EFFECTIVE DATE OF 1994 AMENDMENT

Section 264(h) of Pub. L. 103–432 provided that: ''Each amendment made by this section [amending this section and sections 602, 1382a, and 1383 of this title] shall take effect as if included in the provision of OBRA–1990 [Pub. L. 101–508] to which the amendment relates at the time such provision became law.''

CONSTRUCTION OF 1990 AMENDMENT

Section 264(d) of Pub. L. 103–432 provided that: ''Section 5057 of OBRA–1990 [Pub. L. 101–508, amending this section], and the amendment made by such section, are hereby repealed, and section 1139(d) of the Social Security Act [subsec. (d) of this section] shall be applied and administered as if such section 5057 had never been enacted.''

§ 1320b–9a. Child health quality measures

(a) Development of an initial core set of health care quality measures for children enrolled in Medicaid or CHIP

(1) In general

Not later than January 1, 2010, the Secretary shall identify and publish for general comment an initial, recommended core set of child health quality measures for use by State programs administered under subchapters XIX and XXI, health insurance issuers and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

(2) Identification of initial core measures

In consultation with the individuals and entities described in subsection (b)(3), the Secretary shall identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time.

(3) Recommendations and dissemination

Based on such existing and identified measures, the Secretary shall publish an initial core set of child health quality measures that includes (but is not limited to) the following:

(A) The duration of children's health insurance coverage over a 12-month time period.

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

(i) preventive services, treatments, and services for acute conditions, including services to promote healthy birth, prevent and treat premature birth, and detect the presence or risk of physical or mental conditions that could adversely affect growth and development; and

(ii) treatments to correct or ameliorate the effects of physical and mental conditions, including chronic conditions and, with respect to dental care, conditions requiring the restoration of teeth, relief of pain and infection, and maintenance of dental health, in infants, young children, school-age children, and adolescents.

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

(D) The types of measures that, taken together, can be used to estimate the overall national quality of health care for children, including children with special needs, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.

(4) Encourage voluntary and standardized reporting

Not later than 2 years after February 4, 2009, the Secretary, in consultation with States, shall develop a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measurement set to voluntarily report information regarding the quality of pediatric health care under subchapters XIX and XXI.

(5) Adoption of best practices in implementing quality programs

The Secretary shall disseminate information to States regarding best practices among States with respect to measuring and reporting on the quality of health care for children, and shall facilitate the adoption of such best practices. In developing best practices approaches, the Secretary shall give particular attention to State measurement techniques that ensure the timeliness and accuracy of provider reporting, encourage provider reporting compliance, encourage successful quality improvement strategies, and improve efficiency in data collection using health information technology.

(6) Reports to Congress

Not later than January 1, 2011, and every 3 years thereafter, the Secretary shall report to Congress on—

(A) the status of the Secretary's efforts to improve—

(i) quality related to the duration and stability of health insurance coverage for children under subchapters XIX and XXI;

(ii) the quality of children's health care under such subchapters, including preventive health services, dental care, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions and to aid in growth and development of infants, young children, school-age children, and adolescents with special health care needs; and

(iii) the quality of children's health care under such subchapters across the domains of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care;

(B) the status of voluntary reporting by States under subchapters XIX and XXI, utilizing the initial core quality measurement set; and

(C) any recommendations for legislative changes needed to improve the quality of care provided to children under subchapters

XIX and XXI, including recommendations for quality reporting by States.

(7) Technical assistance

The Secretary shall provide technical assistance to States to assist them in adopting and utilizing core child health quality measures in administering the State plans under subchapters XIX and XXI.

(8) Definition of core set

In this section, the term ''core set'' means a group of valid, reliable, and evidence-based quality measures that, taken together—

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

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

(C) allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services whose purpose is to correct or ameliorate physical, mental, or developmental conditions that could, if untreated or poorly treated, become chronic.

(b) Advancing and improving pediatric quality measures

(1) Establishment of pediatric quality measures program

Not later than January 1, 2011, the Secretary shall establish a pediatric quality measures program to—

(A) improve and strengthen the initial core child health care quality measures established by the Secretary under subsection (a);

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

(C) increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers.

