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VETO OF H.R. 976

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

HIS VETO OF H.R. 976, THE "CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007"

OCTOBER 3, 2007.—Message and accompanying bill ordered to be printed

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To the House of Representatives:

I am returning herewith without my approval H.R. 976, the "Children's Health Insurance Program: Reauthorization Act of 2007," because this legislation would move health care in this country in the wrong direction.

The original purpose of the State Children's Health Insurance Program (SCHIP) was to help children whose families cannot afford private health insurance, but do not qualify for Medicaid, to get the coverage they need. My Administration strongly supports reauthorization of SCHIP. That is why I proposed last February a 20 percent increase in funding for the program over 5 years.

This bill would shift SCHIP away from its original purpose and turn it into a program that would cover children from some families of four earning almost $83,000 a year. In addition, under this bill, government coverage would displace private health insurance for many children. If this bill were enacted, one out of every three children moving onto government coverage would be moving from private coverage. The bill also does not fully fund all its new spending, obscuring the true cost of the bill's expansion of SCHIP, and it raises taxes on working Americans.

Because the Congress has chosen to send me a bill that moves our health care system in the wrong direction, I must veto it. I hope we can now work together to produce a good bill that puts poorer children first, that moves adults out of a program meant for children, and that does not abandon the bipartisan tradition that marked the enactment of SCHIP. Our goal should be to move children who have no health insurance to private coverage, not to move children who already have private health insurance to government coverage.

GEORGE W. BUSH.

THE WHITE HOUSE, *October 3, 2007.*

H. R. 976

One Hundred Tenth Congress of the United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Thursday, the fourth day of January, two thousand and seven

An Act

To amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes.

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; REFERENCES; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as "Children's Health Insurance Program 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) REFERENCES TO CHIP; MEDICAID; 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 of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references; table of contents.
Sec. 2. Purpose.
Sec. 3. General effective date; exception for State legislation; contingent effective date; reliance on law.

TITLE I—FINANCING

Subtitle A—Funding

Sec. 101. Extension of CHIP.
Sec. 102. Allotments for States and territories for fiscal years 2008 through 2012.
Sec. 103. Child Enrollment Contingency Fund.
Sec. 104. CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and retention efforts.
Sec. 105. 2-year initial availability of CHIP allotments.
Sec. 106. Redistribution of unused allotments to address State funding shortfalls.
Sec. 107. Option for qualifying States to receive the enhanced portion of the CHIP matching rate for Medicaid coverage of certain children.
Sec. 108. One-time appropriation.
Sec. 109. Improving funding for the territories under CHIP and Medicaid.

Subtitle B—Focus on Low-Income Children and Pregnant Women

Sec. 111. State option to cover low-income pregnant women under CHIP through a State plan amendment.

Sec. 112. Phase-Out of coverage for nonpregnant childless adults under CHIP; conditions for coverage of parents.
Sec. 113. Elimination of counting Medicaid child presumptive eligibility costs against Title XXI allotment.
Sec. 114. Limitation on matching rate for States that propose to cover children with effective family income that exceeds 300 percent of the poverty line.
Sec. 115. State authority under Medicaid.
Sec. 116. Preventing substitution of CHIP coverage for private coverage.

TITLE II—OUTREACH AND ENROLLMENT

Subtitle A—Outreach and Enrollment Activities

Sec. 201. Grants and enhanced administrative funding for outreach and enrollment.
Sec. 202. Increased outreach and enrollment of Indians.
Sec. 203. State option to rely on findings from an Express Lane agency to conduct simplified eligibility determinations.

Subtitle B—Reducing Barriers to Enrollment

Sec. 211. Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP.
Sec. 212. Reducing administrative barriers to enrollment.
Sec. 213. Model of Interstate coordinated enrollment and coverage process.

TITLE III—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

Sec. 301. Additional State option for providing premium assistance.
Sec. 302. Outreach, education, and enrollment assistance.

Subtitle B—Coordinating Premium Assistance With Private Coverage

Sec. 311. Special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage or eligibility for assistance in purchase of employment-based coverage; coordination of coverage.

TITLE IV—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

Sec. 401. Child health quality improvement activities for children enrolled in Medicaid or CHIP.
Sec. 402. Improved availability of public information regarding enrollment of children in CHIP and Medicaid.
Sec. 403. Application of certain managed care quality safeguards to CHIP.

TITLE V—IMPROVING ACCESS TO BENEFITS

Sec. 501. Dental benefits.
Sec. 502. Mental health parity in CHIP plans.
Sec. 503. Application of prospective payment system for services provided by Federally-Qualified Health Centers and rural health clinics.
Sec. 504. Premium grace period.
Sec. 505. Demonstration projects relating to diabetes prevention.
Sec. 506. Clarification of coverage of services provided through school-based health centers.

TITLE VI—PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS

Subtitle A—Program Integrity and Data Collection

Sec. 601. Payment error rate measurement ("PERM").
Sec. 602. Improving data collection.
Sec. 603. Updated Federal evaluation of CHIP.
Sec. 604. Access to records for IG and GAO audits and evaluations.
Sec. 605. No Federal funding for illegal aliens.

Subtitle B—Miscellaneous Health Provisions

Sec. 611. Deficit Reduction Act technical corrections.
Sec. 612. References to title XXI.
Sec. 613. Prohibiting initiation of new health opportunity account demonstration programs.
Sec. 614. County medicaid health insuring organizations; GAO report on Medicaid managed care payment rates.
Sec. 615. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.

Sec. 616. Moratorium on certain payment restrictions.
Sec. 617. Medicaid DSH allotments for Tennessee and Hawaii.
Sec. 618. Clarification treatment of regional medical center.
Sec. 619. Extension of SSI web-based asset demonstration project to the Medicaid program.

Subtitle C—Other Provisions

Sec. 621. Support for injured servicemembers.
Sec. 622. Military family job protection.
Sec. 623. Outreach regarding health insurance options available to children.
Sec. 624. Sense of Senate regarding access to affordable and meaningful health insurance coverage.

TITLE VII—REVENUE PROVISIONS

Sec. 701. Increase in excise tax rate on tobacco products.
Sec. 702. Administrative improvements.
Sec. 703. Time for payment of corporate estimated taxes.

SEC. 2. PURPOSE.

It is the purpose of this Act to provide dependable and stable funding for children's health insurance under titles XXI and XIX of the Social Security Act in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today through such titles.

