I

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

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National Health Care Quality Act''.

SEC. 2. DEFINITIONS.

In this Act:

(1) HEALTH CARE QUALITY.—The term ''health care quality'' means the degree to which health serv-

ices for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge, based upon the following criteria:

(A) EFFECTIVENESS.—Health care services should be provided based upon scientific knowledge of all who could benefit.

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

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

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

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

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

(2) HEALTH CARE QUALITY MEASURE.—The term ''health care quality measure'' means a national consensus standard for measuring the per-

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

(3) MULTI-STAKEHOLDER GROUP.—The term ''multi-stakeholder group'' means, with respect to a health care quality measure, a voluntary collaborative of public and private organizations representing persons interested in, or affected by, the use of such health care quality measure, including—

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

(B) health care quality entities;

(C) health plans;

(D) patient advocates and consumer groups;

(E) employers;

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

(G) labor organizations;

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

(I) biopharmaceutical companies and manufacturers of medical devices; and

(J) licensing, credentialing, and accrediting bodies.

SEC. 3. DEPARTMENT AND AGENCY QUALITY REVIEW.

Each relevant department and agency of the Federal Government shall review the statutory authority of such department or agency, effective on the date of enactment of this Act, administrative regulations, and policies and procedures for the purpose of determining whether there are any deficiencies or inconsistencies therein which prohibit full compliance with the purposes and provisions of this Act. Each department and agency shall, not later than July 1, 2010, propose to the President such measures as may be necessary to bring the authority and policies and procedures of such department or agency into conformity with the intent, purposes, and provisions set forth in this Act.

SEC. 4. NATIONAL HEALTH CARE QUALITY PRIORITIES.

(a) ESTABLISHMENT OF THE OFFICE OF NATIONAL HEALTH CARE QUALITY IMPROVEMENT.—There is established within the Executive Office of the President an Office of National Health Care Quality Improvement (''NHCQI'') (referred to in this section as the ''Office''). The Office shall be headed by a Director of National

Health Care Quality (referred to in this section as the ''Director'') who shall be appointed by the President and shall report directly to the President.

(b) DIRECTOR.—

(1) RESPONSIBILITIES.—The Director shall perform the duties of the Office, described in paragraph (3), in a manner consistent with the development of a nationwide health care quality infrastructure that—

(A) coordinates and implements health care quality research, measurement, and data collection and reporting across all Federal agencies involved in purchasing, providing, studying, or regulating health care services;

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

(C) includes public and private quality improvement strategies to address activities other than health care quality measurement, such as provider payment models, alternative care models, licensing, professional certification, medical education, alternative staffing models, and public reporting; and

(D) leads to improved health care outcomes for patients across the United States.

(2) QUALIFICATIONS.—The President shall, by and with the advice and consent of the Senate, appoint a Director. The President shall select an individual who has—

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

(B) experience addressing health care quality improvement in more than one health care setting, such as inpatient care, outpatient care, long-term care, public programs, and private programs; and

(C) experience addressing health care quality as it applies to vulnerable populations, including children, underserved populations, rural populations, individuals with disabilities, the elderly, and racial and ethnic minorities.

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

(A) advise the President on the quality of health care in the United States, including priorities and goals for the future;

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

(C) establish annual benchmarks for each relevant Federal department and agency to achieve national priorities for health care quality improvement;

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

(E) in coordination with the heads of other relevant agencies and as part of the annual budget request of Congress, submit funding requirements, in accordance with subsection (d);

(F) serve as the chairperson of the Quality Interagency Coordinating Council (QuICC), established under section 4; and

(G) in consultation with the National Coordinator of Health Information Technology, develop an open source framework for Federal quality communication to create and maintain a standardized, electronic language or interface that enables all relevant Federal entities to communicate information or make requests regarding quality research, definitions, activities, or regulations, or to provide any other functionality, as the Director determines.

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

(1) IN GENERAL.—Not later than January 1, 2010 and at least every 5 years thereafter, the Director, in coordination with public and private stakeholders, shall establish national priorities for health care quality improvement.

