REDUCING ADMINISTRATIVE HEALTH CARE COSTS

Pub. L. 103–43, title XIX, § 1909, June 10, 1993, 107 Stat. 205, as amended by Pub. L. 106–129, § 2(b)(2), Dec. 6, 1999, 113 Stat. 1670; Pub. L. 108–173, title IX, § 900(e)(6)(F), Dec. 8, 2003, 117 Stat. 2374, provided that: ''The Secretary of Health and Human Services, acting through the Agency for Healthcare Research and Quality and, to the extent possible, in consultation with the Centers for Medicare & Medicaid Services, may fund research to develop a text-based standardized billing process, through the utilization of text-based information retrieval and natural language processing techniques applied to automatic coding and analysis of textual patient discharge summaries and other text-based electronic medical records, within a parallel general purpose (shared memory) high performance computing environment. The Secretary shall determine whether such a standardized approach to medical billing, through the utilization of the text-based hospital discharge summary as well as electronic patient records can reduce the administrative billing costs of health care delivery.''

DEMONSTRATION GRANTS FOR THE DEVELOPMENT, IMPLEMENTATION, AND EVALUATION OF ALTERNATIVES TO THE CURRENT MEDICAL LIABILITY SYSTEM

Memorandum of President of the United States, Sept. 17, 2009, 74 F.R. 48133, provided:

Memorandum for the Secretary of Health And Human Services

As part of my Administration's ongoing effort to reform our health care system, we have reached out to members of both political parties and listened to the concerns many have raised about the need to improve patient safety and to reform our medical liability system. Between 44,000 and 98,000 patients die each year from medical errors. Many physicians continue to struggle to pay their medical malpractice premiums, which vary tremendously by specialty and by State. The cost of insurance continues to be one of the highest practice expenses for some specialties. And although malpractice premiums do not account for a large percentage of total medical costs, many physicians report that fear of lawsuits leads them to practice defensive medicine, which may contribute to higher costs.

We should explore medical liability reform as one way to improve the quality of care and patient-safety practices and to reduce defensive medicine. But whatever steps we pursue, medical liability reform must be just one part of broader health insurance reform—reform that offers more security and stability to Americans who have insurance, offers insurance to Americans who lack coverage, and slows the growth of health care costs for families, businesses, and government.

In recent years, there have been calls from organizations like The Joint Commission and the Institute of Medicine to begin funding demonstration projects that can test a variety of medical liability models and determine which reforms work. These groups and others have identified several important goals and core commitments of malpractice reform that should serve as a starting point for such projects. We must put patient safety first and work to reduce preventable injuries. We must foster better communication between doctors and their patients. We must ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits. And we must work to reduce liability premiums.

In 1999, the Congress authorized the Agency for Healthcare Research and Quality, which is located within the Department of Health and Human Services, to support demonstration projects and to evaluate the effectiveness of projects regarding all aspects of health care, including medical liability. I hereby request that you announce, within 30 days of this memorandum, that the Department will make available demonstration grants to States, localities, and health systems for the development, implementation, and evaluation of alternatives to our current medical liability system, consistent with the goals and core commitments outlined above.

This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

You are authorized and directed to publish this memorandum in the Federal Register.

BARACK OBAMA.

§ 299a–1. Research on health disparities

(a) In general

The Director shall—

(1) conduct and support research to identify populations for which there is a significant disparity in the quality, outcomes, cost, or use of health care services or access to and satisfaction with such services, as compared to the general population;

(2) conduct and support research on the causes of and barriers to reducing the health disparities identified in paragraph (1), taking into account such factors as socioeconomic status, attitudes toward health, the language spoken, the extent of formal education, the area or community in which the population resides, and other factors the Director determines to be appropriate;

(3) conduct and support research and support demonstration projects to identify, test, and evaluate strategies for reducing or eliminating health disparities, including development or identification of effective service delivery models, and disseminate effective strategies and models;

(4) develop measures and tools for the assessment and improvement of the outcomes, quality, and appropriateness of health care services provided to health disparity populations;

(5) in carrying out section 299a(c) of this title, provide support to increase the number of researchers who are members of health disparity populations, and the health services research capacity of institutions that train such researchers; and

(6) beginning with fiscal year 2003, annually submit to the Congress a report regarding prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.

