PART D—HEALTH CARE QUALITY IMPROVEMENT

PRIOR PROVISIONS

A prior part D, consisting of sections 299c to 299c–7, was redesignated part E of this subchapter.

SUBPART 1—QUALITY MEASURE DEVELOPMENT

§ 299b–31. Quality measure development

(a) Quality measure

In this subpart, the term ''quality measure'' means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

(b) Identification of quality measures

(1) Identification

The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 280j of this title, to the extent available, for use in Federal health programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration—

(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act [42 U.S.C. 1395aaa(a)] and other stakeholders;

(B) quality measures identified by the pediatric quality measures program under section 1139A of the Social Security Act [42 U.S.C. 1320b–9a]; and

(C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act [42 U.S.C. 1320b–9b].

(2) Publication

The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

(c) Grants or contracts for quality measure development

(1) In general

The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures identified under subsection (b).

(2) Prioritization in the development of quality measures

In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

(A) health outcomes and functional status of patients;

(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to inform decisionmaking about treatment options, including the use of shared decisionmaking tools and preference sensitive care (as defined in section 299b–36 of this title);

(D) the meaningful use of health information technology;

(E) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

(F) the efficiency of care;

(G) the equity of health services and health disparities across health disparity populations (as defined in section 285t[1] of this title) and geographic areas;

(H) patient experience and satisfaction;

(I) the use of innovative strategies and methodologies identified under section 299b–33 of this title; and

(J) other areas determined appropriate by the Secretary.

(3) Eligible entities

To be eligible for a grant or contract under this subsection, an entity shall—

(A) have demonstrated expertise and capacity in the development and evaluation of quality measures;

(B) have adopted procedures to include in the quality measure development process—

(i) the views of those providers or payers whose performance will be assessed by the measure; and

(ii) the views of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers);

(C) collaborate with the entity with a contract under section 1890(a) of the Social Security Act [42 U.S.C. 1395aaa(a)] and other stakeholders, as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a);

(D) have transparent policies regarding governance and conflicts of interest; and

(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

(4) Use of funds

An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

(A) Such measures support measures required to be reported under the Social Security Act [42 U.S.C. 301 et seq.], where applicable, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A).

(B) Such measures support measures developed under section 1139A of the Social Secu-

[1] See References in Text note below.

rity Act [42 U.S.C. 1320b–9a] and the Medicaid Quality Measurement Program under section 1139B of such Act [42 U.S.C. 1320b–9b], where applicable.

(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

(D) Each quality measure is free of charge to users of such measure.

(E) Each quality measure is publicly available on an Internet website.

(d) Other activities by the Secretary

The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by the entity with a contract under section 1890(a) of the Social Security Act [42 U.S.C. 1395aaa(a)] or adopted by the Secretary.

(e) Coordination of grants

The Secretary shall ensure that grants or contracts awarded under this section are coordinated with grants and contracts awarded under sections 1139A(5)[2] and 1139B(4)(A)[2] of the Social Security Act.

(f) Development of outcome measures

(1) In general

The Secretary shall develop, and periodically update (not less than every 3 years), provider-level outcome measures for hospitals and physicians, as well as other providers as determined appropriate by the Secretary.

(2) Categories of measures

The measures developed under this subsection shall include, to the extent determined appropriate by the Secretary—

(A) outcome measurement for acute and chronic diseases, including, to the extent feasible, the 5 most prevalent and resource-intensive acute and chronic medical conditions; and

(B) outcome measurement for primary and preventative care, including, to the extent feasible, measurements that cover provision of such care for distinct patient populations (such as healthy children, chronically ill adults, or infirm elderly individuals).

(3) Goals

In developing such measures, the Secretary shall seek to—

(A) address issues regarding risk adjustment, accountability, and sample size;

(B) include the full scope of services that comprise a cycle of care; and

(C) include multiple dimensions.

(4) Timeframe

(A) Acute and chronic diseases

Not later than 24 months after March 23, 2010,[1] the Secretary shall develop not less than 10 measures described in paragraph (2)(A).

(B) Primary and preventive care

Not later than 36 months after March 23, 2010,[1] the Secretary shall develop not less than 10 measures described in paragraph (2)(B).

[2] So in original. The subsection designation is missing.

(July 1, 1944, ch. 373, title IX, § 931, as added and amended Pub. L. 111–148, title III, § 3013(a)(4), title X, § 10303(a), Mar. 23, 2010, 124 Stat. 381, 937.)

REFERENCES IN TEXT

Section 285t of this title, referred to in subsec. (c)(2)(G), was in the original ''section 485E'', meaning section 485E of act July 1, 1944, which was renumbered section 464z–3 by Pub. L. 111–148, title X, § 10334(c)(1)(D)(i), Mar. 23, 2010, 124 Stat. 973, and is classified to section 285t of this title. The act of July 1, 1944, no longer contains a section 485E.

The Social Security Act, referred to in subsec. (c)(4)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620, which is classified generally to chapter 7 (§ 301 et seq.) of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

March 23, 2010, referred to in subsec. (f)(4)(A), (B), was in the original ''the date of enactment of this Act'' which was translated as meaning the date of the enactment of Pub. L. 111–148 which added and amended this section, to reflect the probable intent of Congress.

PRIOR PROVISIONS

A prior section 931 of act July 1, 1944, was renumbered 941 and is classified to section 299c of this title.

AMENDMENTS

2010—Subsec. (f). Pub. L. 111–148, § 10303(a), added subsec. (f).

SUBPART 2—HEALTH CARE QUALITY IMPROVEMENT PROGRAMS

§ 299b–33. Health care delivery system research

(a) Purpose

The purposes of this section are to—

(1) enable the Director to identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as ''best practices'') in health care quality, safety, and value; and

(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

(b) General functions of the Center

The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ''Center''), or any other relevant agency or department designated by the Director, shall—

(1) carry out its functions using research from a variety of disciplines, which may include epidemiology, health services, sociology, psychology, human factors engineering, biostatistics, health economics, clinical research, and health informatics;

(2) conduct or support activities consistent with the purposes described in subsection (a), and for—

(A) best practices for quality improvement practices in the delivery of health care services; and

(B) that include changes in processes of care and the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill development for health care providers