(2) DEVELOPMENT OF PRIORITIES.—In establishing the national priorities for health care quality improvement under paragraph (1), the Director shall consider—

(A) health care outcomes in the United States in comparison to health outcomes in other World Health Organization member countries;

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

(C) demographics;

(D) variability in practice norms;

(E) potential to eliminate harm to patients;

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

(G) quality measures that may be coordinated across different health care settings, including impatient and outpatient measures, primary care, and specialty care;

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

(I) the unique quality improvement needs disparities and challenges of vulnerable populations, including children, the elderly, individuals with disabilities, individuals near the end of life, and racial and ethnic minorities.

(3) INITIAL PRIORITIES.—The first set of national priorities established under this subsection shall include as a priority pediatric health care quality improvement, for children up to age 21.

(4) COLLABORATION WITH MULTI-STAKEHOLDER GROUPS.—

(A) IN GENERAL.—The Director shall convene and collaborate with multi-stakeholder groups in establishing and updating the national priorities under paragraph (1).

(B) TRANSPARENCY.—All collaboration between the Director and multi-stakeholder groups shall be conducted through an open and transparent process.

(C) STATUTORY CONSTRUCTION.—Notwithstanding any other provision in this paragraph, the Director shall have the final authority to decide whether to accept the recommendations provided by such multi-stakeholder groups.

(5) AGENCY- AND DEPARTMENT-SPECIFIC STRATEGIC PLANS.—Not later than October 1, 2010, and annually thereafter, the Director, in consultation with the heads of relevant Federal agencies and departments, shall develop agency- and department-specific strategic plans for health care quality improvement to achieve national priorities, including annual benchmarks.

(d) ANNUAL BUDGET REQUEST FOR RESOURCES.—As part of the annual budget request made by the President to Congress, beginning with such budget request made in calendar year 2011, the Director, in consultation with the heads of relevant Federal departments and agencies, shall include—

(1) a description of the agency- and department-specific strategic plans for health care quality improvement; and

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

(e) MONITORING.—

(1) IN GENERAL.—The Director shall institute mechanisms for monitoring the progress on achieving national health care quality priorities under subsection (c)(1) as well as department- and agency-specific strategic plans under subsection (c)(5), including objectives, metrics, and benchmarks for the following:

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

(B) Coordination and communication of efforts to achieve interagency goals, including information exchange.

(C) Interagency coordination progress for national quality efforts.

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

(2) REPORTING.—

(A) REPORTING.—Not later than December 31, 2011, and by the end of each calendar year thereafter, the Director shall submit to the President and to Congress a report regarding the progress of Federal agencies in achieving the quality improvement priorities under paragraphs (1) and (5) of subsection (c), and shall make such report publicly available through the Internet.

(B) ANNUAL NATIONAL HEALTH CARE QUALITY REPORT CARD.—Not later than January 31, 2011, and annually thereafter, the Director shall publish a national health care quality report card, which shall include—

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

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

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

(iv) a summary of consumer feedback regarding how well current quality improvement practices work for such consumers and additional ways to improve health care quality.

(f) WEBSITE.—Not later than July 1, 2010, the Director shall create a website to make public information regarding—

(1) the national priorities for health care quality improvement established under subsection (c)(1);

(2) the department- and agency-specific strategic plans for health care quality described in subsection (c)(5);

(3) the annual national health care quality report card described in subsection (e)(2)(B);

(4) ongoing health care quality research efforts;

(5) new and innovative health care quality improvement practices in the public and private sectors;

(6) a consumer feedback mechanism; and

(7) other information, as the Director determines to be appropriate.

(g) STAFF; EXPERTS AND CONSULTANTS; VOLUNTARY AND UNCOMPENSATED SERVICE.—

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

(2) EXPERTS AND CONSULTANTS.—The Director may employ and fix the compensation of such experts and consultants as may be necessary for the carrying out of its functions under this Act, in accordance with section 3109 of title 5, United States Code (without regard to the last sentence).

(3) VOLUNTARY AND UNCOMPENSATED SERVICE.—Notwithstanding section 1342 of title 31, United States Code, the Office may accept and use voluntary and uncompensated services, as the Director determines necessary.

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

SEC. 5. NATIONAL HEALTH CARE QUALITY COORDINATION.

