

111TH CONGRESS
1ST SESSION

H. R. 194

To amend the Social Security Act to guarantee comprehensive health care coverage for all children born after 2009, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 6, 2009

Mr. STARK introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Social Security Act to guarantee comprehensive health care coverage for all children born after 2009, 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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “MediKids Health Insurance Act of 2009”.

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

Sec. 1. Short title; table of contents.

TITLE I—MEDIKIDS HEALTH INSURANCE

Sec. 101. Findings.

Sec. 102. Benefits for all children born after 2009.

“TITLE XXII—MEDIKIDS PROGRAM

“Sec. 2201. Eligibility.

“Sec. 2202. Benefits.

“Sec. 2203. Premiums.

“Sec. 2204. MediKids Trust Fund.

“Sec. 2205. Oversight and accountability.

“Sec. 2206. Inclusion of care coordination services.

“Sec. 2207. Administration and miscellaneous.

Sec. 103. MediKids premium.

Sec. 104. Refundable credit for certain cost-sharing expenses under MediKids program.

Sec. 105. Report on long-term revenues.

TITLE II—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

Sec. 201. Child health quality improvement activities for children enrolled in MediKids, Medicaid, or CHIP.

Sec. 202. Improved availability of public information regarding enrollment of children in CHIP and Medicaid.

Sec. 203. Application of certain managed care quality safeguards to CHIP.

1 **TITLE I—MEDIKIDS HEALTH**
 2 **INSURANCE**

3 **SEC. 101. FINDINGS.**

4 (a) FINDINGS.—Congress finds the following:

5 (1) More than 9 million American children are
 6 uninsured.

7 (2) Children who are uninsured receive less
 8 medical care and less preventive care and have a
 9 poorer level of health, which result in lifetime costs
 10 to themselves and to the entire American economy.

11 (3) Although SCHIP and Medicaid are success-
 12 fully extending a health coverage safety net to a
 13 growing portion of the vulnerable low-income popu-

1 lation of uninsured children, they alone cannot
2 achieve 100 percent health insurance coverage for
3 our nation's children due to inevitable gaps during
4 outreach and enrollment, fluctuations in eligibility,
5 variations in access to private insurance at all in-
6 come levels, and variations in States' ability to pro-
7 vide required matching funds.

8 (4) As all segments of society continue to be-
9 come more transient, with many changes in employ-
10 ment over the working lifetime of parents, the need
11 for a reliable safety net of health insurance which
12 follows children across State lines, already a major
13 problem for the children of migrant and seasonal
14 farmworkers, will become a major concern for all
15 families in the United States.

16 (5) The medicare program has successfully
17 evolved over the years to provide a stable, universal
18 source of health insurance for the nation's disabled
19 and those over age 65, and provides a tested model
20 for designing a program to reach out to America's
21 children.

22 (6) The problem of insuring 100 percent of all
23 American children could be gradually solved by auto-
24 matically enrolling all children born after December
25 31, 2009, in a program modeled after Medicare (and

1 to be known as “MediKids”), and allowing those
2 children to be transferred into other equivalent or
3 better insurance programs, including either private
4 insurance, SCHIP, or Medicaid, if they are eligible
5 to do so, but maintaining the child’s default enroll-
6 ment in MediKids for any times when the child’s ac-
7 cess to other sources of insurance is lost.

8 (7) A family’s freedom of choice to use other in-
9 surers to cover children would not be interfered with
10 in any way, and children eligible for SCHIP and
11 Medicaid would continue to be enrolled in those pro-
12 grams, but the underlying safety net of MediKids
13 would always be available to cover any gaps in insur-
14 ance due to changes in medical condition, employ-
15 ment, income, or marital status, or other changes af-
16 fecting a child’s access to alternate forms of insur-
17 ance.

18 (8) The MediKids program can be administered
19 without impacting the finances or status of the exist-
20 ing Medicare program.

21 (9) The MediKids benefit package can be tai-
22 lored to the special needs of children and updated
23 over time.

24 (10) The financing of the program can be ad-
25 ministered without difficulty by a yearly payment of

1 affordable premiums through a family’s tax filing (or
2 adjustment of a family’s earned income tax credit).

3 (11) The cost of the program will gradually rise
4 as the number of children using MediKIDS as the in-
5 surer of last resort increases, and a future Congress
6 always can accelerate or slow down the enrollment
7 process as desired, while the societal costs for emer-
8 gency room usage, lost productivity and work days,
9 and poor health status for the next generation of
10 Americans will decline.

11 (12) Over time 100 percent of American chil-
12 dren will always have basic health insurance, and we
13 can therefore expect a healthier, more equitable, and
14 more productive society.

15 **SEC. 102. BENEFITS FOR ALL CHILDREN BORN AFTER 2009.**

16 (a) IN GENERAL.—The Social Security Act is amend-
17 ed by adding at the end the following new title:

18 **“TITLE XXII—MEDIKIDS**
19 **PROGRAM**

20 **“SEC. 2201. ELIGIBILITY.**

21 “(a) ELIGIBILITY OF INDIVIDUALS BORN AFTER DE-
22 CEMBER 31, 2009; ALL CHILDREN UNDER 23 YEARS OF
23 AGE IN FIFTH YEAR.—An individual who meets the fol-
24 lowing requirements with respect to a month is eligible to
25 enroll under this title with respect to such month:

1 “(1) AGE.—

2 “(A) FIRST YEAR.—As of the first day of
3 the first year in which this title is effective, the
4 individual has not attained 6 years of age.

5 “(B) SECOND YEAR.—As of the first day
6 of the second year in which this title is effec-
7 tive, the individual has not attained 11 years of
8 age.

9 “(C) THIRD YEAR.—As of the first day of
10 the third year in which this title is effective, the
11 individual has not attained 16 years of age.

12 “(D) FOURTH YEAR.—As of the first day
13 of the fourth year in which this title is effective,
14 the individual has not attained 21 years of age.

15 “(E) FIFTH AND SUBSEQUENT YEARS.—
16 As of the first day of the fifth year in which
17 this title is effective and each subsequent year,
18 the individual has not attained 23 years of age.

19 “(2) CITIZENSHIP.—The individual is a citizen
20 or national of the United States or is permanently
21 residing in the United States under color of law.

22 “(b) ENROLLMENT PROCESS.—An individual may
23 enroll in the program established under this title only in
24 such manner and form as may be prescribed by regula-
25 tions, and only during an enrollment period prescribed by

1 the Secretary consistent with the provisions of this section.