(2) Evidence-based measures

The measures developed under the pediatric quality measures program shall, at a minimum, be—

(A) evidence-based and, where appropriate, risk adjusted;

(B) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care;

(C) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level;

(D) periodically updated; and

(E) responsive to the child health needs, services, and domains of health care quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A).

(3) Process for pediatric quality measures program

In identifying gaps in existing pediatric quality measures and establishing priorities for development and advancement of such measures, the Secretary shall consult with—

(A) States;

(B) pediatricians, children's hospitals, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

(C) dental professionals, including pediatric dental professionals;

(D) health care providers that furnish primary health care to children and families who live in urban and rural medically underserved communities or who are members of distinct population sub-groups at heightened risk for poor health outcomes;

(E) national organizations representing children, including children with disabilities and children with chronic conditions;

(F) national organizations representing consumers and purchasers of children's health care;

(G) national organizations and individuals with expertise in pediatric health quality measurement; and

(H) voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

(4) Developing, validating, and testing a portfolio of pediatric quality measures

As part of the program to advance pediatric quality measures, the Secretary shall—

(A) award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services across the domains of quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A); and

(B) award grants and contracts for—

(i) the development of consensus on evidence-based measures for children's health care services;

(ii) the dissemination of such measures to public and private purchasers of health care for children; and

(iii) the updating of such measures as necessary.

(5) Revising, strengthening, and improving initial core measures

Beginning no later than January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the core measures described in subsection (a) that shall reflect the testing, validation, and consensus process for the development of pediatric quality measures described in subsection[1] paragraphs (1) through (4).

(6) Definition of pediatric quality measure

In this subsection, the term ''pediatric quality measure'' means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant infor-

[1] So in original.

mation, that is developed in order to assess 1 or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences in care.

(7) Construction

Nothing in this section shall be construed as supporting the restriction of coverage, under subchapter XIX or XXI or otherwise, to only those services that are evidence-based.

(c) Annual State reports regarding State-specific quality of care measures applied under Medicaid or CHIP

(1) Annual State reports

Each State with a State plan approved under subchapter XIX or a State child health plan approved under subchapter XXI shall annually report to the Secretary on the—

(A) State-specific child health quality measures applied by the States under such plans, including measures described in subparagraphs (A) and (B) of subsection (a)(6); and

(B) State-specific information on the quality of health care furnished to children under such plans, including information collected through external quality reviews of managed care organizations under section 1396u–2 of this title and benchmark plans under sections 1396u–7 and 1397cc of this title.

(2) Publication

Not later than September 30, 2010, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

(d) Demonstration projects for improving the quality of children's health care and the use of health information technology

(1) In general

During the period of fiscal years 2009 through 2013, the Secretary shall award not more than 10 grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care provided under subchapter XIX or XXI, including projects to—

(A) experiment with, and evaluate the use of, new measures of the quality of children's health care under such subchapters (including testing the validity and suitability for reporting of such measures);

(B) promote the use of health information technology in care delivery for children under such subchapters;

(C) evaluate provider-based models which improve the delivery of children's health care services under such subchapters, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety, and efficiency of health care services for children; or

(D) demonstrate the impact of the model electronic health record format for children developed and disseminated under subsection (f) on improving pediatric health, including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs.

(2) Requirements

In awarding grants under this subsection, the Secretary shall ensure that—

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

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

(3) Authority for multistate projects

A demonstration project conducted with a grant awarded under this subsection may be conducted on a multistate basis, as needed.

(4) Funding

$20,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(e) Childhood obesity demonstration project

(1) Authority to conduct demonstration

The Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such project. Such model shall—

(A) identify, through self-assessment, behavioral risk factors for obesity among children;

(B) identify, through self-assessment, needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors;

(C) provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits; and

(D) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services for which medical assistance is available under subchapter XIX or child health assistance is available under subchapter XXI among such target individuals.

(2) Eligibility entities [2]

For purposes of this subsection, an eligible entity is any of the following:

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

(B) A local or tribal educational agency.

(C) An accredited university, college, or community college.

(D) A Federally-qualified health center.

(E) A local health department.

