**CMS 10393 Supporting Statement – Attachment D**

**Beneficiary and Family Centered Data Collection**

**Related Legislation**

**Section 1154 of the Social Security Act sets forth the functions of the Peer Review Organizations, including 1154 (a) (1) (B)**

**FUNCTIONS OF QUALITY IMPROVEMENT [153] ORGANIZATIONS**

Sec. 1154. [42 U.S.C. 1320c–3] (a) Subject to subsection (b), any[154] quality improvement [155] organization entering into a contract with the Secretary under this part must perform one or more of[156] the following functions:
(1) The organization shall review some or all of the professional activities in the area, subject to the terms of the contract and subject to the requirements of subsection (d), of physicians and other health care practitioners and institutional and non-institutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under title XVIII (including where payment is made for such services to eligible organizations pursuant to contracts under section 1876, to Medicare Advantage organizations pursuant to contracts under part C, and to prescription drug sponsors pursuant to contracts under part D) for the purpose of determining whether—
(A) such services and items are or were reasonable and medically necessary and whether such services and items are not allowable under subsection (a)(1) or (a)(9) of section 1862;
(B) the quality of such services meets professionally recognized standards of health care; and
(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type.
If the organization performs such reviews with respect to a type of health care practitioner other than medical doctors, the organization shall establish procedures for the involvement of health care practitioners of that type in such reviews.
(2) The organization shall determine, on the basis of the review carried out under subparagraphs (A), (B), and (C) of paragraph (1), whether payment shall be made for services under title XVIII. Such determination shall constitute the conclusive determination on those issues for purposes of payment under title XVIII, except that payment may be made if—
(A) such payment is allowed by reason of section 1879;
(B) in the case of inpatient hospital services or extended care services, the quality improvement[157] organization determines that additional time is required in order to arrange for post-discharge care, but payment may be continued under this subparagraph for not more than two days, but only in the case where the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under title XVIII prior to notification by the organization under paragraph (3);
(C) such determination is changed as the result of any hearing or review of the determination under section 1155; or

(D) such payment is authorized under section 1861(v)(1)(G).
The organization shall identify cases for which payment should not be made by reason of paragraph (1)(B) only through the use of criteria developed pursuant to guidelines established by the Secretary.
(3)(A) Subject to subparagraphs (B) and (D), whenever the organization makes a determination that any health care services or items furnished or to be furnished to a patient by any practitioner or provider are disapproved, the organization shall promptly notify such patient and the agency or organization responsible for the payment of claims under title XVIII of this Act of such determination.
(B) The notification under subparagraph (A) with respect to services or items disapproved by reason of subparagraph (A) or (C) of paragraph (1) shall not occur until 20 days after the date that the organization has—
(i) made a preliminary notification to such practitioner or provider of such proposed determination, and
(ii) provided such practitioner or provider an opportunity for discussion and review of the proposed determination.
(C) The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1155).
(D) The notification under subparagraph (A) with respect to services or items disapproved by reason of paragraph (1)(B) shall not occur until after—
(i) the organization has notified the practitioner or provider involved of the determination and of the practitioner's or provider's right to a formal reconsideration of the determination under section 1155, and
(ii) if the provider or practitioner requests such a reconsideration, the organization has made such a reconsideration.
If a provider or practitioner is provided a reconsideration, such reconsideration shall be in lieu of any subsequent reconsideration to which the provider or practitioner may be otherwise entitled under section 1155, but shall not affect the right of a beneficiary from seeking reconsideration under such section of the organization's determination (after any reconsideration requested by the provider or physician under clause (ii)).
(E)(i) In the case of services and items provided by a physician that were disapproved by reason of paragraph (1)(B), the notice to the patient shall state the following: "In the judgment of the quality improvement [158] organization, the medical care received was not acceptable under the Medicare program. The reasons for the denial have been discussed with your physician."
(ii) In the case of services or items provided by an entity or practitioner other than a physician, the Secretary may substitute the entity or practitioner which provided the services or items for the term "physician" in the notice described in clause (i).
(4)(A) The organization shall, after consultation with the Secretary, determine the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order to most effectively carry out the purposes of this part, exercise review authority under the contract. The organization shall notify the Secretary periodically with respect to such determinations. Each quality improvement [159] organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities is made among the different

cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.