2 Such regulations shall provide a process under which—

3 “(1) individuals who are born in the United
4 States after December 31, 2009, are deemed to be
5 enrolled at the time of birth and a parent or guard-
6 ian of such an individual is permitted to pre-enroll
7 in the month prior to the expected month of birth;

8 “(2) individuals who are born outside the
9 United States after such date and who become eligi-
10 ble to enroll by virtue of immigration into (or an ad-
11 justment of immigration status in) the United
12 States are deemed enrolled at the time of entry or
13 adjustment of status;

14 “(3) eligible individuals may otherwise be en-
15 rolled at such other times and manner as the Sec-
16 retary shall specify, including the use of outstationed
17 eligibility sites as described in section
18 1902(a)(55)(A) and the use of presumptive eligi-
19 bility provisions like those described in section
20 1920A; and

21 “(4) at the time of automatic enrollment of a
22 child, the Secretary provides for issuance to a parent
23 or custodian of the individual a card evidencing cov-
24 erage under this title and for a description of such
25 coverage.

1 The provisions of section 1837(h) apply with respect to
2 enrollment under this title in the same manner as they
3 apply to enrollment under part B of title XVIII. An indi-
4 vidual who is enrolled under this title is not eligible to
5 be enrolled under an MA or MA–PD plan under part C
6 of title XVIII.

7 “(c) DATE COVERAGE BEGINS.—

8 “(1) IN GENERAL.—The period during which
9 an individual is entitled to benefits under this title
10 shall begin as follows, but in no case earlier than
11 January 1, 2010:

12 “(A) In the case of an individual who is
13 enrolled under paragraph (1) or (2) of sub-
14 section (b), the date of birth or date of obtain-
15 ing appropriate citizenship or immigration sta-
16 tus, as the case may be.

17 “(B) In the case of another individual who
18 enrolls (including pre-enrolls) before the month
19 in which the individual satisfies eligibility for
20 enrollment under subsection (a), the first day of
21 such month of eligibility.

22 “(C) In the case of another individual who
23 enrolls during or after the month in which the
24 individual first satisfies eligibility for enrollment

1 under such subsection, the first day of the fol-
2 lowing month.

3 “(2) AUTHORITY TO PROVIDE FOR PARTIAL
4 MONTHS OF COVERAGE.—Under regulations, the
5 Secretary may, in the Secretary’s discretion, provide
6 for coverage periods that include portions of a
7 month in order to avoid lapses of coverage.

8 “(3) LIMITATION ON PAYMENTS.—No payments
9 may be made under this title with respect to the ex-
10 penses of an individual enrolled under this title un-
11 less such expenses were incurred by such individual
12 during a period which, with respect to the individual,
13 is a coverage period under this section.

14 “(d) EXPIRATION OF ELIGIBILITY.—An individual’s
15 coverage period under this section shall continue until the
16 individual’s enrollment has been terminated because the
17 individual no longer meets the requirements of subsection
18 (a) (whether because of age or change in immigration sta-
19 tus).

20 “(e) ENTITLEMENT TO MEDIKIDS BENEFITS FOR
21 ENROLLED INDIVIDUALS.—An individual enrolled under
22 this title is entitled to the benefits described in section
23 2202.

24 “(f) LOW-INCOME INFORMATION.—

1 “(1) INQUIRY OF INCOME.—At the time of en-
2 rollment of a child under this title, the Secretary
3 shall make an inquiry as to whether the family in-
4 come (as determined for purposes of section
5 1905(p)) of the family that includes the child is
6 within any of the following income ranges:

7 “(A) UP TO 150 PERCENT OF POVERTY.—

8 The income of the family does not exceed 150
9 percent of the poverty line for a family of the
10 size involved.

11 “(B) BETWEEN 150 AND 200 PERCENT OF

12 POVERTY.—The income of the family exceeds
13 150 percent, but does not exceed 200 percent,
14 of such poverty line.

15 “(C) BETWEEN 200 AND 300 PERCENT OF

16 POVERTY.—The income of the family exceeds
17 200 percent, but does not exceed 300 percent,
18 of such poverty line.

19 “(2) CODING.—If the family income is within a
20 range described in paragraph (1), the Secretary
21 shall encode in the identification card issued in con-
22 nection with eligibility under this title a code indi-
23 cating the range applicable to the family of the child
24 involved.

1 “(3) PROVIDER VERIFICATION THROUGH ELEC-
2 TRONIC SYSTEM.—The Secretary also shall provide
3 for an electronic system through which providers
4 may verify which income range described in para-
5 graph (1), if any, is applicable to the family of the
6 child involved.

7 “(g) CONSTRUCTION.—Nothing in this title shall be
8 construed as requiring (or preventing) an individual who
9 is enrolled under this title from seeking medical assistance
10 under a State medicaid plan under title XIX or child
11 health assistance under a State child health plan under
12 title XXI.

13 **“SEC. 2202. BENEFITS.**

14 “(a) SECRETARIAL SPECIFICATION OF BENEFIT
15 PACKAGE.—

16 “(1) IN GENERAL.—The Secretary shall specify
17 the benefits to be made available under this title
18 consistent with the provisions of this section and in
19 a manner designed to meet the health needs of en-
20 rollees.

21 “(2) UPDATING.—The Secretary shall update
22 the specification of benefits over time to ensure the
23 inclusion of age-appropriate benefits to reflect the
24 enrollee population.

1 “(3) ANNUAL UPDATING.—The Secretary shall
2 establish procedures for the annual review and up-
3 dating of such benefits to account for changes in
4 medical practice, new information from medical re-
5 search, and other relevant developments in health
6 science.

7 “(4) INPUT.—The Secretary shall seek the
8 input of the pediatric community in specifying and
9 updating such benefits.

10 “(5) LIMITATION ON UPDATING.—In no case
11 shall updating of benefits under this subsection re-
12 sult in a failure to provide benefits required under
13 subsection (b).

14 “(b) INCLUSION OF CERTAIN BENEFITS.—

15 “(1) MEDICARE CORE BENEFITS.—Such bene-
16 fits shall include (to the extent consistent with other
17 provisions of this section) at least the same benefits
18 (including coverage, access, availability, duration,
19 and beneficiary rights) that are available under
20 parts A and B of title XVIII.

21 “(2) ALL REQUIRED MEDICAID BENEFITS.—
22 Such benefits shall also include all items and serv-
23 ices for which medical assistance is required to be
24 provided under section 1902(a)(10)(A) to individuals
25 described in such section, including early and peri-

1 odic screening, diagnostic services, and treatment
2 services.

3 “(3) INCLUSION OF PRESCRIPTION DRUGS.—
4 Such benefits also shall include (as specified by the
5 Secretary) benefits for prescription drugs and
6 biologicals which are not less than the benefits for
7 such drugs and biologicals under the standard op-
8 tion for the service benefit plan described in section
9 8903(1) of title 5, United States Code, offered dur-
10 ing 2007.

