REFERENCES IN TEXT

Section 256a–1 of this title, referred to in subsec. (c)(2)(B)(i), was in the original ''section 3602 of the Patient Protection and Affordable Care Act'', and was translated as meaning section 3502 of the Patient Protection and Affordable Care Act, Pub. L. 111–148, to reflect the probable intent of Congress.

AMENDMENTS

2010—Subsec. (b)(2)(A). Pub. L. 111–148, § 10501(f)(2), substituted ''and the departments that train providers in primary care in 1 or more health professions schools in the State'' for ''and the departments of 1 or more health professions schools in the State that train providers in primary care''.

§ 280g–13. National Congenital Heart Disease Surveillance System

(a) In general

The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may—

(1) enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into a nationally-representative, population-based surveillance system that compiles data concerning actual occurrences of congenital heart disease, to be known as the ''National Congenital Heart Disease Surveillance System''; or

(2) award a grant to one eligible entity to undertake the activities described in paragraph (1).

(b) Purpose

The purpose of the Congenital Heart Disease Surveillance System shall be to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the Centers for Disease Control and Prevention.

(c) Content

The Congenital Heart Disease Surveillance System—

(1) may include information concerning the incidence and prevalence of congenital heart disease in the United States;

(2) may be used to collect and store data on congenital heart disease, including data concerning—

(A) demographic factors associated with congenital heart disease, such as age, race, ethnicity, sex, and family history of individuals who are diagnosed with the disease;

(B) risk factors associated with the disease;

(C) causation of the disease;

(D) treatment approaches; and

(E) outcome measures, such that analysis of the outcome measures will allow derivation of evidence-based best practices and guidelines for congenital heart disease patients; and

(3) may ensure the collection and analysis of longitudinal data related to individuals of all ages with congenital heart disease, including infants, young children, adolescents, and adults of all ages.

(d) Public access

The Congenital Heart Disease Surveillance System shall be made available to the public, as appropriate, including congenital heart disease researchers.

(e) Patient privacy

The Secretary shall ensure that the Congenital Heart Disease Surveillance System is maintained in a manner that complies with the regulations promulgated under section 264 of the Health Insurance Portability and Accountability Act of 1996.

(f) Eligibility for grant

To be eligible to receive a grant under subsection (a)(2), an entity shall—

(1) be a public or private nonprofit entity with specialized experience in congenital heart disease; and

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

(July 1, 1944, ch. 373, title III, § 399V–2, as added Pub. L. 111–148, title X, § 10411(b)(1), Mar. 23, 2010, 124 Stat. 988.)

REFERENCES IN TEXT

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (e), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

§ 280g–14. National diabetes prevention program

(a) In general

The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program (referred to in this section as the ''program'') targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes.

(b) Program activities

The program described in subsection (a) shall include—

(1) a grant program for community-based diabetes prevention program model sites;

(2) a program within the Centers for Disease Control and Prevention to determine eligibility of entities to deliver community-based diabetes prevention services;

(3) a training and outreach program for lifestyle intervention instructors; and

(4) evaluation, monitoring and technical assistance, and applied research carried out by the Centers for Disease Control and Prevention.

(c) Eligible entities

To be eligible for a grant under subsection (b)(1), an entity shall be a State or local health department, a tribal organization, a national network of community-based non-profits focused on health and wellbeing, an academic institution, or other entity, as the Secretary determines.

(d) Authorization of appropriations

For the purpose of carrying out this section, there are authorized to be appropriated such

sums as may be necessary for each of fiscal years 2010 through 2014.

(July 1, 1944, ch. 373, title III, § 399V–3, as added Pub. L. 111–148, title X, § 10501(g), Mar. 23, 2010, 124 Stat. 996.)

§ 280g–15. State demonstration programs to evaluate alternatives to current medical tort litigation

(a) In general

The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. In awarding such grants, the Secretary shall ensure the diversity of the alternatives so funded.

(b) Duration

The Secretary may award grants under subsection (a) for a period not to exceed 5 years.

(c) Conditions for demonstration grants

(1) Requirements

Each State desiring a grant under subsection (a) shall develop an alternative to current tort litigation that—

(A) allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and

(B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved under subparagraph (A) by organizations that engage in efforts to improve patient safety and the quality of health care.

(2) Alternative to current tort litigation

Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)—

(A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

(B) encourages the efficient resolution of disputes;

(C) encourages the disclosure of health care errors;

(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;

(E) improves access to liability insurance;

(F) fully informs patients about the differences in the alternative and current tort litigation;

(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;

(H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and

(I) would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.

(3) Sources of compensation

Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

(4) Scope

(A) In general

Each State desiring a grant under subsection (a) shall establish a scope of jurisdiction (such as Statewide, designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative. No scope of jurisdiction shall be established under this paragraph that is based on a health care payer or patient population.

(B) Notification of patients

A State shall demonstrate how patients would be notified that they are receiving health care services that fall within such scope, and the process by which they may opt out of or voluntarily withdraw from participating in the alternative. The decision of the patient whether to participate or continue participating in the alternative process shall be made at any time and shall not be limited in any way.

(5) Preference in awarding demonstration grants

In awarding grants under subsection (a), the Secretary shall give preference to States—

(A) that have developed the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts;

(B) that make proposals that are likely to enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; and

(C) that make proposals that are likely to improve access to liability insurance.

(d) Application

(1) In general

Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(2) Review panel

(A) In general

In reviewing applications under paragraph (1), the Secretary shall consult with a review panel composed of relevant experts appointed by the Comptroller General.