SEC. 3. GENERAL EFFECTIVE DATE; EXCEPTION FOR STATE LEGISLATION; CONTINGENT EFFECTIVE DATE; RELIANCE ON LAW.

(a) GENERAL EFFECTIVE DATE.—Unless otherwise provided in this Act, subject to subsections (b) and (c), this Act (and 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 this Act (or such amendments) have been promulgated by such date.

(b) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX or State child health plan under XXI of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for respective plan to meet one or more additional requirements imposed by amendments made by this Act, the respective State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement 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 previous 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.

(c) CONTINGENT EFFECTIVE DATE FOR CHIP FUNDING FOR FISCAL YEAR 2008.—Notwithstanding any other provision of law, if funds are appropriated under any law (other than this Act) to provide allotments to States under CHIP for all (or any portion) of fiscal year 2008—

(1) any amounts that are so appropriated that are not so allotted and obligated before the date of the enactment of this Act are rescinded; and

(2) any amount provided for CHIP allotments to a State under this Act (and the amendments made by this Act) for such fiscal year shall be reduced by the amount of such appropriations so allotted and obligated before such date.

(d) RELIANCE ON LAW.—With respect to amendments made by this Act (other than title VII) that become effective as of a date—

(1) such amendments are effective as of such date whether or not regulations implementing such amendments have been issued; and

(2) Federal financial participation for medical assistance or child health assistance furnished under title XIX or XXI, respectively, of the Social Security Act on or after such date by a State in good faith reliance on such amendments before the date of promulgation of final regulations, if any, to carry out such amendments (or before the date of guidance, if any, regarding the implementation of such amendments) shall not be denied on the basis of the State's failure to comply with such regulations or guidance.

TITLE I—FINANCING

Subtitle A—Funding

SEC. 101. EXTENSION OF 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, $9,125,000,000;

"(12) for fiscal year 2009, $10,675,000,000;

"(13) for fiscal year 2010, $11,850,000,000;

"(14) for fiscal year 2011, $13,750,000,000; and

"(15) for fiscal year 2012, for purposes of making 2 semi-annual allotments—

"(A) $1,750,000,000 for the period beginning on October 1, 2011, and ending on March 31, 2012, and

"(B) $1,750,000,000 for the period beginning on April 1, 2012, and ending on September 30, 2012.".

SEC. 102. ALLOTMENTS FOR STATES AND TERRITORIES FOR FISCAL YEARS 2008 THROUGH 2012.

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

(1) in subsection (b)(1), by striking "subsection (d)" and inserting "subsections (d) and (i)";

(2) in subsection (c)(1), by striking "subsection (d)" and inserting "subsections (d) and (i)(4)"; and

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

"(i) ALLOTMENTS FOR FISCAL YEARS 2008 THROUGH 2012.—

"(1) FOR FISCAL YEAR 2008.—

"(A) FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA.—Subject to the succeeding provisions of this paragraph and paragraph (4), the Secretary shall allot for fiscal year 2008 from the amount made available under subsection (a)(11), to each of the 50 States and the District of Columbia 110 percent of the highest of the following amounts for such State or District:

"(i) The total Federal payments to the State under this title for fiscal year 2007, multiplied by the allotment increase factor determined under paragraph (5) for fiscal year 2008.

"(ii) The Federal share of the amount allotted to the State for fiscal year 2007 under subsection (b), multiplied by the allotment increase factor determined under paragraph (5) for fiscal year 2008.

"(iii) Only in the case of—

"(I) a State that received a payment, redistribution, or allotment under any of paragraph (1), (2), or (4) of subsection (h), the amount of the projected total Federal payments to the State under this title for fiscal year 2007, as determined on the basis of the November 2006 estimates certified by the State to the Secretary;

"(II) a State whose projected total Federal payments to the State under this title for fiscal year 2007, as determined on the basis of the May 2006 estimates certified by the State to the Secretary, were at least $95,000,000 but not more than $96,000,000 higher than the projected total Federal payments to the State under this title for fiscal year 2007 on the basis of the November 2006 estimates, the amount of the projected total Federal payments to the State under this title for fiscal year 2007 on the basis of the May 2006 estimates; or

"(III) a State whose projected total Federal payments under this title for fiscal year 2007, as determined on the basis of the November 2006 estimates certified by the State to the Secretary, exceeded all amounts available to the State for expenditure for fiscal year 2007 (including any amounts paid, allotted, or redistributed to the State in prior fiscal years), the amount of the projected total Federal payments to the State under this title for fiscal year 2007, as determined on the basis of the November 2006 estimates certified by the State to the Secretary,

multiplied by the allotment increase factor determined under paragraph (5) for fiscal year 2008.

"(iv) The projected total Federal payments to the State under this title for fiscal year 2008, as determined on the basis of the August 2007 projections certified by the State to the Secretary by not later than September 30, 2007.

"(B) FOR THE COMMONWEALTHS AND TERRITORIES.—Subject to the succeeding provisions of this paragraph and paragraph (4), the Secretary shall allot for fiscal year 2008 from the amount made available under subsection (a)(11) to each of the commonwealths and territories described in subsection (c)(3) an amount equal to 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 allotment increase factor determined under paragraph

(5) for fiscal year 2008, except that subparagraph (B) thereof shall be applied by substituting 'the United States' for 'the State'.

"(C) DEADLINE AND DATA FOR DETERMINING FISCAL YEAR 2008 ALLOTMENTS.—In computing the amounts under subparagraphs (A) and (B) that determine the allotments to States for fiscal year 2008, the Secretary shall use the most recent data available to the Secretary before the start of that 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, 2007, but in no case shall the Secretary adjust the allotments provided under subparagraph (A) or (B) for fiscal year 2008 after December 31, 2007.

"(D) ADJUSTMENT FOR QUALIFYING STATES.—In the case of a qualifying State described in paragraph (2) of section 2105(g), the Secretary shall permit the State to submit revised projection described in subparagraph (A)(iv) in order to take into account changes in such projections attributable to the application of paragraph (4) of such section.

"(2) FOR FISCAL YEARS 2009 THROUGH 2011.—

"(A) IN GENERAL.—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (12) through (14) of subsection (a) for each of fiscal years 2009 through 2011, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

"(i) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2009.—For fiscal year 2009, the allotment of the State is equal to the sum of—

"(I) the amount of the State allotment under paragraph (1) for fiscal year 2008; and

"(II) the amount of any payments made to the State under subsection (j) for fiscal year 2008, multiplied by the allotment increase factor under paragraph (5) for fiscal year 2009.

