

S. 1018

At the request of Mr. DURBIN, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 1018, a bill to address security risks posed by global climate change and for other purposes.

S. 1060

At the request of Mr. BIDEN, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 1060, a bill to reauthorize the grant program for reentry of offenders into the community in the Omnibus Crime Control and Safe Streets Act of 1968, to improve reentry planning and implementation, and for other purposes.

S. 1117

At the request of Mr. BOND, the names of the Senator from Hawaii (Mr. INOUE) and the Senator from Maine (Ms. COLLINS) were added as cosponsors of S. 1117, a bill to establish a grant program to provide vision care to children, and for other purposes.

S. 1147

At the request of Mrs. MURRAY, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1147, a bill to amend title 38, United States Code, to terminate the administrative freeze on the enrollment into the health care system of the Department of Veterans Affairs of veterans in the lowest priority category for enrollment (referred to as "Priority 8").

S. 1164

At the request of Mr. CARDIN, the name of the Senator from Nevada (Mr. REID) was added as a cosponsor of S. 1164, a bill to amend title XVIII of the Social Security Act to improve patient access to, and utilization of, the colorectal cancer screening benefit under the Medicare Program.

S. 1181

At the request of Mr. OBAMA, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1181, a bill to amend the Securities Exchange Act of 1934 to provide shareholders with an advisory vote on executive compensation.

S. 1200

At the request of Mr. DORGAN, the name of the Senator from Washington (Mrs. MURRAY) was added as a cosponsor of S. 1200, a bill to amend the Indian Health Care Improvement Act to revise and extend the Act.

At the request of Mr. THOMAS, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1200, supra.

S. 1212

At the request of Ms. MIKULSKI, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 1212, a bill to amend title XVIII of the Social Security Act to permit direct payment under the Medicare program for clinical social worker services provided to residents of skilled nursing facilities.

S. 1213

At the request of Mr. LUGAR, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1213, a bill to give States the flexibility to reduce bureaucracy by streamlining enrollment processes for the Medicaid and State Children's Health Insurance Programs through better linkages with programs providing nutrition and related assistance to low-income families.

S. 1224

At the request of Mr. ROCKEFELLER, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1224, a bill to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes.

S. RES. 125

At the request of Mrs. FEINSTEIN, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. Res. 125, a resolution designating May 18, 2007, as "Endangered Species Day", and encouraging the people of the United States to become educated about, and aware of, threats to species, success stories in species recovery, and the opportunity to promote species conservation worldwide.

S. RES. 146

At the request of Mr. ALEXANDER, the names of the Senator from Pennsylvania (Mr. SPECTER), the Senator from New Hampshire (Mr. GREGG) and the Senator from Idaho (Mr. CRAPO) were added as cosponsors of S. Res. 146, a resolution designating June 20, 2007, as "American Eagle Day", and celebrating the recovery and restoration of the American bald eagle, the national symbol of the United States.

S. RES. 154

At the request of Mr. ALLARD, the name of the Senator from Hawaii (Mr. INOUE) was added as a cosponsor of S. Res. 154, a resolution demanding the return of the USS Pueblo to the United States Navy.

S. RES. 155

At the request of Mr. DODD, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of S. Res. 155, a resolution expressing the sense of the Senate on efforts to control violence and strengthen the rule of law in Guatemala.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS—APRIL 25, 2007

By Mr. ROCKEFELLER (for himself, Ms. SNOWE, and Mr. KENNEDY):

S. 1224. A bill to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program, and for other purposes; to the Committee on Finance.

Mr. KENNEDY. Mr. President, when we enacted the Children's Health Insurance Program a decade ago, we made a promise to low-income working fami-

lies to assist them in obtaining health insurance coverage for their children, and we must continue to keep that promise. Today, with Senators ROCKEFELLER and SNOWE, I am pleased to introduce The Children's Health Insurance Program Reauthorization Act of 2007.

CHIP has been a significant success, and has made a real difference in many children's lives. Over the past decade, the percentage of uninsured children has dropped dramatically, even though more and more of their parents have been losing coverage because employers decide to reduce it or drop it entirely.

In its first year, the program enrolled nearly a million children, and enrollment has grown ever since. Average monthly enrollment is now 4 million, and over 6 million have been enrolled for at least part of the year.

We know CHIP has made a difference in the lives of millions of children, but we also know that this is no time to rest on past success. We can and must do more to enroll the 6 million uninsured children who are eligible but not enrolled for CHIP and Medicaid, and to expand coverage so that all children can obtain the health care they need.

The bill we are introducing today reauthorizes the program and it will make sure that states have enough funds to provide health care to all children who need this assistance. No parents should be faced with the impossible decision of whether they can afford to take their sick child to the doctor.

The bill establishes a strong, reliable financing structure for CHIP. It more than doubles the Federal resources currently available over the next 5 years for covering children through CHIP. It ensures that all states will have the Federal matching funds needed both to sustain their existing programs and to move forward to cover the millions of children who are eligible for CHIP and Medicaid but remain unenrolled.

Millions of uninsured children in America isn't just wrong. It's unacceptable. We need to act now in getting to guarantee them the health coverage they need.

This bill adopts a variety of approaches to help states increase their enrollment. It strengthens CHIP by expanding the current program, improving its outreach, and making sure that all children have access to dental care and mental health services, so that good health care can be a reality for every child in America.

Quality health care for children isn't just a good option or a nice idea. It's not merely something we wish we could do. It's something we have to do. It's an obligation. We started earlier this year by pledging what is needed in the budget, but we also need a CHIP reauthorization that gives children the coverage we've promised them for the healthy future they deserve. The bill we're introducing today does that.

There's a reason the CHIP program has always enjoyed bipartisan support.

It's because all of us know how important it is that all children have the chance to get a healthy start in life. I look forward to working to make sure all children get the health care they need, and I urge my colleagues to support this bill.

Mr. ROCKEFELLER. Mr. President, this week is Cover the Uninsured Week. And, I cannot think of a more appropriate time to introduce the legislation that Senators OLYMPIA SNOWE, TED KENNEDY, and I introduced yesterday—the Children's Health Insurance Program (CHIP) Reauthorization Act of 2007 (S. 1224). There are more than 45 million uninsured people in our country today, and 9 million of them—20 percent—are children. This is an embarrassing statistic for the wealthiest country in the world, and it has catastrophic consequences for our children.

In 1964, when I first came to West Virginia as a VISTA volunteer in Emmons, I was shocked to learn that many of the school-age children living there had never been to a dentist before. I made raising health care standards one of my first priorities in Emmons, and we ultimately got a bus to bring children to the Tiskelwah grade school in Charleston for dental care. Now, more than 30 years later, there are still children in West Virginia and throughout the Nation without access to adequate dental care.

Several weeks ago, millions across the country mourned the death of twelve year old Deamonte Driver, whose lack of dental care led to fatal brain infection. His death was a sad reminder of how our country continues to fail in its efforts to ensure access to vital medical care for our nation's youth. Yet, Deamonte was not the only child to succumb to the perils of inadequate health coverage. There are countless other children who have suffered the same fate. We must make universal coverage for children a national priority and reauthorization of CHIP is the first step in that process.

When CHIP was established in 1997, nearly 10 million children were uninsured. Congress responded by making a landmark, bipartisan commitment to help states provide comprehensive health insurance coverage to millions of these children. As a result, 6 million children have access to medical benefits through CHIP that they would have otherwise been forced to do without. I am proud to have been a part of CHIP's creation, and I am especially proud of the progress this program has made in providing working families an affordable and dependable option for protecting the health and well-being of their children. A healthy start in life is a necessary component in preparing our children to lead healthy, happy and productive lives in the future.

Today, however, we find ourselves in a situation strikingly similar to the dilemma we faced in 1997—more than 9 million children are currently without health insurance in this country. In fact, in 2005, the number of uninsured

children increased for the first time since CHIP was enacted. This means that, despite our best efforts, we have taken a step backwards in terms of covering children. We cannot allow this trend to continue. Instead, we must make covering children a top priority—just like we did in 1997.

The CHIP Reauthorization Act makes health insurance coverage for children a priority. Not only does this important legislation renew and strengthen the commitment we made to our working families 10 years ago; it also provides significant new Federal resources for states to reach the 6 million additional children who are currently eligible for Medicaid and CHIP, but unenrolled. With many states already leading the charge on children's health and the additional federal support this legislation provides them, the Nation will be able to take another substantial step forward toward ensuring that all of America's children have comprehensive health insurance.

Our bill strengthens the underlying CHIP financing formula to provide states a stable and reliable source of funding for their efforts to cover more uninsured children. It also combines a variety of approaches, such as Express Lane eligibility, to help states enroll more uninsured kids who are currently eligible for CHIP or Medicaid. These innovative approaches will allow states to reach millions of additional children, particularly in rural parts of the country.

I am especially proud of our efforts to permit states to provide more meaningful coverage for children by including other vital benefits like dental care and mental health services. I have already talked about the importance of oral health for a child, but I'd also like to say something about children's mental health. I spend a lot of time with veterans, many who suffer from Post-Traumatic Stress Disorder (PTSD), and when those veterans get home, their children often suffer as well. We also need to consider the mental health of our children more broadly. Children are living in very tough times. They face enormous amounts of mental pressure from a variety of sources. If the Virginia Tech tragedy taught us anything, it taught us that we need to hug our children everyday and that we need to get appropriate help for our children when they have mental health needs, no matter how big or small.

While I had hoped that we could require Early Periodic Screening Diagnostic and Treatment (EPDST) services as part of this bill, I believe we were able to reach an appropriate compromise that will help us to achieve broad bipartisan support. I am still as committed as I ever have been to including EPDST services in CHIP. However, Senators SNOWE, KENNEDY, and I wanted to craft a bill that could pass the Senate, and we believe we have achieved that objective.

A final component of our legislation that I would like to highlight are the

important steps we take to develop child-focused quality measures that will directly improve the coverage provided to children enrolled in CHIP. We establish a new child health quality initiative to enhance data collection, identify best practices, develop a pediatric electronic medical record, and disseminate health quality information. We hope this new initiative will greatly improve the health outcomes of children.

In closing, I'd like for our country to get to the point where we never have to have another Cover the Uninsured Week again. Of course I greatly appreciate all the wonderful work the Robert Wood Johnson Foundation has done over the years to raise awareness about the uninsured problem. My hope is that we will eventually have universal coverage for all. Certainly, we can take the first step toward achieving that goal by providing health care coverage for all of our Nation's children.

With this reauthorization bill, Congress now has an opportunity to make profound positive changes in the lives of millions of American children and their families. I urge my colleagues to join us in supporting the passage of the CHIP Reauthorization Act of 2007.

I ask that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1224

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Children's Health Insurance Program (CHIP) Reauthorization Act of 2007”.

(b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) **MEDICAID; CHIP; SECRETARY.**—In this Act:

(1) **CHIP.**—The term “CHIP” means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(2) **MEDICAID.**—The term “Medicaid” means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

(d) **TABLE OF CONTENTS.**—The table of contents for this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; table of contents.

Sec. 2. Findings.

TITLE I—MAKING CHILDREN'S HEALTH COVERAGE A NATIONAL PRIORITY

Sec. 101. Providing necessary funding for CHIP.

TITLE II—IMPROVING CHIP FINANCING

Sec. 201. State CHIP allotments that are responsive to health care costs, population growth, and the needs of low-income uninsured children.

- Sec. 202. 2-year initial availability of CHIP allotments for all States and territories
- Sec. 203. Establishment of timely and responsive redistribution process.
- Sec. 204. Improving funding for the territories under CHIP and Medicaid.
- Sec. 205. Extension of authority for qualifying States to use CHIP allotments for certain Medicaid expenditures.
- Sec. 206. State option to expand coverage of children under CHIP up to 300 percent of the poverty line.
- Sec. 207. Requiring responsible CHIP enrollment growth.

TITLE III—ENROLLING UNINSURED CHILDREN ELIGIBLE FOR CHIP AND MEDICAID

- Sec. 301. “Express Lane” option for States to determine components of a child’s eligibility for Medicaid or CHIP.
- Sec. 302. Information technology connections to simplify health coverage determinations.
- Sec. 303. Enhanced administrative funding for translation or interpretation services.
- Sec. 304. Enhanced assistance with coverage costs for States with increasing or high coverage rates among children.
- Sec. 305. Elimination of counting Medicaid child presumptive eligibility costs against title XXI allotment.
- Sec. 306. State option to require certain individuals to present satisfactory documentary evidence of proof of citizenship or nationality for purposes of eligibility for Medicaid.

TITLE IV—START HEALTHY, STAY HEALTHY

- Sec. 401. State option to expand or add coverage of certain pregnant women under Medicaid and CHIP.
- Sec. 402. Coordination with the maternal and child health program.
- Sec. 403. Optional coverage of legal immigrants under Medicaid and CHIP.
- Sec. 404. Improving benchmark coverage options.
- Sec. 405. Requiring coverage of dental and mental health services.
- Sec. 406. Clarification of requirement to provide EPSDT services for all children in benchmark benefit packages under Medicaid.
- Sec. 407. Childhood obesity demonstration project.