(F) A health care provider.

(G) A community-based organization.

(H) Any other entity determined appropriate by the Secretary, including a consor-

[2] So in original. Probably should be ''Eligible entities''.

tia[3] or partnership of entities described in any of subparagraphs (A) through (G).

(3) Use of funds

An eligible entity awarded a grant under this subsection shall use the funds made available under the grant to—

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

(i) forming partnerships with entities, including schools and other facilities providing recreational services, to establish programs for after school and weekend community activities that are designed to reduce childhood obesity;

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

(iii) developing and evaluating community educational activities targeting good nutrition and promoting healthy eating behaviors;

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

(i) developing and testing educational curricula and intervention programs designed to promote healthy eating behaviors and habits in youth, which may include—

(I) after hours physical activity programs; and

(II) science-based interventions with multiple components to prevent eating disorders including nutritional content, understanding and responding to hunger and satiety, positive body image development, positive self-esteem development, and learning life skills (such as stress management, communication skills, problemsolving and decision-making skills), as well as consideration of cultural and developmental issues, and the role of family, school, and community;

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

(iii) planning and implementing a healthy lifestyle curriculum or program with an emphasis on healthy eating behaviors and physical activity; and

(iv) planning and implementing healthy lifestyle classes or programs for parents or guardians, with an emphasis on healthy eating behaviors and physical activity for children;

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

(i) promoting healthy eating behaviors and physical activity services to treat or prevent eating disorders, being overweight, and obesity;

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

(iii) training health professionals on how to identify and treat obese and overweight individuals which may include nutrition and physical activity counseling; and

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

(D) provide, through qualified health professionals, training and supervision for community health workers to—

(i) educate families regarding the relationship between nutrition, eating habits, physical activity, and obesity;

(ii) educate families about effective strategies to improve nutrition, establish healthy eating patterns, and establish appropriate levels of physical activity; and

(iii) educate and guide parents regarding the ability to model and communicate positive health behaviors.

(4) Priority

In awarding grants under paragraph (1), the Secretary shall give priority to awarding grants to eligible entities—

(A) that demonstrate that they have previously applied successfully for funds to carry out activities that seek to promote individual and community health and to prevent the incidence of chronic disease and that can cite published and peer-reviewed research demonstrating that the activities that the entities propose to carry out with funds made available under the grant are effective;

(B) that will carry out programs or activities that seek to accomplish a goal or goals set by the State in the Healthy People 2010 plan of the State;

(C) that provide non-Federal contributions, either in cash or in-kind, to the costs of funding activities under the grants;

(D) that develop comprehensive plans that include a strategy for extending program activities developed under grants in the years following the fiscal years for which they receive grants under this subsection;

(E) located in communities that are medically underserved, as determined by the Secretary;

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

(G) that submit plans that exhibit multisectoral, cooperative conduct that includes the involvement of a broad range of stakeholders, including—

(i) community-based organizations;

(ii) local governments;

(iii) local educational agencies;

(iv) the private sector;

(v) State or local departments of health;

(vi) accredited colleges, universities, and community colleges;

[3] So in original. Probably should be ''consortium''.

(vii) health care providers;

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

(ix) other entities determined appropriate by the Secretary.

(5) Program design

(A) Initial design

Not later than 1 year after February 4, 2009, the Secretary shall design the demonstration project. The demonstration should draw upon promising, innovative models and incentives to reduce behavioral risk factors. The Administrator of the Centers for Medicare & Medicaid Services shall consult with the Director of the Centers for Disease Control and Prevention, the Director of the Office of Minority Health, the heads of other agencies in the Department of Health and Human Services, and such professional organizations, as the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

(B) Number and project areas

Not later than 2 years after February 4, 2009, the Secretary shall award 1 grant that is specifically designed to determine whether programs similar to programs to be conducted by other grantees under this subsection should be implemented with respect to the general population of children who are eligible for child health assistance under State child health plans under subchapter XXI in order to reduce the incidence of childhood obesity among such population.

(6) Report to Congress

Not later than 3 years after the date the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates the beneficiary satisfaction under the project, and includes any such other information as the Secretary determines to be appropriate.

