SEC. 1159. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING AND PROMOTING HIGH-VALUE HEALTH CARE.

(a) In General.—The Secretary of Health and Human Services (in this section and the succeeding section referred to as the "Secretary") shall enter into an agreement with the Institute of Medicine of the National Academies (referred to in this section as the "Institute") to conduct a study on geographic variation and growth in volume and intensity of services in per capita health care spending among the Medicare, Medicaid, privately insured and uninsured populations. Such study may draw on recent relevant reports of the Institute and shall include each of the following:

(1) An evaluation of the extent and range of such variation using various units of geographic measurement, including micro areas within larger areas.

(2) The extent to which geographic variation can be attributed to differences in input prices; health status; practice patterns; access to medical services; supply of medical services; socio-economic factors, including race, ethnicity, gender, age, income and educational status; and provider and payer organizational models.

(3) The extent to which variations in spending are correlated with patient access to care, insurance status, distribution of health care resources, health care outcomes, and consensus-based measures of health care quality.

(4) The extent to which variation can be attributed to physician and practitioner discretion in making treatment decisions, and the degree to which discretionary treatment decisions are made that could be characterized as different from the best available medical evidence.

(5) The extent to which variation can be attributed to patient preferences and patient compliance with treatment protocols.

(6) An assessment of the degree to which variation cannot be explained by empirical evidence.

(7) For Medicare beneficiaries, the extent to which variations in spending are correlated with insurance status prior to enrollment in the Medicare program under title XVIII of the Social Security Act, and institutionalization status; whether beneficiaries are dually eligible for the Medicare program and Medicaid under title XIX of such Act; and whether beneficiaries are enrolled in fee-for-service Medicare or Medicare Advantage.

(8) Other factors the Institute deems appropriate.

The Institute shall conduct public hearings and provide an opportunity for comments prior to completion of the reports under subsection (e).

(b) Recommendations.—Taking into account the findings under subsection (a) and the changes to the payment systems made by this Act, the Institute shall recommend changes to payment for items and services under parts A and B of title XVIII of the Social Security Act, for addressing variation in Medicare per capita spending for items and services (not including add-ons for graduate medical education, disproportionate share payments, and health information technology, as specified in sections 1886(d)(5)(F), 1886(d)(5)(B), 1886(h), 1848(o), and 1886(n), respectively, of such Act) by promoting high-value care (as defined in subsection (f)),

with particular attention to high-volume, high-cost conditions. In making such recommendations, the Institute shall consider each of the following:

(1) Measurement and reporting on quality and population health.

(2) Reducing fragmented and duplicative care.

(3) Promoting the practice of evidence-based medicine.

(4) Empowering patients to make value-based care decisions.

(5) Leveraging the use of health information technology.

(6) The role of financial and other incentives affecting provision of care.

(7) Variation in input costs.

(8) The characteristics of the patient population, including socio-economic factors (including race, ethnicity, gender, age, income and educational status), and whether the beneficiaries are dually eligible for the Medicare program under title XVIII of the Social Security Act and Medicaid under title XIX of such Act.

(9) Other topics the Institute deems appropriate.

In making such recommendations, the Institute shall consider an appropriate phase-in that takes into account the impact of payment changes on providers and facilities and preserves access to care for Medicare beneficiaries.

(c) Specific Considerations.—In making the recommendations under subsection (b), the Institute shall specifically address whether payment systems under title XVIII of the Social Security Act for physicians and hospitals should be further modified to incentivize high-value care. In so doing, the Institute shall consider the adoption of a value index based on a composite of appropriate measures of quality and cost that would adjust provider payments on a regional or provider-level basis. If the Institute finds that application of such a value index would significantly incentivize providers to furnish high-value care, it shall make specific recommendations on how such an index would be designed and implemented. In so doing, it should identify specific measures of quality and cost appropriate for use in such an index, and include a thorough analysis (including on a geographic basis) of how payments and spending under such title would be affected by such an index.

(d) Additional Considerations.—The Institute shall consider the experience of governmental and community-based programs that promote high-value care.

(e) Reports.—

(1) Not later than April 15, 2011, the Institute shall submit to the Secretary and each House of Congress a report containing findings and recommendations of the study conducted under this section.

(2) Following submission of the report under paragraph (1), the Institute shall use the data collected and analyzed in this section to issue a subsequent report, or series of reports, on how best to address geographic variation or efforts to promote high-value care for items and services reimbursed by private insurance or other programs. Such reports shall include a comparison to the Institute's findings and recommendations regarding the Medicare program. Such reports, and any recommendations, would not be subject to the procedures

outlined in section 1160.

(f) High-Value Care Defined.—For purposes of this section, the term "high-value care" means the efficient delivery of high quality, evidence-based, patient-centered care.

(g) Appropriations.—There is appropriated from amounts in the general fund of the Treasury not otherwise appropriated $10,000,000 to carry out this section. Such sums are authorized to remain available until expended.