11 “(4) COST-SHARING.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (B), such benefits also shall include the
14 cost-sharing (in the form of deductibles, coin-
15 surance, and copayments) which is substantially
16 similar to such cost-sharing under the health
17 benefits coverage in any of the four largest
18 health benefits plans (determined by enroll-
19 ment) offered under chapter 89 of title 5,
20 United States Code, and including an out-of-
21 pocket limit for catastrophic expenditures for
22 covered benefits, except that no cost-sharing
23 shall be imposed with respect to early and peri-
24 odic screening and diagnostic services included
25 under paragraph (2).

1 “(B) REDUCED COST-SHARING FOR LOW
2 INCOME CHILDREN.—Such benefits shall pro-
3 vide that—

4 “(i) there shall be no cost-sharing for
5 children in families the income of which is
6 within the range described in section
7 2201(f)(1)(A);

8 “(ii) the cost-sharing otherwise appli-
9 cable shall be reduced by 75 percent for
10 children in families the income of which is
11 within the range described in section
12 2201(f)(1)(B); or

13 “(iii) the cost-sharing otherwise appli-
14 cable shall be reduced by 50 percent for
15 children in families the income of which is
16 within the range described in section
17 2201(f)(1)(C).

18 “(C) CATASTROPHIC LIMIT ON COST-SHAR-
19 ING.—For a refundable credit for cost-sharing
20 in the case of cost-sharing in excess of a per-
21 centage of the individual’s adjusted gross in-
22 come, see section 36 of the Internal Revenue
23 Code of 1986.

24 “(c) PAYMENT SCHEDULE.—The Secretary, with the
25 assistance of the Medicare Payment Advisory Commission,

1 shall develop and implement a payment schedule for bene-
2 fits covered under this title. To the extent feasible, such
3 payment schedule shall be consistent with comparable pay-
4 ment schedules and reimbursement methodologies applied
5 under parts A and B of title XVIII.

6 “(d) INPUT.—The Secretary shall specify such bene-
7 fits and payment schedules only after obtaining input from
8 appropriate child health providers and experts.

9 “(e) ENROLLMENT IN HEALTH PLANS.—The Sec-
10 retary shall provide for the offering of benefits under this
11 title through enrollment in a health benefit plan that
12 meets the same (or similar) requirements as the require-
13 ments that apply to Medicare Advantage plans under part
14 C of title XVIII (other than any such requirements that
15 relate to part D of such title). In the case of individuals
16 enrolled under this title in such a plan, the payment rate
17 shall be based on payment rates provided for under section
18 1853(c) in effect before the date of the enactment of the
19 Medicare Prescription Drug, Modernization, and Improve-
20 ment Act of 2003 (Public Law 108–173), except that such
21 payment rates shall be adjusted in an appropriate manner
22 to reflect differences between the population served under
23 this title and the population under title XVIII.

24 **“SEC. 2203. PREMIUMS.**

25 “(a) AMOUNT OF MONTHLY PREMIUMS.—

1 “(1) IN GENERAL.—The Secretary shall, during
2 September of each year (beginning with 2009), es-
3 tablish a monthly MediKids premium for the fol-
4 lowing year. Subject to paragraph (2), the monthly
5 MediKids premium for a year is equal to $\frac{1}{12}$ of the
6 annual premium rate computed under subsection
7 (b).

8 “(2) ELIMINATION OF MONTHLY PREMIUM FOR
9 DEMONSTRATION OF EQUIVALENT COVERAGE (IN-
10 CLUDING COVERAGE UNDER LOW-INCOME PRO-
11 GRAMS).—The amount of the monthly premium im-
12 posed under this section for an individual for a
13 month shall be zero in the case of an individual who
14 demonstrates to the satisfaction of the Secretary
15 that the individual has basic health insurance cov-
16 erage for that month. For purposes of the previous
17 sentence enrollment in a medicaid plan under title
18 XIX, a State child health insurance plan under title
19 XXI, or under the medicare program under title
20 XVIII is deemed to constitute basic health insurance
21 coverage described in such sentence.

22 “(b) ANNUAL PREMIUM.—

23 “(1) NATIONAL PER CAPITA AVERAGE.—The
24 Secretary shall estimate the average, annual per
25 capita amount that would be payable under this title

1 with respect to individuals residing in the United
2 States who meet the requirement of section
3 2201(a)(1) as if all such individuals were eligible for
4 (and enrolled) under this title during the entire year
5 (and assuming that section 1862(b)(2)(A)(i) did not
6 apply).

7 “(2) ANNUAL PREMIUM.—Subject to subsection
8 (d), the annual premium under this subsection for
9 months in a year is equal to 25 percent of the aver-
10 age, annual per capita amount estimated under
11 paragraph (1) for the year.

12 “(c) PAYMENT OF MONTHLY PREMIUM.—

13 “(1) PERIOD OF PAYMENT.—In the case of an
14 individual who participates in the program estab-
15 lished by this title, subject to subsection (d), the
16 monthly premium shall be payable for the period
17 commencing with the first month of the individual’s
18 coverage period and ending with the month in which
19 the individual’s coverage under this title terminates.

20 “(2) COLLECTION THROUGH TAX RETURN.—
21 For provisions providing for the payment of monthly
22 premiums under this subsection, see section 59B of
23 the Internal Revenue Code of 1986.

24 “(3) PROTECTIONS AGAINST FRAUD AND
25 ABUSE.—The Secretary shall develop, in coordina-

1 tion with States and other health insurance issuers,
2 administrative systems to ensure that claims which
3 are submitted to more than one payor are coordi-
4 nated and duplicate payments are not made.

5 “(d) REDUCTION IN PREMIUM FOR CERTAIN LOW-
6 INCOME FAMILIES.—For provisions reducing the premium
7 under this section for certain low-income families, see sec-
8 tion 59B(d) of the Internal Revenue Code of 1986.

9 **“SEC. 2204. MEDIKIDS TRUST FUND.**

10 “(a) ESTABLISHMENT OF TRUST FUND.—

11 “(1) IN GENERAL.—There is hereby created on
12 the books of the Treasury of the United States a
13 trust fund to be known as the ‘MediKids Trust
14 Fund’ (in this section referred to as the ‘Trust
15 Fund’). The Trust Fund shall consist of such gifts
16 and bequests as may be made as provided in section
17 201(i)(1) and such amounts as may be deposited in,
18 or appropriated to, such fund as provided in this
19 title.

20 “(2) PREMIUMS.—Premiums collected under
21 section 59B of the Internal Revenue Code of 1986
22 shall be periodically transferred to the Trust Fund.

