110TH CONGRESS
1ST SESSION

S. 2396

To amend title XI of the Social Security Act to modernize the quality improvement organization (QIO) program.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 16, 2007

Mr. HATCH (for himself, Mr. ROCKEFELLER, Mr. LOTT, and Mr. KENNEDY) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XI of the Social Security Act to modernize the quality improvement organization (QIO) program.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Quality Improvement Organization Modernization Act of 2007''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. QUALITY IMPROVEMENT ACTIVITIES.

(a) INCLUSION OF QUALITY IMPROVEMENT FUNCTIONS.—Section 1154(a) of the Social Security Act (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following new paragraph:

''(18)(A) The organization shall offer quality improvement assistance to providers and practitioners who provide health care items and services to individuals who are dually eligible for benefits under titles XVIII and XIX, including such individuals with mental and cognitive disabilities, and programs that provide items and services to such individuals.

''(B) In this paragraph, the term 'quality improvement assistance' includes the following:

''(i) Education on quality improvement initiatives, strategies, and techniques.

''(ii) Instruction on how to collect, submit, aggregate, and interpret data on measures that may be used for quality improvement, public reporting, and payment.

''(iii) Technical assistance to support quality improvement.

''(iv) Technical assistance and instruction in the conduct of root-cause analyses.

''(v) Technical assistance for providers and practitioners in beneficiary education to facilitate patient self-management and improve patient health literacy.

''(vi) Facilitating cooperation among various local stakeholders in quality improvement.

''(vii) Facilitating adoption of procedures that encourage timely candid feedback from patients and their families concerning perceived problems.

''(viii) Guidance on redesigning clinical processes, including the adoption and effective use of health information technology, to improve the coordination, effectiveness, and safety of care.

''(ix) Assistance in improving the quality of care delivered in rural and frontier areas and reducing health care disparities among racial and ethnic minorities, as well as gender disparities, including efforts to prevent or address any disparities or delays in the rate of adoption of health information technology and in the effective use of such technology among such entities

that serve communities designated by the Secretary as medically underserved communities or individuals dually eligible for benefits under titles XVIII and XIX or that furnish such services in rural areas.

''(x) Assistance in improving coordination of care as patients transition between providers and practitioners, including developing the capacity to securely exchange electronic health information and helping providers and practitioners to effectively use secure electronic health information to improve quality.

''(xi) Outreach to beneficiaries.

''(C)(i) The organization should give priority to funding quality improvement assistance described in subparagraph (B)(iv).

''(ii) In this paragraph, the term 'root-cause analysis' means the systematic examination of managerial processes behind a series of actions that lead up to an event.''.

(b) MEDICARE QUALITY ACCOUNTABILITY PROGRAM AND MEDICAL REVIEW AUDIT.—

(1) MEDICARE QUALITY ACCOUNTABILITY PROGRAM.—Paragraph (14) of section 1154(a) of such

Act (42 U.S.C. 1320c–3(a)) is amended to read as follows:

''(14)(A) The organization shall conduct a review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual's behalf). Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner, plan, or person concerned with reasonable notice and opportunity for discussion.

''(B) The organization shall establish and operate a Medicare quality accountability program consistent with the following:

''(i) The organization shall actively educate Medicare beneficiaries of their right to bring quality concerns to quality improvement organizations.

''(ii) The organization shall report findings of its investigations to the beneficiary involved or a representative of such beneficiary, regard-

less of whether such findings involve a provider, physician, or other practitioner. Such report shall describe whether the organization confirms the allegations in the complaint and any actions taken by the provider, practitioner, or plan, respectively, with respect to such findings. Such findings may not be used in any form in a medical malpractice action.

''(iii) The organization shall assist providers, practitioners, and plans in adopting best practices for soliciting and welcoming feedback about patient concerns, and assist providers, practitioners, and plans in remedying patient-reported problems that are confirmed by the organization and shall report findings of patient-reported problems to the provider, practitioner, or plan involved before disclosing investigation results to the patient or patient's representative.

''(iv) The organization shall determine whether the complaint allegations about clinical quality of care are confirmed and assist providers, practitioners, and plans in remedying confirmed complaints.