"(ii) REBASING IN FISCAL YEAR 2010.—For fiscal year 2010, the allotment of a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2009 (including payments made to the State under subsection (j) for fiscal year 2009 as well as amounts redistributed to the State in fiscal year 2009) multiplied by the allotment increase factor under paragraph (5) for fiscal year 2010.

"(iii) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2011.—For fiscal year 2011, the allotment of the State is equal to the sum of—

"(I) the amount of the State allotment under clause (ii) for fiscal year 2010; and

"(II) the amount of any payments made to the State under subsection (j) for fiscal year 2010,

multiplied by the allotment increase factor under paragraph (5) for fiscal year 2011.

"(3) FOR FISCAL YEAR 2012.—

"(A) FIRST HALF.—Subject to paragraphs (4) and (6), from the amount made available under subparagraph (A) of paragraph (15) of subsection (a) for the semi-annual period described in such paragraph, increased by the amount of the appropriation for such period under section 108 of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

"(B) SECOND HALF.—Subject to paragraphs (4) and (6), from the amount made available under subparagraph (B) of paragraph (15) of subsection (a) for the semi-annual period described in such paragraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph multiplied by the ratio of—

"(i) the amount of the allotment to such State under subparagraph (A); to

"(ii) the total of the amount of all of the allotments made available under such subparagraph.

"(C) FULL YEAR AMOUNT BASED ON REBASED AMOUNT.—The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2011 (including payments made to the State under subsection (j) for fiscal year 2011 as well as amounts redistributed to the State in fiscal year 2011) multiplied by the allotment increase factor under paragraph (5) for fiscal year 2012.

"(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—

"(i) the sum of—

"(I) the amount made available under subsection (a)(15)(A); and

"(II) the amount of the appropriation for such period under section 108 of the Children's Health Insurance Program Reauthorization Act of 2007; to

"(ii) the sum of the—

"(I) amount described in clause (i); and

"(II) the amount made available under subsection (a)(15)(B).

"(4) PRORATION RULE.—If, after the application of this subsection without regard to this paragraph, the sum of the allotments determined under paragraph (1), (2), or (3) for a fiscal year (or, in the case of fiscal year 2012, for a semi-annual period in such fiscal year) exceeds the amount available under subsection (a) for such fiscal year or period, the Secretary

shall reduce each allotment for any State under such paragraph for such fiscal year or period on a proportional basis.

"(5) ALLOTMENT INCREASE FACTOR.—The allotment increase factor under this paragraph for a fiscal year is equal to the product of the following:

"(A) PER CAPITA HEALTH CARE GROWTH FACTOR.—1 plus the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary before the beginning of the fiscal year.

"(B) CHILD POPULATION GROWTH FACTOR.—1 plus the percentage increase (if any) in the population of children in the State from July 1 in the previous fiscal year to July 1 in 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, plus 1 percentage point.

"(6) INCREASE IN ALLOTMENT TO ACCOUNT FOR APPROVED PROGRAM EXPANSIONS.—In the case of one of the 50 States or the District of Columbia that—

"(A) has submitted to the Secretary, and has approved by the Secretary, a State plan amendment or waiver request relating to an expansion of eligibility for children or benefits under this title that becomes effective for a fiscal year (beginning with fiscal year 2009 and ending with fiscal year 2012); and

"(B) has submitted to the Secretary, before the August 31 preceding the beginning of the fiscal year, a request for an expansion allotment adjustment under this paragraph for such fiscal year that specifies—

"(i) the additional expenditures that are attributable to the eligibility or benefit expansion provided under the amendment or waiver described in subparagraph (A), as certified by the State and submitted to the Secretary by not later than August 31 preceding the beginning of the fiscal year; and

"(ii) the extent to which such additional expenditures are projected to exceed the allotment of the State or District for the year,

subject to paragraph (4), the amount of the allotment of the State or District under this subsection for such fiscal year shall be increased by the excess amount described in subparagraph (B)(i). A State or District may only obtain an increase under this paragraph for an allotment for fiscal year 2009 or fiscal year 2011.

"(7) AVAILABILITY OF AMOUNTS FOR SEMI-ANNUAL PERIODS IN FISCAL YEAR 2012.—Each semi-annual allotment made under paragraph (3) for a period in fiscal year 2012 shall remain available for expenditure under this title for periods after the end of such fiscal year in the same manner as if the allotment had been made available for the entire fiscal year.".

SEC. 103. CHILD ENROLLMENT CONTINGENCY FUND.

Section 2104 (42 U.S.C. 1397dd), as amended by section 102, is amended by adding at the end the following new subsection:

"(j) CHILD ENROLLMENT CONTINGENCY FUND.—

"(1) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a fund which shall be known as the 'Child Enrollment Contingency Fund' (in this subsection referred to as the 'Fund'). Amounts in the Fund shall be available without further appropriations for payments under this subsection.

"(2) DEPOSITS INTO FUND.—

"(A) INITIAL AND SUBSEQUENT APPROPRIATIONS.—Subject to subparagraphs (B) and (D), out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Fund—

"(i) for fiscal year 2008, an amount equal to 20 percent of the amount made available under paragraph (11) of subsection (a) for the fiscal year; and

"(ii) for each of fiscal years 2009 through 2011 (and for each of the semi-annual allotment periods for fiscal year 2012) , such sums as are necessary for making payments to eligible States for such fiscal year or period, but not in excess of the aggregate cap described in subparagraph (B).

"(B) AGGREGATE CAP.—The total amount available for payment from the Fund for each of fiscal years 2009 through 2011 (and for each of the semi-annual allotment periods for fiscal year 2012), taking into account deposits made under subparagraph (C), shall not exceed 20 percent of the amount made available under subsection (a) for the fiscal year or period.

"(C) INVESTMENT OF FUND.—The Secretary of the Treasury shall invest, in interest bearing securities of the United States, such currently available portions of the Fund as are not immediately required for payments from the Fund. The income derived from these investments constitutes a part of the Fund.

"(D) AVAILABILITY OF EXCESS FUNDS FOR PERFORMANCE BONUSES.—Any amounts in excess of the aggregate cap described in subparagraph (B) for a fiscal year or period shall be made available for purposes of carrying out section 2105(a)(3) for any succeeding fiscal year and the Secretary of the Treasury shall reduce the amount in the Fund by the amount so made available.

