

111TH CONGRESS
1ST SESSION

H. R. 462

To amend titles XIX and XXI of the Social Security Act to improve dental benefits under Medicaid and the State Children’s Health Insurance Program (SCHIP), and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 13, 2009

Mr. CUMMINGS introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend titles XIX and XXI of the Social Security Act to improve dental benefits under Medicaid and the State Children’s Health Insurance Program (SCHIP), and for other purposes.

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.**

4 This Act may be cited as the “Medicaid–SCHIP Den-
5 tal Benefits Improvement Act of 2009”.

6 **SEC. 2. DENTAL BENEFITS.**

7 (a) **COVERAGE.**—

1 (1) IN GENERAL.—Section 2103 of the Social
2 Security Act (42 U.S.C. 1397cc) is amended—

3 (A) in subsection (a)—

4 (i) in the matter before paragraph
5 (1), by striking “subsection (c)(5)” and in-
6 serting “paragraphs (5) and (6) of sub-
7 section (c)” ; and

8 (ii) in paragraph (I) , by inserting “at
9 least” after “that is”; and

10 (B) in subsection (c)—

11 (i) by redesignating paragraph (5) as
12 paragraph (6); and

13 (ii) by inserting after paragraph (4),
14 the following:

15 “(5) DENTAL BENEFITS.—

16 “(A) IN GENERAL.—The child health as-
17 sistance provided to a targeted low-income child
18 shall include coverage of dental services nec-
19 essary to prevent disease and promote oral
20 health, restore oral structures to health and
21 function, and treat emergency conditions.

22 “(B) PERMITTING USE OF DENTAL
23 BENCHMARK PLANS BY CERTAIN STATES.—A
24 State may elect to meet the requirement of sub-
25 paragraph (A) through dental coverage that is

1 equivalent to a benchmark dental benefit pack-
2 age described in subparagraph (C).

3 “(C) BENCHMARK DENTAL BENEFIT PACK-
4 AGES.—The benchmark dental benefit packages
5 are as follows:

6 “(i) FEHBP CHILDREN’S DENTAL
7 COVERAGE.—A dental benefits plan under
8 chapter 89A of title 5, United States Code,
9 that has been selected most frequently by
10 employees seeking dependent coverage,
11 among such plans that provide such de-
12 pendent coverage, in either of the previous
13 2 plan years.

14 “(ii) STATE EMPLOYEE DEPENDENT
15 DENTAL COVERAGE.—A dental benefits
16 plan that is offered and generally available
17 to State employees in the State involved
18 and that has been selected most frequently
19 by employees seeking dependent coverage,
20 among such plans that provide such de-
21 pendent coverage, in either of the previous
22 2 plan years.

23 “(iii) COVERAGE OFFERED THROUGH
24 COMMERCIAL DENTAL PLAN.—A dental
25 benefits plan that has the largest insured

1 commercial, non-medicaid enrollment of
2 dependent covered lives of such plans that
3 is offered in the State involved.”.

4 (2) ASSURING ACCESS TO CARE.—Section
5 2102(a)(7)(B) of such Act (42 U.S.C. 1397bb(c)(2))
6 is amended by inserting “and services described in
7 section 2103(c)(5)” after “emergency services”.

8 (3) EFFECTIVE DATE.—The amendments made
9 by paragraph (1) shall apply to coverage of items
10 and services furnished on or after October 1, 2009.

11 (b) DENTAL EDUCATION FOR PARENTS OF
12 NEWBORNS.—The Secretary of Health and Human Serv-
13 ices shall develop and implement, through entities that
14 fund or provide perinatal care services to targeted low-
15 income children under a State child health plan under title
16 XXI of the Social Security Act, a program to deliver oral
17 health educational materials that inform new parents
18 about risks for, and prevention of, early childhood caries
19 and the need for a dental visit within their newborn’s first
20 year of life.

21 (c) PROVISION OF DENTAL SERVICES THROUGH
22 FQHCS.—

23 (1) MEDICAID.—Section 1902(a) of such Act
24 (42 U.S.C. 1396a(a)) is amended—

1 (A) by striking “and” at the end of para-
2 graph (70);

3 (B) by striking the period at the end of
4 paragraph (71) and inserting “; and”; and

5 (C) by inserting after paragraph (71) the
6 following new paragraph:

7 “(72) provide that the State will not prevent a
8 Federally-qualified health center from entering into
9 contractual relationships with private practice dental
10 providers in the provision of Federally-qualified
11 health center services.”.

12 (2) CHIP.—Section 2107(e)(1) of such Act (42
13 U.S.C. 1397g(e)(1)) is amended by redesignating
14 subparagraphs (B) through (D) as subparagraphs
15 (C) through (E), respectively, and by inserting after
16 subparagraph (A) the following new subparagraph:

17 “(B) Section 1902(a)(72) (relating to lim-
18 iting FQHC contracting for provision of dental
19 services).”.