(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a risk-sharing contract under section 1876 (or that is subject to review under section 1882(t)(3)) for the purpose of determining whether the quality of such services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings and whether individuals enrolled with an eligible organization have adequate access to health care services provided by or through such organization (as determined, in part, by a survey of individuals enrolled with the organization who have not yet used the organization to receive such services). The contract of each organization shall also provide that with respect to health care provided by a health maintenance organization or competitive medical plan under section 1876, the organization shall maintain a beneficiary outreach program designed to apprise individuals receiving care under such section of the role of the quality improvement [160] system, of the rights of the individual under such system, and of the method and purposes for contacting the organization. The previous two sentences shall not apply with respect to a contract year if another entity has been awarded a contract under subparagraph (C). Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization.

(C) [Stricken. [161]]

(5) The organization shall consult with nurses and other professional health care practitioners (other than physicians described in section 1861(r)(1)) and with representatives of institutional and non-institutional providers of health care services, with respect to the organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.

(6)(A) The organization shall, consistent with the provisions of its contract under this part, apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice within the geographic area served by the organization as principal points of evaluation and review, taking into consideration national norms where appropriate. Such norms with respect to treatment for particular illnesses or health conditions shall include—

(i) the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care, are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care; and

(ii) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

As a component of the norms described in clause (i) or (ii), the organization shall take into account the special problems associated with delivering care in remote rural areas, the

availability of service alternatives to inpatient hospitalization, and other appropriate factors (such as the distance from a patient's residence to the site of care, family support, availability of proximate alternative sites of care, and the patient's ability to carry out necessary or prescribed self-care regimens) that could adversely affect the safety or effectiveness of treatment provided on an outpatient basis.
(B) The organization shall—
(i) offer to provide, several times each year, for a physician representing the organization to meet (at a hospital or at a regional meeting) with medical and administrative staff of each hospital (the services of which are reviewed by the organization) respecting the organization's review of the hospital's services for which payment may be made under title XVIII, and
(ii) publish (not less often than annually) and distribute to providers and practitioners whose services are subject to review a report that describes the organization's findings with respect to the types of cases in which the organization has frequently determined that (I) inappropriate or unnecessary care has been provided, (II) services were rendered in an inappropriate setting, or (III) services did not meet professionally recognized standards of health care.
(7) The organization, to the extent necessary and appropriate to the performance of the contract, shall—
(A)(i) make arrangements to utilize the services of persons who are practitioners of, or specialists in, the various areas of medicine (including dentistry, optometry, and podiatry, or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization; and
(ii) in the case of psychiatric and physical rehabilitation services, make arrangements to ensure that (to the extent possible) initial review of such services be made by a physician who is trained in psychiatry or physical rehabilitation (as appropriate).[162]
(B) undertake such professional inquiries either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review which in the judgment of such organization will facilitate its activities;
(C) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1); and
(D) inspect the facilities in which care is rendered or services are provided (which are located in such area) of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under paragraph (1).
(8) The organization shall perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part or as may be required to carry out section 1862(a)(15).
(9)(A) The organization shall collect such information relevant to its functions, and keep and maintain such records, in such form as the Secretary may require to carry out the purposes of this part, and shall permit access to and use of any such information and records as the Secretary may require for such purposes, subject to the provisions of section 1160.
(B) If the organization finds, after reasonable notice to and opportunity for discussion with the physician or practitioner concerned, that the physician or practitioner has furnished services in violation of section 1156(a) and the organization determines that the physician or practitioner should enter into a corrective action plan under section 1156(b)(1), the organization shall notify