''(v) The organization shall assist providers, practitioners, and plans in preventing recurrence of quality problems caused by unsafe processes of care, and refer to an appropriate regulatory body providers, practitioners, or plans that are unwilling or unable to improve.

''(vi) The organization shall publish annual reports on the quality of care provided to individuals entitled to benefits for services under title XVIII in each State in which the organization functions under a contract under this section, including aggregate complaint data.

''(vii) The organization shall promote beneficiary awareness of standardized quality measures that may be used for evaluating care and for choosing providers, practitioners, and plans.

''(C) If an individual entitled to benefits for services under title XVIII (or a person acting on the individual's behalf) makes a credible written request for additional review of a written complaint submitted by such individual (or such a person) to the organization and reviewed under subparagraph (A), the Secretary shall provide for prompt binding independent review of the complaint determination made by the organization as a result of such review.

''(D) The Secretary shall monitor and report to Congress, regarding—

''(i) the reliability of complaint determinations made by quality improvement organizations; and

''(ii) the effect of the disclosure of complaint findings on the availability of primary- and specialty-care physician reviewers.''.

(2) MEDICAL REVIEW AUDIT.—Section 1156 of the Social Security Act (42 U.S.C. 1320c–5) is amended by adding at the end the following new subsection:

''(d) MEDICAL REVIEW AUDIT.—

''(1) The Secretary, acting through the Inspector General of the Department of Health and Human Services, shall enter into a contract with an entity under which the entity shall conduct a medical review audit to evaluate whether quality improvement organizations are making appropriate determinations and recommendations to the Secretary under subsection (b). Such audit shall be conducted in accordance with the following requirements:

''(A) The audit shall consist of a medical review of a randomly selected sample of clinical records involved in not less than 10 percent of

all reviews of complaints about the quality of services filed by an individual entitled to benefits for such services under title XVIII (or a person acting on the individual's behalf) that are conducted by quality improvement organizations in 1 year during each 5-year contract period beginning on or after the date of enactment of this subsection, except that—

''(i) not more than 50 of such complaint reviews conducted by each quality improvement organization shall be selected for such medical review in the year; and

''(ii) in the case where a quality improvement organization conducted a total of 30 or less of such complaint reviews during the sampling period, all such complaint reviews conducted shall be selected for such medical review in the year.

''(B) The complaint reviews selected for medical review under subparagraph (A) with respect to a year during a contract period shall be reviews which were initiated and with respect to which action has been completed by the quality improvement organization during that contract period.

''(C) The Secretary shall ensure that the entity the Secretary contracts with to conduct the medical review audit under this paragraph retains appropriately qualified individuals, in accordance with subsections (a)(7)(A) and (b) of section 1154, to conduct the medical review of clinical records under subparagraph (A).

''(D) In evaluating whether quality improvement organizations are making appropriate determinations and recommendations to the Secretary under subsection (b), the entity the Secretary contracts with to conduct the medical review audit under this paragraph shall—

''(i) rely on the conclusions reached by a panel of physicians who have—

''(I) reviewed the same clinical information the quality improvement organization reviewed with respect to each complaint review selected for the medical review under subparagraph (A); and

''(II) come to an agreement with respect to whether a sanction recommendation was appropriate with re-

spect to each such complaint review selected; and

''(ii) ensure that the individuals conducting the medical review under subparagraph (A), and any other individuals involved in the medical review audit process under this paragraph, adhere to the procedures and rules applicable to entities that contracted with quality improvement organizations at the time the complaint reviews selected for such medical review were originally conducted by the quality improvement organization.

''(E) A quality improvement organization shall disclose any data and information needed to conduct the medical review audit under this paragraph to the entity the Secretary contracts with to conduct such audit. Such disclosure shall be considered necessary to carry out the purposes of this part and subject to the exception to the prohibition against disclosure under section 1160(a)(1), except that any subsequent disclosure of such data and information that identifies a patient or practitioner by any individual associated with such audit shall be sub-

ject to the prohibition against disclosure under section 1160(a).