20 (3) EFFECTIVE DATE.—The amendments made
21 by this subsection shall take effect on January 1,
22 2009.

23 (d) REPORTING INFORMATION ON DENTAL
24 HEALTH.—

1 (1) MEDICAID.—Section 1902(a)(43)(D)(iii) of
2 such Act (42 U.S.C. 1396a(a)(43)(D)(iii)) is amend-
3 ed by inserting “and other information relating to
4 the provision of dental services to such children de-
5 scribed in section 2108(e)” after “receiving dental
6 services,”.

7 (2) CHIP.—Section 2108 of such Act (42
8 U.S.C. 1397hh) is amended by adding at the end
9 the following new subsection:

10 “(e) INFORMATION ON DENTAL CARE FOR CHIL-
11 DREN.—

12 “(1) IN GENERAL.—Each annual report under
13 subsection (a) shall include the following information
14 with respect to care and services described in section
15 1905(r)(3) provided to targeted low-income children
16 enrolled in the State child health plan under this
17 title at any time during the year involved:

18 “(A) The number of enrolled children by
19 age grouping used for reporting purposes under
20 section 1902(a)(43).

21 “(B) For children within each such age
22 grouping, information of the type contained in
23 questions 12(a)–(c) of CMS Form 416 (that
24 consists of the number of enrolled targeted low

1 income children who receive any, preventive, or
2 restorative dental care under the State plan).

3 “(C) For the age grouping that includes
4 children 8 years of age, the number of such
5 children who have received a protective sealant
6 on at least one permanent molar tooth.

7 “(2) INCLUSION OF INFORMATION ON ENROLL-
8 EES IN MANAGED CARE PLANS.—The information
9 under paragraph (1) shall include information on
10 children who are enrolled in managed care plans and
11 other private health plans and contracts with such
12 plans under this title shall provide for the reporting
13 of such information by such plans to the State.”.

14 (3) EFFECTIVE DATE.—The amendments made
15 by this subsection shall be effective for annual re-
16 ports submitted for years beginning after date of en-
17 actment.

18 (e) IMPROVED ACCESSIBILITY OF DENTAL PROVIDER
19 INFORMATION TO ENROLLEES UNDER MEDICAID AND
20 CHIP.—The Secretary of Health and Human Services
21 shall—

22 (1) work with States, pediatric dentists, and
23 other dental providers (including providers that are,
24 or are affiliated with, a school of dentistry) to in-
25 clude, not later than 6 months after the date of the

1 enactment of this Act, on the Insure Kids Now
2 website (<http://www.insurekidsnow.gov/>) and hotline
3 (1-877-KIDS-NOW) (or on any successor websites
4 or hotlines) a current and accurate list of all such
5 dentists and providers within each State that provide
6 dental services to children enrolled in the State plan
7 (or waiver) under Medicaid or the State child health
8 plan (or waiver) under title XXI of the Social Secu-
9 rity Act, and shall ensure that such list is updated
10 at least quarterly; and

11 (2) work with States to include, not later than
12 6 months after the date of the enactment of this
13 Act, a description of the dental services provided
14 under each State plan (or waiver) under Medicaid
15 and each State child health plan (or waiver) under
16 title XXI of the Social Security Act on such Insure
17 Kids Now website, and shall ensure that such list is
18 updated at least annually.

19 (f) GAO STUDY AND REPORT.—

20 (1) STUDY.—The Comptroller General of the
21 United States shall provide for a study that exam-
22 ines—

23 (A) access to dental services by children in
24 underserved areas;

1 (B) children’s access to oral health care,
2 including preventive and restorative services,
3 under Medicaid and the State Children’s Health
4 Insurance Program, including—

5 (i) the extent to which dental pro-
6 viders are willing to treat children eligible
7 for such programs;

8 (ii) information on such children’s ac-
9 cess to networks of care, including such
10 networks that serve special needs children;
11 and

12 (iii) geographic availability of oral
13 health care, including preventive and re-
14 storative services, under such programs;
15 and

16 (C) the feasibility and appropriateness of
17 using qualified mid-level dental health pro-
18 viders, in coordination with dentists, to improve
19 access for children to oral health services and
20 public health overall.

21 (2) REPORT.—Not later than 18 months after
22 the date of the enactment of this Act, the Comp-
23 troller General shall submit to Congress a report on
24 the study conducted under paragraph (1). The re-
25 port shall include recommendations for such Federal

1 and State legislative and administrative changes as
2 the Comptroller General determines are necessary to
3 address any barriers to access to oral health care,
4 including preventive and restorative services, under
5 Medicaid and the State Children’s Health Insurance
6 Program that may exist.