23 “(3) TRANSITIONAL FUNDING BEFORE RECEIPT
24 OF PREMIUMS.—In order to provide for funds in the
25 Trust Fund to cover expenditures from the fund in

1 advance of receipt of premiums under section 2203,
2 there are transferred to the Trust Fund from the
3 general fund of the United States Treasury such
4 amounts as may be necessary.

5 “(b) INCORPORATION OF PROVISIONS.—

6 “(1) IN GENERAL.—Subject to paragraph (2),
7 subsection (b) (other than the last sentence) and
8 subsections (c) through (i) of section 1841 shall
9 apply with respect to the Trust Fund and this title
10 in the same manner as they apply with respect to
11 the Federal Supplementary Medical Insurance Trust
12 Fund and part B, respectively.

13 “(2) MISCELLANEOUS REFERENCES.—In apply-
14 ing provisions of section 1841 under paragraph
15 (1)—

16 “(A) any reference in such section to ‘this
17 part’ is construed to refer to title XXII;

18 “(B) any reference in section 1841(h) to
19 section 1840(d) and in section 1841(i) to sec-
20 tions 1840(b)(1) and 1842(g) are deemed ref-
21 erences to comparable authority exercised under
22 this title;

23 “(C) payments may be made under section
24 1841(g) to the Trust Funds under sections
25 1817 and 1841 as reimbursement to such funds

1 for payments they made for benefits provided
2 under this title; and

3 “(D) the Board of Trustees of the
4 MediKids Trust Fund shall be the same as the
5 Board of Trustees of the Federal Supple-
6 mentary Medical Insurance Trust Fund.

7 **“SEC. 2205. OVERSIGHT AND ACCOUNTABILITY.**

8 “(a) PERIODIC GAO REPORTS.—The Comptroller
9 General of the United States shall periodically submit to
10 Congress reports on the operation of the program under
11 this title, including on the financing of coverage provided
12 under this title.

13 “(b) PERIODIC MEDPAC REPORTS.—The Medicare
14 Payment Advisory Commission shall periodically report to
15 Congress concerning the program under this title.

16 **“SEC. 2206. INCLUSION OF CARE COORDINATION SERVICES.**

17 “(a) IN GENERAL.—

18 “(1) PROGRAM AUTHORITY.—The Secretary,
19 beginning in 2010, may implement a care coordina-
20 tion services program in accordance with the provi-
21 sions of this section under which, in appropriate cir-
22 cumstances, eligible individuals under section 2201
23 may elect to have health care services covered under
24 this title managed and coordinated by a designated
25 care coordinator.

1 “(2) ADMINISTRATION BY CONTRACT.—The
2 Secretary may administer the program under this
3 section through a contract with an appropriate pro-
4 gram administrator.

5 “(3) COVERAGE.—Care coordination services
6 furnished in accordance with this section shall be
7 treated under this title as if they were included in
8 the definition of medical and other health services
9 under section 1861(s) and benefits shall be available
10 under this title with respect to such services without
11 the application of any deductible or coinsurance.

12 “(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND
13 NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

14 “(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The
15 Secretary shall specify criteria to be used in making
16 a determination as to whether an individual may ap-
17 propriately be enrolled in the care coordination serv-
18 ices program under this section, which shall include
19 at least a finding by the Secretary that for cohorts
20 of individuals with characteristics identified by the
21 Secretary, professional management and coordina-
22 tion of care can reasonably be expected to improve
23 processes or outcomes of health care and to reduce
24 aggregate costs to the programs under this title.

1 “(2) PROCEDURES TO FACILITATE ENROLL-
2 MENT.—The Secretary shall develop and implement
3 procedures designed to facilitate enrollment of eligi-
4 ble individuals in the program under this section.

5 “(c) ENROLLMENT OF INDIVIDUALS.—

6 “(1) SECRETARY’S DETERMINATION OF ELIGI-
7 BILITY.—The Secretary shall determine the eligi-
8 bility for services under this section of individuals
9 who are enrolled in the program under this section
10 and who make application for such services in such
11 form and manner as the Secretary may prescribe.

12 “(2) ENROLLMENT PERIOD.—

13 “(A) EFFECTIVE DATE AND DURATION.—
14 Enrollment of an individual in the program
15 under this section shall be effective as of the
16 first day of the month following the month in
17 which the Secretary approves the individual’s
18 application under paragraph (1), shall remain
19 in effect for one month (or such longer period
20 as the Secretary may specify), and shall be
21 automatically renewed for additional periods,
22 unless terminated in accordance with such pro-
23 cedures as the Secretary shall establish by regu-
24 lation. Such procedures shall permit an indi-

1 vidual to disenroll for cause at any time and
2 without cause at re-enrollment intervals.

3 “(B) LIMITATION ON REENROLLMENT.—

4 The Secretary may establish limits on an indi-
5 vidual’s eligibility to reenroll in the program
6 under this section if the individual has
7 disenrolled from the program more than once
8 during a specified time period.

9 “(d) PROGRAM.—The care coordination services pro-
10 gram under this section shall include the following ele-
11 ments:

12 “(1) BASIC CARE COORDINATION SERVICES.—

13 “(A) IN GENERAL.—Subject to the cost-ef-
14 fectiveness criteria specified in subsection
15 (b)(1), except as otherwise provided in this sec-
16 tion, enrolled individuals shall receive services
17 described in section 1905(t)(1) and may receive
18 additional items and services as described in
19 subparagraph (B).

20 “(B) ADDITIONAL BENEFITS.—The Sec-
21 retary may specify additional benefits for which
22 payment would not otherwise be made under
23 this title that may be available to individuals
24 enrolled in the program under this section (sub-
25 ject to an assessment by the care coordinator of

1 an individual’s circumstance and need for such
2 benefits) in order to encourage enrollment in, or
3 to improve the effectiveness of, such program.

4 “(2) CARE COORDINATION REQUIREMENT.—

5 Notwithstanding any other provision of this title, the
6 Secretary may provide that an individual enrolled in
7 the program under this section may be entitled to
8 payment under this title for any specified health
9 care items or services only if the items or services
10 have been furnished by the care coordinator, or co-
11 ordinated through the care coordination services pro-
12 gram. Under such provision, the Secretary shall pre-
13 scribe exceptions for emergency medical services as
14 described in section 1852(d)(3), and other excep-
15 tions determined by the Secretary for the delivery of
16 timely and needed care.

17 “(e) CARE COORDINATORS.—

18 “(1) CONDITIONS OF PARTICIPATION.—In order
19 to be qualified to furnish care coordination services
20 under this section, an individual or entity shall—

21 “(A) be a health care professional or entity
22 (which may include physicians, physician group
23 practices, or other health care professionals or
24 entities the Secretary may find appropriate)

1 meeting such conditions as the Secretary may
2 specify;

3 “(B) have entered into a care coordination
4 agreement; and

5 “(C) meet such criteria as the Secretary
6 may establish (which may include experience in
7 the provision of care coordination or primary
8 care physician’s services).

