

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

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Medicare Quality Improvement Organization Moderniza-
6 tion Act of 2007”.

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

- Sec. 1. Short title; table of contents.
- Sec. 2. Quality improvement activities.
- Sec. 3. Improved program administration.
- Sec. 4. Data disclosure.

Sec. 5. Use of evaluation and competition.

Sec. 6. Quality improvement organization program funding.

Sec. 7. Qualifications of QIOs.

Sec. 8. Conforming name to “quality improvement organizations”.

1 **SEC. 2. QUALITY IMPROVEMENT ACTIVITIES.**

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

6 “(18)(A) The organization shall offer quality
 7 improvement assistance to providers and practi-
 8 tioners who provide health care items and services to
 9 individuals who are dually eligible for benefits under
 10 titles XVIII and XIX, including such individuals
 11 with mental and cognitive disabilities, and programs
 12 that provide items and services to such individuals.

13 “(B) In this paragraph, the term ‘quality im-
 14 provement assistance’ includes the following:

15 “(i) Education on quality improvement ini-
 16 tiatives, strategies, and techniques.

17 “(ii) Instruction on how to collect, submit,
 18 aggregate, and interpret data on measures that
 19 may be used for quality improvement, public re-
 20 porting, and payment.

21 “(iii) Technical assistance to support qual-
 22 ity improvement.

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

3 “(v) Technical assistance for providers and
4 practitioners in beneficiary education to facili-
5 tate patient self-management and improve pa-
6 tient health literacy.

7 “(vi) Facilitating cooperation among var-
8 ious local stakeholders in quality improvement.

9 “(vii) Facilitating adoption of procedures
10 that encourage timely candid feedback from pa-
11 tients and their families concerning perceived
12 problems.

13 “(viii) Guidance on redesigning clinical
14 processes, including the adoption and effective
15 use of health information technology, to im-
16 prove the coordination, effectiveness, and safety
17 of care.

18 “(ix) Assistance in improving the quality of
19 care delivered in rural and frontier areas and
20 reducing health care disparities among racial
21 and ethnic minorities, as well as gender dispari-
22 ties, including efforts to prevent or address any
23 disparities or delays in the rate of adoption of
24 health information technology and in the effec-
25 tive use of such technology among such entities

1 that serve communities designated by the Sec-
2 retary as medically underserved communities or
3 individuals dually eligible for benefits under ti-
4 tles XVIII and XIX or that furnish such serv-
5 ices in rural areas.

6 “(x) Assistance in improving coordination
7 of care as patients transition between providers
8 and practitioners, including developing the ca-
9 pacity to securely exchange electronic health in-
10 formation and helping providers and practi-
11 tioners to effectively use secure electronic health
12 information to improve quality.

13 “(xi) Outreach to beneficiaries.

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

17 “(ii) In this paragraph, the term ‘root-cause
18 analysis’ means the systematic examination of mana-
19 gerial processes behind a series of actions that lead
20 up to an event.”.

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

23 (1) MEDICARE QUALITY ACCOUNTABILITY PRO-
24 GRAM.—Paragraph (14) of section 1154(a) of such

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

3 “(14)(A) The organization shall conduct a re-
4 view of all written complaints about the quality of
5 services (for which payment may otherwise be made
6 under title XVIII) not meeting professionally recog-
7 nized standards of health care, if the complaint is
8 filed with the organization by an individual entitled
9 to benefits for such services under such title (or a
10 person acting on the individual’s behalf). Before the
11 organization concludes that the quality of services
12 does not meet professionally recognized standards of
13 health care, the organization must provide the prac-
14 titioner, plan, or person concerned with reasonable
15 notice and opportunity for discussion.

16 “(B) The organization shall establish and oper-
17 ate a Medicare quality accountability program con-
18 sistent with the following:

19 “(i) The organization shall actively educate
20 Medicare beneficiaries of their right to bring
21 quality concerns to quality improvement organi-
22 zations.

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

1 less of whether such findings involve a provider,
2 physician, or other practitioner. Such report
3 shall describe whether the organization confirms
4 the allegations in the complaint and any actions
5 taken by the provider, practitioner, or plan, re-
6 spectively, with respect to such findings. Such
7 findings may not be used in any form in a med-
8 ical malpractice action.