(b) Research and demonstration projects

(1) In general

In carrying out subsection (a), the Director shall conduct and support research and support demonstrations to—

(A) identify the clinical, cultural, socioeconomic, geographic, and organizational factors that contribute to health disparities, including minority health disparity populations, which research shall include behavioral research, such as examination of patterns of clinical decisionmaking, and research on access, outreach, and the availability of related support services (such as cultural and linguistic services);

(B) identify and evaluate clinical and organizational strategies to improve the quality, outcomes, and access to care for health dis-

parity populations, including minority health disparity populations;

(C) test such strategies and widely disseminate those strategies for which there is scientific evidence of effectiveness; and

(D) determine the most effective approaches for disseminating research findings to health disparity populations, including minority populations.

(2) Use of certain strategies

In carrying out this section, the Director shall implement research strategies and mechanisms that will enhance the involvement of individuals who are members of minority health disparity populations or other health disparity populations, health services researchers who are such individuals, institutions that train such individuals as researchers, members of minority health disparity populations or other health disparity populations for whom the Agency is attempting to improve the quality and outcomes of care, and representatives of appropriate tribal or other community-based organizations with respect to health disparity populations. Such research strategies and mechanisms may include the use of—

(A) centers of excellence that can demonstrate, either individually or through consortia, a combination of multi-disciplinary expertise in outcomes or quality improvement research, linkages to relevant sites of care, and a demonstrated capacity to involve members and communities of health disparity populations, including minority health disparity populations, in the planning, conduct, dissemination, and translation of research;

(B) provider-based research networks, including health plans, facilities, or delivery system sites of care (especially primary care), that make extensive use of health care providers who are members of health disparity populations or who serve patients in such populations and have the capacity to evaluate and promote quality improvement;

(C) service delivery models (such as health centers under section 254b of this title and the Indian Health Service) to reduce health disparities; and

(D) innovative mechanisms or strategies that will facilitate the translation of past research investments into clinical practices that can reasonably be expected to benefit these populations.

(c) Quality measurement development

(1) In general

To ensure that health disparity populations, including minority health disparity populations, benefit from the progress made in the ability of individuals to measure the quality of health care delivery, the Director shall support the development of quality of health care measures that assess the experience of such populations with health care systems, such as measures that assess the access of such populations to health care, the cultural competence of the care provided, the quality of the care provided, the outcomes of care, or other aspects of health care practice that the Director determines to be important.

(2) Examination of certain practices

The Director shall examine the practices of providers that have a record of reducing health disparities or have experience in providing culturally competent health services to minority health disparity populations or other health disparity populations. In examining such practices of providers funded under the authorities of this chapter, the Director shall consult with the heads of the relevant agencies of the Public Health Service.

(3) Report

Not later than 36 months after November 22, 2000, the Secretary, acting through the Director, shall prepare and submit to the appropriate committees of Congress a report describing the state-of-the-art of quality measurement for minority and other health disparity populations that will identify critical unmet needs, the current activities of the Department to address those needs, and a description of related activities in the private sector.

(d) Definition

For purposes of this section:

(1) The term ''health disparity population'' has the meaning given such term in section 285t of this title, except that in addition to the meaning so given, the Director may determine that such term includes populations for which there is a significant disparity in the quality, outcomes, cost, or use of health care services or access to or satisfaction with such services as compared to the general population.

(2) The term ''minority'', with respect to populations, refers to racial and ethnic minority groups as defined in section 300u–6 of this title.

(July 1, 1944, ch. 373, title IX, § 903, as added Pub. L. 106–525, title II, § 201(a)(2), Nov. 22, 2000, 114 Stat. 2505; amended Pub. L. 111–148, title X, § 10334(c)(3)(B), Mar. 23, 2010, 124 Stat. 974.)

PRIOR PROVISIONS

A prior section 299a–1, act July 1, 1944, ch. 373, title IX, § 903, as added Pub. L. 101–239, title VI, § 6103(a), Dec. 19, 1989, 103 Stat. 2190; amended Pub. L. 102–410, § 3, Oct. 13, 1992, 106 Stat. 2094; Pub. L. 103–43, title XIV, § 1422(a), June 10, 1993, 107 Stat. 172, related to public dissemination of information about studies and projects prior to the general amendment of this subchapter by Pub. L. 106–129. See section 299c–3 of this title.

A prior section 903 of act July 1, 1944, was classified to section 299c of this title prior to repeal by Pub. L. 99–117.

Prior sections 299a–2 and 299a–3 were omitted in the general amendment of this subchapter by Pub. L. 106–129.

Section 299a–2, act July 1, 1944, ch. 373, title IX, § 904, as added Pub. L. 101–239, title VI, § 6103(a), Dec. 19, 1989, 103 Stat. 2191; amended Pub. L. 102–410, § 4(a), Oct. 13, 1992, 106 Stat. 2095; Pub. L. 103–43, title XX, § 2013(1), June 10, 1993, 107 Stat. 214, related to health care technology assessment. See section 299b–5 of this title.