TITLE V—IMPROVING ACCESS TO HEALTH CARE FOR CHILDREN

- Sec. 501. Promoting children’s access to covered health services.
- Sec. 502. Institute of Medicine study and report on children’s access to health care.

TITLE VI—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES OF CHILDREN

- Sec. 601. Strengthening child health quality improvement activities.
- Sec. 602. Application of certain managed care quality safeguards to CHIP.

TITLE VII—OTHER IMPROVEMENTS

- Sec. 701. Strengthening premium assistance programs.
- Sec. 702. Permitting coverage of children of State employees.

- Sec. 703. Improving data collection.
- Sec. 704. Moratorium on application of PERM requirements related to eligibility reviews during period of independent study and report.
- Sec. 705. Elimination of confusing program references.

TITLE VIII—EFFECTIVE DATE

- Sec. 801. Effective date.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) AND MEDICAID HAVE GREATLY IMPROVED CHILDREN’S COVERAGE RATES AND ACCESS TO NEEDED HEALTH CARE SERVICES.—

(A) CHIP and Medicaid serve as the critical health care safety net for 34,000,000 children over the course of a year, with 28,000,000 children enrolled in Medicaid and more than 6,000,000 children enrolled in CHIP.

(B) CHIP and Medicaid have accounted for a ½ decline in the rate of uninsured low-income children since 1997.

(C) During the recent economic downturn, and as the number of uninsured people has climbed to the highest number ever recorded in the United States, CHIP and Medicaid offset losses in employer-sponsored coverage that affected children and parents alike.

(D) While the number of children living in low-income families increased between 2000 and 2005, the number of uninsured children fell due to Medicaid and CHIP.

(E) Children enrolled in CHIP or Medicaid are much more likely to have a usual source of care than uninsured children, and are much more likely than uninsured children to receive well-child care, see a doctor during the year, and get dental care. Studies have found that children enrolled in public insurance programs experienced significant improvement in measures of school performance.

(F) Since CHIP was created, coverage rates have increased significantly among children of all ethnic and racial groups.

(G) According to one Federal evaluation of CHIP, uninsured children who gained coverage through the program received more preventive care, and their parents reported better access to providers and improved communications with their children’s doctors.

(2) EVEN WITH THE SUCCESS OF CHIP AND MEDICAID, MORE NEEDS TO BE DONE TO IMPROVE THE HEALTH STATUS OF OUR NATION’S CHILDREN.—

(A) There are currently 9,000,000 uninsured children under age 19, accounting for nearly 20 percent of our Nation’s uninsured.

(B) Approximately 7 out of every 10 uninsured children are eligible for CHIP or Medicaid.

(C) The cost of unmet health needs among children extends beyond measurable health system costs. For example, problems that could be prevented, managed, or treated with regular access to care can become more serious, resulting in lower school attendance and increased health care costs.

(D) Reducing the number of uninsured children in our country is an essential first step to improve health status. CHIP reauthorization presents an opportunity to secure health care coverage for more children who are eligible for CHIP or Medicaid but not yet enrolled.

(3) WE MUST MAINTAIN COVERAGE FOR THE CHILDREN CURRENTLY ENROLLED IN CHIP.—

(A) When CHIP was created in 1997, Congress allocated \$40,000,000,000 for the 10-year authorization.

(B) At current funding levels, nearly 2,000,000 children are at risk of losing their CHIP coverage over the next 5 years because the current CHIP financing structure is inad-

equated and States are facing CHIP funding shortfalls.

(C) We must eliminate Federal funding shortfalls by providing States with significant new Federal resources for children’s health coverage.

(D) CHIP reauthorization offers an opportunity to increase CHIP funding and to provide stable, predictable Federal funding so that States not only have the ability to maintain their current caseloads but also to expand coverage to currently unenrolled children.

(4) WE MUST REACH THE UNINSURED CHILDREN WHO ARE ALREADY ELIGIBLE FOR CHIP OR MEDICAID BUT UNENROLLED.—

(A) More than 6,000,000 uninsured children are eligible for CHIP or Medicaid at any point during the year.

(B) In some States, it is estimated that up to 50 percent of children covered through CHIP do not remain in the program due to reenrollment barriers.

(C) Difficult renewal policies and reenrollment barriers make seamless coverage in CHIP unattainable. Studies indicate that as many as 67 percent of children who were eligible but not enrolled in CHIP or Medicaid had applied for coverage but were denied eligibility due to procedural issues.

(D) States have tools at their disposal to streamline enrollment procedures, but further Federal changes would help States reach more children.

(E) Insuring parents is an effective way to increase children’s participation in public programs and to increase children’s access to health care services.

(F) To reduce the number of uninsured children, improve our children’s health, and continue our progress in reducing health disparities, the reauthorization of CHIP should provide States with the tools and resources necessary to identify, enroll, and maintain coverage for children who are eligible for CHIP or Medicaid.

(5) WE MUST SUPPORT AND ENCOURAGE STATES THAT ARE LEADING THE WAY WITH INITIATIVES TO COVER MORE CHILDREN.—

(A) States in every region of the country are seeking to move forward in covering more children, either by reaching already eligible children or further expanding eligibility.

(B) The Federal government should serve as a partner in these efforts by providing sufficient funding to solidify and strengthen this momentum.

(6) WE MUST PROMOTE HIGH-QUALITY HEALTH CARE THAT PROMOTES CHILDREN’S HEALTHY DEVELOPMENT.—

(A) Children and adolescents deserve better quality care than what they currently receive.

(B) Most States report using some kind of measure to evaluate and improve the quality of care children receive through their CHIP and Medicaid programs. However, State efforts are often hampered by budget constraints, limitations on information technology systems, and a need for improved measurement tools and performance measurement standards.

(C) As we improve access to health coverage as part of CHIP reauthorization, Congress also has an opportunity to enhance quality by improving and standardizing data collection efforts.

(7) WE MUST SUPPORT POLICIES THAT STRENGTHEN AND EXPAND HEALTH INSURANCE COVERAGE.—

(A) There are more than 46,000,000 uninsured Americans today.

(B) No one who is currently covered should lose coverage because of changes to CHIP or Medicaid as part of the reauthorization of CHIP.

(C) Coverage of parents through family coverage waivers furthers the objectives of CHIP in that it promotes children's enrollment, positively impacts children's utilization of services, and improves family well-being.

(D) Coverage of parents through family coverage waivers is also consistent with long-standing CHIP policy – the explicit authorization in the CHIP statute for the Secretary to grant waivers that are consistent with the objectives of CHIP, the parent waiver guidelines for CHIP issued by the Secretary, and the flexibility broadly accorded States through CHIP.

(E) Parent coverage waivers have been granted to States that have made a commitment to cover children first and then to use funding to cover low-income parents.

(F) Research indicates that having an uninsured parent not only decreases the likelihood that a child will have a well-child visit, it also decreases the likelihood that a child will see any medical provider at all.

(G) We strongly support maintaining the current flexibility under CHIP that permits family coverage through waivers to cover parents, while assuring that children remain the primary focus of CHIP.

TITLE I—MAKING CHILDREN'S HEALTH COVERAGE A NATIONAL PRIORITY

SEC. 101. PROVIDING NECESSARY FUNDING FOR CHIP.

Section 2104(a) (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (9), by striking “and” at the end;

(2) in paragraph (10), by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

- “(11) for fiscal year 2008, \$8,525,000,000;
- “(12) for fiscal year 2009, \$10,075,000,000;
- “(13) for fiscal year 2010, \$11,250,000,000;
- “(14) for fiscal year 2011, \$13,150,000,000;
- “(15) for fiscal year 2012, \$15,400,000,000; and
- “(16) for fiscal year 2013 and each fiscal year thereafter, the total allotment amount appropriated under this subsection for the preceding fiscal year, multiplied by the adjustment determined for such fiscal year under subsection (i)(2)(C).”

TITLE II—IMPROVING CHIP FINANCING

SEC. 201. STATE CHIP ALLOTMENTS THAT ARE RESPONSIVE TO HEALTH CARE COSTS, POPULATION GROWTH, AND THE NEEDS OF LOW-INCOME UNINSURED CHILDREN.

(a) IN GENERAL.—Section 2104 (42 U.S.C. 1397dd) is amended by adding at the end the following new subsection:

“(i) ANNUAL ALLOTMENTS FOR STATES OTHER THAN TERRITORIES BEGINNING WITH FISCAL YEAR 2008.—

“(1) IN GENERAL.—Subject to paragraph (4), of the total allotment amount appropriated under subsection (a) for a fiscal year beginning with fiscal year 2008 and remaining available after the application of subsection (j) and subsection (c)(5), the Secretary shall allot to each State (as defined for purposes of this subsection in paragraph (5)) the sum of the following:

“(A) The coverage factor, as determined under paragraph (2), based on the State's prior spending adjusted for health care cost growth and child population growth.

“(B) The uninsured children factor, as determined under paragraph (3), based on the number of low-income children without health insurance in the State, adjusted for geographic variation in health care costs.

“(2) COVERAGE FACTOR.—

“(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraphs (B) and (D), the coverage factor determined for a State is equal to the following:

“(i) FISCAL YEAR 2008.—For fiscal year 2008, the higher of the following:

“(I) The total Federal payments to the State under this title for fiscal year 2007, multiplied by the annual adjustment determined under subparagraph (C) for that fiscal year.

“(II) The amount allotted to the State for fiscal year 2007 under subsection (b), multiplied by the annual adjustment determined under subparagraph (C) for that fiscal year.

“(III) The projected total Federal payments to the State under this title for fiscal year 2007, as reported by the State to the Secretary by the State as of November 2006 (or the projected total Federal payments to the State under this title for fiscal year 2007 as reported by the State to the Secretary as of May 2006 if the projected total Federal payments to the State under this title for such fiscal year were at least \$95,000,000 higher than such projected payments as of November 2006), multiplied by the annual adjustment determined under subparagraph (C) for that fiscal year.

“(IV) The projected total Federal payments to the State under this title for fiscal year 2008, as reported by the State to the Secretary by the State as of February 2007.

“(ii) FISCAL YEAR 2009.—For fiscal year 2009, the amount determined under clause (i), multiplied by the annual adjustment determined under subparagraph (C) for that fiscal year.

“(iii) FISCAL YEAR 2010 AND EACH SECOND SUCCEEDING FISCAL YEAR; PROVIDING FOR REBASING.—Subject to subparagraphs (B) and (D), for fiscal year 2010 and each second succeeding fiscal year, the total Federal payments to the State under this title for the previous fiscal year attributable to any allotments available to the State in such fiscal year under paragraph (1) and subsection (b) multiplied by the annual adjustment determined under subparagraph (C) for that fiscal year.

“(iv) FISCAL YEAR 2011 AND EACH SECOND SUCCEEDING FISCAL YEAR.—For fiscal year 2011 and each second succeeding fiscal year, the amount determined under clause (iii) for the preceding fiscal year, multiplied by the annual adjustment determined under subparagraph (C) for the State for that fiscal year.

“(B) LIMITATION AND MINIMUMS.—

“(i) IN GENERAL.—Subject to clause (ii), if the total of the coverage factors determined under subparagraph (A) for all States exceed in any fiscal year the total allotment amount under subsection (a) for a fiscal year beginning with fiscal year 2008 remaining available after the application of subsections (c)(5) and (j)(2)(C), each State's coverage factor shall be equal to the total allotment amount under subsection (a) for a fiscal year remaining available after application of such subsections, multiplied by the ratio of—

“(I) the amount of the State's coverage factor determined under subparagraph (A); to

“(II) the total of such coverage factors for all States for such fiscal year.

“(ii) MINIMUM COVERAGE FACTOR.—At a minimum, the coverage factor for a State for a fiscal year shall not be less than the lesser of—

“(I) the State's total Federal payments attributable to any allotments available to the State in the prior fiscal year under paragraph (1) and subsection (b), multiplied by the annual adjustment determined under subparagraph (C) for that fiscal year; and

“(II) the total allotment for the State under paragraph (1) for the prior fiscal year, multiplied by the annual adjustment determined under subparagraph (C) for that fiscal year.

“(C) ANNUAL ADJUSTMENT FOR HEALTH CARE COST GROWTH AND CHILD POPULATION GROWTH.—The annual adjustment with respect to a State for any fiscal year is equal to the product of the amounts determined under clauses (i) and (ii):

“(i) PER CAPITA HEALTH CARE GROWTH.—1 plus the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for such fiscal year over the preceding fiscal year, as most recently published by the Secretary before the beginning of the fiscal year involved.

“(ii) CHILD POPULATION GROWTH.—1.01 plus the percentage increase in the population of children under 19 years of age in the United States from July 1 of the previous fiscal year to July 1 of the fiscal year involved, as determined by the Secretary based on the most recent published estimates of the Bureau of the Census before the beginning of the fiscal year involved.