9 “(2) AGREEMENT TERM; PAYMENT.—

10 “(A) DURATION AND RENEWAL.—A care
11 coordination agreement under this subsection
12 shall be for one year and may be renewed if the
13 Secretary is satisfied that the care coordinator
14 continues to meet the conditions of participa-
15 tion specified in paragraph (1).

16 “(B) PAYMENT FOR SERVICES.—The Sec-
17 retary may negotiate or otherwise establish pay-
18 ment terms and rates for services described in
19 subsection (d)(1).

20 “(C) LIABILITY.—Care coordinators shall
21 be subject to liability for actual health damages
22 which may be suffered by recipients as a result
23 of the care coordinator’s decisions, failure or
24 delay in making decisions, or other actions as
25 a care coordinator.

1 “(D) TERMS.—In addition to such other
2 terms as the Secretary may require, an agree-
3 ment under this section shall include the terms
4 specified in subparagraphs (A) through (C) of
5 section 1905(t)(3).

6 **“SEC. 2207. ADMINISTRATION AND MISCELLANEOUS.**

7 “(a) IN GENERAL.—Except as otherwise provided in
8 this title—

9 “(1) the Secretary shall enter into appropriate
10 contracts with providers of services, other health
11 care providers, carriers, and fiscal intermediaries,
12 taking into account the types of contracts used
13 under title XVIII with respect to such entities, to
14 administer the program under this title;

15 “(2) beneficiary protections for individuals en-
16 rolled under this title shall not be less than the ben-
17 eficiary protections (including limits on balance bill-
18 ing) provided medicare beneficiaries under title
19 XVIII;

20 “(3) benefits described in section 2202 that are
21 payable under this title to such individuals shall be
22 paid in a manner specified by the Secretary (taking
23 into account, and based to the greatest extent prac-
24 ticable upon, the manner in which they are provided
25 under title XVIII); and

1 “(4) provider participation agreements under
2 title XVIII shall apply to enrollees and benefits
3 under this title in the same manner as they apply
4 to enrollees and benefits under title XVIII.

5 “(b) COORDINATION WITH MEDICAID AND
6 SCHIP.—Notwithstanding any other provision of law, in-
7 dividuals entitled to benefits for items and services under
8 this title who also qualify for benefits under title XIX or
9 XXI or any other Federally funded health care program
10 that provides basic health insurance coverage described in
11 section 2203(a)(2) may continue to qualify and obtain
12 benefits under such other title or program, and in such
13 case such an individual shall elect either—

14 “(1) such other title or program to be primary
15 payor to benefits under this title, in which case no
16 benefits shall be payable under this title and the
17 monthly premium under section 2203 shall be zero;
18 or

19 “(2) benefits under this title shall be primary
20 payor to benefits provided under such title or pro-
21 gram, in which case the Secretary shall enter into
22 agreements with States as may be appropriate to
23 provide that, in the case of such individuals, the ben-
24 efits under titles XIX and XXI or such other pro-
25 gram (including reduction of cost-sharing) are pro-

1 vided on a ‘wrap-around’ basis to the benefits under
2 this title.”.

3 (b) CONFORMING AMENDMENTS TO SOCIAL SECUR-
4 RITY ACT PROVISIONS.—

5 (1) Section 201(i)(1) of the Social Security Act
6 (42 U.S.C. 401(i)(1)) is amended by striking “or the
7 Federal Supplementary Medical Insurance Trust
8 Fund” and inserting “the Federal Supplementary
9 Medical Insurance Trust Fund, and the MediKids
10 Trust Fund”.

11 (2) Section 201(g)(1)(A) of such Act (42
12 U.S.C. 401(g)(1)(A)) is amended by striking “and
13 the Federal Supplementary Medical Insurance Trust
14 Fund established by title XVIII” and inserting “,
15 the Federal Supplementary Medical Insurance Trust
16 Fund, and the MediKids Trust Fund established by
17 title XVIII”.

18 (c) MAINTENANCE OF MEDICAID ELIGIBILITY AND
19 BENEFITS FOR CHILDREN.—

20 (1) IN GENERAL.—In order for a State to con-
21 tinue to be eligible for payments under section
22 1903(a) of the Social Security Act (42 U.S.C.
23 1396b(a))—

24 (A) the State may not reduce standards of
25 eligibility, or benefits, provided under its State

1 medicaid plan under title XIX of the Social Se-
2 curity Act or under its State child health plan
3 under title XXI of such Act for individuals
4 under 23 years of age below such standards of
5 eligibility, and benefits, in effect on the date of
6 the enactment of this Act; and

7 (B) the State shall demonstrate to the sat-
8 isfaction of the Secretary of Health and Human
9 Services that any savings in State expenditures
10 under title XIX or XXI of the Social Security
11 Act that results from children enrolling under
12 title XXII of such Act shall be used in a man-
13 ner that improves services to beneficiaries
14 under title XIX of such Act, such as through
15 expansion of eligibility, improved nurse and
16 nurse aide staffing and improved inspections of
17 nursing facilities, and coverage of additional
18 services.

19 (2) **MEDIKIDS AS PRIMARY PAYOR.**—In apply-
20 ing title XIX of the Social Security Act, the
21 MediKids program under title XXII of such Act
22 shall be treated as a primary payor in cases in which
23 the election described in section 2207(b)(2) of such
24 Act, as added by subsection (a), has been made.

25 (d) **EXPANSION OF MEDPAC MEMBERSHIP TO 19.**—

1 (1) IN GENERAL.—Section 1805(c) of the So-
2 cial Security Act (42 U.S.C. 1395b–6(c)) is amend-
3 ed—

4 (A) in paragraph (1), by striking “17” and
5 inserting “19”; and

6 (B) in paragraph (2)(B), by inserting “ex-
7 perts in children’s health,” after “other health
8 professionals,”.

9 (2) INITIAL TERMS OF ADDITIONAL MEM-
10 BERS.—

11 (A) IN GENERAL.—For purposes of stag-
12 gering the initial terms of members of the
13 Medicare Payment Advisory Commission under
14 section 1805(c)(3) of the Social Security Act
15 (42 U.S.C. 1395b–6(c)(3)), the initial terms of
16 the 2 additional members of the Commission
17 provided for by the amendment under sub-
18 section (a)(1) are as follows:

19 (i) One member shall be appointed for
20 1 year.

21 (ii) One member shall be appointed
22 for 2 years.

23 (B) COMMENCEMENT OF TERMS.—Such
24 terms shall begin on January 1, 2009.

1 (3) DUTIES.—Section 1805(b)(1)(A) of such
2 Act (42 U.S.C. 1395b–6(b)(1)(A)) is amended by in-
3 serting before the semicolon at the end the following:
4 “and payment policies under title XXII”.