"(3) CHILD ENROLLMENT CONTINGENCY FUND PAYMENTS.—

"(A) IN GENERAL.—If a State's expenditures under this title in fiscal year 2008, fiscal year 2009, fiscal year 2010, fiscal year 2011, or a semi-annual allotment period for fiscal year 2012, exceed the total amount of allotments available under this section to the State in the fiscal year or period (determined without regard to any redistribution it receives under subsection (f) that is available for expenditure during such fiscal year or period, but including any carryover from a previous fiscal year) and if the average monthly unduplicated number of children enrolled under the State plan under this title (including children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during such fiscal year or period exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that

fiscal year or period, subject to subparagraph (D), the Secretary shall pay to the State from the Fund an amount equal to the product of—

"(i) the amount by which such average monthly caseload exceeds such target number of enrollees; and

"(ii) the projected per capita expenditures under the State child health plan (as determined under subparagraph (C) for the fiscal year), multiplied by the enhanced FMAP (as defined in section 2105(b)) for the State and fiscal year involved (or in which the period occurs).

"(B) TARGET AVERAGE NUMBER OF CHILD ENROLLEES.—In this paragraph, the target average number of child enrollees for a State—

"(i) for fiscal year 2008 is equal to the monthly average unduplicated number of children enrolled in the State child health plan under this title (including such children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during fiscal year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

"(ii) for a subsequent fiscal year (or semi-annual period occurring in a fiscal year) is equal to the target average number of child enrollees for the State for the previous fiscal year increased by the child population growth factor described in subsection (i)(5)(B) for the State for the prior fiscal year.

"(C) PROJECTED PER CAPITA EXPENDITURES.—For purposes of subparagraph (A)(ii), the projected per capita expenditures under a State child health plan—

"(i) for fiscal year 2008 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the targeted low-income children counted in the average monthly caseload for purposes of this paragraph during fiscal year 2007, increased by the annual percentage increase in the projected per capita amount of National Health Expenditures (as estimated by the Secretary) for 2008; or

"(ii) for a subsequent fiscal year (or semi-annual period occurring in a fiscal year) is equal to the projected per capita expenditures under such plan for the previous fiscal year (as determined under clause (i) or this clause) increased by the annual percentage increase in the projected per capita amount of National Health Expenditures (as estimated by the Secretary) for the year in which such subsequent fiscal year ends.

"(D) PRORATION RULE.—If the amounts available for payment from the Fund for a fiscal year or period are less than the total amount of payments determined under subparagraph (A) for the fiscal year or period, the amount to be paid under such subparagraph to each eligible State shall be reduced proportionally.

"(E) TIMELY PAYMENT; RECONCILIATION.—Payment under this paragraph for a fiscal year or period shall be

made before the end of the fiscal year or period based upon the most recent data for expenditures and enrollment and the provisions of subsection (e) of section 2105 shall apply to payments under this subsection in the same manner as they apply to payments under such section.

"(F) CONTINUED REPORTING.—For purposes of this paragraph and subsection (f), the State shall submit to the Secretary the State's projected Federal expenditures, even if the amount of such expenditures exceeds the total amount of allotments available to the State in such fiscal year or period.

"(G) APPLICATION TO COMMONWEALTHS AND TERRITORIES.—No payment shall be made under this paragraph to a commonwealth or territory described in subsection (c)(3) until such time as the Secretary determines that there are in effect methods, satisfactory to the Secretary, for the collection and reporting of reliable data regarding the enrollment of children described in subparagraphs (A) and (B) in order to accurately determine the commonwealth's or territory's eligibility for, and amount of payment, under this paragraph.".

SEC. 104. CHIP PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.

Section 2105(a) (42 U.S.C. 1397ee(a)) is amended by adding at the end the following new paragraphs:

"(3) PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL MEDICAID AND CHIP CHILD ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.—

"(A) IN GENERAL.—In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2008 and ending with fiscal year 2012) the Secretary shall pay from amounts made available under subparagraph (E), to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

"(B) AMOUNT.—Subject to subparagraph (E), the amount described in this subparagraph for a State for a fiscal year is equal to the sum of the following amounts:

"(i) FOR ABOVE BASELINE MEDICAID CHILD ENROLLMENT COSTS.—

"(I) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under title XIX for the State and fiscal year multiplied by 15 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

"(II) SECOND TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of

second tier above baseline child enrollees (as determined under subparagraph (C)(ii)) under title XIX for the State and fiscal year multiplied by 60 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

"(ii) FOR ABOVE BASELINE CHIP ENROLLMENT COSTS.—

"(I) FIRST TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees under this title (as determined under subparagraph (C)(i)) for the State and fiscal year multiplied by 10 percent of the projected per capita State CHIP expenditures (as determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

"(II) SECOND TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees under this title (as determined under subparagraph (C)(ii)) for the State and fiscal year multiplied by 40 percent of the projected per capita State CHIP expenditures (as determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

"(C) NUMBER OF FIRST AND SECOND TIER ABOVE BASELINE CHILD ENROLLEES; BASELINE NUMBER OF CHILD ENROLLEES.—For purposes of this paragraph:

"(i) FIRST TIER ABOVE BASELINE CHILD ENROLLEES.—The number of first tier above baseline child enrollees for a State for a fiscal year under this title or title XIX is equal to the number (if any, as determined by the Secretary) by which—

"(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under the State child health plan under this title or under the State plan under title XIX, respectively; exceeds

"(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under this title or title XIX, respectively;

but not to exceed 3 percent (in the case of title XIX) or 7.5 percent (in the case of this title) of the baseline number of enrollees described in subclause (II).

"(ii) SECOND TIER ABOVE BASELINE CHILD ENROLLEES.—The number of second tier above baseline child enrollees for a State for a fiscal year under this title or title XIX is equal to the number (if any, as determined by the Secretary) by which—

"(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under this title or under title XIX, respectively, as described in clause (i)(I); exceeds

"(II) the sum of the baseline number of child enrollees described in clause (iii) for the State

and fiscal year under this title or title XIX, respectively, as described in clause (i)(II), and the maximum number of first tier above baseline child enrollees for the State and fiscal year under this title or title XIX, respectively, as determined under clause (i).