9 “(iii) The organization shall assist pro-
10 viders, practitioners, and plans in adopting best
11 practices for soliciting and welcoming feedback
12 about patient concerns, and assist providers,
13 practitioners, and plans in remedying patient-
14 reported problems that are confirmed by the or-
15 ganization and shall report findings of patient-
16 reported problems to the provider, practitioner,
17 or plan involved before disclosing investigation
18 results to the patient or patient’s representa-
19 tive.

20 “(iv) The organization shall determine
21 whether the complaint allegations about clinical
22 quality of care are confirmed and assist pro-
23 viders, practitioners, and plans in remedying
24 confirmed complaints.

1 “(v) The organization shall assist pro-
2 viders, practitioners, and plans in preventing re-
3 currence of quality problems caused by unsafe
4 processes of care, and refer to an appropriate
5 regulatory body providers, practitioners, or
6 plans that are unwilling or unable to improve.

7 “(vi) The organization shall publish annual
8 reports on the quality of care provided to indi-
9 viduals entitled to benefits for services under
10 title XVIII in each State in which the organiza-
11 tion functions under a contract under this sec-
12 tion, including aggregate complaint data.

13 “(vii) The organization shall promote bene-
14 ficiary awareness of standardized quality meas-
15 ures that may be used for evaluating care and
16 for choosing providers, practitioners, and plans.

17 “(C) If an individual entitled to benefits for
18 services under title XVIII (or a person acting on the
19 individual’s behalf) makes a credible written request
20 for additional review of a written complaint sub-
21 mitted by such individual (or such a person) to the
22 organization and reviewed under subparagraph (A),
23 the Secretary shall provide for prompt binding inde-
24 pendent review of the complaint determination made
25 by the organization as a result of such review.

1 “(D) The Secretary shall monitor and report to
2 Congress, regarding—

3 “(i) the reliability of complaint determina-
4 tions made by quality improvement organiza-
5 tions; and

6 “(ii) the effect of the disclosure of com-
7 plaint findings on the availability of primary-
8 and specialty-care physician reviewers.”.

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

13 “(d) MEDICAL REVIEW AUDIT.—

14 “(1) The Secretary, acting through the Inspec-
15 tor General of the Department of Health and
16 Human Services, shall enter into a contract with an
17 entity under which the entity shall conduct a medical
18 review audit to evaluate whether quality improve-
19 ment organizations are making appropriate deter-
20 minations and recommendations to the Secretary
21 under subsection (b). Such audit shall be conducted
22 in accordance with the following requirements:

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

1 all reviews of complaints about the quality of
2 services filed by an individual entitled to bene-
3 fits for such services under title XVIII (or a
4 person acting on the individual's behalf) that
5 are conducted by quality improvement organiza-
6 tions in 1 year during each 5-year contract pe-
7 riod beginning on or after the date of enact-
8 ment of this subsection, except that—

9 “(i) not more than 50 of such com-
10 plaint reviews conducted by each quality
11 improvement organization shall be selected
12 for such medical review in the year; and

13 “(ii) in the case where a quality im-
14 provement organization conducted a total
15 of 30 or less of such complaint reviews
16 during the sampling period, all such com-
17 plaint reviews conducted shall be selected
18 for such medical review in the year.

19 “(B) The complaint reviews selected for
20 medical review under subparagraph (A) with re-
21 spect to a year during a contract period shall
22 be reviews which were initiated and with respect
23 to which action has been completed by the qual-
24 ity improvement organization during that con-
25 tract period.

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

8 “(D) In evaluating whether quality im-
9 provement organizations are making appro-
10 priate determinations and recommendations to
11 the Secretary under subsection (b), the entity
12 the Secretary contracts with to conduct the
13 medical review audit under this paragraph
14 shall—

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

17 “(I) reviewed the same clinical
18 information the quality improvement
19 organization reviewed with respect to
20 each complaint review selected for the
21 medical review under subparagraph
22 (A); and

23 “(II) come to an agreement with
24 respect to whether a sanction rec-
25 ommendation was appropriate with re-

1 spect to each such complaint review
2 selected; and

3 “(ii) ensure that the individuals con-
4 ducting the medical review under subpara-
5 graph (A), and any other individuals in-
6 volved in the medical review audit process
7 under this paragraph, adhere to the proce-
8 dures and rules applicable to entities that
9 contracted with quality improvement orga-
10 nizations at the time the complaint reviews
11 selected for such medical review were origi-
12 nally conducted by the quality improve-
13 ment organization.