5 **SEC. 103. MEDIKIDS PREMIUM.**

6 (a) GENERAL RULE.—Subchapter A of chapter 1 of
7 the Internal Revenue Code of 1986 (relating to determina-
8 tion of tax liability) is amended by adding at the end the
9 following new part:

10 **“PART VIII—MEDIKIDS PREMIUM**

 “Sec. 59B. MediKids premium.

11 **“SEC. 59B. MEDIKIDS PREMIUM.**

12 “(a) IMPOSITION OF TAX.—In the case of a taxpayer
13 to whom this section applies, there is hereby imposed (in
14 addition to any other tax imposed by this subtitle) a
15 MediKids premium for the taxable year.

16 “(b) INDIVIDUALS SUBJECT TO PREMIUM.—

17 “(1) IN GENERAL.—This section shall apply to
18 a taxpayer if a MediKid is a dependent of the tax-
19 payer for the taxable year.

20 “(2) MEDIKID.—For purposes of this section,
21 the term ‘MediKid’ means any individual enrolled in
22 the MediKids program under title XXII of the Social
23 Security Act.

1 “(c) AMOUNT OF PREMIUM.—For purposes of this
2 section, the MediKids premium for a taxable year is the
3 sum of the monthly premiums (for months in the taxable
4 year) determined under section 2203 of the Social Security
5 Act with respect to each MediKid who is a dependent
6 of the taxpayer for the taxable year.

7 “(d) EXCEPTIONS BASED ON ADJUSTED GROSS IN-
8 COME.—

9 “(1) EXEMPTION FOR VERY LOW-INCOME TAX-
10 PAYERS.—

11 “(A) IN GENERAL.—No premium shall be
12 imposed by this section on any taxpayer having
13 an adjusted gross income not in excess of the
14 exemption amount.

15 “(B) EXEMPTION AMOUNT.—For purposes
16 of this paragraph, the exemption amount is—

17 “(i) \$20,535 in the case of a taxpayer
18 having 1 MediKid,

19 “(ii) \$25,755 in the case of a tax-
20 payer having 2 MediKids,

21 “(iii) \$30,975 in the case of a tax-
22 payer having 3 MediKids, and

23 “(iv) \$35,195 in the case of a tax-
24 payer having 4 or more MediKids.

1 “(C) PHASEOUT OF EXEMPTION.—In the
2 case of a taxpayer having an adjusted gross in-
3 come which exceeds the exemption amount but
4 does not exceed twice the exemption amount,
5 the premium shall be the amount which bears
6 the same ratio to the premium which would
7 (but for this subparagraph) apply to the tax-
8 payer as such excess bears to the exemption
9 amount.

10 “(D) INFLATION ADJUSTMENT OF EXEMP-
11 TION AMOUNTS.—In the case of any taxable
12 year beginning in a calendar year after 2008,
13 each dollar amount contained in subparagraph
14 (C) shall be increased by an amount equal to
15 the product of—

16 “(i) such dollar amount, and

17 “(ii) the cost-of-living adjustment de-
18 termined under section 1(f)(3) for the cal-
19 endar year in which the taxable year be-
20 gins, determined by substituting ‘calendar
21 year 2007’ for ‘calendar year 1992’ in sub-
22 paragraph (B) thereof.

23 If any increase determined under the preceding
24 sentence is not a multiple of \$50, such increase
25 shall be rounded to the nearest multiple of \$50.

1 “(2) PREMIUM LIMITED TO 5 PERCENT OF AD-
2 JUSTED GROSS INCOME.—In no event shall any tax-
3 payer be required to pay a premium under this sec-
4 tion in excess of an amount equal to 5 percent of the
5 taxpayer’s adjusted gross income.

6 “(e) COORDINATION WITH OTHER PROVISIONS.—

7 “(1) NOT TREATED AS MEDICAL EXPENSE.—
8 For purposes of this chapter, any premium paid
9 under this section shall not be treated as expense for
10 medical care.

11 “(2) NOT TREATED AS TAX FOR CERTAIN PUR-
12 POSES.—The premium paid under this section shall
13 not be treated as a tax imposed by this chapter for
14 purposes of determining—

15 “(A) the amount of any credit allowable
16 under this chapter, or

17 “(B) the amount of the minimum tax im-
18 posed by section 55.

19 “(3) TREATMENT UNDER SUBTITLE F.—For
20 purposes of subtitle F, the premium paid under this
21 section shall be treated as if it were a tax imposed
22 by section 1.”.

23 (b) TECHNICAL AMENDMENTS.—

1 (1) Subsection (a) of section 6012 of such Code
2 is amended by inserting after paragraph (9) the fol-
3 lowing new paragraph:

4 “(10) Every individual liable for a premium
5 under section 59B.”.

6 (2) The table of parts for subchapter A of chap-
7 ter 1 of such Code is amended by adding at the end
8 the following new item:

 “PART VIII. MEDIKIDS PREMIUM”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to months beginning after Decem-
11 ber 2008, in taxable years ending after such date.

12 **SEC. 104. REFUNDABLE CREDIT FOR CERTAIN COST-SHAR-**
13 **ING EXPENSES UNDER MEDIKIDS PROGRAM.**

14 (a) IN GENERAL.—Subpart C of part IV of sub-
15 chapter A of chapter 1 of the Internal Revenue Code of
16 1986 (relating to refundable credits) is amended by redес-
17 ignating section 37 as section 37A and by inserting after
18 section 36 the following new section:

19 **“SEC. 37. CATASTROPHIC LIMIT ON COST-SHARING EX-**
20 **PENSES UNDER MEDIKIDS PROGRAM.**

21 “(a) IN GENERAL.—In the case of a taxpayer who
22 has a MediKid (as defined in section 59B) at any time
23 during the taxable year, there shall be allowed as a credit
24 against the tax imposed by this subtitle an amount equal
25 to the excess of—

1 “(1) the amount paid by the taxpayer during
2 the taxable year as cost-sharing under section
3 2202(b)(4) of the Social Security Act, over

4 “(2) 5 percent of the taxpayer’s adjusted gross
5 income for the taxable year.

6 “(b) COORDINATION WITH OTHER PROVISIONS.—
7 The excess described in subsection (a) shall not be taken
8 into account in computing the amount allowable to the
9 taxpayer as a deduction under section 162(l) or 213(a).”.

10 (b) TECHNICAL AMENDMENTS.—

11 (1) The table of sections for subpart C of part
12 IV of subchapter A of chapter 1 of such Code is
13 amended by redesignating the item relating to sec-
14 tion 37 as an item relating to section 37A and by
15 inserting before such item the following new item:

“Sec. 37. Catastrophic limit on cost-sharing expenses under MediKids pro-
gram.”.

