent with current professional knowledge,
23 based upon the following criteria:

24 “(A) EFFECTIVENESS.—Health care serv-
25 ices should be provided based upon scientific
26 knowledge of all who could benefit.

1 “(B) EFFICIENCY.—Waste, including
2 waste of equipment, supplies, ideas, and ener-
3 gies, should be avoided.

4 “(C) EQUITY.—The provision of health
5 care should not vary in quality because of per-
6 sonal characteristics of the individuals involved.

7 “(D) PATIENT-CENTEREDNESS.—Health
8 care should be responsive to, and respectful of,
9 individual patient preferences.

10 “(E) SAFETY.—Injuries to patients from
11 the health care that is supposed to help them
12 should be avoided.

13 “(F) TIMELINESS.—Waiting times and
14 harmful delays in providing health care should
15 be reduced.

16 “(2) HEALTH CARE QUALITY MEASURE.—The
17 term ‘health care quality measure’ means a national
18 consensus standard for measuring the performance
19 and improvement of population health or of institu-
20 tional providers of services, physicians, and other cli-
21 nicians in the delivery of health care services, con-
22 sistent with the health care quality criteria described
23 in paragraph (1).

24 “(3) MULTI-STAKEHOLDER GROUP.—The term
25 ‘multi-stakeholder group’ means, with respect to a

1 health care quality measure, a voluntary collabora-
2 tive of public and private organizations rep-
3 resenting persons interested in, or affected by, the
4 use of such health care quality measure, including—

5 “(A) health care providers and practi-
6 tioners, including providers and practitioners
7 primarily serving children and those with long-
8 term health care needs;

9 “(B) health care quality entities;

10 “(C) health plans;

11 “(D) patient advocates and consumer
12 groups;

13 “(E) employers;

14 “(F) public and private purchasers of
15 health care items and services;

16 “(G) labor organizations;

17 “(H) relevant departments or agencies of
18 the United States;

19 “(I) biopharmaceutical companies and
20 manufacturers of medical devices; and

21 “(J) licensing, credentialing, and accred-
22 iting bodies.

23 “(4) the term ‘health care quality measure’
24 means a national consensus standard for measuring
25 the performance and improvement of population

1 health or of institutional providers of services, physi-
2 cians, and other clinicians in the delivery of health
3 care services; and

4 “(5) the term ‘multi-stakeholder group’ means,
5 with respect to a health care quality measure, a vol-
6 untary collaborative of public and private organiza-
7 tions representing persons interested in, or affected
8 by, the use of such health care quality measure, in-
9 cluding—

10 “(A) hospitals and other health care set-
11 tings;

12 “(B) physicians, including pediatricians;

13 “(C) health care quality alliances;

14 “(D) nurses and other health care practi-
15 tioners;

16 “(E) health plans;

17 “(F) patient advocates and consumer
18 groups;

19 “(G) employers;

20 “(H) public and private purchasers of
21 health care items and services;

22 “(I) labor organizations;

23 “(J) relevant departments or agencies of
24 the United States;

1 “(K) biopharmaceutical companies and
2 manufacturers of medical devices; and

3 “(L) licensing, credentialing, and accred-
4 iting bodies.

5 **“SEC. 941. RESEARCH PRIORITIES.**

6 “The Director, in consultation with the heads of
7 agencies within the Department of Health and Human
8 Services shall ensure that the health care quality improve-
9 ment priorities identified by the Director of the Office of
10 National Health Care Quality Improvement, established
11 under section 4 of the National Health Care Quality Act,
12 are taken into consideration in all applicable research con-
13 ducted under the Department of Health and Human Serv-
14 ices, including the National Institutes of Health and the
15 demonstration projects.

16 **“SEC. 942. QUALITY MEASURES.**

17 “(a) APPLICATION OF QUALITY MEASURES TO PRO-
18 GRAMS UNDER THE DEPARTMENT OF HEALTH AND
19 HUMAN SERVICES.—

20 “(1) IN GENERAL.—The Director, in consulta-
21 tion with the Administrator of the Centers for Medi-
22 care & Medicaid Services, the Director of the Cen-
23 ters for Disease Control and Prevention, the Direc-
24 tor of the National Institutes of Health, and a con-
25 sensus-based entity (as such term is used in section

1 1890 of the Social Security Act), shall define uni-
2 form health care quality measures, which shall apply
3 to Federal health programs under the Department
4 of Health and Human Services, including the fol-
5 lowing Federal programs, in order of priority:

6 “(A) The Medicare program under title
7 XVIII of the Social Security Act, the rural
8 health and pharmacy programs of the Health
9 Resources and Services Administration, and the
10 health programs of the Administration on
11 Aging.