7 **SEC. 3. CHILD HEALTH QUALITY IMPROVEMENT ACTIVI-**
8 **TIES FOR CHILDREN ENROLLED IN MED-**
9 **ICAID OR CHIP.**

10 (a) DEVELOPMENT OF CHILD HEALTH QUALITY
11 MEASURES FOR CHILDREN ENROLLED IN MEDICAID OR
12 CHIP.—Title XI of the Social Security Act (42 U.S.C.
13 1301 et seq.) is amended by inserting after section 1139
14 the following new section:

15 **“SEC. 1139A. CHILD HEALTH QUALITY MEASURES.**

16 “(a) DEVELOPMENT OF AN INITIAL CORE SET OF
17 HEALTH CARE QUALITY MEASURES FOR CHILDREN EN-
18 ROLLED IN MEDICAID OR CHIP.—

19 “(1) IN GENERAL.—Not later than January 1,
20 2010, the Secretary shall identify and publish for
21 general comment an initial, recommended core set of
22 child health quality measures for use by State pro-
23 grams administered under titles XIX and XXI,
24 health insurance issuers and managed care entities
25 that enter into contracts with such programs, and

1 providers of items and services under such pro-
2 grams.

3 “(2) IDENTIFICATION OF INITIAL CORE MEAS-
4 URES.—In consultation with the individuals and en-
5 tities described in subsection (b)(3), the Secretary
6 shall identify existing quality of care measures for
7 children that are in use under public and privately
8 sponsored health care coverage arrangements, or
9 that are part of reporting systems that measure both
10 the presence and duration of health insurance cov-
11 erage over time.

12 “(3) RECOMMENDATIONS AND DISSEMINA-
13 TION.—Based on such existing and identified meas-
14 ures, the Secretary shall publish an initial core set
15 of child health quality measures that includes (but
16 is not limited to) the following:

17 “(A) The duration of children’s health in-
18 surance coverage over a 12-month time period.

19 “(B) The availability and effectiveness of a
20 full range of—

21 “(i) preventive services, treatments,
22 and services for acute conditions, including
23 services to promote healthy birth, prevent
24 and treat premature birth, and detect the
25 presence or risk of physical or mental con-

1 ditions that could adversely affect growth
2 and development; and

3 “(ii) treatments to correct or amelio-
4 rate the effects of physical and mental con-
5 ditions, including chronic conditions, and,
6 with respect to dental care, conditions re-
7 quiring the restoration of teeth, relief of
8 pain and infection, and maintenance of
9 dental health, in infants, young children,
10 school-age children, and adolescents.

11 “(C) The availability of care in a range of
12 ambulatory and inpatient health care settings
13 in which such care is furnished.

14 “(D) The types of measures that, taken to-
15 gether, can be used to estimate the overall na-
16 tional quality of health care for children, includ-
17 ing children with special needs, and to perform
18 comparative analyses of pediatric health care
19 quality and racial, ethnic, and socioeconomic
20 disparities in child health and health care for
21 children.

22 “(4) ENCOURAGE VOLUNTARY AND STANDARD-
23 IZED REPORTING.—Not later than 2 years after the
24 date of enactment of this section, the Secretary, in
25 consultation with States, shall develop a standard-

1 ized format for reporting information and proce-
2 dures and approaches that encourage States to use
3 the initial core measurement set to voluntarily report
4 information regarding the quality of pediatric health
5 care under titles XIX and XXI.

6 “(5) ADOPTION OF BEST PRACTICES IN IMPLE-
7 MENTING QUALITY PROGRAMS.—The Secretary shall
8 disseminate information to States regarding best
9 practices among States with respect to measuring
10 and reporting on the quality of health care for chil-
11 dren, and shall facilitate the adoption of such best
12 practices. In developing best practices approaches,
13 the Secretary shall give particular attention to State
14 measurement techniques that ensure the timeliness
15 and accuracy of provider reporting, encourage pro-
16 vider reporting compliance, encourage successful
17 quality improvement strategies, and improve effi-
18 ciency in data collection using health information
19 technology.

20 “(6) REPORTS TO CONGRESS.—Not later than
21 January 1, 2011, and every 3 years thereafter, the
22 Secretary shall report to Congress on—

23 “(A) the status of the Secretary’s efforts
24 to improve—

1 “(i) quality related to the duration
2 and stability of health insurance coverage
3 for children under titles XIX and XXI;

4 “(ii) the quality of children’s health
5 care under such titles, including preventive
6 health services, dental services, health care
7 for acute conditions, chronic health care,
8 and health services to ameliorate the ef-
9 fects of physical and mental conditions and
10 to aid in growth and development of in-
11 fants, young children, school-age children,
12 and adolescents with special health care
13 needs; and

14 “(iii) the quality of children’s health
15 care under such titles across the domains
16 of quality, including clinical quality, health
17 care safety, family experience with health
18 care, health care in the most integrated
19 setting, and elimination of racial, ethnic,
20 and socioeconomic disparities in health and
21 health care;

22 “(B) the status of voluntary reporting by
23 States under titles XIX and XXI, utilizing the
24 initial core quality measurement set; and

1 “(C) any recommendations for legislative
2 changes needed to improve the quality of care
3 provided to children under titles XIX and XXI,
4 including recommendations for quality reporting
5 by States.