the State board or boards responsible for the licensing or disciplining of the physician or practitioner of its finding and of any action taken as a result of the finding.
(10) The organization shall coordinate activities, including information exchanges, which are consistent with economical and efficient operation of programs among appropriate public and private agencies or organizations including—
(A) agencies under contract pursuant to sections 1816 and 1842 of this Act;
(B) other quality improvement [163] organizations having contracts under this part; and
(C) other public or private review organizations as may be appropriate.
(11) The organization shall make available its facilities and resources for contracting with private and public entities paying for health care in its area for review, as feasible and appropriate, of services reimbursed by such entities.
(12) [164] As part of the organization's review responsibility under paragraph (1), the organization shall review all ambulatory surgical procedures specified pursuant to section 1833(i)(1)(A) which are performed in the area, or, at the discretion of the Secretary, a sample of such procedures.
(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an "early readmission case" is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge.
(14) The organization shall conduct an appropriate 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). The organization shall inform the individual (or representative) of the organization's final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.
(15) During each year of the contract entered into under section 1153(b), the organization shall perform on-site review activities as the Secretary determines appropriate [165].
(16) The organization shall provide for a review and report to the Secretary when requested by the Secretary under section 1867(d)(3). The organization shall provide reasonable notice of the review to the physician and hospital involved. Within the time period permitted by the Secretary, the organization shall provide a reasonable opportunity for discussion with the physician and hospital involved, and an opportunity for the physician and hospital to submit additional information, before issuing its report to the Secretary under such section.
(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, Medicare Advantage organizations offering Medicare Advantage plans under part C, and prescription drug sponsors offering prescription drug plans under part D quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.

(18) [166] The organization shall perform, subject to the terms of the contract, such other activities as the Secretary determines may be necessary for the purposes of improving the quality of care furnished to individuals with respect to items and services for which payment may be made under title XVIII.
(b)[167] A quality improvement organization entering into a contract with the Secretary to perform a function described in a paragraph under subsection (a) must perform all of the activities described in such paragraph, except to the extent otherwise negotiated with the Secretary pursuant to the contract or except for a function for which the Secretary determines it is not appropriate for the organization to perform, such as a function that could cause a conflict of interest with another function.
(c) [168] (1) No physician shall be permitted to review—
(A) health care services provided to a patient if he was directly responsible for providing such services; or
(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.
(2) For purposes of this subsection, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.
(d)[169] No quality improvement[170] organization shall utilize the services of any individual who is not a duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry to make final determinations of denial decisions in accordance with its duties and functions under this part with respect to the professional conduct of any other duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry, or any act performed by any duly licensed doctor of medicine, osteopathy, dentistry, optometry, or podiatry in the exercise of his profession.
(e)(1) If—
(A) a hospital has determined that a patient no longer requires inpatient hospital care, and
(B) the attending physician has agreed with the hospital's determination,
the hospital may provide the patient (or the patient's representative) with a notice (meeting conditions prescribed by the Secretary under section 1879) of the determination.
(2)-(4) [ Stricken.[171]]
(f) The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist quality improvement [172] organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care.
[153] P.L. 112-40, §261(a)(2)(B), struck out "PEER REVIEW" and inserted "QUALITY IMPROVEMENT", applicable to contracts entered into or renewed on or after January 1, 2012.
[154] P.L. 112-40, §261(c)(2)(A)(i)(I), struck out "Any" and inserted "Subject to subsection (b), any", applicable to contracts entered into or renewed on or after January 1, 2012.
[155] P.L. 112-40, §261(a)(2)(C), struck out "utilization and quality control peer review" and inserted "quality improvement", applicable to contracts entered into or renewed on or after January 1, 2012.
[156] P.L. 112-40, §261(c)(2)(A)(i)(II), inserted "one or more of", applicable to contracts entered into or renewed on or after January 1, 2012.
[157] P.L. 112-40, §261(a)(2)(C), struck out "peer review" and inserted "quality improvement", applicable to contracts entered into or renewed on or after January 1, 2012.