14 “(E) A quality improvement organization
15 shall disclose any data and information needed
16 to conduct the medical review audit under this
17 paragraph to the entity the Secretary contracts
18 with to conduct such audit. Such disclosure
19 shall be considered necessary to carry out the
20 purposes of this part and subject to the excep-
21 tion to the prohibition against disclosure under
22 section 1160(a)(1), except that any subsequent
23 disclosure of such data and information that
24 identifies a patient or practitioner by any indi-
25 vidual associated with such audit shall be sub-

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

3 “(2) Not later than 180 days after the date on
4 which the medical review audit under paragraph (1)
5 is completed with respect to a year during the first
6 contract period beginning after the date of enact-
7 ment of this subsection, the Inspector General of the
8 Department of Health and Human Services shall
9 submit a report to the Committee on Finance of the
10 Senate and the Committee on Ways and Means and
11 the Committee on Energy and Commerce of the
12 House of Representatives containing the results of
13 the medical review audit with respect to such year,
14 including—

15 “(A) a brief review of the peer-reviewed lit-
16 erature relevant to such medical review audit
17 that is published prior to such year;

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

22 “(C) a review of published studies on con-
23 sumer complaint behavior within and outside of
24 the health care field;

1 “(D) a description of actions taken by
2 quality improvement organizations to address
3 issues alleged in complaints selected for such
4 medical review with respect to such year (in-
5 cluding facilitated mediation, agreements with
6 providers and practitioners, referrals to State or
7 Federal authorities for regulatory action, and
8 any other actions taken by such organizations
9 to address such issues);

10 “(E) information on the extent to which—

11 “(i) the panel of physicians described
12 in paragraph (1)(D)(i) comes to an agree-
13 ment that a sanction recommendation was
14 appropriate with respect to such com-
15 plaints; and

16 “(ii) such agreement differs from the
17 recommendations of the quality improve-
18 ment organization that originally reviewed
19 such complaint;

20 “(F) a description of the disposition by the
21 Secretary of recommendations received from
22 quality improvement organizations pursuant to
23 subsection (b), including the reasons for such
24 disposition; and

1 “(G) recommendations for improving the
2 sanction referral process with respect to com-
3 plaints about the quality of services that are
4 filed with a quality improvement organization
5 by an individual entitled to benefits for such
6 services under title XVIII (or a person acting
7 on the individual’s behalf).

8 “(3) The Secretary shall—

9 “(A) take into consideration the findings of
10 the medical review audit under paragraph (1) in
11 evaluating the performance of a quality im-
12 provement organization during each contract
13 period beginning after the date enactment of
14 this subsection; and

15 “(B) require that a quality improvement
16 organization take corrective action when appro-
17 priate.

18 “(4) The cost of implementing the medical re-
19 view audit under paragraph (1) (including the cost
20 of entering into a contract with an entity to conduct
21 such medical review audit) shall be payable as an ex-
22 pense under section 1159.”.

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

1 “(d)(1) A quality improvement organization may
2 enter into business agreements with public or private enti-
3 ties, including health care plans, providers, practitioners,
4 and purchasers, to provide quality improvement technical
5 assistance or other services, if—

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

10 “(B) the organization has a qualifying arrange-
11 ment under this subsection to avoid or mitigate po-
12 tential conflicts of interest.

13 “(2) A quality improvement organization shall be
14 deemed to have a qualifying arrangement under this sub-
15 section that permits the organization to enter into a busi-
16 ness agreement with a public or private entity without the
17 Secretary’s approval if the arrangement satisfies 1 or
18 more of the following criteria:

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

22 “(B) The organization’s business agreement
23 with the entity yields revenue of less than 5 percent
24 of the total annual revenue yielded by the organiza-
25 tion under its contract under this part.

1 “(C) The organization’s business agreement is
2 with an agency of local, State, or national govern-
3 ment, including a nation other than the United
4 States, unless that agency is an individual provider
5 or practitioner that is subject to review by the orga-
6 nization under its contract under this part.

7 “(D) The organization’s business agreement is
8 with an association or other group of plans, pro-
9 viders, or practitioners that represent a significant
10 number of entities engaged in competition with one
11 another.