6 “(7) TECHNICAL ASSISTANCE.—The Secretary
7 shall provide technical assistance to States to assist
8 them in adopting and utilizing core child health
9 quality measures in administering the State plans
10 under titles XIX and XXI.

11 “(8) DEFINITION OF CORE SET.—In this sec-
12 tion, the term ‘core set’ means a group of valid, reli-
13 able, and evidence-based quality measures that,
14 taken together—

15 “(A) provide information regarding the
16 quality of health coverage and health care for
17 children;

18 “(B) address the needs of children
19 throughout the developmental age span; and

20 “(C) allow purchasers, families, and health
21 care providers to understand the quality of care
22 in relation to the preventive needs of children,
23 treatments aimed at managing and resolving
24 acute conditions, and diagnostic and treatment
25 services whose purpose is to correct or amelio-

1 rate physical, mental, or developmental condi-
2 tions that could, if untreated or poorly treated,
3 become chronic.

4 “(b) ADVANCING AND IMPROVING PEDIATRIC QUAL-
5 ITY MEASURES.—

6 “(1) ESTABLISHMENT OF PEDIATRIC QUALITY
7 MEASURES PROGRAM.—Not later than January 1,
8 2011, the Secretary shall establish a pediatric qual-
9 ity measures program to—

10 “(A) improve and strengthen the initial
11 core child health care quality measures estab-
12 lished by the Secretary under subsection (a);

13 “(B) expand on existing pediatric quality
14 measures used by public and private health care
15 purchasers and advance the development of
16 such new and emerging quality measures; and

17 “(C) increase the portfolio of evidence-
18 based, consensus pediatric quality measures
19 available to public and private purchasers of
20 children’s health care services, providers, and
21 consumers.

22 “(2) EVIDENCE-BASED MEASURES.—The meas-
23 ures developed under the pediatric quality measures
24 program shall, at a minimum, be—

1 “(A) evidence-based and, where appro-
2 priate, risk adjusted;

3 “(B) designed to identify and eliminate ra-
4 cial and ethnic disparities in child health and
5 the provision of health care;

6 “(C) designed to ensure that the data re-
7 quired for such measures is collected and re-
8 ported in a standard format that permits com-
9 parison of quality and data at a State, plan,
10 and provider level;

11 “(D) periodically updated; and

12 “(E) responsive to the child health needs,
13 services, and domains of health care quality de-
14 scribed in clauses (i), (ii), and (iii) of subsection
15 (a)(6)(A).

16 “(3) PROCESS FOR PEDIATRIC QUALITY MEAS-
17 URES PROGRAM.—In identifying gaps in existing pe-
18 diatric quality measures and establishing priorities
19 for development and advancement of such measures,
20 the Secretary shall consult with—

21 “(A) States;

22 “(B) pediatricians, children’s hospitals,
23 and other primary and specialized pediatric
24 health care professionals (including members of
25 the allied health professions) who specialize in

1 the care and treatment of children, particularly
2 children with special physical, mental, and de-
3 velopmental health care needs;

4 “(C) dental professionals, including pedi-
5 atric dental professionals;

6 “(D) health care providers that furnish
7 primary health care to children and families
8 who live in urban and rural medically under-
9 served communities or who are members of dis-
10 tinct population sub-groups at heightened risk
11 for poor health outcomes;

12 “(E) national organizations representing
13 children, including children with disabilities and
14 children with chronic conditions;

15 “(F) national organizations representing
16 consumers and purchasers of children’s health
17 care;

18 “(G) national organizations and individuals
19 with expertise in pediatric health quality meas-
20 urement; and

21 “(H) voluntary consensus standards set-
22 ting organizations and other organizations in-
23 volved in the advancement of evidence-based
24 measures of health care.

1 “(4) DEVELOPING, VALIDATING, AND TESTING
2 A PORTFOLIO OF PEDIATRIC QUALITY MEASURES.—
3 As part of the program to advance pediatric quality
4 measures, the Secretary shall—

5 “(A) award grants and contracts for the
6 development, testing, and validation of new,
7 emerging, and innovative evidence-based meas-
8 ures for children’s health care services across
9 the domains of quality described in clauses (i),
10 (ii), and (iii) of subsection (a)(6)(A); and

11 “(B) award grants and contracts for—

12 “(i) the development of consensus on
13 evidence-based measures for children’s
14 health care services;

15 “(ii) the dissemination of such meas-
16 ures to public and private purchasers of
17 health care for children; and

18 “(iii) the updating of such measures
19 as necessary.