(7) Definitions

In this subsection:

(A) Federally-qualified health center

The term ''Federally-qualified health center'' has the meaning given that term in section 1396d(*l*)(2)(B) of this title.

(B) Indian tribe

The term ''Indian tribe'' has the meaning given that term in section 1603 of title 25.

(C) Self-assessment

The term ''self-assessment'' means a form that—

(i) includes questions regarding—

(I) behavioral risk factors;

(II) needed preventive and screening services; and

(III) target individuals' preferences for receiving follow-up information;

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

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

(D) Ongoing support

The term ''ongoing support'' means—

(i) to provide any target individual with information, feedback, health coaching, and recommendations regarding—

(I) the results of a self-assessment given to the individual;

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

(III) any need for clinical preventive and screening services or treatment including medical nutrition therapy;

(ii) to provide any target individual with referrals to community resources and programs available to assist the target individual in reducing health risks; and

(iii) to provide the information described in clause (i) to a health care provider, if designated by the target individual to receive such information.

(8) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2010 through 2014.

(f) Development of model electronic health record format for children enrolled in Medicaid or CHIP

(1) In general

Not later than January 1, 2010, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in the State plan under subchapter XIX or the State child health plan under subchapter XXI that is—

(A) subject to State laws, accessible to parents, caregivers, and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, such as appropriate immunizations or physicals;

(B) designed to allow interoperable exchanges that conform with Federal and State privacy and security requirements;

(C) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality; and

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

(2) Funding

$5,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(g) Study of pediatric health and health care quality measures

(1) In general

Not later than July 1, 2010, the Institute of Medicine shall study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments aimed at amelio-

rating or correcting physical, mental, and developmental conditions in children. In conducting such study and preparing such report, the Institute of Medicine shall—

(A) consider all of the major national population-based reporting systems sponsored by the Federal Government that are currently in place, including reporting requirements under Federal grant programs and national population surveys and estimates conducted directly by the Federal Government;

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

(C) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment; and

(D) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care quality.

(2) Funding

Up to $1,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(h) Rule of construction

Notwithstanding any other provision in this section, no evidence based quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving medical assistance under subchapter XIX or child health assistance under subchapter XXI.

(i) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2009 through 2013, $45,000,000 for the purpose of carrying out this section (other than subsection (e)). Funds appropriated under this subsection shall remain available until expended.

(Aug. 14, 1935, ch. 531, title XI, § 1139A, as added and amended Pub. L. 111–3, title IV, § 401(a), title V, § 501(g), Feb. 4, 2009, 123 Stat. 72, 88; Pub. L. 111–148, title IV, § 4306, Mar. 23, 2010, 124 Stat. 587.)

AMENDMENTS

2010—Subsec. (e)(8). Pub. L. 111–148 amended par. (8) generally. Prior to amendment, text read as follows: ''There is authorized to be appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2009 through 2013.''

2009—Subsec. (a)(3)(B)(ii). Pub. L. 111–3, § 501(g)(1), inserted ''and, with respect to dental care, conditions requiring the restoration of teeth, relief of pain and infection, and maintenance of dental health'' after ''chronic conditions''.

Subsec. (a)(6)(A)(ii). Pub. L. 111–3, § 501(g)(2), inserted ''dental care,'' after ''preventive health services,''.

EFFECTIVE DATE

Section and amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as a note under section 1396 of this title.

§ 1320b–9b. Adult health quality measures

(a) Development of core set of health care quality measures for adults eligible for benefits under Medicaid

The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1320b–9a of this title, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.

(b) Deadlines

(1) Recommended measures

Not later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults.

(2) Dissemination

Not later than January 1, 2012, the Secretary shall publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults.

(3) Standardized reporting

Not later than January 1, 2013, the Secretary, in consultation with States, shall develop a standardized format for reporting information based on the initial core set of adult health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

(4) Reports to Congress

Not later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1320b–9a(a)(6) of this title information similar to the information required under that section with respect to the measures established under this section.

(5) Establishment of Medicaid quality measurement program

(A) In general

Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1))[1], the

[1] So in original. The second closing parenthesis probably should not appear.