12 “(E) The organization has arranged for another
13 quality improvement organization to make review de-
14 terminations that may arise pertaining to a plan,
15 provider, or practitioner that is paying the organiza-
16 tion for services and which would otherwise be sub-
17 ject to review by the organization under its contract
18 under this part. Under such arrangement, review de-
19 terminations shall be made by reviewers that are li-
20 censed in the State where the health care services
21 under review are provided.

22 “(3) A quality improvement organization may apply
23 to the Secretary for approval of an arrangement for avoid-
24 ing or mitigating a potential conflict of interest that is
25 not an arrangement described in paragraph (2). If the

1 Secretary does not formally respond to the application in
 2 writing, accompanied by an explanation of the reasons for
 3 any adverse decision, by not later than the 30th business
 4 day following receipt of the application, the application
 5 shall be deemed approved. In the case where the Secretary
 6 makes an adverse decision with respect to an application,
 7 the organization may submit a revised application. If the
 8 Secretary does not formally responded to the revised appli-
 9 cation in writing, accompanied by an explanation of the
 10 reasons for any adverse decision, by not later than the
 11 30th business day following receipt of the revised applica-
 12 tion, the revised application shall be deemed approved.

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

16 “(A) of training and maintaining qualified per-
 17 sonnel to review proposed arrangements to avoid or
 18 mitigate potential conflicts of interest; and

19 “(B) of establishing and maintaining agree-
 20 ments with 1 or more independent review entities.”.

21 **SEC. 3. IMPROVED PROGRAM ADMINISTRATION.**

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

24 **“SEC. 1164. PROGRAM ADMINISTRATION.**

25 “(a) IMPROVED PROGRAM MANAGEMENT.—

1 “(1) REPORT ON MANAGEMENT OF THE QIO
2 PROGRAM.—The Comptroller General of the United
3 States shall submit to Congress reports on the im-
4 plementation by the Secretary and the Director of
5 the Office of Management and Budget of this part
6 and their overall management of the program under
7 this part, according to the following schedule:

8 “(A) Not later than 1 year after the date
9 of enactment of this section, a report with re-
10 spect to the review conducted under subpara-
11 graphs (F), (G), and (I) of paragraph (2).

12 “(B) Not later than 1 year following the
13 end of the first statement of work that begins
14 after the date of enactment of this section, a re-
15 port with respect to the review conducted under
16 subparagraphs (A), (B), (C), (D), (E), and (H)
17 of such paragraph.

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

22 “(A) Implementation of the priorities, rec-
23 ommendations, and strategies of the strategic
24 advisory committee under subsection (c).

1 “(B) Implementation of appropriate pro-
2 gram and quality improvement organization
3 evaluation.

4 “(C) Ensuring timely issuance of state-
5 ments of work.

6 “(D) Ensuring timely and priority QIO ac-
7 cess to Medicare data for quality improvement
8 purposes.

9 “(E) Ensuring timely apportionment of
10 funding.

11 “(F) Ensuring funding levels are commen-
12 surate with new work added to the QIO con-
13 tract, as described in the second sentence of
14 section 1159(b)(1).

15 “(G) The process of developing the appor-
16 tionment request and determining the funding
17 allocation to QIOs.

18 “(H) The identification of, and progress
19 toward, measures of effective management by
20 the Secretary of the QIO program.

21 “(I) A review of the experience and quali-
22 fications of staff of the Centers for Medicare &
23 Medicaid Services in overseeing the program.

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

1 flexibility in designing and applying intervention
2 strategies for local quality improvement, but must
3 comply with national topic assignments and stand-
4 ardized measures.

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

12 “(c) DETERMINATION OF STRATEGIC PRIORITIES.—

13 “(1) APPOINTMENT OF STRATEGIC ADVISORY
14 COMMITTEE.—The Secretary shall appoint an inde-
15 pendent strategic advisory committee chaired by the
16 Director of the Agency for Healthcare Research and
17 Quality, composed of national quality measurement
18 and improvement experts and a diverse range of
19 stakeholders, such as the following:

20 “(A) Medicare beneficiaries.

21 “(B) The Health Resources and Services
22 Administration.

23 “(C) The Federal Employee Health Bene-
24 fits Program.

25 “(D) The Indian Health Service.

1 “(E) The TRICARE program.

2 “(F) The Veterans Health Affairs pro-
3 gram.

4 “(G) State Medicaid programs.

5 “(H) Private purchasers.

6 “(I) Health care providers.

7 “(J) Physicians.