20 “(5) REVISING, STRENGTHENING, AND IMPROV-
21 ING INITIAL CORE MEASURES.—Beginning no later
22 than January 1, 2013, and annually thereafter, the
23 Secretary shall publish recommended changes to the
24 core measures described in subsection (a) that shall
25 reflect the testing, validation, and consensus process

1 for the development of pediatric quality measures
2 described in subsection paragraphs (1) through (4).

3 “(6) DEFINITION OF PEDIATRIC QUALITY
4 MEASURE.—In this subsection, the term ‘pediatric
5 quality measure’ means a measurement of clinical
6 care that is capable of being examined through the
7 collection and analysis of relevant information, that
8 is developed in order to assess 1 or more aspects of
9 pediatric health care quality in various institutional
10 and ambulatory health care settings, including the
11 structure of the clinical care system, the process of
12 care, the outcome of care, or patient experiences in
13 care.

14 “(7) CONSTRUCTION.—Nothing in this section
15 shall be construed as supporting the restriction of
16 coverage, under title XIX or XXI or otherwise, to
17 only those services that are evidence-based.

18 “(c) ANNUAL STATE REPORTS REGARDING STATE-
19 SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER
20 MEDICAID OR CHIP.—

21 “(1) ANNUAL STATE REPORTS.—Each State
22 with a State plan approved under title XIX or a
23 State child health plan approved under title XXI
24 shall annually report to the Secretary on the—

1 “(A) State-specific child health quality
2 measures applied by the States under such
3 plans, including measures described in subpara-
4 graphs (A) and (B) of subsection (a)(6); and

5 “(B) State-specific information on the
6 quality of health care furnished to children
7 under such plans, including information col-
8 lected through external quality reviews of man-
9 aged care organizations under section 1932 of
10 the Social Security Act (42 U.S.C. 1396u-4)
11 and benchmark plans under sections 1937 and
12 2103 of such Act (42 U.S.C. 1396u-7, 1397ee).

13 “(2) PUBLICATION.—Not later than September
14 30, 2010, and annually thereafter, the Secretary
15 shall collect, analyze, and make publicly available the
16 information reported by States under paragraph (1).

17 “(d) DEMONSTRATION PROJECTS FOR IMPROVING
18 THE QUALITY OF CHILDREN’S HEALTH CARE AND THE
19 USE OF HEALTH INFORMATION TECHNOLOGY.—

20 “(1) IN GENERAL.—During the period of fiscal
21 years 2009 through 2013, the Secretary shall award
22 not more than 10 grants to States and child health
23 providers to conduct demonstration projects to
24 evaluate promising ideas for improving the quality of

1 children’s health care provided under title XIX or
2 XXI, including projects to—

3 “(A) experiment with, and evaluate the use
4 of, new measures of the quality of children’s
5 health care under such titles (including testing
6 the validity and suitability for reporting of such
7 measures);

8 “(B) promote the use of health information
9 technology in care delivery for children under
10 such titles;

11 “(C) evaluate provider-based models which
12 improve the delivery of children’s health care
13 services under such titles, including care man-
14 agement for children with chronic conditions
15 and the use of evidence-based approaches to im-
16 prove the effectiveness, safety, and efficiency of
17 health care services for children; or

18 “(D) demonstrate the impact of the model
19 electronic health record format for children de-
20 veloped and disseminated under subsection (f)
21 on improving pediatric health, including the ef-
22 fects of chronic childhood health conditions, and
23 pediatric health care quality as well as reducing
24 health care costs.

1 “(2) REQUIREMENTS.—In awarding grants
2 under this subsection, the Secretary shall ensure
3 that—

4 “(A) only 1 demonstration project funded
5 under a grant awarded under this subsection
6 shall be conducted in a State; and

7 “(B) demonstration projects funded under
8 grants awarded under this subsection shall be
9 conducted evenly between States with large
10 urban areas and States with large rural areas.

11 “(3) AUTHORITY FOR MULTISTATE
12 PROJECTS.—A demonstration project conducted with
13 a grant awarded under this subsection may be con-
14 ducted on a multistate basis, as needed.

15 “(4) FUNDING.—\$20,000,000 of the amount
16 appropriated under subsection (i) for a fiscal year
17 shall be used to carry out this subsection.