''(2) Not later than 180 days after the date on which the medical review audit under paragraph (1) is completed with respect to a year during the first contract period beginning after the date of enactment of this subsection, the Inspector General of the Department of Health and Human Services shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives containing the results of the medical review audit with respect to such year, including—

''(A) a brief review of the peer-reviewed literature relevant to such medical review audit that is published prior to such year;

''(B) a characterization of the quality of care issues identified in complaints selected for the medical review under paragraph (1)(A) with respect to such year;

''(C) a review of published studies on consumer complaint behavior within and outside of the health care field;

''(D) a description of actions taken by quality improvement organizations to address issues alleged in complaints selected for such medical review with respect to such year (including facilitated mediation, agreements with providers and practitioners, referrals to State or Federal authorities for regulatory action, and any other actions taken by such organizations to address such issues);

''(E) information on the extent to which—

''(i) the panel of physicians described in paragraph (1)(D)(i) comes to an agreement that a sanction recommendation was appropriate with respect to such complaints; and

''(ii) such agreement differs from the recommendations of the quality improvement organization that originally reviewed such complaint;

''(F) a description of the disposition by the Secretary of recommendations received from quality improvement organizations pursuant to subsection (b), including the reasons for such disposition; and

"(G) recommendations for improving the sanction referral process with respect to complaints about the quality of services that are filed with a quality improvement organization by an individual entitled to benefits for such services under title XVIII (or a person acting on the individual's behalf).

"(3) The Secretary shall—

"(A) take into consideration the findings of the medical review audit under paragraph (1) in evaluating the performance of a quality improvement organization during each contract period beginning after the date enactment of this subsection; and

"(B) require that a quality improvement organization take corrective action when appropriate.

"(4) The cost of implementing the medical review audit under paragraph (1) (including the cost of entering into a contract with an entity to conduct such medical review audit) shall be payable as an expense under section 1159.".

(c) BUSINESS AGREEMENTS.—Section 1154 of the Social Security Act (42 U.S.C. 1320c–3) is amended by adding at the end the following new subsection:

''(d)(1) A quality improvement organization may enter into business agreements with public or private entities, including health care plans, providers, practitioners, and purchasers, to provide quality improvement technical assistance or other services, if—

''(A) the services provided to a specific business partner by the organization are not already being paid for under a contract with the organization under this part; and

''(B) the organization has a qualifying arrangement under this subsection to avoid or mitigate potential conflicts of interest.

''(2) A quality improvement organization shall be deemed to have a qualifying arrangement under this subsection that permits the organization to enter into a business agreement with a public or private entity without the Secretary's approval if the arrangement satisfies 1 or more of the following criteria:

''(A) The organization's business agreement is with an entity that is not subject to review by the organization under its contract under this part.

''(B) The organization's business agreement with the entity yields revenue of less than 5 percent of the total annual revenue yielded by the organization under its contract under this part.

''(C) The organization's business agreement is with an agency of local, State, or national government, including a nation other than the United States, unless that agency is an individual provider or practitioner that is subject to review by the organization under its contract under this part.

''(D) The organization's business agreement is with an association or other group of plans, providers, or practitioners that represent a significant number of entities engaged in competition with one another.

''(E) The organization has arranged for another quality improvement organization to make review determinations that may arise pertaining to a plan, provider, or practitioner that is paying the organization for services and which would otherwise be subject to review by the organization under its contract under this part. Under such arrangement, review determinations shall be made by reviewers that are licensed in the State where the health care services under review are provided.

''(3) A quality improvement organization may apply to the Secretary for approval of an arrangement for avoiding or mitigating a potential conflict of interest that is not an arrangement described in paragraph (2). If the

Secretary does not formally respond to the application in writing, accompanied by an explanation of the reasons for any adverse decision, by not later than the 30th business day following receipt of the application, the application shall be deemed approved. In the case where the Secretary makes an adverse decision with respect to an application, the organization may submit a revised application. If the Secretary does not formally responded to the revised application in writing, accompanied by an explanation of the reasons for any adverse decision, by not later than the 30th business day following receipt of the revised application, the revised application shall be deemed approved.