"(iii) BASELINE NUMBER OF CHILD ENROLLEES.—Subject to subparagraph (H), the baseline number of child enrollees for a State under this title or title XIX—

"(I) for fiscal year 2008 is equal to the monthly average unduplicated number of qualifying children enrolled in the State child health plan under this title or in the State plan under title XIX, respectively, during fiscal year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

"(II) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under this title or title XIX, respectively, increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

"(D) PROJECTED PER CAPITA STATE EXPENDITURES.—For purposes of subparagraph (B)—

"(i) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—The projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State plan under such title, including under waivers but not including such children eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) for the fiscal year involved.

"(ii) PROJECTED PER CAPITA STATE CHIP EXPENDITURES.—The projected per capita State CHIP expenditures for a State and fiscal year under this title is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State child health plan under this title, including under waivers, for the most recent fiscal year for which actual data are available (as determined

by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the enhanced FMAP (as defined in section 2105(b)) for the fiscal year involved.

"(E) AMOUNTS AVAILABLE FOR PAYMENTS.—

"(i) INITIAL APPROPRIATION.—Out of any money in the Treasury not otherwise appropriated, there are appropriated $3,000,000,000 for fiscal year 2008 for making payments under this paragraph, to be available until expended.

"(ii) TRANSFERS.—Notwithstanding any other provision of this title, the following amounts shall also be available, without fiscal year limitation, for making payments under this paragraph:

"(I) UNOBLIGATED NATIONAL ALLOTMENT.—

"(aa) FISCAL YEARS 2008 THROUGH 2011.—As of December 31 of fiscal year 2008, and as of December 31 of each succeeding fiscal year through fiscal year 2011, the portion, if any, of the amount appropriated under subsection (a) for such fiscal year that is unobligated for allotment to a State under subsection (i) for such fiscal year or set aside under subsection (a)(3) or (b)(2) of section 2111 for such fiscal year.

"(bb) FIRST HALF OF FISCAL YEAR 2012.—As of December 31 of fiscal year 2012, the portion, if any, of the sum of the amounts appropriated under subsection (a)(15)(A) and under section 108 of the Children's Health Insurance Reauthorization Act of 2007 for the period beginning on October 1, 2011, and ending on March 31, 2012, that is unobligated for allotment to a State under subsection (i) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

"(cc) SECOND HALF OF FISCAL YEAR 2012.—As of June 30 of fiscal year 2012, the portion, if any, of the amount appropriated under subsection (a)(15)(B) for the period beginning on April 1, 2012, and ending on September 30, 2012, that is unobligated for allotment to a State under subsection (i) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

"(II) UNEXPENDED ALLOTMENTS NOT USED FOR REDISTRIBUTION.—As of November 15 of each of fiscal years 2009 through 2012, the total amount of allotments made to States under section 2104 for the second preceding fiscal year (third preceding fiscal year in the case of the fiscal year

2006 and 2007 allotments) that is not expended or redistributed under section 2104(f) during the period in which such allotments are available for obligation.

"(III) EXCESS CHILD ENROLLMENT CONTINGENCY FUNDS.—As of October 1 of each of fiscal years 2009 through 2012, any amount in excess of the aggregate cap applicable to the Child Enrollment Contingency Fund for the fiscal year under section 2104(j).

"(IV) UNEXPENDED TRANSITIONAL COVERAGE BLOCK GRANT FOR NONPREGNANT CHILDLESS ADULTS.—As of October 1, 2009, any amounts set aside under section 2111(a)(3) that are not expended by September 30, 2009.

"(iii) PROPORTIONAL REDUCTION.—If the sum of the amounts otherwise payable under this paragraph for a fiscal year exceeds the amount available for the fiscal year under this subparagraph, the amount to be paid under this paragraph to each State shall be reduced proportionally.

"(F) QUALIFYING CHILDREN DEFINED.—For purposes of this subsection, the term 'qualifying children' means, with respect to this title or title XIX, children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2007, for enrollment under this title or title XIX, respectively, taking into account criteria applied as of such date under this title or title XIX, respectively, pursuant to a waiver under section 1115.

"(G) APPLICATION TO COMMONWEALTHS AND TERRITORIES.—The provisions of subparagraph (H) of section 2104(j)(3) shall apply with respect to payments under this paragraph in the same manner as such provisions apply to payment under such section.

"(H) APPLICATION TO STATES THAT IMPLEMENT A MEDICAID EXPANSION FOR CHILDREN AFTER FISCAL YEAR 2007.—In the case of a State that provides coverage under paragraph (1) or (2) of section 115(b) of the Children's Health Insurance Program Reauthorization Act of 2007 for any fiscal year after fiscal year 2007—

"(i) any child enrolled in the State plan under title XIX through the application of such an election shall be disregarded from the determination for the State of the monthly average unduplicated number of qualifying children enrolled in such plan during the first 3 fiscal years in which such an election is in effect; and

"(ii) in determining the baseline number of child enrollees for the State for any fiscal year subsequent to such first 3 fiscal years, the baseline number of child enrollees for the State under this title or title XIX for the third of such fiscal years shall be the monthly average unduplicated number of qualifying children enrolled in the State child health plan under this title or in the State plan under title XIX, respectively, for such third fiscal year.

"(4) ENROLLMENT AND RETENTION PROVISIONS FOR CHILDREN.—For purposes of paragraph (3)(A), a State meets the condition of this paragraph for a fiscal year if it is implementing at least 4 of the following enrollment and retention provisions (treating each subparagraph as a separate enrollment and retention provision) throughout the entire fiscal year:

"(A) CONTINUOUS ELIGIBILITY.—The State has elected the option of continuous eligibility for a full 12 months for all children described in section 1902(e)(12) under title XIX under 19 years of age, as well as applying such policy under its State child health plan under this title.

"(B) LIBERALIZATION OF ASSET REQUIREMENTS.—The State meets the requirement specified in either of the following clauses:

"(i) ELIMINATION OF ASSET TEST.—The State does not apply any asset or resource test for eligibility for children under title XIX or this title.

"(ii) ADMINISTRATIVE VERIFICATION OF ASSETS.—The State—

"(I) permits a parent or caretaker relative who is applying on behalf of a child for medical assistance under title XIX or child health assistance under this title to declare and certify by signature under penalty of perjury information relating to family assets for purposes of determining and redetermining financial eligibility; and

"(II) takes steps to verify assets through means other than by requiring documentation from parents and applicants except in individual cases of discrepancies or where otherwise justified.

"(C) ELIMINATION OF IN-PERSON INTERVIEW REQUIREMENT.—The State does not require an application of a child for medical assistance under title XIX (or for child health assistance under this title), including an application for renewal of such assistance, to be made in person nor does the State require a face-to-face interview, unless there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview.