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

tional Health Care Quality Improvement, the Quality Interagency Coordinating Council (referred to in this section as the ''QuICC'').

(b) PURPOSE.—The purpose of the QuICC is to coordinate health care quality improvement efforts across all Federal agencies involved in purchasing, providing, studying, or regulating health care services in order to achieve the common goal of improving patient health outcomes.

(c) ORGANIZATION OF THE QUICC.—

(1) CO-CHAIRPERSONS.—The Director of National Health Care Quality (referred to in this section as the ''Director'') and the Secretary of Health and Human Services shall serve as co-chairpersons of the QuICC, and the Director shall manage day-to-day operations of the QuICC.

(2) FEDERAL MEMBERS.—The Federal members of the QuICC, each of whom shall have equal standing in the QuICC, shall include—

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

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

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

(D) the Commissioner of Food and Drugs;

(E) the Administrator of the Health Resources and Services Administration;

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

(G) the Assistant Secretary of the Administration for Children and Families;

(H) the Secretary of Labor;

(I) the Secretary of Defense;

(J) the Secretary of Veterans Affairs;

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

(L) the Secretary of Commerce;

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

(N) the Director of the Office of Management and Budget;

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

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

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

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

(S) the Commissioner of the Social Security Administration.

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

(1) Collaboration between Federal departments and agencies with respect to developing goals, models, and timetables that are consistent with—

(A) reducing the underlying causes of illness, injury, and disability;

(B) reducing health care errors;

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

(D) expanding research on effectiveness of treatments;

(E) addressing over-supply and under-supply of health care resources; and

(F) increasing patient participation in their care.

(2) Collaboration between Federal departments and agencies with respect to the development and utilization of quality improvement strategies, including quality measurement, for public sector programs that are flexible enough to respond to changing health care needs, technology, and information, while

being sufficiently standardized to be comparably measured.

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

(4) Cooperation between Federal departments and agencies in the development and dissemination of user-friendly information for both consumer and business purchasers that facilitates meaningful comparisons of quality performances of health care plans, facilities and practitioners.

(5) Consultation with multi-stakeholder groups, where appropriate, in order to develop interdepartmental and interagency models for quality improvement.

(6) Avoidance of inefficient duplication of ongoing health care quality improvement efforts and resources, where feasible and appropriate.

(7) Coordination and implementation by Federal departments and agencies of a streamlined process for quality reporting and compliance requirements to reduce administrative burdens on private

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

(e) WORKGROUPS.—

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

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

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

(B) identify opportunities to improve the process of implementing such health care priority.

(3) MEMBERSHIP.—

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

(B) REPRESENTATION.—Each of the Federal members listed in subsection (c)(2) may appoint 1 or more representatives to each workgroup.

(4) REPORTING.—

(A) REPORT.—Not later than December 31, 2010, and annually thereafter, the co-chairpersons of the QuICC shall submit a report to the relevant committees of Congress describing—

(i) the QuICC's progress in meeting the goals described in subsection (d);

(ii) recommendations for legislation to improve the processes of health care quality coordination and prioritization; and

(iii) recommendations for new and innovative quality initiatives.

(B) PUBLICATION.—Not later than December 31, 2010, and annually thereafter, the co-chairpersons shall publish the report described in subparagraph (A) on the website of the Office of National Health Care Quality Improvement.

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

SEC. 6. INCREASED AUTHORITY OF THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(a) DIRECTOR OF THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.—Section 901(a) of the Public Health Service Act (42 U.S.C. 299(a)) is amended by striking ''by the Secretary'' and inserting ''by the President, by and with the advice and consent of the Senate''.

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

''PART E—NATIONAL HEALTH CARE QUALITY PRIORITIES

''SEC. 940. DEFINITIONS.

''In this part:

''(1) HEALTH CARE QUALITY.—The term 'health care quality' means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge, based upon the following criteria:

''(A) EFFECTIVENESS.—Health care services should be provided based upon scientific knowledge of all who could benefit.

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

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

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

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

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

''(2) HEALTH CARE QUALITY MEASURE.—The term 'health care quality measure' means a national consensus standard for measuring the performance and improvement of population health or of institutional providers of services, physicians, and other clinicians in the delivery of health care services, consistent with the health care quality criteria described in paragraph (1).