12 “(B) The Medicaid program under title
13 XIX of the Social Security Act, the Children’s
14 Health Insurance program under title XXI of
15 such Act, the health programs of the Adminis-
16 tration for Children and Families, and the ma-
17 ternal and child health programs of the Health
18 Resources and Services Administration.

19 “(C) The Indian Health Service.

20 “(D) The Substance Abuse and Mental
21 Health Services Administration.

22 “(E) Programs of the Health Resources
23 and Services Administration other than those
24 described in subparagraph (B).

1 “(F) Centers of the Food and Drug Ad-
2 ministration.

3 “(2) PRIORITIZATION.—The Director shall
4 apply the health care quality measures under this
5 section to the Federal programs in the order of pri-
6 ority described in paragraph (1).

7 “(3) CONSIDERATIONS REGARDING QUALITY
8 MEASURE APPLICATION.—Before applying the health
9 care quality measures described in paragraph (1),
10 the Director shall consider—

11 “(A) the potential of such measures to im-
12 prove patient outcomes;

13 “(B) the ease of integration as a factor in
14 health care provider reimbursement;

15 “(C) the applicability of such measures
16 across health care settings;

17 “(D) the unique quality improvement
18 needs of vulnerable populations, including chil-
19 dren, the elderly, individuals with disabilities,
20 individuals near the end of life, and racial and
21 ethnic minorities;

22 “(E) the burden of disease, including the
23 prevalence, incidence, and cost of disease to the
24 United States; and

1 “(F) payment distortions that encourage
2 certain practice norms which may not lead to
3 greater patient health outcomes.

4 “(4) UPDATING OF THE APPLICATION OF QUAL-
5 ITY MEASURES.—The Director, in consultation with
6 the Administrator of the Centers for Medicare &
7 Medicaid Services, the Director of the Centers for
8 Disease Control and Prevention, the Director of the
9 National Institutes of Health, and a consensus-based
10 entity (as such term is used in section 1890 of the
11 Social Security Act), shall develop a process for up-
12 dating the health care quality measures defined
13 under paragraph (1) as new research and evidence
14 become available.

15 “(b) QUALITY MEASURE REPORTING TO FEDERAL
16 HEALTH PROGRAMS.—The Director, in cooperation with
17 the Administrator of the Centers for Medicare & Medicaid
18 Services, the National Coordinator for Health Information
19 Technology, the Administrator of the Health Resources
20 and Services Administration, the Director of the Centers
21 for Disease Control and Prevention, and the Commis-
22 sioner of Food and Drugs, shall create a streamlined proc-
23 ess for health care providers to report quality measures
24 to the heads of relevant agencies and departments for the

1 purpose of quality improvement in the Federal health pro-
2 grams described in subsection (a)(1).

3 “(c) DEVELOPMENT OF ADDITIONAL QUALITY IM-
4 PROVEMENT STRATEGIES.—The Director, in consultation
5 with the Administrator of the Centers for Medicare &
6 Medicaid Services, the Director of the Centers for Disease
7 Control and Prevention, the Director of the National Insti-
8 tutes of Health, and multi-stakeholder groups, shall de-
9 velop quality improvement strategies to address activities
10 other than health care quality measurement that lead to
11 improved patient outcomes, such as alternative care mod-
12 els, licensing, professional certification, medical education,
13 alternative staffing models, and public reporting.

14 **“SEC. 943. PUBLIC EDUCATION CAMPAIGNS.**

15 “(a) IN GENERAL.—The Director shall conduct a
16 public education campaign, designed to educate health
17 care providers and consumers of health care about health
18 care quality improvement.

19 “(b) CONSUMER EDUCATION CAMPAIGNS.—

20 “(1) IN GENERAL.—The Director, in coordina-
21 tion with the Administrator of the Centers for Medi-
22 care & Medicaid Services and the Director of the
23 Centers for Disease Control and Prevention, shall
24 create a consumer education campaign to develop ac-
25 curate and reliable information about health care

1 quality. In compiling the information for the con-
2 sumer education campaign, the Secretary may use
3 mechanisms and sources of information that are
4 available through other Federal agencies.

5 “(2) REQUIREMENTS.—The consumer edu-
6 cation campaign shall include information regard-
7 ing—

8 “(A) the importance of quality in health
9 care decisions;

10 “(B) the ways in which health care experts
11 define and identify quality in health care;

12 “(C) the variance of quality among health
13 insurance plans, health care facilities, health
14 care organizations, and health care providers;
15 and

16 “(D) the role of consumers in improving
17 the quality of health care.