"(D) USE OF JOINT APPLICATION FOR MEDICAID AND CHIP.—The application form and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children for medical assistance under title XIX and child health assistance under this title.

"(E) AUTOMATIC RENEWAL (USE OF ADMINISTRATIVE RENEWAL).—

"(i) IN GENERAL.—The State provides, in the case of renewal of a child's eligibility for medical assistance under title XIX or child health assistance under this title, a pre-printed form completed by the State based on the information available to the State and notice to the parent or caretaker relative of the child that eligibility of the child will be renewed and continued based on such information unless the State is provided other information. Nothing in this clause shall be construed as preventing a State from verifying, through

electronic and other means, the information so provided.

"(ii) SATISFACTION THROUGH DEMONSTRATED USE OF EX PARTE PROCESS.—A State shall be treated as satisfying the requirement of clause (i) if renewal of eligibility of children under title XIX or this title is determined without any requirement for an in-person interview, unless sufficient information is not in the State's possession and cannot be acquired from other sources (including other State agencies) without the participation of the applicant or the applicant's parent or caretaker relative.

"(F) PRESUMPTIVE ELIGIBILITY FOR CHILDREN.—The State is implementing section 1920A under title XIX as well as, pursuant to section 2107(e)(1), under this title.

"(G) EXPRESS LANE.—The State is implementing the option described in section 1902(e)(13) under title XIX as well as, pursuant to section 2107(e)(1), under this title.".

SEC. 105. 2-YEAR INITIAL AVAILABILITY OF CHIP ALLOTMENTS.

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

"(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

"(1) IN GENERAL.—Except as provided in paragraph (2), amounts allotted to a State pursuant to this section—

"(A) 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

"(B) 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.

"(2) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are redistributed.".

SEC. 106. REDISTRIBUTION OF UNUSED ALLOTMENTS TO ADDRESS STATE FUNDING SHORTFALLS.

(a) FISCAL YEAR 2005 ALLOTMENTS.—

(1) IN GENERAL.—Notwithstanding section 2104(f) of the Social Security Act (42 U.S.C. 1397dd(f)), subject to paragraph (2), with respect to fiscal year 2008, the Secretary shall provide for a redistribution under such section from the allotments for fiscal year 2005 under subsections (b) and (c) of such section that are not expended by the end of fiscal year 2007, to each State described in clause (iii) of section 2104(i)(1)(A) of the Social Security Act, as added by section 102, of an amount that bears the same ratio to such unexpended fiscal year 2005 allotments as the ratio of the fiscal year 2007 allotment determined for each such State under subsection (b) of section 2104 of such Act for fiscal year 2007 (without regard to any amounts paid, allotted, or redistributed to the State under section 2104 for any preceding fiscal year) bears to the total amount of the fiscal year 2007 allotments for all such States (as so determined).

(2) CONTINGENCY.—Paragraph (1) shall not apply if the redistribution described in such paragraph has occurred as of the date of the enactment of this Act.

(b) ALLOTMENTS FOR SUBSEQUENT FISCAL YEARS.—Section 2104(f) (42 U.S.C. 1397dd(f)) is amended—

(1) by striking "The Secretary" and inserting the following: "(1) IN GENERAL.—The Secretary";

(2) by striking "States that have fully expended the amount of their allotments under this section." and inserting "States that the Secretary determines with respect to the fiscal year for which unused allotments are available for redistribution under this subsection, are shortfall States described in paragraph (2) for such fiscal year, but not to exceed the amount of the shortfall described in paragraph (2)(A) for each such State (as may be adjusted under paragraph (2)(C)).";" and

(3) by adding at the end the following new paragraph: "(2) SHORTFALL STATES DESCRIBED.—

"(A) IN GENERAL.—For purposes of paragraph (1), with respect to a fiscal year, a shortfall State described in this subparagraph is a State with a State child health plan approved under this title for which the Secretary estimates on the basis of the most recent data available to the Secretary, that the projected expenditures under such plan for the State for the fiscal year will exceed the sum of—

"(i) the amount of the State's allotments for any preceding fiscal years that remains available for expenditure and that will not be expended by the end of the immediately preceding fiscal year;

"(ii) the amount (if any) of the child enrollment contingency fund payment under subsection (j); and

"(iii) the amount of the State's allotment for the fiscal year.

"(B) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) for a fiscal year are less than the total amounts of the estimated shortfalls determined for the year under subparagraph (A), the amount to be redistributed under such paragraph for each shortfall State shall be reduced proportionally.

"(C) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made under paragraph (1) and this paragraph with respect to a fiscal year as necessary on the basis of the amounts reported by States not later than November 30 of the succeeding fiscal year, as approved by the Secretary.".

SEC. 107. OPTION FOR QUALIFYING STATES TO RECEIVE THE ENHANCED PORTION OF THE CHIP MATCHING RATE FOR MEDICAID COVERAGE OF CERTAIN CHILDREN.

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

(1) in paragraph (1)(A), by inserting "subject to paragraph (4)," after "Notwithstanding any other provision of law,"; and

(2) by adding at the end the following new paragraph: "(4) OPTION FOR ALLOTMENTS FOR FISCAL YEARS 2008 THROUGH 2012.—

"(A) PAYMENT OF ENHANCED PORTION OF MATCHING RATE FOR CERTAIN EXPENDITURES.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State's allotment made under section 2104 for any of fiscal years 2008 through 2012 (insofar as the allotment

is available to the State under subsections (e) and (i) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

"(B) EXPENDITURES DESCRIBED.—For purposes of subparagraph (A), the expenditures described in this subparagraph are expenditures made after the date of the enactment of this paragraph and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under title XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under title XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.".

SEC. 108. ONE-TIME APPROPRIATION.

There is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated, $12,500,000,000 to accompany the allotment made for the period beginning on October 1, 2011, and ending on March 31, 2012, under section 2104(a)(15)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(15)(A)) (as added by section 101), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (3) of section 2104(i) of the Social Security Act (42 U.S.C. 1397dd(i)), as added by section 102, for the first 6 months of fiscal year 2012 in the same manner as allotments are provided under subsection (a)(15)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(15)(A).

SEC. 109. IMPROVING FUNDING FOR THE TERRITORIES UNDER CHIP AND MEDICAID.