Section 299a–3, act July 1, 1944, ch. 373, title IX, § 905, as added Pub. L. 105–115, title IV, § 409, Nov. 21, 1997, 111 Stat. 2371, established demonstration program regarding centers for education and research on therapeutics. See section 299b–1(b) of this title.

AMENDMENTS

2010—Subsec. (d)(1). Pub. L. 111–148 substituted ''285t'' for ''287c–31''.

PART B—HEALTH CARE IMPROVEMENT RESEARCH

§ 299b. Health care outcome improvement research

(a) Evidence rating systems

In collaboration with experts from the public and private sector, the Agency shall identify and disseminate methods or systems to assess health care research results, particularly methods or systems to rate the strength of the scientific evidence underlying health care practice, recommendations in the research literature, and technology assessments. The Agency shall make methods or systems for evidence rating widely available. Agency publications containing health care recommendations shall indicate the level of substantiating evidence using such methods or systems.

(b) Health care improvement research centers and provider-based research networks

(1) In general

In order to address the full continuum of care and outcomes research, to link research to practice improvement, and to speed the dissemination of research findings to community practice settings, the Agency shall employ research strategies and mechanisms that will link research directly with clinical practice in geographically diverse locations throughout the United States, including—

(A) health care improvement research centers that combine demonstrated multidisciplinary expertise in outcomes or quality improvement research with linkages to relevant sites of care;

(B) provider-based research networks, including plan, facility, or delivery system sites of care (especially primary care), that can evaluate outcomes and evaluate and promote quality improvement; and

(C) other innovative mechanisms or strategies to link research with clinical practice.

(2) Requirements

The Director is authorized to establish the requirements for entities applying for grants under this subsection.

(July 1, 1944, ch. 373, title IX, § 911, as added Pub. L. 106–129, § 2(a), Dec. 6, 1999, 113 Stat. 1656.)

PRIOR PROVISIONS

A prior section 299b, act July 1, 1944, ch. 373, title IX, § 911, as added Pub. L. 101–239, title VI, § 6103(a), Dec. 19, 1989, 103 Stat. 2192; amended Pub. L. 102–410, § 5(b), Oct. 13, 1992, 106 Stat. 2097, related to establishment of Office of the Forum for Quality and Effectiveness in Health Care, prior to the general amendment of this subchapter by Pub. L. 106–129.

Another prior section 299b, act July 1, 1944, ch. 373, title IX, § 902, as added Oct. 6, 1965, Pub. L. 89–239, § 2, 79 Stat. 927; amended Oct. 15, 1968, Pub. L. 90–574, title I, § 103, 82 Stat. 1005; Oct. 30, 1970, Pub. L. 91–515, title I, §§ 104, 111(b), 84 Stat. 1299, 1301, defined terms for purposes of this subchapter, prior to repeal by Pub. L. 99–117, § 12(d), Oct. 7, 1985, 99 Stat. 495.

§ 299b–1. Private-public partnerships to improve organization and delivery

(a) Support for efforts to develop information on quality

(1) Scientific and technical support

In its role as the principal agency for health care research and quality, the Agency may provide scientific and technical support for private and public efforts to improve health care quality, including the activities of accrediting organizations.

(2) Role of the Agency

With respect to paragraph (1), the role of the Agency shall include—

(A) the identification and assessment of methods for the evaluation of the health of—

(i) enrollees in health plans by type of plan, provider, and provider arrangements; and

(ii) other populations, including those receiving long-term care services;

(B) the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes;

(C) the compilation and dissemination of health care quality measures developed in the private and public sector;

(D) assistance in the development of improved health care information systems;

(E) the development of survey tools for the purpose of measuring participant and beneficiary assessments of their health care; and

(F) identifying and disseminating information on mechanisms for the integration of information on quality into purchaser and consumer decision-making processes.

(b) Centers for education and research on therapeutics

(1) In general

The Secretary, acting through the Director and in consultation with the Commissioner of Food and Drugs, shall establish a program for the purpose of making one or more grants for the establishment and operation of one or more centers to carry out the activities specified in paragraph (2).

(2) Required activities

The activities referred to in this paragraph are the following:

(A) The conduct of state-of-the-art research for the following purposes:

(i) To increase awareness of—

(I) new uses of drugs, biological products, and devices;

(II) ways to improve the effective use of drugs, biological products, and devices; and

(III) risks of new uses and risks of combinations of drugs and biological products.

(ii) To provide objective clinical information to the following individuals and entities:

(I) Health care practitioners and other providers of health care goods or services.

(II) Pharmacists, pharmacy benefit managers and purchasers.