18 “(3) PUBLICATION.—The Director shall make
19 the information described in paragraph (1) available
20 to the public through the Internet.

21 “(4) GRANT PROGRAM.—The Director shall
22 award grants to States and private nonprofit organi-
23 zations to assist with the creation and dissemination
24 of the information described in paragraph (1).

1 “(c) QUALITY RESOURCE CENTER FOR HEALTH
2 CARE PROVIDERS.—

3 “(1) IN GENERAL.—The Director, in coordina-
4 tion with the Administrator of the Centers for Medi-
5 care & Medicaid Services, shall create a National
6 Quality Resource Center (referred to in this sub-
7 section as the ‘NQRC’) for health care providers to
8 assist with the understanding and implementation of
9 quality improvement initiatives for health care pro-
10 viders.

11 “(2) DUTIES.—The national resource center de-
12 veloped under paragraph (1) shall—

13 “(A) inform providers about quality im-
14 provement techniques and the value of such
15 techniques to improving quality;

16 “(B) accelerate the transfer of lessons
17 learned from other initiatives in the public and
18 private sectors, including those initiatives re-
19 ceiving Federal financial support;

20 “(C) provide a forum for exchange of
21 knowledge and experience among health care
22 providers;

23 “(D) provide technical assistance to health
24 care providers for implementing quality im-
25 provement efforts; and

1 “(E) provide a forum for feedback from
2 health care providers concerning the effect of
3 the efforts under subparagraphs (A) through
4 (D).

5 “(3) NATIONAL QUALITY SUPPORT EXTENSION
6 GRANT PROGRAM.—

7 “(A) IN GENERAL.—The Director, in co-
8 ordination with the NQRC, shall award Na-
9 tional Quality Support Extension grants (re-
10 ferred to in this paragraph as ‘NQSE grants’
11 or the ‘NQSE grant program’), on a competi-
12 tive basis, to eligible entities for the purpose of
13 supporting and facilitating local health care
14 quality improvement efforts throughout the
15 United States.

16 “(B) PURPOSES.—The purposes of the
17 NQSE grant program are—

18 “(i) to assist qualified eligible entities
19 in carrying out projects related to health
20 care quality improvement activities among
21 the provider community to help test and
22 acclimate to new, innovative quality im-
23 provement activities;

24 “(ii) to facilitate communication
25 among local health care quality groups re-

1 garding the best practices in the area of
2 quality improvement and prevention in the
3 clinical setting; and

4 “(iii) to enable, empower, support,
5 and assist local health care quality im-
6 provement efforts, particularly those that
7 facilitate collaboration between inde-
8 pendent providers.

9 “(C) ELIGIBLE ENTITIES.—An entity de-
10 siring a grant under this paragraph shall—

11 “(i) be a public or private nonprofit
12 entity engaged in health care quality im-
13 provement;

14 “(ii) submit to the Director a program
15 design that describes the purpose of the
16 plan for which the entity seeks a grant and
17 the community leadership that will support
18 the entity in carrying out such plan; and

19 “(iii) submit to the Director an appli-
20 cation at such time, in such manner, and
21 containing such information as the Direc-
22 tor may require.

23 “(4) IMPLEMENTATION ASSISTANCE.—The
24 Health Information Technology regional extension
25 centers under section 3012(c) shall operate as exten-

1 sion centers for the NQRC, for the purposes of im-
2 plementation assistance.

3 “(5) TECHNICAL ASSISTANCE FOR HEALTH
4 CARE PROVIDERS WORKING WITH VULNERABLE POP-
5 ULATIONS.—In carrying out this subsection, the Di-
6 rector shall give particular attention to the technical
7 assistance that health care providers who serve vul-
8 nerable populations need.

9 **“SEC. 944. FUNDING.**

10 “(a) TRUST FUNDS.—For purposes of funding the
11 activities under this part, the Secretary shall provide for
12 the transfer from the Federal Hospital Insurance Trust
13 Fund under section 1817 of the Social Security Act (42
14 U.S.C. 1395i) and the Federal Supplementary Insurance
15 Trust Fund under section 1841 of the Social Security Act
16 (42 U.S.C. 1395t), including the Medicare Prescription
17 Drug Account in such Trust Fund, in such proportion as
18 determined appropriate by the Secretary, of \$150,000,000
19 for each of fiscal years 2010 through 2014.