SEC. 1160. IMPLEMENTATION, AND CONGRESSIONAL REVIEW, OF PROPOSAL TO REVISE MEDICARE PAYMENTS TO PROMOTE HIGH VALUE HEALTH CARE.

(a) Preparation and Submission of Implementation Plans.—

(1) FINAL IMPLEMENTATION PLAN.—Not later than 240 days after the date of receipt by the Secretary and each House of Congress of the report under section 1159(e)(1), the Secretary shall submit to each House of Congress a final implementation plan describing proposed changes to payment for items and services under parts A and B of title XVIII of the Social Security Act (which may include payment for inpatient and outpatient hospital services for services furnished in PPS and PPS-exempt hospitals, physicians' services, dialysis facility services, skilled nursing facility services, home health services, hospice care, clinical laboratory services, durable medical equipment, and other items and services, but which shall exclude add-on payments for graduate medical education, disproportionate share payments, and health information technology, as specified in sections 1886(d)(5)(F), 1886(d)(5)(B), 1886(h), 1848(o), and 1886(n), respectively, of the Social Security Act) taking into consideration, as appropriate, the recommendations of the report submitted under section 1159(e)(1) and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participation in the Medicare program under title XVIII of the Social Security Act and preserves access to care for Medicare beneficiaries.

(2) PRELIMINARY IMPLEMENTATION PLAN.—Not later than 90 days after the date the Institute of Medicine submits to each House of Congress the report under section 1159(e)(1), the Secretary shall submit to each House of Congress a preliminary version of the implementation plan provided for under paragraph (1)(A).

(3) NO INCREASE IN BUDGET EXPENDITURES.—The Secretary shall include with the submission of the final implementation plan under paragraph (1) a certification by the Chief Actuary of the Centers for Medicare & Medicaid Services that over the initial 10-year period in which the plan is implemented, the aggregate level of net expenditures under the Medicare program under title XVIII of the Social Security Act will not exceed the aggregate level of such expenditures that would have occurred if the plan were not implemented.

(4) WAIVERS REQUIRED.—To the extent the final implementation plan under paragraph (1) proposes changes that are not otherwise permitted under title XVIII of the Social Security Act, the Secretary shall specify in the plan the specific waivers required under such title to implement such changes. Except as provided in subsection (c), the Secretary is

authorized to waive the requirements so specified in order to implement such changes.

(5) ASSESSMENT OF IMPACT.—In addition, both the preliminary and final implementation plans under this subsection shall include a detailed assessment of the effects of the proposed payment changes by provider or supplier type and State relative to the payments that would otherwise apply.

(b) Review by Medpac and Gao.—Not later than 45 days after the date the preliminary implementation plan is received by each House of Congress under subsection (a)(2), the Medicare Payment Advisory Committee and the Comptroller General of the United States shall each evaluate such plan and submit to each House of Congress a report containing its analysis and recommendations regarding implementation of the plan, including an analysis of the effects of the proposed changes in the plan on payments and projected spending.

(c) Implementation.—

(1) IN GENERAL.—The Secretary shall include, in applicable proposed rules for the next rulemaking cycle beginning after the Congressional action deadline, appropriate proposals to revise payments under title XVIII of the Social Security Act in accordance with the final implementation plan submitted under subsection (a)(1), and the waivers specified in subsection (a)(4) to the extent required to carry out such plan are effective, unless a joint resolution (described in subsection (d)(5)(A)) with respect to such plan is enacted by not later than such deadline. If such a joint resolution is enacted, the Secretary is not authorized to implement such plan and the waiver authority provided under subsection (a)(4) shall no longer be effective.

(2) CONGRESSIONAL ACTION DEADLINE.—For purposes of this section, the term "Congressional action deadline" means, with respect to a final implementation plan under subsection (a)(1), May 31, 2012, or, if later, the date that is 145 days after the date of receipt of such plan by each House of Congress under subsection (a).

(d) Congressional Procedures.—

(1) INTRODUCTION.—On the day on which the final implementation plan is received by the House of Representatives and the Senate under subsection (a), a joint resolution specified in paragraph (5)(A) shall be introduced in the House of Representatives by the majority leader and minority leader of the House of Representatives and in the Senate by the majority leader and minority leader of the Senate. If either House is not in session on the day on which such a plan is received, the joint resolution with respect to such plan shall be introduced in that House, as provided in the preceding sentence, on the first day thereafter on which that House is in session.