8 “(K) Pharmacists.

9 “(L) Nurses.

10 “(M) quality improvement organizations.

11 “(2) DUTIES OF COMMITTEE.—Such committee
12 shall—

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

16 “(i) the same as or coordinated with
17 measures under other Federal and non-
18 Federal quality programs; and

19 “(ii) reliable and valid (as used under
20 the program for measuring the quality of
21 care provided and the performance of qual-
22 ity improvement organizations);

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

1 with the strategic priorities for improvement in
2 the quality of care recommended by the Insti-
3 tute of Medicine’s 6 aims for health care im-
4 provement, including safety, effectiveness, pa-
5 tient centeredness, timeliness, efficiency, and
6 equity;

7 “(C) advise the Secretary as to how eval-
8 uation of quality improvement organizations
9 under the program under this part may be im-
10 proved, taking into account—

11 “(i) the value of longitudinal tracking
12 of performance and comparison groups in
13 assessing change attributable to the pro-
14 gram;

15 “(ii) the value of stakeholder partner-
16 ships;

17 “(iii) the activities of stakeholders
18 that may affect evaluation of the perform-
19 ance of those partnering with quality im-
20 provement organizations;

21 “(iv) the availability of timely, valid,
22 and reliable data for evaluating the per-
23 formance of quality improvement organiza-
24 tions; and

1 “(v) the cost of such performance
2 evaluation; and

3 “(D) prepare and provide for public com-
4 ment a draft statement of work for each pro-
5 gram cycle.

6 “(3) FUNDING.—The Secretary shall apportion
7 funds for the strategic advisory committee under
8 this subsection from the Federal Hospital Insurance
9 Trust Fund and the Federal Supplementary Medical
10 Insurance Trust Fund in the same manner, and in
11 addition to, the amounts that would otherwise be ap-
12 portioned for contracts with organizations under sec-
13 tion 1159(b).

14 “(d) TAKING INTO ACCOUNT RECOMMENDATIONS
15 FROM STAKEHOLDERS IN STATEMENTS OF WORK.—Each
16 statement of work under this part for a contract period
17 beginning on or after August 1, 2008, shall include a task
18 for the contracting quality improvement organization to
19 convene stakeholders to identify high priority quality prob-
20 lems for work in the next contract period that are relevant
21 to Medicare beneficiaries in the State. Each such organi-
22 zation shall propose, to be incorporated as part of such
23 statement, 1 or more projects to the Secretary taking into
24 consideration the recommendations of such stakeholders,

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

3 “(e) **QUALITY COORDINATION.**—quality improvement
4 organizations holding contracts under this part shall be
5 an integral part of Federal performance improvement ini-
6 tiatives and each organization’s activities shall be coordi-
7 nated with initiatives developed by the Secretary and other
8 Federal agencies.”.

9 **SEC. 4. DATA DISCLOSURE.**

10 Section 1160 of the Social Security Act (42 U.S.C.
11 1320c–9) is amended—

12 (1) in subsection (a)(3), by striking “subsection
13 (b)” and inserting “subsections (b) and (f)”; and

14 (2) by adding at the end the following new sub-
15 section:

16 “(f)(1) An organization with a contract with the Sec-
17 retary under this part may share individual-specific data
18 with a physician treating the individual, for quality im-
19 provement and patient safety purposes.

20 “(2) The Secretary shall promulgate, not later than
21 180 days after the date of the enactment of this sub-
22 section, a regulation that permits the sharing of data
23 under paragraph (1).

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

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

3 **SEC. 5. USE OF EVALUATION AND COMPETITION.**

4 Section 1153 of the Social Security Act (42 U.S.C.
5 1320c-2) is amended—

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

8 “(3) contract terms are consistent with sub-
9 section (j);”;

10 (2) in subsection (c)(1), by inserting “, at the
11 sole discretion of the organization,” after “or may
12 subcontract”;

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

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

20 (4) by adding at the end the following new sub-
21 sections:

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

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

3 “(2) Before publishing a request for proposals for a
4 contract period, the Secretary shall, in consultation with
5 the strategic advisory committee appointed under section
6 1164(c)(1) establish measurable goals for each task to be
7 included in such proposal. The contract shall include per-
8 formance thresholds by which an organization holding a
9 contract under this section may demonstrate excellent per-
10 formance. The Secretary may not establish such perform-
11 ance thresholds in such a way as to predetermine or limit
12 either the number or percentage of organizations which
13 may demonstrate excellent performance.