20 “(b) AMERICAN RECOVERY AND REINVESTMENT
21 FUNDS.—At the end of the recession adjustment period
22 (as defined in section 5001(h)(3) of the American Recov-
23 ery and Reinvestment Act (Public Law 111–5; 123 Stat.
24 496), the Secretary of the Treasury shall transfer any
25 funds appropriated under such Act and not otherwise ex-

1 pended to the Agency for purposes of carrying out this
2 part.

3 “(c) MEDICAID AND MEDICARE IMPROVEMENT
4 FUNDS.—For purposes of funding the activities under this
5 part for fiscal year 2014, the Secretary shall provide for
6 the transfer of \$100,000,000 from the Medicaid Improve-
7 ment Fund under section 1898 of the Social Security Act
8 (42 U.S.C. 1395iii), and \$100,000,000 from the Medicare
9 Improvement Fund under section 1941 of such Act (42
10 U.S.C 1396w-1).”.

11 (c) TECHNICAL AMENDMENT.—Section 937(b) of the
12 Public Health Service Act (42 U.S.C. 299e-6(b)) is
13 amended by inserting “except for part E,” after “this
14 title”.

15 (d) DEVELOPMENT OF QUALITY MEASURES FOR
16 FEDERAL HEALTH PROGRAMS.—

17 (1) PERIOD OF CONTRACT.—Section 1890(a)(3)
18 of the Social Security Act (42 U.S.C.
19 1395aaa(a)(3)) is amended—

20 (A) by striking “4 years” and inserting “4
21 years, in the case of the first contract entered
22 into under such paragraph, and 3 years in the
23 case of each subsequent contract entered into
24 under such paragraph”; and

1 (B) by inserting “for a period of 3 years”
2 after “renewed”.

3 (2) PRIORITY SETTING PROCESS.—Section
4 1890(b)(1) of the Social Security Act (42 U.S.C.
5 1395aaa(b)(1)) is amended—

6 (A) in the matter preceding subparagraph

7 (A)—

8 (i) by striking “an integrated national
9 strategy and priorities for”; and

10 (ii) by inserting “in a manner con-
11 sistent with the national priorities for
12 health care quality improvement (as de-
13 fined in section 4(c)(1))” after “settings”;

14 (B) in subparagraph (A)—

15 (i) by redesignating clauses (i)
16 through (iii) as clauses (ii) through (iv),
17 respectively; and

18 (ii) by inserting before clause (ii), as
19 so redesignated, the following new clause:

20 “(i) that are consistent with such na-
21 tional priorities for health care quality im-
22 provement;”.

23 (3) ANNUAL REPORT TO CONGRESS.—Section
24 1890(b)(5) of the Social Security Act (42 U.S.C.
25 1395aaa(b)(5)) is amended—

1 (A) by redesignating clauses (i) through
2 (iii) as clauses (ii) through (iv); and

3 (B) by inserting before clause (ii), as so re-
4 designated, the following new clause:

5 “(i) the extent to which the priorities
6 set and the quality improvement measures
7 endorsed by the entity under paragraphs
8 (1) and (2), respectively, are consistent
9 with the national priorities for health care
10 quality improvement (as so defined);”.

11 (4) FUNDING.—Section 1890(d) of the Social
12 Security Act (42 U.S.C. 1395aaa(d)) is amended by
13 inserting “and, for purposes of carrying out this sec-
14 tion under a new or renewed contract, there are au-
15 thorized to be appropriated such sums as are nec-
16 essary, taking into consideration the results of the
17 study contained in the 18-month report submitted to
18 Congress under section 183(b)(2) of the Medicare
19 Improvements for Patients and Providers Act of
20 2008 (Public Law 110–275), for each of fiscal years
21 2013 through 2015” before the period at the end.

22 **SEC. 7. REPORTS TO CONGRESS.**

23 (a) EVALUATION OF THE CONSUMER EDUCATION
24 CAMPAIGN.—Not later than 18 months after the establish-
25 ment of the quality resource center under section 943(c)

1 of the Public Health Service Act (as added by section 6),
2 the Comptroller General of the United States shall submit
3 to Congress a report describing—

4 (1) the effectiveness of the quality resource cen-
5 ter for health care providers under such section
6 943(c); and

7 (2) the effectiveness of the consumer education
8 program under section 943(b) of such Act (as added
9 by section 6).