''(3) MULTI-STAKEHOLDER GROUP.—The term 'multi-stakeholder group' means, with respect to a

health care quality measure, a voluntary collaborative of public and private organizations representing persons interested in, or affected by, the use of such health care quality measure, including—

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

"(B) health care quality entities;

"(C) health plans;

"(D) patient advocates and consumer groups;

"(E) employers;

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

"(G) labor organizations;

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

"(I) biopharmaceutical companies and manufacturers of medical devices; and

"(J) licensing, credentialing, and accrediting bodies.

"(4) the term 'health care quality measure' means a national consensus standard for measuring the performance and improvement of population

health or of institutional providers of services, physicians, and other clinicians in the delivery of health care services; and

''(5) the term 'multi-stakeholder group' means, with respect to a health care quality measure, a voluntary collaborative of public and private organizations representing persons interested in, or affected by, the use of such health care quality measure, including—

''(A) hospitals and other health care settings;

''(B) physicians, including pediatricians;

''(C) health care quality alliances;

''(D) nurses and other health care practitioners;

''(E) health plans;

''(F) patient advocates and consumer groups;

''(G) employers;

''(H) public and private purchasers of health care items and services;

''(I) labor organizations;

''(J) relevant departments or agencies of the United States;

''(K) biopharmaceutical companies and manufacturers of medical devices; and

''(L) licensing, credentialing, and accrediting bodies.

''SEC. 941. RESEARCH PRIORITIES.

''The Director, in consultation with the heads of agencies within the Department of Health and Human Services shall ensure that the health care quality improvement priorities identified by the Director of the Office of National Health Care Quality Improvement, established under section 4 of the National Health Care Quality Act, are taken into consideration in all applicable research conducted under the Department of Health and Human Services, including the National Institutes of Health and the demonstration projects.

''SEC. 942. QUALITY MEASURES.

''(a) APPLICATION OF QUALITY MEASURES TO PROGRAMS UNDER THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—

''(1) IN GENERAL.—The Director, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, the Director of the Centers for Disease Control and Prevention, the Director of the National Institutes of Health, and a consensus-based entity (as such term is used in section

1890 of the Social Security Act), shall define uniform health care quality measures, which shall apply to Federal health programs under the Department of Health and Human Services, including the following Federal programs, in order of priority:

"(A) The Medicare program under title XVIII of the Social Security Act, the rural health and pharmacy programs of the Health Resources and Services Administration, and the health programs of the Administration on Aging.

"(B) The Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance program under title XXI of such Act, the health programs of the Administration for Children and Families, and the maternal and child health programs of the Health Resources and Services Administration.

"(C) The Indian Health Service.

"(D) The Substance Abuse and Mental Health Services Administration.

"(E) Programs of the Health Resources and Services Administration other than those described in subparagraph (B).

''(F) Centers of the Food and Drug Administration.

''(2) PRIORITIZATION.—The Director shall apply the health care quality measures under this section to the Federal programs in the order of priority described in paragraph (1).

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

''(A) the potential of such measures to improve patient outcomes;

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

''(C) the applicability of such measures across health care settings;

''(D) the unique quality improvement needs of vulnerable populations, including children, the elderly, individuals with disabilities, individuals near the end of life, and racial and ethnic minorities;

''(E) the burden of disease, including the prevalence, incidence, and cost of disease to the United States; and

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

"(4) UPDATING OF THE APPLICATION OF QUALITY MEASURES.—The Director, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, the Director of the Centers for Disease Control and Prevention, the Director of the National Institutes of Health, and a consensus-based entity (as such term is used in section 1890 of the Social Security Act), shall develop a process for updating the health care quality measures defined under paragraph (1) as new research and evidence become available.

"(b) QUALITY MEASURE REPORTING TO FEDERAL HEALTH PROGRAMS.—The Director, in cooperation with the Administrator of the Centers for Medicare & Medicaid Services, the National Coordinator for Health Information Technology, the Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Commissioner of Food and Drugs, shall create a streamlined process for health care providers to report quality measures to the heads of relevant agencies and departments for the

purpose of quality improvement in the Federal health programs described in subsection (a)(1).