“(D) REBASING RULE FOR FISCAL YEAR 2010 AND EACH SECOND SUCCEEDING FISCAL YEAR FOR CERTAIN STATES.—

“(i) IN GENERAL.—For fiscal year 2010 and each second succeeding fiscal year, a State receiving reallocated funds under subsection (j) in the prior fiscal year shall receive an additional spending amount equal to the proportion (determined under clause (ii)) of the total allotment amount under subsection (a) for such fiscal year remaining available after the application of subsections (c)(5) and (j)(2)(C), and subparagraphs (A) and (B), if any, multiplied by the ratio of—

“(I) the total Federal payments to the State under this title for the previous fiscal year attributable to any funds made available to the State in the previous fiscal year under subsection (j), multiplied by the annual adjustment determined under subparagraph (C) for the fiscal year; to

“(II) the total of such payments for all States for the previous fiscal year.

“(ii) PROPORTION.—For purposes of clause (i), the proportion shall equal—

“(I) for fiscal year 2010, 20 percent; and

“(II) for fiscal year 2012 and each second succeeding fiscal year, 40 percent.

“(3) UNINSURED CHILDREN FACTOR.—

“(A) IN GENERAL.—For purposes of paragraph (1)(B), subject to subparagraph (B), the uninsured children factor for a State is equal to the total allotment amount under subsection (a) for a fiscal year beginning with fiscal year 2008, remaining available after application of subsections (c)(5) and (j)(2)(C) and paragraph (2), multiplied by the following:

“(i) FISCAL YEAR 2008 AND EACH SECOND SUCCEEDING FISCAL YEAR.—In the case of fiscal year 2008, and each second succeeding fiscal year, the ratio of—

“(I) the uninsured children adjustment for the State determined under subparagraph (B); to

“(II) the sum of the uninsured children adjustments for all States determined under subparagraph (B).

“(ii) FISCAL YEAR 2009 AND EACH SECOND SUCCEEDING FISCAL YEAR.—In the case of fiscal year 2009, and each second succeeding fiscal year, the ratio determined under clause (i) for the previous fiscal year.

“(B) UNINSURED CHILDREN ADJUSTMENT.—The uninsured children adjustment determined under this subparagraph for a State is equal to the product of the following:

“(i) NUMBER OF LOW-INCOME CHILDREN WITHOUT HEALTH INSURANCE.—The average of the number of low-income children under 19 years of age in the State with no health insurance for a fiscal year, as reported and defined in the 2 most recent March supplement to the Current Population Survey of the Bureau of the Census available prior to the beginning of such fiscal year.

“(ii) GEOGRAPHIC VARIATION IN HEALTH CARE COSTS.—The adjustment for geographic variation in health care costs, as determined under subsection (b)(3).

“(4) DATA.—In computing the amounts under paragraphs (2) and (3) and subsection (c)(5) that determine the allotments to States for each fiscal year, the Secretary shall use the most recent expenditure data for the prior year available to the Secretary before the start of each fiscal year. The Secretary may adjust such amounts and allotments, as necessary, on the basis of the expenditure data for the prior year reported by States on CMS Form 64 or CMS Form 21 not later than November 30 of each fiscal year but in no case shall the Secretary adjust the allotments provided under this subsection or subsection (c)(5) for a fiscal year after December 31 of such year.

“(5) STATE DEFINED.—In this subsection, the term ‘State’ means one of the 50 States or the District of Columbia.”

(b) CONFORMING AMENDMENTS.—Section 2104 (42 U.S.C. 1397dd) is amended—

(1) in subsection (a), by striking “subsection (d)” and inserting “subsections (d), (h), and (i)”;

(2) in subsection (b)—

(A) in paragraph (1), by striking “subsection (d)” and inserting “subsections (d), (h), and (i)”;

(B) in paragraph (3)(A), by inserting “and subsection (i)(3)(D)(ii)” after “paragraph (1)(A)(ii)”.

(3) in subsection (c)(1), by striking “subsection (d)” and inserting “subsections (d), (h), and (i)”.

SEC. 202. 2-YEAR INITIAL AVAILABILITY OF CHIP ALLOTMENTS FOR ALL STATES AND TERRITORIES.

Section 2104(e) (42 U.S.C. 1397dd(e)) is amended to read as follows:

“(e) AVAILABILITY OF AMOUNTS ALLOTTED.—Subject to paragraphs (3) and (4) of subsection (j), amounts allotted to a State pursuant to subsections (b), (c), or (i)—

“(1) for each of fiscal years 1998 through 2007, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

“(2) for fiscal year 2008 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the succeeding fiscal year.”

SEC. 203. ESTABLISHMENT OF TIMELY AND RESPONSIVE REDISTRIBUTION PROCESS.

(a) IN GENERAL.—Section 2104 (42 U.S.C. 1397dd), as amended by section 201, is amended by adding at the end the following new subsection:

“(j) TIMELY AND RESPONSIVE REDISTRIBUTIONS BEGINNING WITH FISCAL YEAR 2008.—

“(1) REALLOCATION TO STATES FACING FEDERAL FUNDING SHORTFALLS.—

“(A) IN GENERAL.—Notwithstanding subsection (f), in each fiscal year quarter of fiscal year 2008 and each subsequent fiscal year, the Secretary shall reallocate to a shortfall State described in subparagraph (D) from the funds available under paragraph (2) an amount equal to the projected amount of the shortfall for the fiscal year. The Secretary shall only make such a reallocation under this paragraph to the extent that there are amounts available under paragraph (2).

“(B) PRORATION RULE.—If the amounts available under paragraph (2) for any fiscal year quarter for reallocation under subparagraph (A) are less than the total shortfall amounts for the fiscal year determined under subparagraph (A), the reallocated amount to each shortfall State shall be reduced proportionally.

“(C) AVAILABILITY OF REALLOCATED FUNDS.—Any funds made available to a shortfall State described in subparagraph (D)

shall remain available to such State through the end of the fiscal year in which such funds are reallocated.

“(D) SHORTFALL STATE DESCRIBED.—For purposes of subparagraph (A), a shortfall State is a State (as defined in subsection (i)(5)) that has a State child health plan approved under this title (or waiver of such title approved by the Secretary) for which the Secretary estimates on a quarterly basis using the most recent data available to the Secretary as of such quarter, that the projected expenditures under such plan (or waiver) for the State for the fiscal year will exceed the sum of—

“(i) the amount of the allotments provided under subsection (b) or (i) in fiscal years preceding such fiscal year that remain available to the State;

“(ii) the amount of the allotment under subsection (i) for such fiscal year to the State; and

“(iii) the amount of any reallocated funds made available under subparagraph (A) in previous quarters of such fiscal year to the State.

“(2) AMOUNTS AVAILABLE FOR REALLOCATION.—Amounts available for reallocation in any fiscal year under this subsection shall equal the sum of the following:

“(A) Any allotments remaining unexpended after the period of availability under subsection (e).

“(B) Any amounts available for reallocation and remaining unexpended at the end of the previous fiscal year under paragraph (3).

“(C) Subject to paragraph (4), 5 percent of the total amount available under subsection (a) for such fiscal year.

“(3) CONTINUED AVAILABILITY OF UNEXPENDED REALLOCATED FUNDS.—Any unexpended amounts reallocated to a shortfall State remaining available after the period of availability under paragraph (1)(C) and any amounts available for redistribution in a fiscal year that are not reallocated to a shortfall State because the total amount available for reallocation exceeds the total of all reallocated amounts under paragraph (1)(A) shall remain available for reallocation until expended.

“(4) LIMITS ON WITHHOLDING FROM TOTAL ALLOTMENTS FOR PURPOSES OF REALLOCATION.—If the Secretary determines that the total amounts available for reallocation under paragraph (2) for a fiscal year exceeds 10 percent of the total amount available under subsection (a) for that fiscal year, the Secretary shall reduce the percentage under paragraph (2)(C) accordingly so that the total amount available for reallocation under paragraph (2) for the fiscal year does not exceed 10 percent of the total amount available under subsection (a) for such fiscal year.”

SEC. 204. IMPROVING FUNDING FOR THE TERRITORIES UNDER CHIP AND MEDICAID.

(a) UPDATE OF CHIP ALLOTMENTS.—Section 2104(c) (42 U.S.C. 1397dd(c)) is amended—

(1) in paragraph (1), by inserting “and paragraphs (5) and (6)” after “subsection (d)”;

(2) by adding at the end the following new paragraphs:

“(5) ANNUAL ALLOTMENTS FOR TERRITORIES BEGINNING WITH FISCAL YEAR 2008.—Of the total allotment amount appropriated under subsection (a) for a fiscal year beginning with fiscal year 2008 and remaining available after the application of subsection (j), the Secretary shall allot to each of the commonwealths and territories described in paragraph (3) the following:

“(A) FISCAL YEAR 2008.—For fiscal year 2008, the highest amount of Federal payments to the commonwealth or territory under this title for any fiscal year occurring during the

period of fiscal years 1998 through 2007, multiplied by the annual adjustment determined under subsection (i)(2)(C) for the fiscal year.

“(B) FISCAL YEAR 2009 AND SUCCEEDING FISCAL YEARS.—For fiscal year 2009 and each succeeding fiscal year, the amount determined under clause (i), multiplied by the annual adjustment determined under subsection (i)(2)(C) for the fiscal year.

“(6) REDISTRIBUTIONS FOR TERRITORIES FACING FEDERAL FUNDING SHORTFALLS.—Notwithstanding subsection (f), the Secretary shall determine an appropriate procedure for reallocating to each commonwealth or territory described in paragraph (3) that would, with respect to each fiscal year quarter of fiscal year 2008 be a shortfall State described in subsection (j)(1)(D) if such subsection applied to such commonwealth or territory, from the funds available under subsection (j)(2) for such fiscal year, the same proportion as the proportion of the commonwealth’s or territory’s allotment under paragraph (2) to such percentage (not to exceed 1.05 percent) as the Secretary determines appropriate of such funds.”

(b) REMOVAL OF FEDERAL MATCHING PAYMENTS FOR DATA REPORTING SYSTEMS FROM THE OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER TITLE XIX.—Section 1108(g) (42 U.S.C. 1308(g)) is amended by adding at the end the following new paragraph:

“(4) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal year 2008 and each fiscal year thereafter, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (A) (iii), (A)(iv), or (B) of section 1903(a)(3) for a calendar quarter of such fiscal year, the limitation on expenditures under title XIX for such commonwealth or territory otherwise determined under subsection (f) and this subsection for such fiscal year shall be determined without regard to such payment.”

(c) GAO STUDY AND REPORT.—Not later than September 30, 2009, the Comptroller General of the United States shall submit a report to Congress regarding Federal funding under Medicaid and the State Children’s Health Insurance Program for Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. The report shall include the following:

(1) An analysis of all relevant factors with respect to—

(A) eligible Medicaid and CHIP populations in such commonwealths and territories;

(B) historical and projected spending needs of such commonwealths and territories and the ability of capped funding streams to respond to those spending needs;

(C) the extent to which Federal poverty guidelines are used by such commonwealths and territories to determine Medicaid and CHIP eligibility; and

(D) the extent to which such commonwealths and territories participate in data collection and reporting related to Medicaid and CHIP, including an analysis of territory participation in the Current Population Survey versus the American Community Survey.

(2) Recommendations for improving Federal funding under Medicaid and the State Children’s Health Insurance Program for such commonwealths and territories.

SEC. 205. EXTENSION OF AUTHORITY FOR QUALIFYING STATES TO USE CHIP ALLOTMENTS FOR CERTAIN MEDICAID EXPENDITURES.

Section 2105(g)(1)(A) (42 U.S.C. 1397ee(g)(1)(A)), as amended by section 201(b) of the National Institutes of Health Reform Act of 2006 (Public Law 109-482) is amended by striking “not more than 20 percent of any

allotment under section 2104 for fiscal year 1998, 1999, 2000, 2001, 2004, 2005, 2006, or 2007" and inserting "any allotment under subsection (b) or (i) of section 2104 for a fiscal year".

SEC. 206. STATE OPTION TO EXPAND COVERAGE OF CHILDREN UNDER CHIP UP TO 300 PERCENT OF THE POVERTY LINE.

Section 2110(b)(1)(B) (42 U.S.C. 1397jj(b)(1)(B)) is amended—

(1) in clause (i), by striking " , or" at the end and inserting a semicolon;

(2) in clause (ii)(III), by striking "and" at the end and inserting "or"; and

(3) by adding at the end the following new clause:

"(iii) is a child—

"(I) whose family income (as determined under the State child health plan) does not exceed 300 percent of the poverty line for a family of the size involved; or

"(II) whose family income exceeds 300 percent of the poverty line but does not exceed 50 percentage points above the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) applied under the State child health plan on the date of enactment of this clause; and"

SEC. 207. REQUIRING RESPONSIBLE CHIP ENROLLMENT GROWTH.