16 (2) Paragraph (2) of section 1324(b) of title
17 31, United States Code, is amended by inserting “,
18 37,” after “section 35”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to taxable years beginning after
21 December 31, 2009.

22 **SEC. 105. REPORT ON LONG-TERM REVENUES.**

23 Within one year after the date of the enactment of
24 this Act, the Secretary of the Treasury shall propose a

1 gradual schedule of progressive tax changes to fund the
 2 program under title XXII of the Social Security Act, as
 3 the number of enrollees grows in the out-years.

4 **TITLE II—STRENGTHENING**
 5 **QUALITY OF CARE AND**
 6 **HEALTH OUTCOMES**

7 **SEC. 201. CHILD HEALTH QUALITY IMPROVEMENT ACTIVI-**
 8 **TIES FOR CHILDREN ENROLLED IN**
 9 **MEDIKIDS, MEDICAID, OR CHIP.**

10 (a) DEVELOPMENT OF CHILD HEALTH QUALITY
 11 MEASURES FOR CHILDREN ENROLLED IN MEDIKIDS,
 12 MEDICAID, OR CHIP.—Title XI of the Social Security Act
 13 (42 U.S.C. 1301 et seq.) is amended by inserting after
 14 section 1139 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 MEDIKIDS, 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 under title
 23 XXII, by State programs administered under titles
 24 XIX and XXI, health insurance issuers and man-
 25 aged care entities that enter into contracts with such

1 programs, and providers of items and services under
2 such programs.

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, in in-
6 fants, young children, school-age children,
7 and adolescents.

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

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

19 “(4) ENCOURAGE VOLUNTARY AND STANDARD-
20 IZED REPORTING.—Not later than 2 years after the
21 date of this section, the Secretary, in consultation
22 with States, shall develop a standardized format for
23 reporting information and procedures and ap-
24 proaches that encourage States to use the initial
25 core measurement set to voluntarily report informa-

1 tion regarding the quality of pediatric health care
2 under titles XIX and XXI and for the reporting of
3 such standardized reporting under title XXII.

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

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

21 “(A) the status of the Secretary’s efforts
22 to improve—

23 “(i) quality related to the duration
24 and stability of health insurance coverage

1 for children under titles XIX, XXI, and
2 XXII;

3 “(ii) the quality of children’s health
4 care under such titles, including preventive
5 health services, health care for acute condi-
6 tions, chronic health care, and health serv-
7 ices to ameliorate the effects of physical
8 and mental conditions and to aid in growth
9 and development of infants, young chil-
10 dren, school-age children, and adolescents
11 with special health care needs; and

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

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

24 “(C) any recommendations for legislative
25 changes needed to improve the quality of care

1 provided to children under titles XIX, XXI, and
2 XXII, including recommendations for quality
3 reporting by States.

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

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

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

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

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

1 tions that could, if untreated or poorly treated,
2 become chronic.

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

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

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

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

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

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

24 “(A) evidence-based and, where appro-
25 priate, risk adjusted;

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

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

9 “(D) periodically updated; and

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

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

19 “(A) States;

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

1 children with special physical, mental, and de-
2 velopmental health care needs;

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

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

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

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

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

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

24 “(4) DEVELOPING, VALIDATING, AND TESTING
25 A PORTFOLIO OF PEDIATRIC QUALITY MEASURES.—

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

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

9 “(B) award grants and contracts for—

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

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

16 “(iii) the updating of such measures
17 as necessary.

18 “(5) REVISING, STRENGTHENING, AND IMPROV-
19 ING INITIAL CORE MEASURES.—Beginning no later
20 than January 1, 2013, and annually thereafter, the
21 Secretary shall publish recommended changes to the
22 core measures described in subsection (a) that shall
23 reflect the testing, validation, and consensus process
24 for the development of pediatric quality measures
25 described in subsection paragraphs (1) through (4).

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

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

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

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

23 “(A) State-specific child health quality
24 measures applied by the States under such

1 plans, including measures described in subpara-
2 graphs (A) and (B) of subsection (a)(6); and

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

11 The Secretary shall collect such information with re-
12 spect to children under title XXII.

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 or collected by the Secretary under such paragraph.

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

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

1 children’s health care provided under title XIX,
2 XXI, or XXII, 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,
17 child health assistance is available under title
18 XXI, or benefits are available under title XXII
19 among such target individuals.

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

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

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

1 “(C) An accredited university, college, or
2 community college.

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

4 “(E) A local health department.

5 “(F) A health care provider.

6 “(G) A community-based organization.

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

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

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

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

23 “(ii) forming partnerships with
24 daycare facilities to establish programs

1 that promote healthy eating behaviors and
2 physical activity; and

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

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

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

15 “(I) after hours physical activity
16 programs; and

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

1 and decisionmaking skills), as well as
2 consideration of cultural and develop-
3 mental issues, and the role of family,
4 school, and community;

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

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

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

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

22 “(i) promoting healthy eating behav-
23 iors and physical activity services to treat
24 or prevent eating disorders, being over-
25 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 or for benefits
4 under title XXII in order to reduce the inci-
5 dence of childhood obesity among such popu-
6 lation.

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

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

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

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

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

3 “(i) includes questions regarding—

4 “(I) behavioral risk factors;

5 “(II) needed preventive and
6 screening services; and

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

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

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

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

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

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

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

24 “(III) any need for clinical pre-
25 ventive and screening services or

1 treatment including medical nutrition
2 therapy;

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

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

11 “(8) AUTHORIZATION OF APPROPRIATIONS.—

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

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

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

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

6 “(B) designed to allow interoperable ex-
7 changes that conform with Federal and State
8 privacy and security requirements;

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

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

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

20 “(g) STUDY OF PEDIATRIC HEALTH AND HEALTH
21 CARE QUALITY MEASURES.—

22 “(1) IN GENERAL.—Not later than July 1,
23 2010, the Institute of Medicine shall study and re-
24 port to Congress on the extent and quality of efforts
25 to measure child health status and the quality of

1 health care for children across the age span and in
2 relation to preventive care, treatments for acute con-
3 ditions, and treatments aimed at ameliorating or
4 correcting physical, mental, and developmental con-
5 ditions in children. In conducting such study and
6 preparing such report, the Institute of Medicine
7 shall—

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

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

22 “(C) identify gaps in knowledge related to
23 children’s health status, health disparities
24 among subgroups of children, the effects of so-
25 cial conditions on children’s health status and

1 use and effectiveness of health care, and the re-
2 lationship between child health status and fam-
3 ily income, family stability and preservation,
4 and children’s school readiness and educational
5 achievement and attainment; and

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

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

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

23 “(i) APPROPRIATION.—Out of any funds in the
24 Treasury not otherwise appropriated, there is appro-
25 priated for each of fiscal years 2009 through 2013,

1 \$45,000,000 for the purpose of carrying out this section
2 (other than subsection (e)). Funds appropriated under
3 this subsection shall remain available until expended.”.