18 “(e) CHILDHOOD OBESITY DEMONSTRATION
19 PROJECT.—

20 “(1) AUTHORITY TO CONDUCT DEMONSTRA-
21 TION.—The Secretary, in consultation with the Ad-
22 ministrator of the Centers for Medicare & Medicaid
23 Services, shall conduct a demonstration project to
24 develop a comprehensive and systematic model for
25 reducing childhood obesity by awarding grants to eli-

1 gible entities to carry out such project. Such model
2 shall—

3 “(A) identify, through self-assessment, be-
4 havioral risk factors for obesity among children;

5 “(B) identify, through self-assessment,
6 needed clinical preventive and screening benefits
7 among those children identified as target indi-
8 viduals on the basis of such risk factors;

9 “(C) provide ongoing support to such tar-
10 get individuals and their families to reduce risk
11 factors and promote the appropriate use of pre-
12 ventive and screening benefits; and

13 “(D) be designed to improve health out-
14 comes, satisfaction, quality of life, and appro-
15 priate use of items and services for which med-
16 ical assistance is available under title XIX or
17 child health assistance is available under title
18 XXI among such target individuals.

19 “(2) ELIGIBILITY ENTITIES.—For purposes of
20 this subsection, an eligible entity is any of the fol-
21 lowing:

22 “(A) A city, county, or Indian tribe.

23 “(B) A local or tribal educational agency.

24 “(C) An accredited university, college, or
25 community college.

1 “(D) A Federally-qualified health center.

2 “(E) A local health department.

3 “(F) A health care provider.

4 “(G) A community-based organization.

5 “(H) Any other entity determined appro-
6 priate by the Secretary, including a consortia or
7 partnership of entities described in any of sub-
8 paragraphs (A) through (G).

9 “(3) USE OF FUNDS.—An eligible entity award-
10 ed a grant under this subsection shall use the funds
11 made available under the grant to—

12 “(A) carry out community-based activities
13 related to reducing childhood obesity, including
14 by—

15 “(i) forming partnerships with enti-
16 ties, including schools and other facilities
17 providing recreational services, to establish
18 programs for after school and weekend
19 community activities that are designed to
20 reduce childhood obesity;

21 “(ii) forming partnerships with
22 daycare facilities to establish programs
23 that promote healthy eating behaviors and
24 physical activity; and

1 “(iii) developing and evaluating com-
2 munity educational activities targeting
3 good nutrition and promoting healthy eat-
4 ing behaviors;

5 “(B) carry out age-appropriate school-
6 based activities that are designed to reduce
7 childhood obesity, including by—

8 “(i) developing and testing edu-
9 cational curricula and intervention pro-
10 grams designed to promote healthy eating
11 behaviors and habits in youth, which may
12 include—

13 “(I) after hours physical activity
14 programs; and

15 “(II) science-based interventions
16 with multiple components to prevent
17 eating disorders including nutritional
18 content, understanding and respond-
19 ing to hunger and satiety, positive
20 body image development, positive self-
21 esteem development, and learning life
22 skills (such as stress management,
23 communication skills, problemsolving
24 and decisionmaking skills), as well as
25 consideration of cultural and develop-

1 mental issues, and the role of family,
2 school, and community;

3 “(ii) providing education and training
4 to educational professionals regarding how
5 to promote a healthy lifestyle and a
6 healthy school environment for children;

7 “(iii) planning and implementing a
8 healthy lifestyle curriculum or program
9 with an emphasis on healthy eating behav-
10 iors and physical activity; and

11 “(iv) planning and implementing
12 healthy lifestyle classes or programs for
13 parents or guardians, with an emphasis on
14 healthy eating behaviors and physical ac-
15 tivity for children;

16 “(C) carry out educational, counseling,
17 promotional, and training activities through the
18 local health care delivery systems including
19 by—

20 “(i) promoting healthy eating behav-
21 iors and physical activity services to treat
22 or prevent eating disorders, being over-
23 weight, and obesity;

1 “(ii) providing patient education and
2 counseling to increase physical activity and
3 promote healthy eating behaviors;

4 “(iii) training health professionals on
5 how to identify and treat obese and over-
6 weight individuals which may include nu-
7 trition and physical activity counseling;
8 and

9 “(iv) providing community education
10 by a health professional on good nutrition
11 and physical activity to develop a better
12 understanding of the relationship between
13 diet, physical activity, and eating disorders,
14 obesity, or being overweight; and

15 “(D) provide, through qualified health pro-
16 fessionals, training and supervision for commu-
17 nity health workers to—

18 “(i) educate families regarding the re-
19 lationship between nutrition, eating habits,
20 physical activity, and obesity;

21 “(ii) educate families about effective
22 strategies to improve nutrition, establish
23 healthy eating patterns, and establish ap-
24 propriate levels of physical activity; and

1 “(iii) educate and guide parents re-
2 garding the ability to model and commu-
3 nicate positive health behaviors.