(a) LIMITATION ON APPROVAL OF PROPOSED PLAN AMENDMENTS.—Section 2106(b)(3)(B) (42 U.S.C. 1397ff(b)(3)(B)) is amended by adding at the end the following new clause:

"(iii) AMENDMENTS TO EXPAND ELIGIBILITY BEYOND HIGHEST INCOME ELIGIBILITY PERMITTED.—Any plan amendment that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage for a child whose family income exceeds the highest income eligibility level permitted under section 2110(b)(1)(B)(iii) (in this clause referred to as an 'expansion amendment') may not take effect, and shall not remain in effect, unless the Secretary determines that the following conditions are met:

"(I) UNINSURED RATE FOR LOW-INCOME CHILDREN IS BELOW THE NATIONAL AVERAGE.—With respect to each fiscal year in which the expansion amendment is in effect, the percentage of low-income children without private health coverage who are uninsured is below the national average percentage of such children, for the most recent year for which such data is available (as determined by the Secretary on the basis of the 2 most recent Annual Social and Economic Supplements of the Current Population Survey of the Bureau of the Census).

"(II) OPEN ENROLLMENT; MAINTENANCE OF ELIGIBILITY STANDARDS.—The State does not impose any numerical limitation, waiting list, or similar limitation on eligibility for targeted low-income children described in section 2110(b)(1)(B)(iii) under the State child health plan, or to make more restrictive the eligibility standards for such children, while the expansion amendment is in effect.

"(III) IMPLEMENTATION OF SIMPLIFIED OUTREACH AND ENROLLMENT PROCEDURES.—The State submitting the expansion amendment has implemented procedures to effectively enroll and retain children eligible for medical assistance under title XIX and children eligible for child health assistance under this title by adopting and effectively implementing with respect to such children at least 3 of the following policies and procedures under title XIX and this title:

"(aa) JOINT APPLICATION AND RENEWAL PROCESS THAT PERMITS APPLICATION OTHER THAN IN PERSON.—The application and renewal forms and supplemental forms (if any) and information verification process is the same for purposes of establishing and renew-

ing eligibility for children for medical assistance under title XIX and child health assistance under this title, and such process does not require an application to be made in person or a face-to-face interview.

"(bb) NO ASSETS TEST.—The State does not apply any assets test for eligibility under title XIX and this title with respect to children.

"(cc) 12-MONTHS CONTINUOUS ELIGIBILITY.—The State has elected the option of continuous eligibility for a full 12 months for children described in section 1902(e)(12) under title XIX, and applies such option under this title.

"(dd) PRESUMPTIVE ELIGIBILITY FOR CHILDREN.—The State has implemented the option, for purposes of title XIX and this title, of applying presumptive eligibility for children in accordance with sections 1920A and 2107(e)(1)(F).

"(IV) ANNUAL REPORTING OF MEASURES OF QUALITY OF HEALTH CARE FOR CHILDREN.—The State satisfies the requirements of section 1905(y)(2)(B)(iv) (relating to annual reporting of measures of quality of health care for children under title XIX and this title)."

(b) APPLICATION TO WAIVERS.—Section 2107(f) (42 U.S.C. 1397gg(f)) is amended—

(1) by striking " , the Secretary" and inserting "

"(1) The Secretary"; and

(2) by adding at the end the following new paragraph:

"(2) The Secretary may not approve a waiver, experimental, pilot, or demonstration project with respect to a State that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage for a child whose family income exceeds the highest income eligibility level permitted under section 2110(b)(1)(B)(iii) (in this paragraph referred to as an 'expansion waiver') unless the Secretary determines that the conditions described in each of subparagraphs (I) through (IV) of section 2106(b)(3)(B)(iii) are met (and determines on an ongoing basis, that such conditions continue to be met while the expansion waiver is in effect)."

TITLE III—ENROLLING UNINSURED CHILDREN ELIGIBLE FOR CHIP AND MEDICAID

SEC. 301. "EXPRESS LANE" OPTION FOR STATES TO DETERMINE COMPONENTS OF A CHILD'S ELIGIBILITY FOR MEDICAID OR CHIP.

(a) MEDICAID.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following new paragraph:

"(13)(A)(i) At the option of the State, notwithstanding any other provision of law, including subsection (a)(46)(B) and sections 1137(d) and 1903(x), the State may rely on a determination made within a reasonable period (as determined by the State) by an Express Lane agency (as defined in subparagraph (F)(i)) to determine whether an individual has met the income, assets or resources, or citizenship status criteria for eligibility for medical assistance under this title (including under a waiver of the requirements of this title).

"(ii) The option under clause (i) shall apply to redeterminations or renewals of eligibility for medical assistance, as well as to initial applications for such assistance.

"(iii) The option under clause (i) shall apply to a child who is under an age specified by the State (not to exceed 21 years of age) and, at State option, may also apply to an individual who is not a child.

"(B) Nothing in this paragraph shall be construed to relieve a State of the obligation to determine eligibility for medical assistance under this title if an individual is determined ineligible for such assistance on the

basis of information furnished pursuant to this paragraph.

"(C) A State shall inform an individual (or, in the case of a child, the family of the child) enrolled in the State plan under this title and required to pay premiums for such enrollment based on an income determination furnished to the State pursuant to this paragraph that the individual or family may qualify for lower premium payments if directly evaluated for eligibility by the State Medicaid agency.

"(D) If a State applies the eligibility process described in subparagraph (A) to individuals eligible for medical assistance under this title, the State may, at its option, implement its duties under subparagraphs (A) and (B) of section 2102(b)(3) using either or both of the following approaches:

"(i) The State may—

"(I) establish a threshold percentage of the Federal poverty level (that shall exceed the income eligibility level applicable for a population of individuals under this title by 30 percentage points (as a fraction of the Federal poverty level) or such other higher number of percentage points as the State determines reflects the typical application of income methodologies by the program administered by the Express Lane agency and the State plan under this title); and

"(II) provide that, with respect to any individual within such population whom an Express Lane agency determines has income that does not exceed such threshold percentage for such population, such individual is eligible for medical assistance under this title (regardless of whether such individual would otherwise be determined to be eligible to receive such assistance).

In exercising the approach under this clause, a State shall inform families whose children are enrolled in a State child health plan under title XXI based on having family income above the threshold described in subclause (I) that they may qualify for medical assistance under this title and, at their option, can seek a regular eligibility determination for such assistance for their child, and that if their child is determined to be eligible for such assistance, the child may receive health benefits coverage that is more affordable and comprehensive than the coverage that would be provided to the child under the State child health plan.

"(ii) Regardless of whether a State otherwise provides for presumptive eligibility under section 1920A, a State may provide presumptive eligibility under this title, consistent with subsection (e) of section 1920A, to a child who, based on a determination by an Express Lane agency, would qualify for child health assistance under a State child health plan under title XXI. During such presumptive eligibility period, the State may determine the child's eligibility for medical assistance under this title, pursuant to subparagraph (A) of section 2102(b)(3), based on telephone contact with family members, access to data available in electronic or paper form, and other means of gathering information that are less burdensome to the family than completing an application form on behalf of the child. The procedures described in the previous sentence may be used regardless of whether the State uses similar procedures under other circumstances for purposes of determining eligibility for medical assistance under this title.

"(E)(i) At the option of a State, an individual determined to be eligible for medical assistance pursuant to subparagraph (A), (C), or (D) or other procedures through which eligibility is determined based on data obtained from sources other than the individual, may receive medical assistance under this title if such individual (or, in the case of an individual under age 19 (or if the State elects the

option under subparagraph (A), age 20 or 21) who is not authorized to consent to medical care, the individual's parent, guardian, or other caretaker relative) has acknowledged notice of such determination and has consented to being enrolled in the State plan under this title. The State (at its option) may waive any otherwise applicable requirements for signatures by or on behalf of an individual who has so consented.

“(ii) In the case of an individual enrolled pursuant to clause (i), the State shall inform the individual (or, in the case of an individual under age 19 (or if the State elects the option under subparagraph (A), age 20 or 21), the individual's parent, guardian, or other caretaker relative) about the significance of such enrollment, including appropriate methods to access covered services.

“(F) In this paragraph, the term ‘Express Lane agency’ means a Federal or State agency, or a public or private entity making such determination on behalf of such agency, specified by the plan, including an agency administering the State program funded under part A of title IV, the State child health plan under title XXI, the Food Stamp Act of 1977, the Richard B. Russell National School Lunch Act, or the Child Nutrition Act of 1966, notwithstanding any differences in budget unit, disregard, deeming, or other methodology, but only if—

“(i) the agency or entity has fiscal liabilities or responsibilities affected by such determination;

“(ii) the agency or entity notifies the child's family—

“(I) of the information which shall be disclosed in accordance with this paragraph;

“(II) that the information disclosed will be used solely for purposes of determining eligibility for medical assistance under this title or for child health assistance under title XXI;

“(III) that interagency agreements limit the use of such information to such purposes; and

“(IV) that the family may elect to not have the information disclosed for such purposes; and

“(iii) the requirements of section 1939 are satisfied.”

(b) CHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (B) through (D) as subparagraphs (C) through (E), respectively, and by inserting after subparagraph (A) the following new subparagraph:

“(B) Section 1902(e)(13) (relating to the State option to base a determination of a child's eligibility for assistance on determinations made by an agency other than the State Medicaid agency).”

(c) PRESUMPTIVE ELIGIBILITY.—Section 1920A(b)(3)(A)(i) (42 U.S.C. 1396r-1a(b)(3)(A)(i)) is amended by striking “or (IV)” and inserting “(IV) is an agency or entity described in section 1902(e)(13)(F), or (V)”.

(d) SIGNATURE REQUIREMENTS.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended by adding at the end the following new sentence: “Notwithstanding any other provision of law, a signature under penalty of perjury shall not be required on an application form for medical assistance as to any element of eligibility for which eligibility is based on information received from a source other than an applicant, rather than on representations from the applicant. Notwithstanding any other provision of law, any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note).”

SEC. 302. INFORMATION TECHNOLOGY CONNECTIONS TO SIMPLIFY HEALTH COVERAGE DETERMINATIONS.

(A) ENHANCED ADMINISTRATIVE FUNDING FOR INFORMATION TECHNOLOGY USED TO SIMPLIFY ELIGIBILITY DETERMINATIONS.—Section 1903(a)(3)(A) (42 U.S.C. 1396b(a)(3)(A)) is amended—

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

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

“(iii) 75 percent of so much of the sums expended during such quarter as are attributable to information technology needed to conduct data matches or for the exchange of electronic information with an Express Lane agency (as defined in 1902(e)(13)(F)) as the Secretary determines is directly related to reducing the need for an individual undergoing an eligibility determination for medical assistance under this title or child health assistance under title XXI (including a determination of a renewal of eligibility for such assistance) to provide information previously submitted by or on behalf of the individual to such agency, and”.

(b) AUTHORIZATION OF INFORMATION DISCLOSURE.—

(1) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

(A) by redesignating section 1939 as section 1940; and

(B) by inserting after section 1938 the following new section:

“AUTHORIZATION TO RECEIVE PERTINENT INFORMATION

“SEC. 1939. (a) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data potentially pertinent to eligibility determinations under this title (including eligibility files maintained by Express Lane agencies described in section 1902(e)(13)(F), information described in paragraph (2) or (3) of section 1137(a), vital records information about births in any State, and information described in sections 453(i) and 1902(a)(25)(I)) is authorized to convey such data or information to the State agency administering the State plan under this title, if—

“(1) such data or information are used only to establish or verify eligibility or provide coverage under this title; and

“(2) an interagency or other agreement, consistent with standards developed by the Secretary, prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements safeguarding privacy and data security.

(b) REQUIREMENTS FOR CONVEYANCE.—Data or information may be conveyed pursuant to this section only if the following requirements are met:

“(1) The individual whose circumstances are described in the data or information (or such individual's parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

“(2) Such data or information are used solely for the purposes of—

“(A) identifying individuals who are eligible or potentially eligible for medical assistance under this title and enrolling such individuals in the State plan; and

“(B) verifying the eligibility of individuals for medical assistance under the State plan.

“(3) An interagency or other agreement, consistent with standards developed by the Secretary—

“(A) prevents the unauthorized use, disclosure, or modification of such data and other-

wise meets applicable Federal requirements safeguarding privacy and data security; and

“(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll individuals in the plan.

“(c) CRIMINAL PENALTY.—A person described in the subsection (a) who publishes, divulges, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section shall be fined not more than \$1,000 or imprisoned not more than 1 year, or both, for each such unauthorized activity.

“(d) RULE OF CONSTRUCTION.—The limitations and requirements that apply to disclosure pursuant to this section shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under Federal law (without regard to this section).”

(2) CONFORMING AMENDMENT TO TITLE XXI.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by section 301(b), is amended by adding at the end the following new subparagraph:

“(F) Section 1939 (relating to authorization to receive data potentially pertinent to eligibility determinations).”