[158] P.L. 112-40, §261(a)(2)(C), struck out “utilization and quality control peer review” and inserted “quality improvement”, applicable to contracts entered into or renewed on or after January 1, 2012.
[159] P.L. 112-40, §261(a)(2)(C), struck out “peer review” and inserted “quality improvement”, applicable to contracts entered into or renewed on or after January 1, 2012.
[160] P.L. 112-40, §261(a)(2)(C), struck out “peer review” and inserted “quality improvement”, applicable to contracts entered into or renewed on or after January 1, 2012.
[161] P.L. 112-40, §261(c)(2)(A)(ii), struck out subparagraph (C), applicable to contracts entered into or renewed on or after January 1, 2012. For subparagraph (C) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 112-40.
[162] Punctuation as in original.
[163] P.L. 112-40, §261(a)(2)(C), struck out “utilization and quality control peer review” and inserted “quality improvement”, applicable to contracts entered into or renewed on or after January 1, 2012.
[164] P.L. 112-40, §261(c)(2)(A)(iii), inserted a new paragraph (12), applicable to contracts entered into or renewed on or after January 1, 2012.
[165] P.L. 112-40, §261(c)(2)(A)(iv), struck out “significant on-site review activities, including on-site review in at least 20 percent of the rural hospitals in the organization’s area” and inserted “on-site review activities as the Secretary determines appropriate”, applicable to contracts entered into or renewed on or after January 1, 2012.
[166] P.L. 112-40, §261(d), added this new paragraph (18), applicable to contracts entered into or renewed on or after January 1, 2012.
[167] P.L. 112-40, §261(c)(2)(C), inserted this new subsection (b), applicable to contracts entered into or renewed on or after January 1, 2012.
[168] P.L. 112-40, §261(c)(2)(B), redesignated the former subsection (b) as subsection (c), applicable to contracts entered into or renewed on or after January 1, 2012.
[169] P.L. 112-40, §261(c)(2)(B), struck out the former subsection (d), applicable to contracts entered into or renewed on or after January 1, 2012. For subsection (d) as it formerly read, see Vol. II, Appendix J, Superseded Provisions, P.L. 112-40.
P.L. 112-40, §261(c)(2)(B), redesignated the former subsection (c) as subsection (d), applicable to contracts entered into or renewed on or after January 1, 2012.
[170] P.L. 112-40, §261(a)(2)(C), struck out “utilization and quality control peer review” and inserted “quality improvement”, applicable to contracts entered into or renewed on or after January 1, 2012.
[171] P.L. 106-554, Appendix F, [title V, §521(c)]; 114 Stat. 2763, 2763A-543.
[172] P.L. 112-40, §261(a)(2)(C), struck out “utilization and quality control peer review” and inserted “quality i

**Public Law 112-40**
**112th Congress Public Law 40**
**From the U.S. Government Printing Office**

**[Page 125 STAT. 401]**

An Act to extend the Generalized System of Preferences, and for other purposes. <<NOTE: Oct. 21, 2011 - [H.R. 2832]>>

TITLE II--TRADE ADJUSTMENT ASSISTANCE

Sec. 241. Health care tax credit.
Sec. 242. TAA pre-certification period rule for purposes of determining whether there is a 63-day lapse in creditable coverage.
Sec. 243. Extension of COBRA benefits for certain TAA-eligible individuals and PBGC recipients.

Subtitle C--Offsets

PART I--Unemployment Compensation Program Integrity

Sec. 251. Mandatory penalty assessment on fraud claims.
Sec. 252. Prohibition on noncharging due to employer fault.

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Sec. 253. Reporting of rehired employees to the directory of new hires.

PART II--Additional Offsets

Sec. 261. Improvements to contracts with Medicare quality improvement organizations (QIOs) in order to improve the quality of care furnished to Medicare beneficiaries.
Sec. 262. Rates for merchandise processing fees.
Sec. 263. Time for remitting certain merchandise processing fees.