''(4) The Secretary may be reimbursed from funds available to administer the provisions of this part for the reasonable costs—

''(A) of training and maintaining qualified personnel to review proposed arrangements to avoid or mitigate potential conflicts of interest; and

''(B) of establishing and maintaining agreements with 1 or more independent review entities.''.

SEC. 3. IMPROVED PROGRAM ADMINISTRATION.

Part B of title XI of the Social Security Act is amended by adding at the end the following new section:

''SEC. 1164. PROGRAM ADMINISTRATION.

''(a) IMPROVED PROGRAM MANAGEMENT.—

''(1) REPORT ON MANAGEMENT OF THE QIO PROGRAM.—The Comptroller General of the United States shall submit to Congress reports on the implementation by the Secretary and the Director of the Office of Management and Budget of this part and their overall management of the program under this part, according to the following schedule:

''(A) Not later than 1 year after the date of enactment of this section, a report with respect to the review conducted under subparagraphs (F), (G), and (I) of paragraph (2).

''(B) Not later than 1 year following the end of the first statement of work that begins after the date of enactment of this section, a report with respect to the review conducted under subparagraphs (A), (B), (C), (D), (E), and (H) of such paragraph.

''(2) PROGRAM MANAGEMENT.—In accordance with the schedule under paragraph (1), the reports under such paragraph shall include a review of the following:

''(A) Implementation of the priorities, recommendations, and strategies of the strategic advisory committee under subsection (c).

"(B) Implementation of appropriate program and quality improvement organization evaluation.

"(C) Ensuring timely issuance of statements of work.

"(D) Ensuring timely and priority QIO access to Medicare data for quality improvement purposes.

"(E) Ensuring timely apportionment of funding.

"(F) Ensuring funding levels are commensurate with new work added to the QIO contract, as described in the second sentence of section 1159(b)(1).

"(G) The process of developing the apportionment request and determining the funding allocation to QIOs.

"(H) The identification of, and progress toward, measures of effective management by the Secretary of the QIO program.

"(I) A review of the experience and qualifications of staff of the Centers for Medicare & Medicaid Services in overseeing the program.

"(3) INNOVATION.—The Secretary shall ensure that quality improvement organizations are provided

flexibility in designing and applying intervention strategies for local quality improvement, but must comply with national topic assignments and standardized measures.

''(b) ASSURING DATA ACCESS.—The Secretary shall ensure that quality improvement organizations have timely access to data for all parts of the program under title XVIII that are pertinent to contract activities, in a form allowing the data to be integrated and analyzed by such organizations according to the needs of partners and Medicare beneficiaries in each jurisdiction.

''(c) DETERMINATION OF STRATEGIC PRIORITIES.—

''(1) APPOINTMENT OF STRATEGIC ADVISORY COMMITTEE.—The Secretary shall appoint an independent strategic advisory committee chaired by the Director of the Agency for Healthcare Research and Quality, composed of national quality measurement and improvement experts and a diverse range of stakeholders, such as the following:

''(A) Medicare beneficiaries.

''(B) The Health Resources and Services Administration.

''(C) The Federal Employee Health Benefits Program.

''(D) The Indian Health Service.

''(E) The TRICARE program.

''(F) The Veterans Health Affairs program.

''(G) State Medicaid programs.

''(H) Private purchasers.

''(I) Health care providers.

''(J) Physicians.

''(K) Pharmacists.

''(L) Nurses.

''(M) quality improvement organizations.

''(2) DUTIES OF COMMITTEE.—Such committee shall—

''(A) advise the Secretary on methods to ensure that the quality measures used under the program under this part are—

''(i) the same as or coordinated with measures under other Federal and non-Federal quality programs; and

''(ii) reliable and valid (as used under the program for measuring the quality of care provided and the performance of quality improvement organizations);

''(B) advise the Secretary as to how the function and structure of the program under this part may be made to better correspond

with the strategic priorities for improvement in the quality of care recommended by the Institute of Medicine's 6 aims for health care improvement, including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;

''(C) advise the Secretary as to how evaluation of quality improvement organizations under the program under this part may be improved, taking into account—

''(i) the value of longitudinal tracking of performance and comparison groups in assessing change attributable to the program;

''(ii) the value of stakeholder partnerships;

''(iii) the activities of stakeholders that may affect evaluation of the performance of those partnering with quality improvement organizations;

''(iv) the availability of timely, valid, and reliable data for evaluating the performance of quality improvement organizations; and

"(v) the cost of such performance evaluation; and

"(D) prepare and provide for public comment a draft statement of work for each program cycle.