(3) CONFORMING AMENDMENT TO ASSURE ACCESS TO NATIONAL NEW HIRES DATABASE.—Section 453(i)(1) (42 U.S.C. 653(i)(1)) is amended by striking “and programs funded under part A” and inserting “, programs funded under part A, and State plans approved under title XIX or XXI”.

(4) CONFORMING AMENDMENT TO PROVIDE CHIP PROGRAMS WITH ACCESS TO NATIONAL INCOME DATA.—Section 6103(1)(7)(D)(ii) of the Internal Revenue Code of 1986 is amended by inserting “or title XXI” after “title XIX”.

(5) CONFORMING AMENDMENT TO PROVIDE ACCESS TO DATA ABOUT ENROLLMENT IN INSURANCE FOR PURPOSES OF EVALUATING APPLICATIONS AND FOR CHIP.—Section 1902(a)(25)(I)(i) (42 U.S.C. 1396a(a)(25)(I)(i)) is amended—

(A) by inserting “(and, at State option, individuals who are potentially eligible or who apply)” after “with respect to individuals who are eligible”; and

(B) by inserting “under this title (and, at State option, child health assistance under title XXI)” after “the State plan”.

SEC. 303. ENHANCED ADMINISTRATIVE FUNDING FOR TRANSLATION OR INTERPRETATION SERVICES.

Section 1903(a)(2) (42 U.S.C. 1396b(a)(2)) is amended by adding at the end the following new subparagraph:

“(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment and use of services under this title by individuals for whom English is not their primary language; plus”.

SEC. 304. ENHANCED ASSISTANCE WITH COVERAGE COSTS FOR STATES WITH INCREASING OR HIGH COVERAGE RATES AMONG CHILDREN.

Section 1905 (42 U.S.C. 1396d) is amended—

(1) in subsection (b), in the first sentence—

(A) by striking “and (4)” and inserting “(4)”; and

(B) by inserting “, and (5) the Federal medical assistance percentage with respect to medical assistance provided to individuals who have not attained age 19 for a fiscal year shall be increased, notwithstanding the previous clauses of this sentence, in the case of a State that meets the conditions described in subparagraph (A) of subsection (y)(1) in the preceding fiscal year by the number of percentage points determined under subparagraph (B) of that subsection, in the case of a State that is described in subparagraph (A)

of subsection (y)(2) in the preceding fiscal year, by the number of percentage points determined under subparagraph (D) of that subsection, and, in the case of a State described in both such subparagraphs in the preceding fiscal year, by the greater of the number of percentage points determined under paragraph (1)(B) or (2)(D) of subsection (y)" before the period; and

(2) by adding at the end the following new subsection:

"(y) DETERMINATION OF INCREASE IN FMAP FOR MEDICAL ASSISTANCE FOR CHILDREN FOR CERTAIN STATES.—

"(1) FOR STATES SIGNIFICANTLY INCREASING ENROLLMENT OF ELIGIBLE CHILDREN.—

"(A) SIGNIFICANT INCREASE IN ENROLLMENT OF ELIGIBLE CHILDREN.—

"(i) IN GENERAL.—For purposes of clause (5) of the first sentence of subsection (b), a State described in this paragraph is a State that satisfies the reporting requirements described in clause (iii) and has a percentage increase in the child caseload in the reference year over the initial reference year that exceeds the benchmark rate of growth.

"(ii) DEFINITIONS.—For purposes of clause (i):

"(I) CHILD CASELOAD.—The term 'child caseload' means the average monthly enrollment of individuals under age 19 in the State plan under this title or under a waiver of such title, as determined by the Secretary.

"(II) INITIAL REFERENCE YEAR.—The term 'initial reference year' means the 12-month period preceding August 1, 2007.

"(III) REFERENCE YEAR.—The term 'reference year' means, with respect to a fiscal year, the 12-month period preceding August 1 of such fiscal year.

"(IV) BENCHMARK RATE OF GROWTH.—The term 'benchmark rate of growth' means, with respect to a fiscal year, the product of the projected rate of growth of children in Medicaid at time of enactment, multiplied by the number of fiscal years that have elapsed since the initial reference year.

"(V) PROJECTED RATE OF GROWTH OF CHILDREN IN MEDICAID AT TIME OF ENACTMENT.—The term 'projected rate of growth of children in Medicaid at time of enactment' means the average annual rate of growth for children enrolled in all State plans under this title (or under waivers of such title) during the period beginning with fiscal year 2007 and ending with fiscal year 2010, as projected in March 2007 by the Director of the Congressional Budget Office.

"(iii) STATE REPORTING REQUIREMENTS.—The State shall submit to the Secretary such data relating to the average monthly enrollment of individuals who have not attained age 19 under this title and title XXI (including under waivers of such titles) as the Secretary shall specify for the purpose of increasing under clause (5) of subsection (b) the Federal medical assistance percentage for a State for a fiscal year in accordance with this subsection.

"(B) DETERMINATION OF INCREASE.—

"(i) IN GENERAL.—Subject to clause (ii), for purposes of clause (5) of the first sentence of subsection (b), in the case of a State described in subparagraph (A), the number of percentage points determined under this subparagraph is equal to the percentage increase in the State child caseload determined for purposes of subparagraph (A)(i).

"(ii) LIMITATION ON INCREASE.—In no event may the Federal medical assistance percentage for a State for a fiscal year exceed 85 percent as a result of an increase under this paragraph.

"(C) SECRETARIAL RESPONSIBILITIES.—

"(i) REVIEW AND VERIFICATION OF CHILD CASELOAD DATA.—The Secretary shall review the child caseload data provided by States for purposes of this paragraph and shall con-

duct data matches on a periodic basis to verify the child caseloads determined for States.

"(ii) NOTICE TO STATES.—Not later than September 30 of each fiscal year beginning with fiscal year 2008, the Secretary shall inform each State on the extent to which the child caseload in the most recent reference year exceeds or does not exceed the benchmark rate of growth for such fiscal year.

"(2) FOR STATES THAT HAVE ACHIEVED AT LEAST A HIGH PARTICIPATION RATE FOR COVERAGE OF UNINSURED LOW-INCOME CHILDREN.—

"(A) IN GENERAL.—For purposes of clause (5) of the first sentence of subsection (b), a State described in this paragraph is a State—

"(i) for which the percentage of low-income children without private health coverage who are uninsured (as determined under subparagraph (D)) is at least 90 percent; and

"(ii) that satisfies the conditions described in subparagraph (B) (with respect to coverage of children under this title and title XXI) and paragraph (1)(A)(iii).

"(B) CONDITIONS DESCRIBED.—The conditions described in this subparagraph are the following:

"(i) CONTINUOUS ELIGIBILITY REQUIREMENT.—The State has elected the option of continuous eligibility for a full 12 months for children described in section 1902(e)(12) under this title, as well as applying such policy under its State child health plan under title XXI.

"(ii) NO WAITING LIST FOR TITLE XXI.—The State does not impose any numerical limitation, waiting list, or similar limitation on eligibility for assistance under title XXI and has not imposed any such limitation or list within the preceding 3 years.

"(iii) NO ASSETS TEST.—The State does not apply any assets test for eligibility under this title or title XXI with respect to children.

"(iv) ANNUAL REPORTING OF MEASURES OF QUALITY OF HEALTH CARE FOR CHILDREN.—The State annually reports on the measures required under section 601 of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2007 with respect to the quality of health care for children under the State plan under this title and the State child health plan under title XXI or is otherwise determined by the Secretary to have implemented a comprehensive system for gathering information and reporting on the quality of health care for children enrolled under such plans.

"(C) DETERMINATION OF INCREASE.—

"(i) IN GENERAL.—Subject to clause (ii), for purposes of clause (5) of the first sentence of subsection (b), in the case of a State described in subparagraph (A), the number of percentage points determined under this subparagraph is equal to the number of percentage points by which the percentage described in subparagraph (A)(i) exceeds 90 percent.

"(ii) LIMITATION ON INCREASE.—In no event may the Federal medical assistance percentage for a State for a fiscal year exceed 85 percent as a result of an increase under this paragraph.

"(D) SECRETARIAL RESPONSIBILITIES.—

"(i) DETERMINATION OF STATE RATES.—The rates described in subparagraph (A)(i) shall be determined by the Secretary on the basis of the 2 most recent Annual Social and Economic Supplements of the Current Population Survey of the Bureau of the Census.

"(ii) NOTICE TO STATES.—Not later than September 30 of each fiscal year beginning with fiscal year 2008, the Secretary shall inform each State on the extent to which the State's participation rate among uninsured low-income children exceeds or does not exceed 90 percent.

"(3) INCREASE IN CAP ON PAYMENTS TO TERRITORIES.—If Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for an increase in the Federal medical assistance percentage under subsection (b)(5) for a fiscal year, the additional Federal financial participation under this title that results from such increase shall not be counted towards the limitation on total payments under this title for such commonwealth or territory otherwise determined under subsections (f) and (g) of section 1108.

"(4) SCOPE OF APPLICATION.—The increase in the Federal medical assistance percentage under subsection (b)(5) shall only apply for purposes of payments under section 1903 with respect to medical assistance provided to individuals who have not attained age 19 and shall not apply with respect to—

"(A) disproportionate share hospital payments described in section 1923;

"(B) payments under title IV or XXI; or

"(C) any payments under this title that are based on the enhanced FMAP described in section 2105(b)."

SEC. 305. ELIMINATION OF COUNTING MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST TITLE XXI ALLOTMENT.

Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)) is amended—

(1) in the matter preceding subparagraph (A), by striking "(or, in the case of expenditures described in subparagraph (B), the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)))"; and

(2) by striking subparagraph (B) and inserting the following new subparagraph:

"(B) [reserved]".

SEC. 306. STATE OPTION TO REQUIRE CERTAIN INDIVIDUALS TO PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID.

(a) IN GENERAL.—Section 1902(a)(46) (42 U.S.C. 1396a(a)(46)) is amended—

(1) by inserting "(A)" after "(46)";

(2) by adding "and" after the semicolon; and

(3) by adding at the end the following new subparagraph:

"(B) at the option of the State and subject to section 1903(x), require that, with respect to an individual (other than an individual described in section 1903(x)(1)) who declares to be a citizen or national of the United States for purposes of establishing initial eligibility for medical assistance under this title (or, at State option, for purposes of renewing or re-determining such eligibility to the extent that such satisfactory documentary evidence of citizenship or nationality has not yet been presented), there is presented satisfactory documentary evidence of citizenship or nationality of the individual (using criteria determined by the State, which shall be no more restrictive than the criteria used by the Social Security Administration to determine citizenship, and which shall accept as such evidence a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood, and, with respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation (including tribal documentation, if appropriate) that the Secretary, after consulting with such tribes, determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subparagraph));".

(b) LIMITATION ON WAIVER AUTHORITY.—Notwithstanding any provision of section 1105 of the Social Security Act (42 U.S.C. 1315), or any other provision of law, the Secretary may not waive the requirements of section 1902(a)(46)(B) of such Act (42 U.S.C. 1396a(a)(46)(B)) with respect to a State.

(c) CONFORMING AMENDMENTS.—Section 1903 (42 U.S.C. 1396b) is amended—

(1) in subsection (i)—
(A) in paragraph (20), by adding “or” after the semicolon;

(B) in paragraph (21), by striking “; or” and inserting a period; and

(C) by striking paragraph (22); and

(2) in subsection (x) (as amended by section 405(c)(1)(A) of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109-432))—

(A) by striking paragraphs (1) and (3);

(B) by redesignating paragraph (2) as paragraph (1);

(C) in paragraph (1), as so redesignated, by striking “paragraph (1)” and inserting “section 1902(a)(46)(B)”; and

(D) by adding at the end the following new paragraph:

“(2) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.”

(d) CLARIFICATION OF RULES FOR CHILDREN BORN IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR MEDICAID.—Section 1903(x) (42 U.S.C. 1396b(x)), as amended by subsection (c)(2), is amended—

(1) in paragraph (1)—
(A) in subparagraph (C), by striking “or” at the end;

(B) by redesignating subparagraph (D) as subparagraph (E); and

(C) by inserting after subparagraph (C) the following new subparagraph:

“(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or”;

(2) by adding at the end the following new paragraph:

“(3) Nothing in subparagraph (A) or (B) of section 1902(a)(46), the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1902(e)(4) that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child’s life.”

(e) EFFECTIVE DATE.—

(1) RETROACTIVE APPLICATION.—The amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109-171; 120 Stat. 4).

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on the

date of enactment of this Act, was determined to be ineligible for medical assistance under a State Medicaid program solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by this section, had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

TITLE IV—START HEALTHY, STAY HEALTHY

SEC. 401. STATE OPTION TO EXPAND OR ADD COVERAGE OF CERTAIN PREGNANT WOMEN UNDER MEDICAID AND CHIP.