PART II--ADDITIONAL OFFSETS

SEC. 261. IMPROVEMENTS TO CONTRACTS WITH MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS (QIOS) IN ORDER TO IMPROVE THE QUALITY OF CARE FURNISHED TO MEDICARE BENEFICIARIES.

(a) Authority to Contract With a Broad Range of Entities.--
(1) Definition.--Section 1152 of the Social Security Act (42 U.S.C. 1320c-1) is amended by striking paragraphs (1) and (2) and inserting the following new paragraphs:
``(1) is able, as determined by the Secretary, to perform its functions under this part in a manner consistent with the efficient and effective administration of this part and title XVIII;
``(2) has at least one individual who is a representative of health care providers on its governing body; and".
(2) Name change.--Part B of title XI of the Social Security Act (42 U.S.C. 1320c et seq.) is amended--
(A) in the headings for sections 1152 and 1153, <<NOTE: 42 USC 1320c-1, 1320c-2.>> by striking ``utilization and quality control peer review" and

inserting ``quality improvement";
(B) in the heading for section 1154, <<NOTE: 42 USC 1320c-3.>> by striking ``peer review" and inserting ``quality improvement"; and
(C) by <<NOTE: 42 USC 1320c-1320c-7, 1320c-9, 1320c-10.>> striking ``utilization and quality control peer review" and ``peer review" each place it appears before ``organization" or ``organizations" and inserting ``quality improvement".

(3) Conforming amendments to the medicare program.--Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended--

(A) by <<NOTE: 42 USC 1395y, 1395cc, 1395dd, 1395ff, 1395mm, 1395pp, 1395ww.>> striking ``utilization and quality control peer review" and inserting ``quality improvement" each place it appears;
(B) by <<NOTE: 42 USC 1395g, 1395k, 1395x, 1395pp.>> striking ``quality control and peer review" and inserting ``quality improvement" each place it appears;
(C) in paragraphs (1)(A)(iii)(I) and (2) of <<NOTE: 42 USC 1395u.>> section 1842(l), by striking ``peer review organization" and inserting ``quality improvement organization";
(D) in subparagraphs (A) and (B) of section <<NOTE: 42 USC 1395cc.>> 1866(a)(3), by striking ``peer review" and inserting ``quality improvement";
(E) in section 1867(d)(3), <<NOTE: 42 USC 1395dd.>> in the heading, by striking ``peer review" and inserting ``quality improvement"; and
(F) in section 1869(c)(3)(G), <<NOTE: 42 USC 1395ff.>> by striking ``peer review organizations" and inserting ``quality improvement organizations".

(b) Improvements With Respect to the Contract.--

(1) Flexibility with respect to the geographic scope of contracts.--Section 1153 of the Social Security Act (42 U.S.C. 1320c-2) is amended--

(A) by striking subsection (a) and inserting the following new subsection:

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``(a) The Secretary shall establish throughout the United States such local, State, regional, national, or other geographic areas as the

Secretary determines appropriate with respect to which contracts under this part will be made.";

(B) in subsection (b)(1), as amended by subsection (a)(2)--

(i) in the first sentence, by striking ``a contract with a quality improvement organization'' and inserting ``contracts with one or more quality improvement organizations''; and

(ii) in the second sentence, by striking ``meets the requirements'' and all that follows before the period at the end and inserting ``will be operating in an area, the Secretary shall ensure that there is no duplication of the functions carried out by such organizations within the area";

(C) in subsection (b)(2)(B), by inserting ``or the Secretary determines that there is a more qualified entity to perform one or more of the functions in section 1154(a)'' after ``under this part";

(D) in subsection (b)(3)--

(i) in subparagraph (A), by striking ``, or association of such facilities,''; and

(ii) in subparagraph (B)--

(I) by striking ``or association of such facilities''; and

(II) by striking ``or associations''; and

(E) by striking subsection (i).

