

ciety has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.

(5) The term “hospital” means an entity described in paragraphs (1) and (7) of section 1395x(e) of this title.

(6) The terms “licensed health care practitioner” and “practitioner” mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.

(7) The term “medical malpractice action or claim” means a written claim or demand for payment based on a health care provider’s furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.

(8) The term “physician” means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

(9) The term “professional review action” means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on—

(A) the physician’s association, or lack of association, with a professional society or association,

(B) the physician’s fees or the physician’s advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician’s participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician’s association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

(10) The term “professional review activity” means an activity of a health care entity with respect to an individual physician—

(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,

(B) to determine the scope or conditions of such privileges or membership, or

(C) to change or modify such privileges or membership.

(11) The term “professional review body” means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

(12) The term “Secretary” means the Secretary of Health and Human Services.

(13) The term “State” means the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(14) The term “State licensing board” means, with respect to a physician or health care provider in a State, the agency of the State which is primarily responsible for the licensing of the physician or provider to furnish health care services.

(Pub. L. 99-660, title IV, § 431, Nov. 14, 1986, 100 Stat. 3792.)

§ 11152. Reports and memoranda of understanding

(a) Annual reports to Congress

The Secretary shall report to Congress, annually during the three years after November 14, 1986, on the implementation of this chapter.

(b) Memoranda of understanding

The Secretary of Health and Human Services shall seek to enter into memoranda of understanding with the Secretary of Defense and the Administrator of Veterans’ Affairs to apply the provisions of subchapter II of this chapter to hospitals and other facilities and health care providers under the jurisdiction of the Secretary or Administrator, respectively. The Secretary shall report to Congress, not later than two years after November 14, 1986, on any such memoranda and on the cooperation among such officials in establishing such memoranda.

(c) Memorandum of understanding with Drug Enforcement Administration

The Secretary of Health and Human Services shall seek to enter into a memorandum of understanding with the Administrator of Drug Enforcement relating to providing for the reporting by the Administrator to the Secretary of information respecting physicians and other practitioners whose registration to dispense controlled substances has been suspended or revoked under section 824 of title 21. The Secretary shall report to Congress, not later than two years after November 14, 1986, on any such memorandum and on the cooperation between the Secretary and the Administrator in establishing such a memorandum.

(Pub. L. 99-660, title IV, § 432, Nov. 14, 1986, 100 Stat. 3794.)

CHANGE OF NAME

Reference to Administrator of Veterans’ Affairs deemed to refer to Secretary of Veterans Affairs pursu-

ant to section 10 of Pub. L. 100-527, set out as a Department of Veterans Affairs Act note under section 301 of Title 38, Veterans' Benefits.

CHAPTER 118—ALZHEIMER'S DISEASE AND RELATED DEMENTIAS RESEARCH

SUBCHAPTER I—GENERAL PROVISIONS

Sec.

11201. Findings.

SUBCHAPTER II—COUNCIL ON ALZHEIMER'S DISEASE

11211, 11212. Repealed.

SUBCHAPTER III—ADVISORY PANEL ON ALZHEIMER'S DISEASE

11221 to 11223. Omitted.

SUBCHAPTER III-A—NATIONAL ALZHEIMER'S PROJECT

11225. The National Alzheimer's Project.

SUBCHAPTER IV—RESEARCH RELATING TO SERVICES FOR INDIVIDUALS WITH ALZHEIMER'S DISEASE AND RELATED DEMENTIAS AND THEIR FAMILIES

11231, 11232. Repealed or Transferred.

11241 to 11243. Repealed or Transferred.

PART 1—RESPONSIBILITIES OF NATIONAL INSTITUTE OF MENTAL HEALTH

11251. Research program and plan.

11252. Dissemination.

11253. Authorization of appropriations.

PART 2—RESPONSIBILITIES OF AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

11261. Research program.

11262. Dissemination.

11263. Authorization of appropriations.

PART 3—RESPONSIBILITIES OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES

11271. Research program and plan.

11272. Dissemination.

11273. Authorization of appropriations.

11281 to 11283. Repealed or Transferred.

SUBCHAPTER V—EDUCATIONAL ACTIVITIES

11291. Providing information for personnel of Social Security Administration.

11292. Education of public, individuals with Alzheimer's disease and their families, and health and long-term care providers.

11293. Education programs for safety and transportation personnel.

11294. Authorization of appropriations.

SUBCHAPTER I—GENERAL PROVISIONS

§ 11201. Findings

The Congress finds that—

(1) best estimates indicate that between 2,000,000 and 3,000,000 Americans presently have Alzheimer's disease or related dementias;

(2) estimates of the number of individuals afflicted with Alzheimer's disease and related dementias are unreliable because current diagnostic procedures lack accuracy and sensitivity and because there is a need for epidemiological data on incidence and prevalence of such disease and dementias;

(3) studies estimate that between one-half and two-thirds of patients in nursing homes meet the clinical and mental status criteria for dementia;

(4) the cost of caring for individuals with Alzheimer's disease and related dementias is great, and conservative estimates range between \$38,000,000,000 and \$42,000,000,000 per year solely for direct costs;

(5) progress in the neurosciences and behavioral sciences has demonstrated the interdependence and mutual reinforcement of basic science, clinical research, and services research for Alzheimer's disease and related dementias;

(6) programs initiated as part of the Decade of the Brain are likely to provide significant progress in understanding the fundamental mechanisms underlying the causes of, and treatments for, Alzheimer's disease and related dementias;

(7) although substantial progress has been made in recent years in identifying possible leads to the causes of Alzheimer's disease and related dementias, and more progress can be expected in the near future, there is little likelihood of a breakthrough in the immediate future that would eliminate or substantially reduce—

(A) the number of individuals with the disease and dementias; or

(B) the difficulties of caring for the individuals;

(8) the responsibility for care of individuals with Alzheimer's disease and related dementias falls primarily on their families, and the care is financially and emotionally devastating;

(9) attempts to reduce the emotional and financial burden of caring for dementia patients is impeded by a lack of knowledge about such patients, how to care for such patients, the costs associated with such care, the effectiveness of various modes of care, the quality and type of care necessary at various stages of the disease, and other appropriate services that are needed to provide quality care;

(10) the results of the little research that has been undertaken concerning dementia has been inadequate or the results have not been widely disseminated;

(11) more knowledge is needed concerning—

(A) the epidemiology of, and the identification of risk factors for, Alzheimer's disease and related dementias;

(B) the development of methods for early diagnosis, functional assessment, and psychological evaluation of individuals with Alzheimer's disease for the purpose of monitoring the course of the disease and developing strategies for improving the quality of life for such individuals;

(C) the understanding of the optimal range and cost-effectiveness of community and institutional services for individuals with Alzheimer's disease and related dementias and their families, particularly with respect to the design, delivery, staffing, and mix of such services and the coordination of such services with other services, and with respect to the relationship of formal to informal support services;

(D) the understanding of optimal methods to combine formal support services provided by health care professionals with informal