4 “(4) PRIORITY.—In awarding grants under
5 paragraph (1), the Secretary shall give priority to
6 awarding grants to eligible entities—

7 “(A) that demonstrate that they have pre-
8 viously applied successfully for funds to carry
9 out activities that seek to promote individual
10 and community health and to prevent the inci-
11 dence of chronic disease and that can cite pub-
12 lished and peer-reviewed research dem-
13 onstrating that the activities that the entities
14 propose to carry out with funds made available
15 under the grant are effective;

16 “(B) that will carry out programs or ac-
17 tivities that seek to accomplish a goal or goals
18 set by the State in the Healthy People 2010
19 plan of the State;

20 “(C) that provide non-Federal contribu-
21 tions, either in cash or in-kind, to the costs of
22 funding activities under the grants;

23 “(D) that develop comprehensive plans
24 that include a strategy for extending program
25 activities developed under grants in the years

1 following the fiscal years for which they receive
2 grants under this subsection;

3 “(E) located in communities that are medi-
4 cally underserved, as determined by the Sec-
5 retary;

6 “(F) located in areas in which the average
7 poverty rate is at least 150 percent or higher of
8 the average poverty rate in the State involved,
9 as determined by the Secretary; and

10 “(G) that submit plans that exhibit multi-
11 sectoral, cooperative conduct that includes the
12 involvement of a broad range of stakeholders,
13 including—

14 “(i) community-based organizations;

15 “(ii) local governments;

16 “(iii) local educational agencies;

17 “(iv) the private sector;

18 “(v) State or local departments of
19 health;

20 “(vi) accredited colleges, universities,
21 and community colleges;

22 “(vii) health care providers;

23 “(viii) State and local departments of
24 transportation and city planning; and

1 “(ix) other entities determined appro-
2 priate by the Secretary.

3 “(5) PROGRAM DESIGN.—

4 “(A) INITIAL DESIGN.—Not later than 1
5 year after the date of enactment of this section,
6 the Secretary shall design the demonstration
7 project. The demonstration should draw upon
8 promising, innovative models and incentives to
9 reduce behavioral risk factors. The Adminis-
10 trator of the Centers for Medicare & Medicaid
11 Services shall consult with the Director of the
12 Centers for Disease Control and Prevention, the
13 Director of the Office of Minority Health, the
14 heads of other agencies in the Department of
15 Health and Human Services, and such profes-
16 sional organizations, as the Secretary deter-
17 mines to be appropriate, on the design, conduct,
18 and evaluation of the demonstration.

19 “(B) NUMBER AND PROJECT AREAS.—Not
20 later than 2 years after the date of enactment
21 of this section, the Secretary shall award 1
22 grant that is specifically designed to determine
23 whether programs similar to programs to be
24 conducted by other grantees under this sub-
25 section should be implemented with respect to

1 the general population of children who are eligi-
2 ble for child health assistance under State child
3 health plans under title XXI in order to reduce
4 the incidence of childhood obesity among such
5 population.

6 “(6) REPORT TO CONGRESS.—Not later than 3
7 years after the date the Secretary implements the
8 demonstration project under this subsection, the
9 Secretary shall submit to Congress a report that de-
10 scribes the project, evaluates the effectiveness and
11 cost effectiveness of the project, evaluates the bene-
12 ficiary satisfaction under the project, and includes
13 any such other information as the Secretary deter-
14 mines to be appropriate.

15 “(7) DEFINITIONS.—In this subsection:

16 “(A) FEDERALLY-QUALIFIED HEALTH
17 CENTER.—The term ‘Federally-qualified health
18 center’ has the meaning given that term in sec-
19 tion 1905(l)(2)(B).

20 “(B) INDIAN TRIBE.—The term ‘Indian
21 tribe’ has the meaning given that term in sec-
22 tion 4 of the Indian Health Care Improvement
23 Act (25 U.S.C. 1603).

24 “(C) SELF-ASSESSMENT.—The term ‘self-
25 assessment’ means a form that—

1 “(i) includes questions regarding—

2 “(I) behavioral risk factors;

3 “(II) needed preventive and
4 screening services; and

5 “(III) target individuals’ pref-
6 erences for receiving follow-up infor-
7 mation;

8 “(ii) is assessed using such computer
9 generated assessment programs; and

10 “(iii) allows for the provision of such
11 ongoing support to the individual as the
12 Secretary determines appropriate.

13 “(D) ONGOING SUPPORT.—The term ‘on-
14 going support’ means—

15 “(i) to provide any target individual
16 with information, feedback, health coach-
17 ing, and recommendations regarding—

18 “(I) the results of a self-assess-
19 ment given to the individual;

20 “(II) behavior modification based
21 on the self-assessment; and

22 “(III) any need for clinical pre-
23 ventive and screening services or
24 treatment including medical nutrition
25 therapy;

1 “(ii) to provide any target individual
2 with referrals to community resources and
3 programs available to assist the target in-
4 dividual in reducing health risks; and

5 “(iii) to provide the information de-
6 scribed in clause (i) to a health care pro-
7 vider, if designated by the target individual
8 to receive such information.