(a) MEDICAID.—

(1) AUTHORITY TO EXPAND COVERAGE.—Section 1902(1)(2)(A)(i) (42 U.S.C. 1396a(1)(2)(A)(i)) is amended by inserting “(or such higher percentage as the State may elect for purposes of expenditures for medical assistance for pregnant women described in section 1905(u)(4)(A))” after “185 percent”.

(2) ENHANCED MATCHING FUNDS AVAILABLE IF CERTAIN CONDITIONS MET.—Section 1905 (42 U.S.C. 1396d) is amended—

(A) in the fourth sentence of subsection (b), by striking “or subsection (u)(3)” and inserting “, (u)(3), or (u)(4)”; and

(B) in subsection (u)—

(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following new paragraph:

“(4) For purposes of the fourth sentence of subsection (b) and section 2105(a), the expenditures described in this paragraph are the following:

“(A) CERTAIN PREGNANT WOMEN.—If the conditions described in subparagraph (B) are met, expenditures for medical assistance for pregnant women described in subsection (n) or in section 1902(1)(1)(A) in a family the income of which exceeds 185 percent of the poverty line, but does not exceed the income eligibility level established under title XXI for a targeted low-income child.

“(B) CONDITIONS.—The conditions described in this subparagraph are the following:

“(i) The State plans under this title and title XXI do not provide coverage for pregnant women described in subparagraph (A) with higher family income without covering such pregnant women with a lower family income.

“(ii) The State does not apply an effective income level for pregnant women that is lower than the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) specified under the State plan under subsection (a)(10)(A)(i)(III) or (1)(2)(A) of section 1902, on the date of enactment of this paragraph to be eligible for medical assistance as a pregnant woman.

“(C) DEFINITION OF POVERTY LINE.—In this subsection, the term ‘poverty line’ has the meaning given such term in section 2110(c)(5).”

(3) PAYMENT FROM TITLE XXI ALLOTMENT FOR MEDICAID EXPANSION COSTS.—Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)), as amended by section 305, is amended by striking subparagraph (B) and inserting the following new subparagraph:

“(B) for the portion of the payments made for expenditures described in section 1905(u)(4)(A) that represents the additional amount paid for such expenditures as a result of the enhanced FMAP being substituted for the Federal medical assistance percentage of such expenditures;”.

(b) CHIP.—

(1) COVERAGE.—Title XXI (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following new section:

“SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN.

“(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State may provide for coverage, through an amendment to its State child health plan under section 2102, of pregnancy-related assistance for targeted low-income pregnant women in accordance with this section, but only if—

“(1) the State has established an income eligibility level for pregnant women under subsection (a)(10)(A)(i)(III) or (1)(2)(A) of section 1902 that is at least 185 percent of the income official poverty line; and

“(2) the State meets the conditions described in section 1905(u)(4)(B).

“(b) DEFINITIONS.—For purposes of this title:

“(1) PREGNANCY-RELATED ASSISTANCE.—The term ‘pregnancy-related assistance’ has the meaning given the term ‘child health assistance’ in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women.

“(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term ‘targeted low-income pregnant woman’ means a woman—

“(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

“(B) whose family income exceeds the effective income level (expressed as a percent of the poverty line and considering applicable income disregards) specified under subsection (a)(10)(A)(i)(III) or (1)(2)(A) of section 1902, on January 1, 2008, to be eligible for medical assistance as a pregnant woman under title XIX but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and

“(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

“(c) REFERENCES TO TERMS AND SPECIAL RULES.—In the case of, and with respect to, a State providing for coverage of pregnancy-related assistance to targeted low-income pregnant women under subsection (a), the following special rules apply:

“(1) Any reference in this title (other than in subsection (b)) to a targeted low-income child is deemed to include a reference to a targeted low-income pregnant woman.

“(2) Any such reference to child health assistance with respect to such women is deemed a reference to pregnancy-related assistance.

“(3) Any such reference to a child is deemed a reference to a woman during pregnancy and the period described in subsection (b)(2)(A).

“(4) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State Medicaid plan under title XIX is deemed a reference to pregnant women.

“(5) There shall be no exclusion of benefits for services described in subsection (b)(1) based on any preexisting condition and no waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) shall apply.

“(6) In applying section 2103(e)(3)(B) in the case of a pregnant woman provided coverage under this section, the limitation on total annual aggregate cost sharing shall be applied to such pregnant woman.

“(7) The reference in section 2107(e)(1)(F) to section 1920A (relating to presumptive eligibility for children) is deemed a reference to section 1920 (relating to presumptive eligibility for pregnant women).”

“(d) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING PREGNANCY-RELATED ASSISTANCE.—If a child is born to a targeted low-income pregnant woman who was receiving pregnancy-related assistance under this section on the date of the child’s birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title, as appropriate, on the date of such birth and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the child health or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).”

(2) ADDITIONAL CONFORMING AMENDMENTS.—

(A) NO COST SHARING FOR PREGNANCY-RELATED BENEFITS.—Section 2103(e)(2) (42 U.S.C. 1397cc(e)(2)) is amended—

(i) in the heading, by inserting “OR PREGNANCY-RELATED SERVICES” after “PREVENTIVE SERVICES”; and

(ii) by inserting before the period at the end the following: “or for pregnancy-related services”.

(B) NO WAITING PERIOD.—Section 2102(b)(1)(B) (42 U.S.C. 1397bb(b)(1)(B)) is amended—

(i) in clause (i), by striking “, and” at the end and inserting a semicolon;

(ii) in clause (ii), by striking the period at the end and inserting “; and”; and

(iii) by adding at the end the following new clause:

“(iii) may not apply a waiting period (including a waiting period to carry out paragraph (3)(C)) in the case of a targeted low-income pregnant woman.”

(c) OTHER AMENDMENTS TO MEDICAID.—

(1) ELIGIBILITY OF A NEWBORN.—Section 1902(e)(4) (42 U.S.C. 1396a(e)(4)) is amended in the first sentence by striking “so long as the child is a member of the woman’s household and the woman remains (or would remain if pregnant) eligible for such assistance”.

(2) APPLICATION OF QUALIFIED ENTITIES TO PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN UNDER MEDICAID.—Section 1920(b) (42 U.S.C. 1396r-1(b)) is amended by adding after paragraph (2) the following new flush sentence:

“The term ‘qualified provider’ includes a qualified entity as defined in section 1920A(b)(3).”

SEC. 402. COORDINATION WITH THE MATERNAL AND CHILD HEALTH PROGRAM.

(a) IN GENERAL.—Section 2102(b)(3) (42 U.S.C. 1397bb(b)(3)) is amended—

(1) in subparagraph (D), by striking “and” at the end;

(2) in subparagraph (E), by striking the period at the end and inserting “; and”; and

(3) by adding at the end the following new subparagraph:

“(F) that operations and activities under this title are developed and implemented in consultation and coordination with the program operated by the State under title V in areas including outreach and enrollment, benefits and services, service delivery standards, public health and social service agency

relationships, and quality assurance and data reporting.”

(b) CONFORMING MEDICAID AMENDMENT.—Section 1902(a)(11) (42 U.S.C. 1396a(a)(11)) is amended—

(1) by striking “and” before “(C)”; and

(2) by inserting before the semicolon at the end the following: “, and (D) provide that operations and activities under this title are developed and implemented in consultation and coordination with the program operated by the State under title V in areas including outreach and enrollment, benefits and services, service delivery standards, public health and social service agency relationships, and quality assurance and data reporting”.

SEC. 403. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS UNDER MEDICAID AND CHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking “paragraph (2)” and inserting “paragraphs (2) and (4)”; and

(2) by adding at the end the following new paragraph:

“(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

“(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

“(ii) CHILDREN.—Individuals under 21 years of age, including optional targeted low-income children described in section 1905(u)(2)(B).

“(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.”

(b) CHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by sections 301(b) and 302(b)(2), is amended by redesignating subparagraphs (D), (E), and (F) as subparagraphs (E), (F), and (G), respectively, and by inserting after subparagraph (B) the following new subparagraph:

“(C) Section 1903(v)(4) (relating to optional coverage of categories of lawfully residing immigrant children), but only if the State has elected to apply such section to the category of children under title XIX.”

(c) CHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by sections 301(b) and 302(b)(2), is amended by redesignating subparagraphs (D), (E), and (F) as subparagraphs (E), (F), and (G), respectively, and by inserting after subparagraph (B) the following new subparagraph:

“(C) Section 1903(v)(4) (relating to optional coverage of categories of lawfully residing immigrant children), but only if the State has elected to apply such section to the category of children under title XIX.”

(d) CHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by sections 301(b) and 302(b)(2), is amended by redesignating subparagraphs (D), (E), and (F) as subparagraphs (E), (F), and (G), respectively, and by inserting after subparagraph (B) the following new subparagraph:

“(C) Section 1903(v)(4) (relating to optional coverage of categories of lawfully residing immigrant children), but only if the State has elected to apply such section to the category of children under title XIX.”

SEC. 404. IMPROVING BENCHMARK COVERAGE OPTIONS.

(a) LIMITATION ON USE OF SECRETARY-APPROVED COVERAGE.—Section 2103(a)(4) (42 U.S.C. 1397cc(a)(4)) is amended by striking the period at the end and inserting “, but only if such determination was made before March 1, 2007.”

(b) STATE EMPLOYEE COVERAGE BENCHMARK.—Section 2103(b)(2) (42 U.S.C. 1397(b)(2)) is amended—

(1) by striking “A health benefits coverage plan” and inserting “The health benefits coverage plan”; and

(2) by inserting “and that has the largest enrollment among such employees with dependent coverage in either of the previous 2 plan years” before the period.

SEC. 405. REQUIRED COVERAGE OF DENTAL AND MENTAL HEALTH SERVICES.

(a) REQUIRED COVERAGE OF DENTAL AND MENTAL HEALTH SERVICES.—Section 2103 (42 U.S.C. 1397cc(c)) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking “subsection (c)(5)” and inserting “paragraphs (5) and (6) of subsection (c)”; and

(2) in subsection (c)—

(A) by redesignating paragraph (5) as paragraph (6); and

(B) by inserting after paragraph (4), the following new paragraph:

“(5) OTHER REQUIRED SERVICES.—The child health assistance provided to a targeted low-income child shall include coverage of the following:

“(A) DENTAL SERVICES.—Dental services described in section 1905(r)(3) and provided in accordance with section 1902(a)(43).

“(B) MENTAL HEALTH SERVICES.—Mental health services.”

(b) STATE CHILD HEALTH PLAN REQUIREMENT.—Section 2102(a)(7)(B) (42 U.S.C. 1397bb(c)(2)) is amended by inserting “and services described in section 2103(c)(5)” after “emergency services”

(c) CONFORMING AMENDMENTS.—Section 2103(c)(2) (42 U.S.C. 1397cc(c)(2)) is amended—

(1) by striking subparagraph (B); and

(2) by redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

SEC. 406. CLARIFICATION OF REQUIREMENT TO PROVIDE EPSDT SERVICES FOR ALL CHILDREN IN BENCHMARK BENEFIT PACKAGES UNDER MEDICAID.

(a) IN GENERAL.—Section 1937(a)(1), as inserted by section 6044(a) of the Deficit Reduction Act of 2005, is amended—

(1) in subparagraph (A)—

(A) in the matter before clause (i), by striking “Notwithstanding any other provision of this title” and inserting “Subject to subparagraph (E)”; and

(B) by striking “enrollment in coverage that provides” and all that follows and inserting “benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2).”;

(2) by striking subparagraph (C) and inserting the following new subparagraph:

“(C) STATE OPTION TO PROVIDE ADDITIONAL BENEFITS.—A State, at its option, may provide such additional benefits to benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2) as the State may specify.”; and

(3) by adding at the end the following new subparagraph:

“(E) REQUIRING COVERAGE OF EPSDT SERVICES.—Nothing in this paragraph shall be construed as affecting a child’s entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1905 and provided in accordance with section 1903(a)(43) whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.”

(b) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

SEC. 407. CHILDHOOD OBESITY DEMONSTRATION PROJECT.

(a) 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—

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

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

(3) 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

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

(b) **ELIGIBILITY ENTITIES.**—For purposes of this section, an eligible entity is any of the following:

- (1) A city, county, or Indian tribe.
- (2) A local or tribal educational agency.
- (3) An accredited university, college, or community college.
- (4) A federally-qualified health center.
- (5) A local health department.
- (6) A health care provider.
- (7) A community-based organization.
- (8) Any other entity determined appropriate by the Secretary, including a consortia or partnership of entities described in any of paragraphs (1) through (7).