14 “(3) In evaluating proposals from bidders for a con-
15 tract under this section, the Secretary shall consider the
16 performance of the incumbent contractor bidding in each
17 State, and if the incumbent contractor has demonstrated
18 excellent performance (as defined under the process de-
19 scribed in paragraph (2)) in fulfilling the terms of the con-
20 tract during the previous contract period, the Secretary
21 shall add to the score of the technical proposal of such
22 contractor a bonus equivalent to 10 percent of the total
23 possible score for the proposal.

1 “(4) The Secretary shall publish the request for pro-
2 posals not later than 4 months prior to the beginning of
3 each contract period.

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

9 “(6) The Secretary may not reduce the amount of
10 a contract award below the amount proposed by the bidder
11 prevailing in a competitive bidding process unless the
12 scope of work has been reduced. In the case where the
13 scope of work has been reduced, any reduction in the con-
14 tract award shall be commensurate with the reduction in
15 the scope of work.

16 “(7) The Secretary shall design the process for per-
17 formance evaluation of contracts under this section—

18 “(A) to hold harmless and not penalize quality
19 improvement organizations when performance is im-
20 paired or delayed by failures of the Secretary, per-
21 sonnel of the Department of Health and Human
22 Services, or entities or individuals that contract with
23 the Secretary, to provide timely deliverables;

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

4 “(C) to require that evaluation metrics be mon-
5 itored and permit their adjustment based on experi-
6 ence or evolving science over the course of a contract
7 cycle, subject to subparagraph (A).

8 “(k)(1) Notwithstanding the provisions of section
9 1153(c)(3), the Secretary shall extend each contract under
10 this section for which the contract period began on or after
11 August 1, 2005, to ensure that the subsequent contract
12 period for all quality improvement organizations begins on
13 October 1, 2009.

14 “(2) The Secretary shall apportion adequate funding
15 so that organizations with contracts extended under this
16 subsection can perform existing and new tasks, as deter-
17 mined by the Secretary, during the period of the contract
18 extension.

19 “(3) There are authorized to be appropriated such
20 sums as are necessary to respond to increased personnel
21 requirements resulting from starting all contracts simulta-
22 neously, as provided under this subsection.”.

1 **SEC. 6. QUALITY IMPROVEMENT ORGANIZATION PROGRAM**
2 **FUNDING.**

3 Section 1159 of the Social Security Act (42 U.S.C.
4 1320c-8) is amended—

5 (1) by inserting “(a)” before “Expenses in-
6 curred”; and

7 (2) by adding at the end the following new sub-
8 sections:

9 “(b)(1) The aggregate annual funding for contracts
10 under this part that begin after August 1, 2008, shall not
11 be less than \$421,666,000. In addition, there are author-
12 ized to be apportioned for contract periods in subsequent
13 years such additional amounts as may be necessary to ade-
14 quately fund any resource needs in excess of the amount
15 provided under the previous sentence.

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

22 “(A) additional core contract tasks, require-
23 ments, deliverables, and performance thresholds;

24 “(B) technical assistance for additional pro-
25 viders, practitioners, and health plans and in addi-
26 tional provider settings;

1 “(C) increased outreach and communications to
2 Medicare beneficiaries, providers, practitioners, and
3 plans; and

4 “(D) increased volume of medical reviews.

5 Nothing in this paragraph shall be construed as limiting
6 the ability of the Secretary to negotiate contracts under
7 this part individually with each quality improvement orga-
8 nization.

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

11 “(A) the Secretary shall submit a proposed ap-
12 portionment to the Director of the Office of Manage-
13 ment and Budget not later than 1 year before the
14 first date of the contract period;

15 “(B) such Director shall approve an apportion-
16 ment not later than 9 months before the first date
17 of such contract period;

18 “(C) for tasks the Secretary proposes to con-
19 tinue from the previous contract period, if the ap-
20 portionment is not authorized by the deadline speci-
21 fied in subparagraph (B), funding shall continue for
22 the next contract period at a level no less than the
23 level for the previous contract period, increased by
24 the percentage increase in the consumer price index

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

3 “(4) A quality improvement organization shall have
4 the ability to meet the terms of its contract under this
5 part by allocating funds to the functions provided under
6 such contract at its discretion. The Secretary shall review
7 whether the organization met the functions and goals set
8 out for the organization, without regard to the allocation
9 of funds at the time of the initial acceptance of the con-
10 tract.