''(c) DEVELOPMENT OF ADDITIONAL QUALITY IMPROVEMENT STRATEGIES.—The Director, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, the Director of the Centers for Disease Control and Prevention, the Director of the National Institutes of Health, and multi-stakeholder groups, shall develop quality improvement strategies to address activities other than health care quality measurement that lead to improved patient outcomes, such as alternative care models, licensing, professional certification, medical education, alternative staffing models, and public reporting.

''SEC. 943. PUBLIC EDUCATION CAMPAIGNS.

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

''(b) CONSUMER EDUCATION CAMPAIGNS.—

''(1) IN GENERAL.—The Director, in coordination with the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Centers for Disease Control and Prevention, shall create a consumer education campaign to develop accurate and reliable information about health care

quality. In compiling the information for the consumer education campaign, the Secretary may use mechanisms and sources of information that are available through other Federal agencies.

''(2) REQUIREMENTS.—The consumer education campaign shall include information regarding—

''(A) the importance of quality in health care decisions;

''(B) the ways in which health care experts define and identify quality in health care;

''(C) the variance of quality among health insurance plans, health care facilities, health care organizations, and health care providers; and

''(D) the role of consumers in improving the quality of health care.

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

''(4) GRANT PROGRAM.—The Director shall award grants to States and private nonprofit organizations to assist with the creation and dissemination of the information described in paragraph (1).

''(c) QUALITY RESOURCE CENTER FOR HEALTH CARE PROVIDERS.—

''(1) IN GENERAL.—The Director, in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall create a National Quality Resource Center (referred to in this subsection as the 'NQRC') for health care providers to assist with the understanding and implementation of quality improvement initiatives for health care providers.

''(2) DUTIES.—The national resource center developed under paragraph (1) shall—

''(A) inform providers about quality improvement techniques and the value of such techniques to improving quality;

''(B) accelerate the transfer of lessons learned from other initiatives in the public and private sectors, including those initiatives receiving Federal financial support;

''(C) provide a forum for exchange of knowledge and experience among health care providers;

''(D) provide technical assistance to health care providers for implementing quality improvement efforts; and

''(E) provide a forum for feedback from health care providers concerning the effect of the efforts under subparagraphs (A) through (D).

''(3) NATIONAL QUALITY SUPPORT EXTENSION GRANT PROGRAM.—

''(A) IN GENERAL.—The Director, in coordination with the NQRC, shall award National Quality Support Extension grants (referred to in this paragraph as 'NQSE grants' or the 'NQSE grant program'), on a competitive basis, to eligible entities for the purpose of supporting and facilitating local health care quality improvement efforts throughout the United States.

''(B) PURPOSES.—The purposes of the NQSE grant program are—

''(i) to assist qualified eligible entities in carrying out projects related to health care quality improvement activities among the provider community to help test and acclimate to new, innovative quality improvement activities;

''(ii) to facilitate communication among local health care quality groups re-

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

"(iii) to enable, empower, support, and assist local health care quality improvement efforts, particularly those that facilitate collaboration between independent providers.

"(C) ELIGIBLE ENTITIES.—An entity desiring a grant under this paragraph shall—

"(i) be a public or private nonprofit entity engaged in health care quality improvement;

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

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

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

sion centers for the NQRC, for the purposes of implementation assistance.

''(5) TECHNICAL ASSISTANCE FOR HEALTH CARE PROVIDERS WORKING WITH VULNERABLE POPULATIONS.—In carrying out this subsection, the Director shall give particular attention to the technical assistance that health care providers who serve vulnerable populations need.

''SEC. 944. FUNDING.

''(a) TRUST FUNDS.—For purposes of funding the activities under this part, the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), including the Medicare Prescription Drug Account in such Trust Fund, in such proportion as determined appropriate by the Secretary, of $150,000,000 for each of fiscal years 2010 through 2014.