(c) **USE OF FUNDS.**—An eligible entity awarded a grant under this section shall use the funds made available under the grant to—

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

(A) 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;

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

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

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

(A) 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, problem-solving and decisionmaking skills), as well as consideration of cultural and developmental issues, and the role of family, school, and community;

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

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

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

(3) carry out activities through the local health care delivery systems including by—

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

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

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

(D) 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

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

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

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

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

(d) **PRIORITY.**—In awarding grants under subsection (a), the Secretary shall give priority to awarding grants to eligible entities—

(1) 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;

(2) 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;

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

(4) 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 section;

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

(6) 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

(7) that submit plans that exhibit multi-sectoral, cooperative conduct that includes the involvement of a broad range of stakeholders, including—

- (A) community-based organizations;
- (B) local governments;
- (C) local educational agencies;
- (D) the private sector;
- (E) State or local departments of health;
- (F) accredited colleges, universities, and community colleges;
- (G) health care providers;
- (H) State and local departments of transportation and city planning; and
- (I) other entities determined appropriate by the Secretary.

(e) **PROGRAM DESIGN.**—

(1) **INITIAL DESIGN.**—Not later than 1 year after the date of enactment of this Act, 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.

(2) **NUMBER AND PROJECT AREAS.**—Not later than 2 years after the date of enactment of this Act, 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 section should be implemented with respect to the general population of children who are eligible for child health assistance under State child health plans under title XXI of the Social Security Act in order to reduce the incidence of childhood obesity among such population.

(f) **REPORT TO CONGRESS.**—Not later than 3 years after the date the Secretary implements the demonstration project under this section, 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.

(g) **DEFINITIONS.**—In this section:

(1) **FEDERALLY-QUALIFIED HEALTH CENTER.**—The term “Federally-qualified health center” has the meaning given that term in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B)).

(2) **INDIAN TRIBE.**—The term “Indian tribe” has the meaning given that term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(3) **SELF-ASSESSMENT.**—The term “self-assessment” means a form that—

(A) includes questions regarding—

- (i) behavioral risk factors;
- (ii) needed preventive and screening services; and
- (iii) target individuals’ preferences for receiving follow-up information;

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

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

(4) **ONGOING SUPPORT.**—The term “ongoing support” means—

(A) 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;

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

(C) to provide the information described in subparagraph (A) to a health care provider, if designated by the target individual to receive such information.

(h) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section, \$25,000,000 for each of fiscal years 2008 through 2012.

TITLE V—IMPROVING ACCESS TO HEALTH CARE FOR CHILDREN

SEC. 501. PROMOTING CHILDREN'S ACCESS TO COVERED HEALTH SERVICES.

(a) **MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION.**—Title XIX (42 U.S.C. 1396 et seq.) is amended by inserting before section 1901 the following new section:

“MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

“SEC. 1900. (a) **ESTABLISHMENT.**—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as ‘MACPAC’).

“(b) DUTIES.—

“(1) REVIEW OF ACCESS POLICIES AND ANNUAL REPORTS.—MACPAC shall—

“(A) review policies of the Medicaid program established under this title (in this section referred to as ‘Medicaid’) and the State Children’s Health Insurance Program established under title XXI (in this section referred to as ‘CHIP’) affecting children’s access to covered items and services, including topics described in paragraph (2);

“(B) make recommendations to Congress concerning such access policies;

“(C) by not later than March 1 of each year (beginning with 2009), submit a report to Congress containing the results of such reviews and MACPAC’s recommendations concerning such policies; and

“(D) by not later than June 1 of each year (beginning with 2009), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

“(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

“(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

“(i) the factors affecting expenditures for items and services in different sectors, including the process for updating hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees;

“(ii) payment methodologies; and

“(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries.

“(B) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

“(C) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers.

“(3) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas or any other problems that threaten access to care or the health care status of Medicaid and CHIP beneficiaries.

“(4) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary’s report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

“(5) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC’s agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such top-

ics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

“(6) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

“(7) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term ‘appropriate committees of Congress’ means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

“(8) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

“(9) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

“(c) MEMBERSHIP.—

“(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

“(2) QUALIFICATIONS.—

“(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, health information technology, pediatric physicians, dentists, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

“(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include consumers representing children, pregnant women, the elderly, and individuals with disabilities, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

“(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

“(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).

“(3) TERMS.—

“(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

“(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expira-

tion of the term for which the member’s predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member’s term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

“(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member’s regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

“(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member’s term.

“(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

“(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

“(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

“(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

“(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

“(4) make advance, progress, and other payments which relate to the work of MACPAC;

“(5) provide transportation and subsistence for persons serving without compensation; and

“(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

“(e) POWERS.—

“(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

“(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

“(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

“(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

“(C) adopt procedures allowing any interested party to submit information for MACPAC’s use in making reports and recommendations.

“(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

“(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

“(f) AUTHORIZATION OF APPROPRIATIONS.—

“(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

“(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.”.

(b) DEADLINE FOR INITIAL APPOINTMENTS.—Not later than January 1, 2008, the Comptroller General of the United States shall appoint the initial members of the Medicaid and CHIP Payment and Access Commission established under section 1900 of the Social Security Act (as added by subsection (a)).

SEC. 502. INSTITUTE OF MEDICINE STUDY AND REPORT ON CHILDREN’S ACCESS TO HEALTH CARE.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall enter into a contract with the Institute of Medicine of the National Academy of Sciences (in this section referred to as the “Institute”), to update the data and analyses of the June 1998 report of the Institute entitled, “America’s Children: Health Insurance and Access to Care”. Specifically, the Institute shall—

(A) examine the extent of health insurance coverage for children in the United States; and

(B) analyze the extent to which there is evidence of the relationship between health insurance coverage and children’s access to health care.

(2) REQUIREMENT.—In carrying out the study required under paragraph (1), the Institute shall focus on a broad range of providers that offer health care services to children, including (but not limited to) providers of oral health care services and mental health care services.

(3) SUPPORT.—The Secretary shall provide to the Institute any relevant data available to the Secretary during the period in which the study required under paragraph (1) is conducted.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary and the Institute shall submit a report to Congress on the results of the study conducted under subsection (a).

(c) APPROPRIATIONS.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for fiscal year 2008 such sums as may be necessary for the purpose of carrying out this section, not to exceed \$1,000,000. Funds appropriated under this subsection shall remain available until expended.

TITLE VI—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES OF CHILDREN

SEC. 601. STRENGTHENING CHILD HEALTH QUALITY IMPROVEMENT ACTIVITIES.

(a) UPDATING AND ENHANCEMENT OF QUALITY OF CARE MEASURES FOR CHILDREN.—

(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall do the following:

(A) UPDATE AND ENHANCE QUALITY MEASURES.—In consultation with States, providers, and child health experts, update and enhance the HEDIS measures and other measures that the Secretary recommends States use to annually report on the quality of health care for children enrolled in Medicaid or CHIP to include additional and more comprehensive information with respect to health care delivered to children in both ambulatory and inpatient care settings, that can be used to develop national quality measures and perform comparative analyses.

(B) ENCOURAGE VOLUNTARY REPORTING.—In consultation with States, develop procedures to encourage States to voluntarily report the same set of measures with respect to the quality of health care for children under Medicaid and CHIP.

(C) ADOPTION OF BEST PRACTICES.—Develop programs to identify best practices with respect to the quality of health care for children and facilitate the adoption of such best practices, including in areas such as provider reporting compliance, successful quality improvement strategies, and improved efficiency in data collection using health information technology.

(D) TECHNICAL ASSISTANCE.—Provide technical assistance to States to help them comply with the measures updated in accordance with subparagraph (A) and adopt the best practices identified in accordance with subparagraph (C).

(b) DISSEMINATION OF HEALTH QUALITY INFORMATION.—

(1) STATE-SPECIFIC REPORT ON CHILD HEALTH QUALITY MEASURES.—Not later than January 1, 2008, and annually thereafter, the Secretary shall collect, analyze, and make publicly available State-specific data on child health quality measures, including State-specific data collected on external quality review activities related to managed care organizations under Medicaid and CHIP.

(2) REPORTS TO CONGRESS.—Not later than January 1, 2008, and every 3 years thereafter, the Secretary shall report to Congress on—

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

(i) children’s health care, including children’s needs with respect to preventive, acute, and chronic health care; and

(ii) all domains of quality, including safety, family experience of care, and elimination of disparities; and

(B) the quality of care furnished to ameliorate at least 1 type of physical, mental, or developmental condition recognized as having an effect on growth and development in children and adolescents.

(c) DEVELOPMENT, ENDORSEMENT, AND UPDATING OF CHILD-SPECIFIC HEALTH QUALITY MEASURES.—

(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall establish a program to support the development of quality measures for children’s health care services.

(2) AUTHORITY TO AWARD GRANTS AND CONTRACTS.—As part of such program, the Secretary shall award grants and contracts for the—

(A) development of new child health quality measures to supplement or replace, as appropriate, the HEDIS measures updated and enhanced in accordance with subsection (a)(1)(A);

(B) advancement (through validation and consensus among the entities described in

paragraph (3)) of such new measures and of child health quality measures used as of the date of enactment of this Act; and

(C) updating of such measures as necessary.

(3) CONSULTATION REQUIRED.—In carrying out the program required under this subsection, the Secretary shall consult with the following:

(A) ESTABLISHMENT OF AREAS OF NEED AND PRIORITIES.—For purposes of identifying gaps in child health quality measures used as of the date of enactment of this Act and establishing priorities for development:

- (i) States.
- (ii) National pediatric organizations.
- (iii) Consumers.
- (iv) Other entities with expertise in pediatric quality measures, such as quality improvement organizations.

(B) ESTABLISHMENT OF PORTFOLIO OF MEASURES.—For purposes of developing a portfolio of child health quality measures for use by States, other purchasers, and providers, an organization involved in the advancement of consensus on evidence-based measures of health care, such as the National Quality Forum.

(C) ESTABLISHMENT OF MEDICAID AND CHIP CORE PEDIATRIC QUALITY MEASURES.—For purposes of identifying a core pediatric data set that includes specific quality measures for Medicaid and CHIP, States, health care providers, consumers, purchasers, child health experts, and public and private organizations with experience and expertise in the outreach and enrollment of children in public and private health insurance programs.

(4) SPECIFIC REQUIREMENTS FOR MEDICAID AND CHIP PEDIATRIC QUALITY MEASURES.—

(A) CORE PEDIATRIC DATA SET.—The core pediatric data set identified under paragraph (3)(C) shall include specific quality measures for Medicaid and CHIP, including with respect to at least the following:

(i) State-specific quality measures for Medicaid and CHIP (including State-specific data on enrollment and retention of eligible children; coordination of Medicaid and CHIP children’s coverage; measures of children’s access to preventive, acute and chronic care, including the availability of providers and adequacy of provider payments relative to private coverage).

(ii) Quality measures and data for health plans and providers at the State, plan, and provider levels of care.

(B) QUALITY MEASURES.—In identifying quality measures for Medicaid and CHIP, the Secretary shall—

(i) identify measures specific to managed care plans and providers of primary care case management services;

(ii) build on the core set of quality measures reported by States as of the date of enactment of this Act, including the HEDIS measures and evidence-based measures (to the extent such measures are available);

(iii) assure that the measures identified are selected from measures that have been approved through an independent process that includes a broad consensus determined by a voluntary, standard setting organization, with broad participation by providers, patient advocates, health plans, and purchasers;

(iv) assure that the measures place an emphasis on physical and mental conditions for which amelioration is necessary to promote growth and development;

(v) assure that the measures are evidence-based and risk adjusted;

(vi) assure that the measures are designed to identify and eliminate racial and ethnic disparities in the provision of care;

(vii) assure 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; and

(viii) periodically update such measures.

(d) DEMONSTRATION PROJECTS FOR IMPROVING THE QUALITY OF CHILDREN'S HEALTH CARE AND THE USE OF HEALTH INFORMATION TECHNOLOGY.—

(1) IN GENERAL.—The Secretary shall award grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care, including projects to—

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

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

(C) evaluate value-based purchasing of health care services for children.

(2) AUTHORITY FOR MULTI-STATE PROJECTS.—A demonstration project conducted with a grant awarded under this subsection may be conducted on a multi-State basis, as needed.

(e) INCREASED MATCHING RATE FOR COLLECTING AND REPORTING ON CHILD HEALTH MEASURES.—Section 1903(a)(3)(A) (42 U.S.C. 1396b(a)(3)(A)), as amended by section 302, is amended—

(1) by striking “and” at the end of clause (ii); and

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

“(iv) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and”.

(f) DEVELOPMENT OF MODEL ELECTRONIC HEALTH RECORD FOR CHILDREN.—Not later than January 1, 2009, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record for children. Such model electronic health record should be—

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

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

(g) DEFINITION OF HEDIS MEASURES.—In this section, the term “HEDIS measures” means the Health Plan Employer Data and Information Set (HEDIS) measures established by the National Committee for Quality Assurance (NCQA).

(h) APPROPRIATIONS.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2008 through 2012, \$20,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.

SEC. 602. APPLICATION OF CERTAIN MANAGED CARE QUALITY SAFEGUARDS TO CHIP.

Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by sections 301(b), 302(b)(2), and 403(b), is amended by redesignating subparagraph (G) as subparagraph (H), and by inserting after subparagraph (F) the following new subparagraph:

“(G) Subsections (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care).”.

TITLE VII—OTHER IMPROVEMENTS

SEC. 701. STRENGTHENING PREMIUM ASSISTANCE PROGRAMS.

(a) IMPROVING THE COST-EFFECTIVENESS STANDARD.—Section 2105(c)(3) (42 U.S.C. 1397ee(c)(3)) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii) and indenting appropriately;

(2) by striking “Payment may be made” and inserting the following:

“(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, payment may be made”; and

(3) by adding at the end the following new subparagraph:

“(B) IMPROVEMENTS IN COST-EFFECTIVENESS MEASURE.—

“(i) APPLICATION OF FAMILY-BASED TEST.—Coverage described in subparagraph (A) shall be deemed cost-effective if the State establishes to the satisfaction of the Secretary that the cost of such coverage is less than the expenditures that the State would have made to enroll the family in the State child health plan.

“(ii) AGGREGATE PROGRAM OPERATIONAL COSTS DO NOT EXCEED THE COST OF PROVIDING COVERAGE UNDER THE STATE CHILD HEALTH PLAN.—In the case of a State that does not establish cost-effectiveness under clause (i), payment may not be made under subsection (a)(1) for the purchase of any coverage described in subparagraph (A) for a family unless the State establishes to the satisfaction of the Secretary that the aggregate amount of expenditures by the State for the purchase of all such coverage (including administrative expenditures) does not exceed the aggregate amount of expenditures that the State would have made for providing coverage under the State child health plan for all such families.”.

(b) DISCLOSURE OF GROUP HEALTH PLAN BENEFITS.—Section 2105(c)(3) (42 U.S.C. 1397ee(c)(3)), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

“(D) DISCLOSURE OF GROUP HEALTH PLAN BENEFITS.—Notwithstanding any other provision of law, the plan administrator of a group health plan in which participants or beneficiaries are covered under a State plan under title XIX or this title, shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity so that the State may determine—

“(i) whether purchasing coverage for the participant or beneficiary under the group health plan meets the cost-effectiveness standard applied under subparagraph (B); and

“(ii) what additional benefits and cost-sharing assistance must be provided to ensure that the participant or beneficiary receives through the provision of additional benefits by the State, benefits that are equivalent to the coverage that would be provided to such participant or beneficiary under such State plan.”.

(c) APPROVAL OF SECTION 1115 WAIVERS FOR PREMIUM ASSISTANCE.—Section 1115 (42 U.S.C. 1315) is amended by inserting after subsection (c), the following new subsection:

“(d) In approving a request by a State for an experimental, pilot, or demonstration project under this section with respect to the purchase of private insurance for individuals eligible for assistance under title XIX or XXI, the Secretary shall not waive compliance with requirements of such titles or treat expenditures under the project as expenditures under the State plans approved under such titles unless the State demonstrates both of the following:

“(1) The fact that an individual is enrolled in a group health plan or an insurance plan

purchased on the individual market shall not change the individual's eligibility for assistance under the such State plans.

“(2) The cost to the Federal Government and State of purchasing private insurance for the individual (including administrative costs), as well as any additional costs incurred in providing items and services covered under such State plans but not through the private insurance for such individual, does not exceed, on an average per individual basis, the cost of providing coverage to the individual directly under such State plans.”.

(d) GAO STUDY AND REPORT.—Not later than January 1, 2009, the Comptroller General of the United States shall study cost and coverage issues relating to State premium assistance programs for which Federal matching payments are made under title XIX or XXI of the Social Security Act and submit a report to Congress on the results of such study.

SEC. 702. PERMITTING COVERAGE OF CHILDREN OF EMPLOYEES OF A PUBLIC AGENCY IN THE STATE.

Section 2110(b) (42 U.S.C. 1397jj(b)) is amended—

(1) in paragraph (2)(B), by inserting “except as provided in paragraph (5),” before “a child”; and

(2) by adding at the end the following new paragraph:

“(5) EXCEPTIONS TO EXCLUSION OF CHILDREN OF EMPLOYEES OF A PUBLIC AGENCY IN THE STATE.—

“(A) IN GENERAL.—A child shall not be considered to be described in paragraph (2)(B) if—

“(i) the public agency that employs a member of the child's family to which such paragraph applies satisfies subparagraph (B); or

“(ii) subparagraph (C) applies to such child.

“(B) MAINTENANCE OF EFFORT WITH RESPECT TO PER PERSON AGENCY CONTRIBUTION FOR FAMILY COVERAGE.—For purposes of subparagraph (A)(i), a public agency satisfies this subparagraph if the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent State fiscal year is not less than the amount of such expenditures made by the agency for the 1997 State fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for such preceding fiscal year.

“(C) HARDSHIP EXCEPTION.—For purposes of subparagraph (A)(ii), this subparagraph applies to a child if the State determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family's income for the year involved.”.

SEC. 703. IMPROVING DATA COLLECTION.

(a) INCREASED APPROPRIATION.—Section 2109(b)(2) (42 U.S.C. 1397ii(b)(2)) is amended by striking “\$10,000,000 for fiscal year 2000” and inserting “\$20,000,000 for fiscal year 2008”.

(b) USE OF ADDITIONAL FUNDS.—Section 2109(b) (42 U.S.C. 1397ii(b)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (2) as paragraph (3); and

(2) by inserting after paragraph (1), the following new paragraph:

“(2) ADDITIONAL REQUIREMENTS.—In addition to making the adjustments required to produce the data described in paragraph (1), with respect to data collection occurring for fiscal years beginning with fiscal year 2008, in appropriate consultation with the Secretary of Health and Human Services, the

Secretary of Commerce shall do the following:

“(A) Make appropriate adjustments to the Current Population Survey to develop more accurate State-specific estimates of the number of children enrolled in health coverage under title XIX or this title.

“(B) Make appropriate adjustments to the Current Population Survey to improve the survey estimates used to compile the State-specific and national number of low-income children without health insurance for purposes of sections 1905(y)(2)(A)(i), 2106(b)(3)(B)(iii)(I), and 2104(i)(3)(D)(i).

“(C) Assist in the incorporation of health insurance survey information in the American Community Survey related to children.

“(D) Assess whether American Community Survey estimates, once such survey data are first available, produce more reliable estimates than the Current Population Survey for purposes of section 2104(i)(3)(D)(i).

“(E) Recommend to the Secretary of Health and Human Services whether American Community Survey estimates should be used for purposes of 2104(i)(3)(D)(i).

“(F) Continue making the adjustments described in the last sentence of paragraph (1) with respect to expansion of the sample size used in State sampling units, the number of sampling units in a State, and using an appropriate verification element.”.

SEC. 704. MORATORIUM ON APPLICATION OF PERM REQUIREMENTS RELATED TO ELIGIBILITY REVIEWS DURING PERIOD OF INDEPENDENT STUDY AND REPORT.

(a) **MORATORIUM.**—Notwithstanding parts 431 and 457 of title 42, Code of Federal Regulations, or any other provision of law, except as provided in paragraph (2), during the period that begins on the date of enactment of this Act and ends on the final effective date for the regulations required under subsection (c), the Secretary shall not apply the payment error rate measurement (PERM) requirements related to eligibility reviews imposed under such parts with respect to Medicaid or CHIP.

(b) **STUDY AND REPORT.**—

(1) **INSTITUTE OF MEDICINE STUDY.**—The Secretary shall enter into a contract with the Institute of Medicine of the National Academy of Sciences (in this section referred to as the “Institute”) to conduct an independent study of the payment error rate measurement (PERM) requirements related to eligibility reviews imposed under parts 431 and 457 of title 42, Code of Federal Regulations with respect to Medicaid and CHIP and established in accordance with the Improper Payments Information Act of 2002 (Public Law 107-300). Such study shall examine and develop recommendations for modifying such requirements in order to—

(A) minimize the administrative cost burden on States under Medicaid and CHIP;

(B) avoid inadvertent error findings with respect to such programs despite compliance with Federal and State policies and procedures in effect as of the date of the submission of the claim or action that led to such finding;

(C) maintain State flexibility to manage such programs; and

(D) ensure that such requirements do not interfere with State efforts to simplify application and renewal procedures that increase enrollment in Medicaid and CHIP and do not reduce beneficiary participation in such programs.

(2) **SUPPORT.**—The Secretary shall provide the Institute with any relevant data available to the Secretary during the period in which the study required under paragraph (1) is conducted.

(3) **REPORT.**—Not later than the date that is 18 months after the date of enactment of

this Act, the Institute shall submit to the Secretary and Congress a report on the results of the study conducted under this subsection.

(c) **REGULATIONS.**—Not later than 6 months after the date on which the report required under subsection (b)(3) has been submitted to the Secretary, the Secretary, after taking into consideration the recommendations contained in the report, shall promulgate such regulations revising the PERM requirements as the Secretary determines are appropriate.

(d) **APPROPRIATIONS.**—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for fiscal year 2008 such sums as may be necessary for the purpose of carrying out this section, not to exceed \$1,000,000. Funds appropriated under this subsection shall remain available until expended.

SEC. 705. ELIMINATION OF CONFUSING PROGRAM REFERENCES.

Section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, as enacted into law by division B of Public Law 106-113 (113 Stat. 1501A-402) is repealed.

TITLE VIII—EFFECTIVE DATE

SEC. 801. EFFECTIVE DATE.

(a) **IN GENERAL.**—Unless otherwise provided, subject to subsection (b), the amendments made by this Act shall take effect on October 1, 2007, and shall apply to child health assistance and medical assistance provided on or after that date without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(b) **EXCEPTION FOR STATE LEGISLATION.**—In the case of a State plan under title XIX or XXI of the Social Security Act, which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by an amendment made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DURBIN (for himself and Mr. OBAMA):

S. 1228. A bill to amend section 485(f) of the Higher Education Act of 1965 regarding law enforcement emergencies; to the Committee on Health, Education, Labor, and Pensions.

Mr. DURBIN. Mr. President, I ask unanimous consent that the text of the bill be printed in the REORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1228

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Campus Law Enforcement Emergency Response Act of 2007”.

SEC. 2. LAW ENFORCEMENT EMERGENCIES.

Section 485(f) of the Higher Education Act of 1965 (20 U.S.C. 1092(f)) is amended—

(1) by redesignating paragraphs (9) through (15) as paragraphs (10) through (16), respectively;

(2) by inserting after paragraph (8) the following:

“(9)(A) Each institution of higher education participating in any program under this title shall develop and distribute as part of the report described in paragraph (1)—

“(i) a statement of policy regarding the institution’s law enforcement emergency response program; and

“(ii) statistics concerning the occurrence of law enforcement emergencies on the campus of the institution.

“(B) In this paragraph:

“(i) The term ‘campus’ has the meaning given the term in paragraph 6(A)(i), except that the term includes—

“(I) a noncampus building or property, as defined in paragraph (6)(A)(ii), of an institution of higher education; and

“(II) any public property, as defined in paragraph (6)(A)(iii), of an institution of higher education.

“(ii) The term ‘law enforcement emergency’ means a shooting, the presence of an armed and dangerous person, a bomb threat, the presence of an unauthorized hazardous or toxic material that poses a threat to health and safety, a lock-down, a reverse evacuation, or any other comparable type of incident, on the campus of an institution of higher education, that involves the participation of one or more law enforcement agencies.

“(C) The policy described in subparagraph (A) shall address the following:

“(i) Procedures students, employees, and others on the campus of the institution will be directed to follow if a law enforcement emergency occurs.

“(ii) Procedures the institution and law enforcement agencies will follow to inform students, employees, and others on the campus of the institution about a law enforcement emergency on the campus and will follow to direct the actions of the students, employees, and others. Such procedures may include e-mail alerts, telephone alerts, text-message alerts, radio announcements, television alerts, audible alert signals, and public address announcements.

“(D) Each institution participating in any program under this title shall test the institution’s law enforcement emergency response policy and procedures on at least an annual basis.

“(E) Each institution participating in any program under this title shall make reports to the students, employees, and others on the campus of the institution, not later than 30 minutes after the discovery of a law enforcement emergency on the campus, through the procedures described in subparagraph (C)(ii).

“(F) The Secretary and the Attorney General shall jointly have the authority—

“(i) to review, monitor, and ensure compliance with this paragraph;

“(ii) to advise institutions of higher education on model law enforcement emergency response policies, procedures, and practices; and

“(iii) to disseminate information concerning those policies, procedures, and practices.

“(G) **CAMPUS LAW ENFORCEMENT EMERGENCY RESPONSE GRANTS.**—

“(i) **PROGRAM AUTHORITY.**—The Secretary may make grants to institutions of higher education or consortia of such institutions, or enter into contracts with such institutions, consortia, and other organizations, to develop, implement, operate, improve, test, or disseminate campus law enforcement emergency response policies, procedures, or programs.