9 “(8) AUTHORIZATION OF APPROPRIATIONS.—

10 There is authorized to be appropriated to carry out
11 this subsection, \$25,000,000 for the period of fiscal
12 years 2009 through 2013.

13 “(f) DEVELOPMENT OF MODEL ELECTRONIC
14 HEALTH RECORD FORMAT FOR CHILDREN ENROLLED IN
15 MEDICAID OR CHIP.—

16 “(1) IN GENERAL.—Not later than January 1,
17 2010, the Secretary shall establish a program to en-
18 courage the development and dissemination of a
19 model electronic health record format for children
20 enrolled in the State plan under title XIX or the
21 State child health plan under title XXI that is—

22 “(A) subject to State laws, accessible to
23 parents, caregivers, and other consumers for
24 the sole purpose of demonstrating compliance

1 with school or leisure activity requirements,
2 such as appropriate immunizations or physicals;

3 “(B) designed to allow interoperable ex-
4 changes that conform with Federal and State
5 privacy and security requirements;

6 “(C) structured in a manner that permits
7 parents and caregivers to view and understand
8 the extent to which the care their children re-
9 ceive is clinically appropriate and of high qual-
10 ity; and

11 “(D) capable of being incorporated into,
12 and otherwise compatible with, other standards
13 developed for electronic health records.

14 “(2) FUNDING.—\$5,000,000 of the amount ap-
15 propriated under subsection (i) for a fiscal year shall
16 be used to carry out this subsection.

17 “(g) STUDY OF PEDIATRIC HEALTH AND HEALTH
18 CARE QUALITY MEASURES.—

19 “(1) IN GENERAL.—Not later than July 1,
20 2010, the Institute of Medicine shall study and re-
21 port to Congress on the extent and quality of efforts
22 to measure child health status and the quality of
23 health care for children across the age span and in
24 relation to preventive care, treatments for acute con-
25 ditions, and treatments aimed at ameliorating or

1 correcting physical, mental, and developmental con-
2 ditions in children. In conducting such study and
3 preparing such report, the Institute of Medicine
4 shall—

5 “(A) consider all of the major national
6 population-based reporting systems sponsored
7 by the Federal Government that are currently
8 in place, including reporting requirements
9 under Federal grant programs and national
10 population surveys and estimates conducted di-
11 rectly by the Federal Government;

12 “(B) identify the information regarding
13 child health and health care quality that each
14 system is designed to capture and generate, the
15 study and reporting periods covered by each
16 system, and the extent to which the information
17 so generated is made widely available through
18 publication;

19 “(C) identify gaps in knowledge related to
20 children’s health status, health disparities
21 among subgroups of children, the effects of so-
22 cial conditions on children’s health status and
23 use and effectiveness of health care, and the re-
24 lationship between child health status and fam-
25 ily income, family stability and preservation,

1 and children’s school readiness and educational
2 achievement and attainment; and

3 “(D) make recommendations regarding im-
4 proving and strengthening the timeliness, qual-
5 ity, and public transparency and accessibility of
6 information about child health and health care
7 quality.

8 “(2) FUNDING.—Up to \$1,000,000 of the
9 amount appropriated under subsection (i) for a fis-
10 cal year shall be used to carry out this subsection.

11 “(h) RULE OF CONSTRUCTION.—Notwithstanding
12 any other provision in this section, no evidence based qual-
13 ity measure developed, published, or used as a basis of
14 measurement or reporting under this section may be used
15 to establish an irrebuttable presumption regarding either
16 the medical necessity of care or the maximum permissible
17 coverage for any individual child who is eligible for and
18 receiving medical assistance under title XIX or child
19 health assistance under title XXI.

20 “(i) APPROPRIATION.—Out of any funds in the
21 Treasury not otherwise appropriated, there is appro-
22 priated for each of fiscal years 2009 through 2013,
23 \$45,000,000 for the purpose of carrying out this section
24 (other than subsection (e)). Funds appropriated under
25 this subsection shall remain available until expended.”.

1 (b) INCREASED MATCHING RATE FOR COLLECTING
2 AND REPORTING ON CHILD HEALTH MEASURES.—Sec-
3 tion 1903(a)(3)(A) of such Act (42 U.S.C.
4 1396b(a)(3)(A)), is amended—

5 (1) by striking “and” at the end of clause (i);
6 and

7 (2) by adding at the end the following new
8 clause:

9 “(iii) an amount equal to the Federal med-
10 ical assistance percentage (as defined in section
11 1905(b)) of so much of the sums expended dur-
12 ing such quarter (as found necessary by the
13 Secretary for the proper and efficient adminis-
14 tration of the State plan) as are attributable to
15 such developments or modifications of systems
16 of the type described in clause (i) as are nec-
17 essary for the efficient collection and reporting
18 on child health measures; and”.

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