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

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

''(c) MEDICAID AND MEDICARE IMPROVEMENT FUNDS.—For purposes of funding the activities under this part for fiscal year 2014, the Secretary shall provide for the transfer of $100,000,000 from the Medicaid Improvement Fund under section 1898 of the Social Security Act (42 U.S.C. 1395iii), and $100,000,000 from the Medicare Improvement Fund under section 1941 of such Act (42 U.S.C 1396w–1).''.

(c) TECHNICAL AMENDMENT.—Section 937(b) of the Public Health Service Act (42 U.S.C. 299c–6(b)) is amended by inserting ''except for part E,'' after ''this title''.

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

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

(A) by striking ''4 years'' and inserting ''4 years, in the case of the first contract entered into under such paragraph, and 3 years in the case of each subsequent contract entered into under such paragraph''; and

(B) by inserting ''for a period of 3 years'' after ''renewed''.

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

(A) in the matter preceding subparagraph (A)—

(i) by striking ''an integrated national strategy and priorities for''; and

(ii) by inserting ''in a manner consistent with the national priorities for health care quality improvement (as defined in section 4(c)(1))'' after ''settings'';

(B) in subparagraph (A)—

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

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

''(i) that are consistent with such national priorities for health care quality improvement;''.

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

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

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

"(i) the extent to which the priorities set and the quality improvement measures endorsed by the entity under paragraphs (1) and (2), respectively, are consistent with the national priorities for health care quality improvement (as so defined);".

(4) FUNDING.—Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended by inserting "and, for purposes of carrying out this section under a new or renewed contract, there are authorized to be appropriated such sums as are necessary, taking into consideration the results of the study contained in the 18-month report submitted to Congress under section 183(b)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), for each of fiscal years 2013 through 2015" before the period at the end.

SEC. 7. REPORTS TO CONGRESS.

(a) EVALUATION OF THE CONSUMER EDUCATION CAMPAIGN.—Not later than 18 months after the establishment of the quality resource center under section 943(c)

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

(1) the effectiveness of the quality resource center for health care providers under such section 943(c); and

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

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

(1) a description of the efforts made to translate clinical information regarding health care quality improvement into reasonable clinical practice;

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

(3) recommendations for the most effective methods for translating and disseminating information concerning health care quality, and required

statutory changes to implement the recommended methods.

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

(1) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with the Director of the Institute of Medicine requiring that, not later than 18 months after the date of enactment of this Act, the Director submit to Congress a report regarding the value of quality measure reporting in improving patient health outcomes.

(2) CONSIDERATIONS.—In preparing the report described in paragraph (1), the Director of the Institutes of Medicine shall consider—

(A) specific instances in the history of existing public health care programs within the Federal Government in which quality measure reporting has been shown, through peer-reviewed studies or literature, to result in improved patient health outcomes; and

(B) instances in which quality measure reporting has been shown to improve existing health disparities among vulnerable populations, including children, underserved populations,

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

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subsection.

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

(1) in subparagraph (A), by striking ''and'' after the semicolon;

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

(3) by inserting after subparagraph (B) the following:

''(C) any negative effect on patients, particularly on patients in underserved or vulnerable populations; and

''(D) any negative effect on health care providers, particularly health care providers in rural and underserved areas.''.

SEC. 8. DATA COLLECTION.

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

the ''Comptroller General'') shall conduct evaluations of the implementation of the data collection processes for quality measures used by the Federal health programs administered through the Department of Health and Human Services.

(b) CONSIDERATIONS.—In conducting the evaluations under subsection (a), the Comptroller General shall consider—

(1) whether the system for the collection of data for quality measures provides for validation of data in a manner that is relevant, fair, and scientifically credible;

(2) whether data collection efforts under the system—

(A) use the most efficient and cost-effective means in a manner that minimizes administrative burden on persons required to collect data;

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

(C) provides data security;

(3) whether standards under the system provide for an opportunity for health care providers and institutional providers of services to review and correct any inaccuracies with regard to the findings; and

(4) the extent to which quality measures—

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

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

(C) assess patient experience and patient engagement;

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

(E) assess health disparities, including disparities associated with race, ethnicity, age, gender, place of residence, or language;

(F) assess the efficiency and use of resources in the provision of care;

(G) are designed to be collected as part of health information technologies supporting better delivery of health care services; and

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

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

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