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

14 “(A) meals and refreshments are incidental to
15 the meeting or conference;

16 “(B) attendance at the meals and when refresh-
17 ments are provided is important for the host agency
18 to ensure full participation in essential discussions,
19 lectures, or speeches concerning the purpose of the
20 meeting or conference; and

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

1 stantial functions occurring separately from when
2 the food is served.

3 “(c)(1) Not later than 180 days after the date of en-
4 actment of this subsection, the Secretary shall enter into
5 an arrangement under which the Institute of Medicine of
6 the National Academy of Sciences (in this subsection re-
7 ferred to as the ‘Institute’) shall conduct a study on—

8 “(A) the adequacy of overall funding of the pro-
9 gram under this part to meet program goals, based
10 on the most recent statement of work for which the
11 Office of Management and Budget has made a fund-
12 ing decision;

13 “(B) a recommended national percentage of
14 funding for quality improvement organizations, to be
15 used for the core contract work with providers, prac-
16 titioners, plans, and beneficiaries and on national
17 initiatives established by the Secretary;

18 “(C) a recommended national percentage of
19 such funding to be used for local initiatives, identi-
20 fied by quality improvement organizations in con-
21 sultation with stakeholders in each State; and

22 “(D) a recommended national percentage of
23 overall funds under the program under this part
24 that will not be available for the work of quality im-
25 provement organizations in the field and that may

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

3 “(2) Not later than 2 years after the date of enact-
4 ment of this subsection, the Institute shall submit a report
5 to the Committee on Finance of the Senate and the Com-
6 mittees on Ways and Means and Energy and Commerce
7 of the House of Representatives, containing the results of
8 the study conducted under paragraph (1) together with
9 recommendations for such legislation and administrative
10 action as the Institute determines appropriate.

11 “(3)(A) On or before the date that the proposal for
12 each statement of work is submitted to the Office of Man-
13 agement and Budget, the Secretary shall enter into an ar-
14 rangement under which the Institute shall conduct a study
15 on the issues described in subparagraphs (A) through (D)
16 of paragraph (1).

17 “(B) Not later than 180 days after the date on which
18 the proposal for each statement of work is submitted to
19 the Office of Management and Budget, the Institute shall
20 submit a report to the Committee on Finance of the Sen-
21 ate and the Committees on Ways and Means and Energy
22 and Commerce of the House of Representatives, con-
23 taining the results of the studies conducted under sub-
24 paragraph (A) and paragraph (1) together with rec-

1 ommendations for such legislation and administrative ac-
2 tion as the Institute determines appropriate.

3 “(4) The Secretary shall apportion funds for the
4 studies conducted by the Institute of Medicine under this
5 subsection from the Federal Hospital Insurance Trust
6 Fund and the Federal Supplementary Medical Insurance
7 Trust Fund in the same manner, and in addition to, the
8 amounts that would otherwise be apportioned for con-
9 tracts with organizations under subsection (b).”.

10 **SEC. 7. QUALIFICATIONS OF QIOS.**

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

14 “(4)(A) The Secretary shall not enter into or
15 renew a contract under this section with an entity
16 unless the entity has demonstrated success in facili-
17 tating clinical and administrative system redesign to
18 improve the coordination, effectiveness, and safety of
19 health care, and in facilitating cooperation among
20 stakeholders in quality improvement.

21 “(B) The Secretary shall ensure that the entity
22 complies with standards to ensure organizational in-
23 tegrity, including—

24 “(i) appropriate representation of con-
25 sumers, quality assurance experts, and stake-

1 holders in the composition of the governing
2 body;

3 “(ii) market-based compensation of board
4 members and executives;

5 “(iii) avoidance and mitigation of board
6 member conflict of interest; and

7 “(iv) safeguards to ensure appropriate
8 travel expenses.

9 To the extent practicable, the Secretary shall utilize
10 standards developed in the private sector for pur-
11 poses of carrying out this subparagraph and shall
12 conduct audits as necessary to ensure compliance
13 with such standards.”.

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

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

19 (c) REMOVAL OF PHYSICIAN-ACCESS AND PHYSI-
20 CIAN-SPONSORED REQUIREMENTS FOR ORGANIZA-
21 TIONS.—

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