4 (b) INCREASED MATCHING RATE FOR COLLECTING
5 AND REPORTING ON CHILD HEALTH MEASURES.—Sec-
6 tion 1903(a)(3)(A) of the Social Security Act (42 U.S.C.
7 1396b(a)(3)(A)) is amended—

8 (1) by striking “and” at the end of clause (i);
9 and

10 (2) by adding at the end the following new
11 clause:

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

1 **SEC. 202. IMPROVED AVAILABILITY OF PUBLIC INFORMA-**
2 **TION REGARDING ENROLLMENT OF CHIL-**
3 **DREN IN CHIP AND MEDICAID.**

4 (a) INCLUSION OF PROCESS AND ACCESS MEASURES
5 IN ANNUAL STATE REPORTS.—Section 2108 of the Social
6 Security Act (42 U.S.C. 1397hh) is amended—

7 (1) in subsection (a), in the matter preceding
8 paragraph (1), by striking “The State” and insert-
9 ing “Subject to subsection (e), the State”; and

10 (2) by adding at the end the following new sub-
11 section:

12 “(e) INFORMATION REQUIRED FOR INCLUSION IN
13 STATE ANNUAL REPORT.—The State shall include the fol-
14 lowing information in the annual report required under
15 subsection (a):

16 “(1) Eligibility criteria, enrollment, and reten-
17 tion data (including data with respect to continuity
18 of coverage or duration of benefits).

19 “(2) Data regarding the extent to which the
20 State uses process measures with respect to deter-
21 mining the eligibility of children under the State
22 child health plan, including measures such as 12-
23 month continuous eligibility, self-declaration of in-
24 come for applications or renewals, or presumptive
25 eligibility.

1 “(3) Data regarding denials of eligibility and
2 redeterminations of eligibility.

3 “(4) Data regarding access to primary and spe-
4 cialty services, access to networks of care, and care
5 coordination provided under the State child health
6 plan, using quality care and consumer satisfaction
7 measures included in the Consumer Assessment of
8 Healthcare Providers and Systems (CAHPS) survey.

9 “(5) If the State provides child health assist-
10 ance in the form of premium assistance for the pur-
11 chase of coverage under a group health plan, data
12 regarding the provision of such assistance, including
13 the extent to which employer-sponsored health insur-
14 ance coverage is available for children eligible for
15 child health assistance under the State child health
16 plan, the range of the monthly amount of such as-
17 sistance provided on behalf of a child or family, the
18 number of children or families provided such assist-
19 ance on a monthly basis, the income of the children
20 or families provided such assistance, the benefits
21 and cost-sharing protection provided under the State
22 child health plan to supplement the coverage pur-
23 chased with such premium assistance, the effective
24 strategies the State engages in to reduce any admin-
25 istrative barriers to the provision of such assistance,

1 and, the effects, if any, of the provision of such as-
2 sistance on preventing the coverage provided under
3 the State child health plan from substituting for cov-
4 erage provided under employer-sponsored health in-
5 surance offered in the State.

6 “(6) To the extent applicable, a description of
7 any State activities that are designed to reduce the
8 number of uncovered children in the State, including
9 through a State health insurance connector program
10 or support for innovative private health coverage ini-
11 tiatives.”.

12 (b) STANDARDIZED REPORTING FORMAT.—

13 (1) IN GENERAL.—Not later than 1 year after
14 the date of enactment of this Act, the Secretary
15 shall specify a standardized format for States to use
16 for reporting the information required under section
17 2108(e) of the Social Security Act, as added by sub-
18 section (a)(2).

19 (2) TRANSITION PERIOD FOR STATES.—Each
20 State that is required to submit a report under sub-
21 section (a) of section 2108 of the Social Security Act
22 that includes the information required under sub-
23 section (e) of such section may use up to 3 reporting
24 periods to transition to the reporting of such infor-

1 mation in accordance with the standardized format
2 specified by the Secretary under paragraph (1).

3 (c) ADDITIONAL FUNDING FOR THE SECRETARY TO
4 IMPROVE TIMELINESS OF DATA REPORTING AND ANAL-
5 YSIS FOR PURPOSES OF DETERMINING ENROLLMENT IN-
6 CREASES UNDER MEDICAID AND CHIP.—

7 (1) APPROPRIATION.—There is appropriated,
8 out of any money in the Treasury not otherwise ap-
9 propriated, \$5,000,000 to the Secretary for fiscal
10 year 2009 for the purpose of improving the timeli-
11 ness of the data reported and analyzed from the
12 Medicaid Statistical Information System (MSIS) for
13 purposes of providing more timely data on enroll-
14 ment and eligibility of children under Medicaid and
15 CHIP and to provide guidance to States with re-
16 spect to any new reporting requirements related to
17 such improvements. Amounts appropriated under
18 this paragraph shall remain available until expended.

19 (2) REQUIREMENTS.—The improvements made
20 by the Secretary under paragraph (1) shall be de-
21 signed and implemented (including with respect to
22 any necessary guidance for States to report such in-
23 formation in a complete and expeditious manner) so
24 that, beginning no later than October 1, 2009, data
25 regarding the enrollment of low-income children (as

1 defined in section 2110(c)(4) of the Social Security
2 Act (42 U.S.C. 1397jj(c)(4)) of a State enrolled in
3 the State plan under Medicaid or the State child
4 health plan under CHIP with respect to a fiscal year
5 shall be collected and analyzed by the Secretary
6 within 6 months of submission.

7 (d) GAO STUDY AND REPORT ON ACCESS TO PRI-
8 MARY AND SPECIALTY SERVICES.—

9 (1) IN GENERAL.—The Comptroller General of
10 the United States shall conduct a study of children’s
11 access to primary and specialty services under Med-
12 icaid, CHIP, and MediKids, including—

13 (A) the extent to which providers are will-
14 ing to treat children eligible for such programs;

15 (B) information on such children’s access
16 to networks of care;

17 (C) geographic availability of primary and
18 specialty services under such programs;

19 (D) the extent to which care coordination
20 is provided for children’s care under Medicaid,
21 CHIP, and MediKids; and

22 (E) as appropriate, information on the de-
23 gree of availability of services for children under
24 such programs.

1 to coverage and such entities and organizations
2 under title XIX.”.

3 (b) **EFFECTIVE DATE.**—The amendment made by
4 subsection (a) shall apply to contract years for health
5 plans beginning on or after July 1, 2009.

○