(2) CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(A) REPORTING AND DISCHARGE.—Any committee of the House of Representatives to which a joint resolution introduced under paragraph (1) is referred shall report such joint resolution to the House not later than 50 legislative days after the applicable date of introduction of the joint resolution. If a committee fails to report such joint resolution within that period, a motion to discharge the committee from further consideration of the joint resolution shall be in order. Such a motion shall be in order only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent announces an intention to offer

the motion. Notice may not be given on an anticipatory basis. Such a motion shall not be in order after the last committee authorized to consider the joint resolution reports it to the House or after the House has disposed of a motion to discharge the joint resolution. The previous question shall be considered as ordered on the motion to its adoption without intervening motion except 20 minutes of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(B) PROCEEDING TO CONSIDERATION.—After each committee authorized to consider a joint resolution reports such joint resolution to the House of Representatives or has been discharged from its consideration, a motion to proceed to consider such joint resolution shall be in order. Such a motion shall be in order only at a time designated by the Speaker in the legislative schedule within two legislative days after the day on which the proponent announces an intention to offer the motion. Notice may not be given on an anticipatory basis. Such a motion shall not be in order after the House of Representatives has disposed of a motion to proceed on the joint resolution. The previous question shall be considered as ordered on the motion to its adoption without intervening motion. A motion to reconsider the vote by which the motion is disposed of shall not be in order.

(C) CONSIDERATION.—The joint resolution shall be considered in the House and shall be considered as read. All points of order against a joint resolution and against its consideration are waived. The previous question shall be considered as ordered on the joint resolution to its passage without intervening motion except two hours of debate equally divided and controlled by the proponent and an opponent. A motion to reconsider the vote on passage of a joint resolution shall not be in order.

(3) CONSIDERATION IN THE SENATE.—[Note from Rules Committee: Senate procedures have to be constructed to assure a simple majority and ease any other procedural motions that would delay its prompt consideration. Language below is a placeholder only.]

(A) REPORTING AND DISCHARGE.—Any committee of the Senate to which a joint resolution introduced under paragraph (1) is referred shall report such joint resolution to the Senate within 50 legislative days. If a committee fails to report such joint resolution at the close of the 15th legislative day after its receipt by the Senate, such committee shall be automatically discharged from further consideration of such joint resolution and such joint resolution or joint resolutions shall be placed on the calendar. A vote on final passage of such joint resolution shall be taken in the Senate on or before the close of the second legislative day after such joint resolution is reported by the committee or committees of the Senate to which it was referred, or after such committee or committees have been discharged from further consideration of such joint resolution.

(B) PROCEEDING TO CONSIDERATION.—A motion in the Senate to proceed to the consideration of a joint resolution shall be privileged and not debatable. An amendment to such a motion shall not be in order, nor shall it be in order to move to reconsider the vote by which such a motion is agreed to or disagreed to.

(C) CONSIDERATION.—

(i) Debate in the Senate on a joint resolution, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the majority leader and the minority leader or their designees.

(ii) Debate in the Senate on any debatable motion or appeal in connection with a joint resolution shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the resolution, except that in the event the manager of the joint resolution is in favor of any such motion or appeal, the time in opposition thereto shall be controlled by the minority leader or a designee. Such leaders, or either of them, may, from time under their control on the passage of a joint resolution, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(iii) A motion in the Senate to further limit debate is not debatable. A motion to recommit a joint resolution is not in order.

(4) RULES RELATING TO SENATE AND HOUSE OF REPRESENTATIVES.—

(A) COORDINATION WITH ACTION BY OTHER HOUSE.—If, before the passage by one House of a joint resolution of that House, that House receives from the other House a joint resolution, then the following procedures shall apply:

(i) The joint resolution of the other House shall not be referred to a committee.

(ii) With respect to the joint resolution of the House receiving the resolution, the procedure in that House shall be the same as if no such joint resolution had been received from the other House; but the vote on passage shall be on the joint resolution of the other House.

(B) TREATMENT OF COMPANION MEASURES.—If, following passage of a joint resolution in the Senate, the Senate then receives the companion measure from the House of Representatives, the companion measure shall not be debatable.

(C) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This paragraph and the preceding paragraphs are enacted by Congress—

(i) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a joint resolution, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(ii) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(5) DEFINITIONS.—In this section:

(A) JOINT RESOLUTION.—The term "joint resolution" means only a joint resolution—

(i) which does not have a preamble;

(ii) the title of which is as follows: "Joint resolution disapproving a Medicare final implementation plan of the Secretary of Health and Human Services submitted under section 1160(a) of the America's Affordable Health Choices Act of 2009"; and

(iii) the sole matter after the resolving clause of which is as follows: "That the Congress disapproves the final implementation plan of the Secretary of Health and Human Services transmitted to the Congress on————————.", the blank space being filled with the appropriate date.

(B) LEGISLATIVE DAY.—The term "legislative day" means any calendar day excluding any day on which that House was not in session.

(6) BUDGETARY TREATMENT.—For the purposes of consideration of a joint resolution, the Chairmen of the House of Representatives and Senate Committees on the Budget shall exclude from the evaluation of the budgetary effects of the measure, any such effects that are directly attributable to disapproving a Medicare final implementation plan of the Secretary submitted under subsection (a).