"(3) FUNDING.—The Secretary shall apportion funds for the strategic advisory committee under this subsection from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the same manner, and in addition to, the amounts that would otherwise be apportioned for contracts with organizations under section 1159(b).

"(d) TAKING INTO ACCOUNT RECOMMENDATIONS FROM STAKEHOLDERS IN STATEMENTS OF WORK.—Each statement of work under this part for a contract period beginning on or after August 1, 2008, shall include a task for the contracting quality improvement organization to convene stakeholders to identify high priority quality problems for work in the next contract period that are relevant to Medicare beneficiaries in the State. Each such organization shall propose, to be incorporated as part of such statement, 1 or more projects to the Secretary taking into consideration the recommendations of such stakeholders,

along with suggested performance measures to evaluate progress on such projects.

''(e) QUALITY COORDINATION.—quality improvement organizations holding contracts under this part shall be an integral part of Federal performance improvement initiatives and each organization's activities shall be coordinated with initiatives developed by the Secretary and other Federal agencies.''.

SEC. 4. DATA DISCLOSURE.

Section 1160 of the Social Security Act (42 U.S.C. 1320c–9) is amended—

(1) in subsection (a)(3), by striking ''subsection (b)'' and inserting ''subsections (b) and (f)''; and

(2) by adding at the end the following new subsection:

''(f)(1) An organization with a contract with the Secretary under this part may share individual-specific data with a physician treating the individual, for quality improvement and patient safety purposes.

''(2) The Secretary shall promulgate, not later than 180 days after the date of the enactment of this subsection, a regulation that permits the sharing of data under paragraph (1).

''(3) Nothing in this subsection shall be construed to limit, alter, or affect the requirements imposed by the reg-

ulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.''.

SEC. 5. USE OF EVALUATION AND COMPETITION.

Section 1153 of the Social Security Act (42 U.S.C. 1320c–2) is amended—

(1) by amending paragraph (3) of subsection (c) to read as follows:

''(3) contract terms are consistent with subsection (j);'';

(2) in subsection (c)(1), by inserting '', at the sole discretion of the organization,'' after ''or may subcontract'';

(3) in subsection (e), by striking paragraph (1) and inserting the following:

''(1) Contracting authority of the Secretary under this section shall be carried out in accordance with the Federal Acquisition Regulation issued in accordance with section 25 of the Office of Federal Procurement Policy Act (41 U.S.C. 421).''; and

(4) by adding at the end the following new subsections:

''(j)(1) Subject to the succeeding provisions of this subsection, each contract with an organization under this section shall be for an initial term of 5 years, beginning and ending on a common date for all quality improvement

organizations as required under this subsection and shall be renewable for 5 year terms thereafter.

''(2) Before publishing a request for proposals for a contract period, the Secretary shall, in consultation with the strategic advisory committee appointed under section 1164(c)(1) establish measurable goals for each task to be included in such proposal. The contract shall include performance thresholds by which an organization holding a contract under this section may demonstrate excellent performance. The Secretary may not establish such performance thresholds in such a way as to predetermine or limit either the number or percentage of organizations which may demonstrate excellent performance.

''(3) In evaluating proposals from bidders for a contract under this section, the Secretary shall consider the performance of the incumbent contractor bidding in each State, and if the incumbent contractor has demonstrated excellent performance (as defined under the process described in paragraph (2)) in fulfilling the terms of the contract during the previous contract period, the Secretary shall add to the score of the technical proposal of such contractor a bonus equivalent to 10 percent of the total possible score for the proposal.