(2) Extension of length of contracts.--Section 1153(c)(3) of the Social Security Act (42 U.S.C. 1320c-2(c)(3)) is amended--

(A) by striking ``three years'' and inserting ``five years''; and

(B) by striking ``on a triennial basis'' and inserting ``for terms of five years".

(3) Authority to terminate in a manner consistent with the federal acquisition regulation.--Section 1153 of the Social Security Act (42 U.S.C. 1320c-2) is amended--

(A) in subsection (b), by adding at the end the following new paragraph:

``(4) The Secretary may consider a variety of factors in selecting the contractors that the Secretary determines would provide for the most efficient and effective administration of this part, such as geographic location, size, and prior experience in health care quality improvement. Quality improvement organizations operating as of January 1, 2012, shall be allowed to compete for new contracts (as determined appropriate by

the Secretary) along with other qualified organizations and are eligible for renewal of contracts for terms five years thereafter (as determined appropriate by the Secretary).";

(B) in subsection (c), by striking paragraphs (4) through (6) and redesignating paragraphs (7) and (8) as paragraphs (4) and (5), respectively; and

(C) by striking subsection (d).

(4) Administrative improvement.--Section 1153(c)(5) of the Social Security Act (42 U.S.C. 1320c-2(c)(5)), as redesignated by this subsection, is amended to read as follows:

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``(5) reimbursement shall be made to the organization on a monthly basis, with payments for any month being made consistent with the Federal Acquisition Regulation.".

(c) Authority for Quality Improvement Organizations To Perform Specialized Functions and to Eliminate Conflicts of Interest.--Part B of title XI of the Social Security Act (42 U.S.C. 1320c et seq.) is amended--

(1) in <<NOTE: 42 USC 1320c-2.>> section 1153--

(A) in subsection (b)(1), as amended by subsection (b)(1)(B), by inserting after the first sentence the following new sentence: ``In entering into contracts with such qualified organizations, the Secretary shall, to the extent appropriate, seek to ensure that each of the functions described in section 1154(a) are carried out within an area established under subsection (a).''; and

(B) in subsection (c)(1), by striking ``the functions set forth in section 1154(a), or may subcontract for the performance of all or some of such functions" and inserting ``a function or functions under section 1154 directly or may subcontract for the performance of all or some of such function or functions"; and

(2) in <<NOTE: 42 USC 1320c-3.>> section 1154--

(A) in subsection (a)--

(i) in the matter preceding paragraph (1)--

(I) by striking ``Any" and inserting ``Subject to subsection (b), any"; and

(II) by inserting ``one or more of" before ``the following functions";

(ii) in paragraph (4), by striking

subparagraph (C);

(iii) by inserting after paragraph (11) the following new paragraph:

``(12) As part of the organization's review responsibility under paragraph (1), the organization shall review all ambulatory surgical procedures specified pursuant to section 1833(i)(1)(A) which are performed in the area, or, at the discretion of the Secretary, a sample of such procedures."; and

(iv) in paragraph (15), by striking ``significant on-site review activities" and all that follows before the period at the end and inserting ``on-site review activities as the Secretary determines appropriate".

(B) by striking subsection (d) and redesignating subsections (b) and (c) as subsections (c) and (d), respectively; and

(C) by inserting after subsection (a) the following new subsection:

``(b) A quality improvement organization entering into a contract with the Secretary to perform a function described in a paragraph under subsection (a) must perform all of the activities described in such paragraph, except to the extent otherwise negotiated with the Secretary pursuant to the contract or except for a function for which the Secretary determines it is not appropriate for the organization to perform, such as a function that could cause a conflict of interest with another function.".

(d) Quality Improvement as Specified Function.--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:

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``(18) The organization shall perform, subject to the terms of the contract, such other activities as the Secretary determines may be necessary for the purposes of improving the quality of care furnished to individuals with respect to items and services for which payment may be made under title XVIII.".

(e) Effective <<NOTE: 42 USC 1320c note.>> Date.--The amendments made by this section shall apply to contracts entered into or renewed on or after January 1, 2012.