(a) 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 years beginning with fiscal year 2008, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (B), or (F) of section 1903(a)(3) for a calendar quarter of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), and (3) of this subsection) to such commonwealth or territory for such fiscal year.".

(b) GAO STUDY AND REPORT.—Not later than September 30, 2009, the Comptroller General of the United States shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives regarding Federal funding under Medicaid and CHIP 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 regarding methods for the collection and reporting of reliable data regarding the enrollment under Medicaid and CHIP of children in such commonwealths and territories.

(3) Recommendations for improving Federal funding under Medicaid and CHIP for such commonwealths and territories.

Subtitle B—Focus on Low-Income Children and Pregnant Women

SEC. 111. STATE OPTION TO COVER LOW-INCOME PREGNANT WOMEN UNDER CHIP THROUGH A STATE PLAN AMENDMENT.

(a) IN GENERAL.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 112(a), is amended by adding at the end the following new section:

"SEC. 2112. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN THROUGH A STATE PLAN AMENDMENT.

"(a) IN GENERAL.—Subject to the succeeding provisions of this section, a State may elect through an amendment to its State child health plan under section 2102 to provide pregnancy-related assistance under such plan for targeted low-income pregnant women.

"(b) CONDITIONS.—A State may only elect the option under subsection (a) if the following conditions are satisfied:

"(1) MINIMUM INCOME ELIGIBILITY LEVELS FOR PREGNANT WOMEN AND CHILDREN.—The State has established an income eligibility level—

"(A) for pregnant women under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1902 that is at least 185 percent (or such higher percent as the State has in effect with regard to pregnant women under this title) of the poverty line applicable to a family of the size involved, but in no case lower than the percent in effect under any such subsection as of July 1, 2007; and

"(B) for children under 19 years of age under this title (or title XIX) that is at least 200 percent of the poverty line applicable to a family of the size involved.

"(2) NO CHIP INCOME ELIGIBILITY LEVEL FOR PREGNANT WOMEN LOWER THAN THE STATE'S MEDICAID LEVEL.—The State does not apply an effective income level for pregnant women under the State plan amendment that is lower than 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), (a)(10)(A)(i)(IV), or (l)(1)(A) of section 1902, on the date of enactment of this paragraph to be eligible for medical assistance as a pregnant woman.

"(3) NO COVERAGE FOR HIGHER INCOME PREGNANT WOMEN WITHOUT COVERING LOWER INCOME PREGNANT WOMEN.—The State does not provide coverage for pregnant women with higher family income without covering pregnant women with a lower family income.

"(4) APPLICATION OF REQUIREMENTS FOR COVERAGE OF TARGETED LOW-INCOME CHILDREN.—The State provides pregnancy-related assistance for targeted low-income pregnant women in the same manner, and subject to the same requirements, as the State provides child health assistance for targeted low-income children under the State child health plan, and in addition to providing child health assistance for such women.

"(5) NO PREEXISTING CONDITION EXCLUSION OR WAITING PERIOD.—The State does not apply any exclusion of benefits for pregnancy-related assistance based on any preexisting condition or any waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) for receipt of such assistance.

"(6) APPLICATION OF COST-SHARING PROTECTION.—The State provides pregnancy-related assistance to a targeted low-income woman consistent with the cost-sharing protections under section 2103(e) and applies the limitation on total annual aggregate cost sharing imposed under paragraph (3)(B) of such section to the family of such a woman.

"(7) NO WAITING LIST FOR CHILDREN.—The State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

"(c) OPTION TO PROVIDE PRESUMPTIVE ELIGIBILITY.—A State that elects the option under subsection (a) and satisfies the conditions described in subsection (b) may elect to apply section 1920 (relating to presumptive eligibility for pregnant women) to the State child health plan in the same manner as such section applies to the State plan under title XIX.

"(d) DEFINITIONS.—For purposes of this section:

"(1) PREGNANCY-RELATED ASSISTANCE.—The term 'pregnancy-related assistance' has the meaning given the term 'child health assistance' in section 2110(a) and includes any medical assistance that the State would provide for a pregnant woman under the State plan under title XIX during the period described in paragraph (2)(A).

"(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 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, 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.

"(e) 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).

"(f) STATES PROVIDING ASSISTANCE THROUGH OTHER OPTIONS.—

"(1) CONTINUATION OF OTHER OPTIONS FOR PROVIDING ASSISTANCE.—The option to provide assistance in accordance with the preceding subsections of this section shall not limit any other option for a State to provide—

"(A) child health assistance through the application of sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) of title 42, Code of Federal Regulations (as in effect after the final rule adopted by the Secretary and set forth at 67 Fed. Reg. 61956–61974 (October 2, 2002)), or

"(B) pregnancy-related services through the application of any waiver authority (as in effect on June 1, 2007).

"(2) CLARIFICATION OF AUTHORITY TO PROVIDE POSTPARTUM SERVICES.—Any State that provides child health assistance under any authority described in paragraph (1) may continue to provide such assistance, as well as postpartum services, through the end of the month in which the 60-day period (beginning on the last day of the pregnancy) ends, in the same manner as such assistance and postpartum services would be provided if provided under the State plan under title XIX, but only if the mother would otherwise satisfy the eligibility requirements that apply under the State child health plan (other than with respect to age) during such period.

"(3) NO INFERENCE.—Nothing in this subsection shall be construed—

"(A) to infer congressional intent regarding the legality or illegality of the content of the sections specified in paragraph (1)(A); or

"(B) to modify the authority to provide pregnancy-related services under a waiver specified in paragraph (1)(B).".

(b) ADDITIONAL CONFORMING AMENDMENTS.—

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

(A) in the heading, by inserting "**OR PREGNANCY-RELATED ASSISTANCE**" after "**PREVENTIVE SERVICES**"; and

(B) by inserting before the period at the end the following: "or for pregnancy-related assistance".

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

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

(B) in clause (ii), by striking the period at the end and inserting "; and"; and

(C) 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 provided pregnancy-related assistance under section 2112.".

SEC. 112. PHASE-OUT OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS UNDER CHIP; CONDITIONS FOR COVERAGE OF PARENTS.

(a) PHASE-OUT RULES.—

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

"SEC. 2111. PHASE-OUT OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS; CONDITIONS FOR COVERAGE OF PARENTS.