''(4) The Secretary shall publish the request for proposals not later than 4 months prior to the beginning of each contract period.

''(5) The Secretary shall utilize the strategic advisory committee appointed under section 1164(c)(1) to qualify the performance measures to be used in evaluating the performance of the quality improvement organizations on a program-wide basis and individually.

''(6) The Secretary may not reduce the amount of a contract award below the amount proposed by the bidder prevailing in a competitive bidding process unless the scope of work has been reduced. In the case where the scope of work has been reduced, any reduction in the contract award shall be commensurate with the reduction in the scope of work.

''(7) The Secretary shall design the process for performance evaluation of contracts under this section—

''(A) to hold harmless and not penalize quality improvement organizations when performance is impaired or delayed by failures of the Secretary, personnel of the Department of Health and Human Services, or entities or individuals that contract with the Secretary, to provide timely deliverables;

''(B) to use a continuous measurement strategy with provision for frequent performance updates for evaluating interim progress; and

''(C) to require that evaluation metrics be monitored and permit their adjustment based on experience or evolving science over the course of a contract cycle, subject to subparagraph (A).

''(k)(1) Notwithstanding the provisions of section 1153(c)(3), the Secretary shall extend each contract under this section for which the contract period began on or after August 1, 2005, to ensure that the subsequent contract period for all quality improvement organizations begins on October 1, 2009.

''(2) The Secretary shall apportion adequate funding so that organizations with contracts extended under this subsection can perform existing and new tasks, as determined by the Secretary, during the period of the contract extension.

''(3) There are authorized to be appropriated such sums as are necessary to respond to increased personnel requirements resulting from starting all contracts simultaneously, as provided under this subsection.''.

SEC. 6. QUALITY IMPROVEMENT ORGANIZATION PROGRAM FUNDING.

Section 1159 of the Social Security Act (42 U.S.C. 1320c–8) is amended—

(1) by inserting ''(a)'' before ''Expenses incurred''; and

(2) by adding at the end the following new subsections:

''(b)(1) The aggregate annual funding for contracts under this part that begin after August 1, 2008, shall not be less than $421,666,000. In addition, there are authorized to be apportioned for contract periods in subsequent years such additional amounts as may be necessary to adequately fund any resource needs in excess of the amount provided under the previous sentence.

''(2) The Secretary shall determine the total program resource needs for a contract period. The determination shall take into account factors including any new work added via contract modification during the course of the contract period or added from 1 contract cycle to the next cycle. New work includes—

''(A) additional core contract tasks, requirements, deliverables, and performance thresholds;

''(B) technical assistance for additional providers, practitioners, and health plans and in additional provider settings;

''(C) increased outreach and communications to Medicare beneficiaries, providers, practitioners, and plans; and

''(D) increased volume of medical reviews.

Nothing in this paragraph shall be construed as limiting the ability of the Secretary to negotiate contracts under this part individually with each quality improvement organization.

''(3) With respect to the apportionment of funds under this part for a contract period—

''(A) the Secretary shall submit a proposed apportionment to the Director of the Office of Management and Budget not later than 1 year before the first date of the contract period;

''(B) such Director shall approve an apportionment not later than 9 months before the first date of such contract period;

''(C) for tasks the Secretary proposes to continue from the previous contract period, if the apportionment is not authorized by the deadline specified in subparagraph (B), funding shall continue for the next contract period at a level no less than the level for the previous contract period, increased by the percentage increase in the consumer price index

for all urban consumers during the most recent 12-month period.

''(4) A quality improvement organization shall have the ability to meet the terms of its contract under this part by allocating funds to the functions provided under such contract at its discretion. The Secretary shall review whether the organization met the functions and goals set out for the organization, without regard to the allocation of funds at the time of the initial acceptance of the contract.

''(5) Organizations with a contract under this part may utilize funding allocated to such contracts to pay for food costs at meetings and conferences if—

''(A) meals and refreshments are incidental to the meeting or conference;

''(B) attendance at the meals and when refreshments are provided is important for the host agency to ensure full participation in essential discussions, lectures, or speeches concerning the purpose of the meeting or conference; and

''(C) the meals and refreshments are part of a formal conference that includes (in addition to the meals and refreshment) discussions, speeches, or other business that may take place when the meals and refreshments are served and also includes sub-

stantial functions occurring separately from when the food is served.