10 (b) QUALITY DISSEMINATION STRATEGIES.—Not
11 later than 18 months after the date of enactment of this
12 Act, the Secretary of Health and Human Services, acting
13 through the Director of the Agency for Healthcare Re-
14 search and Quality, shall submit a report to Congress that
15 includes—

16 (1) a description of the efforts made to trans-
17 late clinical information regarding health care qual-
18 ity improvement into reasonable clinical practice;

19 (2) the processes through which the Secretary
20 disseminated the information described in paragraph
21 (1); and

22 (3) recommendations for the most effective
23 methods for translating and disseminating informa-
24 tion concerning health care quality, and required

1 statutory changes to implement the recommended
2 methods.

3 (c) IOM REPORT TO CONGRESS REGARDING THE
4 VALUE OF QUALITY MEASURE REPORTING.—

5 (1) IN GENERAL.—The Secretary of Health and
6 Human Services shall enter into a contract with the
7 Director of the Institute of Medicine requiring that,
8 not later than 18 months after the date of enact-
9 ment of this Act, the Director submit to Congress a
10 report regarding the value of quality measure report-
11 ing in improving patient health outcomes.

12 (2) CONSIDERATIONS.—In preparing the report
13 described in paragraph (1), the Director of the Insti-
14 tutes of Medicine shall consider—

15 (A) specific instances in the history of ex-
16 isting public health care programs within the
17 Federal Government in which quality measure
18 reporting has been shown, through peer-re-
19 viewed studies or literature, to result in im-
20 proved patient health outcomes; and

21 (B) instances in which quality measure re-
22 porting has been shown to improve existing
23 health disparities among vulnerable populations,
24 including children, underserved populations,

1 rural populations, individuals with disabilities,
2 the elderly, and racial and ethnic minorities.

3 (3) AUTHORIZATION OF APPROPRIATIONS.—

4 There are authorized to be appropriated such sums
5 as may be necessary to carry out this subsection.

6 (d) GAO STUDY AND REPORTS.—Section 183(b)(1)
7 of the Medicare Improvements for Patients and Providers
8 Act of 2008 (Public Law 110–275; 122 Stat. 2586) is
9 amended—

10 (1) in subparagraph (A), by striking “and”
11 after the semicolon;

12 (2) in subparagraph (B), by striking the period
13 at the end and inserting a semicolon; and

14 (3) by inserting after subparagraph (B) the fol-
15 lowing:

16 “(C) any negative effect on patients, par-
17 ticularly on patients in underserved or vulner-
18 able populations; and

19 “(D) any negative effect on health care
20 providers, particularly health care providers in
21 rural and underserved areas.”.

22 **SEC. 8. DATA COLLECTION.**

23 (a) IN GENERAL.—Not later than January 1, 2011,
24 and at least every 5 years thereafter, the Comptroller Gen-
25 eral of the United States (referred to in this section as

1 the “Comptroller General”) shall conduct evaluations of
2 the implementation of the data collection processes for
3 quality measures used by the Federal health programs ad-
4 ministered through the Department of Health and Human
5 Services.

6 (b) CONSIDERATIONS.—In conducting the evalua-
7 tions under subsection (a), the Comptroller General shall
8 consider—

9 (1) whether the system for the collection of
10 data for quality measures provides for validation of
11 data in a manner that is relevant, fair, and scientif-
12 ically credible;

13 (2) whether data collection efforts under the
14 system—

15 (A) use the most efficient and cost-effec-
16 tive means in a manner that minimizes admin-
17 istrative burden on persons required to collect
18 data;

19 (B) adequately protects the privacy the
20 personal health information of patients; and

21 (C) provides data security;

22 (3) whether standards under the system provide
23 for an opportunity for health care providers and in-
24 stitutional providers of services to review and correct
25 any inaccuracies with regard to the findings; and

1 (4) the extent to which quality measures—

2 (A) assess outcomes and the functional
3 status of patients;

4 (B) assess the continuity and coordination
5 of care and care transitions, including episodes
6 of care, for patients across providers and health
7 care settings;

8 (C) assess patient experience and patient
9 engagement;

10 (D) assess the safety, effectiveness, and
11 timeliness of care;

12 (E) assess health disparities, including dis-
13 parities associated with race, ethnicity, age,
14 gender, place of residence, or language;

15 (F) assess the efficiency and use of re-
16 sources in the provision of care;

17 (G) are designed to be collected as part of
18 health information technologies supporting bet-
19 ter delivery of health care services; and

20 (H) result in direct or indirect costs to
21 users of such measures.

22 (c) AUTHORIZATION OF APPROPRIATIONS.—There
23 are authorized to be appropriated to carry out this section
24 \$1,000,000 for fiscal years 2010 through 2014.

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