''(c)(1) Not later than 180 days after the date of enactment of this subsection, the Secretary shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this subsection referred to as the 'Institute') shall conduct a study on—

''(A) the adequacy of overall funding of the program under this part to meet program goals, based on the most recent statement of work for which the Office of Management and Budget has made a funding decision;

''(B) a recommended national percentage of funding for quality improvement organizations, to be used for the core contract work with providers, practitioners, plans, and beneficiaries and on national initiatives established by the Secretary;

''(C) a recommended national percentage of such funding to be used for local initiatives, identified by quality improvement organizations in consultation with stakeholders in each State; and

''(D) a recommended national percentage of overall funds under the program under this part that will not be available for the work of quality improvement organizations in the field and that may

be used by the Secretary for central management of the program.

''(2) Not later than 2 years after the date of enactment of this subsection, the Institute shall submit a report to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives, containing the results of the study conducted under paragraph (1) together with recommendations for such legislation and administrative action as the Institute determines appropriate.

''(3)(A) On or before the date that the proposal for each statement of work is submitted to the Office of Management and Budget, the Secretary shall enter into an arrangement under which the Institute shall conduct a study on the issues described in subparagraphs (A) through (D) of paragraph (1).

''(B) Not later than 180 days after the date on which the proposal for each statement of work is submitted to the Office of Management and Budget, the Institute shall submit a report to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives, containing the results of the studies conducted under subparagraph (A) and paragraph (1) together with rec-

ommendations for such legislation and administrative action as the Institute determines appropriate.

''(4) The Secretary shall apportion funds for the studies conducted by the Institute of Medicine under this subsection from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the same manner, and in addition to, the amounts that would otherwise be apportioned for contracts with organizations under subsection (b).''.

SEC. 7. QUALIFICATIONS OF QIOS.

(a) IN GENERAL.—Subsection (b) of section 1153 of the Social Security Act (42 U.S.C. 1320c–2) is amended by adding at the end the following new paragraph:

''(4)(A) The Secretary shall not enter into or renew a contract under this section with an entity unless the entity has demonstrated success in facilitating clinical and administrative system redesign to improve the coordination, effectiveness, and safety of health care, and in facilitating cooperation among stakeholders in quality improvement.

''(B) The Secretary shall ensure that the entity complies with standards to ensure organizational integrity, including—

''(i) appropriate representation of consumers, quality assurance experts, and stake-

holders in the composition of the governing body;

"(ii) market-based compensation of board members and executives;

"(iii) avoidance and mitigation of board member conflict of interest; and

"(iv) safeguards to ensure appropriate travel expenses.

To the extent practicable, the Secretary shall utilize standards developed in the private sector for purposes of carrying out this subparagraph and shall conduct audits as necessary to ensure compliance with such standards.".

(b) USE OF STATES FOR GEOGRAPHIC AREAS.—Subsection (a) of such section is amended to read as follows:

"(a) The Secretary shall designate each State as a geographic area with respect to which contracts under this part will be made.".

(c) REMOVAL OF PHYSICIAN-ACCESS AND PHYSICIAN-SPONSORED REQUIREMENTS FOR ORGANIZATIONS.—

(1) IN GENERAL.—Section 1152 of the Social Security Act (42 U.S.C. 1320c–1) is amended by striking paragraph (1).

(2) CONFORMING AMENDMENT.—Section 1153(b)(1) of the Social Security Act (42 U.S.C. 1320c–2(b)(1)) is amended by striking the second sentence.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to contract periods beginning after the date of the enactment of this Act.

SEC. 8. CONFORMING NAME TO "QUALITY IMPROVEMENT ORGANIZATIONS".

Part C of title XI of the Social Security Act is amended by striking ''utilization and quality control peer review'' (and ''peer review'') each place it appears before ''organization'' or ''organizations'' and inserting ''quality improvement''.

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