"(a) TERMINATION OF COVERAGE FOR NONPREGNANT CHILDLESS ADULTS.—

"(1) NO NEW CHIP WAIVERS; AUTOMATIC EXTENSIONS AT STATE OPTION THROUGH FISCAL YEAR 2008.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

"(A) the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2007, approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult; and

"(B) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for purposes of any fiscal year beginning on or after October 1, 2008, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

"(2) TERMINATION OF CHIP COVERAGE UNDER APPLICABLE EXISTING WAIVERS AT THE END OF FISCAL YEAR 2008.—

"(A) IN GENERAL.—No funds shall be available under this title for child health assistance or other health benefits coverage that is provided to a nonpregnant childless adult under an applicable existing waiver after September 30, 2008.

"(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before October 1, 2008, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only through September 30, 2008.

"(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a nonpregnant childless adult during fiscal year 2008.

"(3) OPTIONAL 1-YEAR TRANSITIONAL COVERAGE BLOCK GRANT FUNDED FROM STATE ALLOTMENT.—Subject to paragraph (4)(B), each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may elect to provide nonpregnant childless adults who were provided child health assistance or health benefits coverage under the applicable existing waiver at any time during fiscal year 2008 with such assistance or coverage during fiscal year 2009, as if the authority to provide such assistance or coverage under an applicable existing waiver was extended through that fiscal year, but subject to the following terms and conditions:

"(A) BLOCK GRANT SET ASIDE FROM STATE ALLOTMENT.—The Secretary shall set aside for the State an amount equal to the Federal share of the State's projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all nonpregnant childless adults under such waiver for fiscal year 2008 (as certified by the State and submitted to the Secretary by not later than August 31, 2008, and without regard to whether any such individual lost coverage during fiscal year 2008 and was later provided child health assistance or other health benefits coverage under the waiver in that fiscal year), increased by the annual adjustment for fiscal year 2009 determined under section 2104(i)(5)(A). The Secretary may adjust the amount set aside under the preceding sentence, as necessary, on the basis of the expenditure data for fiscal year 2008 reported by States on CMS Form 64 or CMS Form 21 not later than November 30, 2008, but in no case shall the Secretary adjust such amount after December 31, 2008.

"(B) NO COVERAGE FOR NONPREGNANT CHILDLESS ADULTS WHO WERE NOT COVERED DURING FISCAL YEAR 2008.—

"(i) FMAP APPLIED TO EXPENDITURES.—The Secretary shall pay the State for each quarter of fiscal year 2009, from the amount set aside under subparagraph (A), an amount equal to the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) of expenditures in the quarter for providing child health assistance or other health benefits coverage to

a nonpregnant childless adult but only if such adult was enrolled in the State program under this title during fiscal year 2008 (without regard to whether the individual lost coverage during fiscal year 2008 and was reenrolled in that fiscal year or in fiscal year 2009).

"(ii) FEDERAL PAYMENTS LIMITED TO AMOUNT OF BLOCK GRANT SET-ASIDE.—No payments shall be made to a State for expenditures described in this subparagraph after the total amount set aside under subparagraph (A) for fiscal year 2009 has been paid to the State.

"(4) STATE OPTION TO APPLY FOR MEDICAID WAIVER TO CONTINUE COVERAGE FOR NONPREGNANT CHILDLESS ADULTS.—

"(A) IN GENERAL.—Each State for which coverage under an applicable existing waiver is terminated under paragraph (2)(A) may submit, not later than June 30, 2009, an application to the Secretary for a waiver under section 1115 of the State plan under title XIX to provide medical assistance to a nonpregnant childless adult whose coverage is so terminated (in this subsection referred to as a 'Medicaid nonpregnant childless adults waiver').

"(B) DEADLINE FOR APPROVAL.—The Secretary shall make a decision to approve or deny an application for a Medicaid nonpregnant childless adults waiver submitted under subparagraph (A) within 90 days of the date of the submission of the application. If no decision has been made by the Secretary as of September 30, 2009, on the application of a State for a Medicaid nonpregnant childless adults waiver that was submitted to the Secretary by June 30, 2009, the application shall be deemed approved.

"(C) STANDARD FOR BUDGET NEUTRALITY.—The budget neutrality requirement applicable with respect to expenditures for medical assistance under a Medicaid nonpregnant childless adults waiver shall—

"(i) in the case of fiscal year 2010, allow expenditures for medical assistance under title XIX for all such adults to not exceed the total amount of payments made to the State under paragraph (3)(B) for fiscal year 2009, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for calendar year 2010 over calendar year 2009, as most recently published by the Secretary; and

"(ii) in the case of any succeeding fiscal year, allow such expenditures to not exceed the amount in effect under this subparagraph for the preceding fiscal year, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the calendar year that begins during the fiscal year involved over the preceding calendar year, as most recently published by the Secretary.

"(b) RULES AND CONDITIONS FOR COVERAGE OF PARENTS OF TARGETED LOW-INCOME CHILDREN.—

"(1) TWO-YEAR TRANSITION PERIOD; AUTOMATIC EXTENSION AT STATE OPTION THROUGH FISCAL YEAR 2009.—

"(A) NO NEW CHIP WAIVERS.—Notwithstanding section 1115 or any other provision of this title, except as provided in this subsection—

"(i) the Secretary shall not on or after the date of the enactment of the Children's Health Insurance Program Reauthorization Act of 2007 approve or renew a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a parent of a targeted low-income child; and

"(ii) notwithstanding the terms and conditions of an applicable existing waiver, the provisions of paragraphs (2) and (3) shall apply for purposes of any fiscal year beginning on or after October 1, 2009, in determining the period to which the waiver applies, the individuals eligible to be covered by the waiver, and the amount of the Federal payment under this title.

"(B) EXTENSION UPON STATE REQUEST.—If an applicable existing waiver described in subparagraph (A) would otherwise expire before October 1, 2009, and the State requests an extension of such waiver, the Secretary shall grant such an extension, but only, subject to paragraph (2)(A), through September 30, 2009.

"(C) APPLICATION OF ENHANCED FMAP.—The enhanced FMAP determined under section 2105(b) shall apply to expenditures under an applicable existing waiver for the provision of child health assistance or other health benefits coverage to a parent of a targeted low-income child during fiscal years 2008 and 2009.

"(2) RULES FOR FISCAL YEARS 2010 THROUGH 2012.—

"(A) PAYMENTS FOR COVERAGE LIMITED TO BLOCK GRANT FUNDED FROM STATE ALLOTMENT.—Any State that provides child health assistance or health benefits coverage under an applicable existing waiver for a parent of a targeted low-income child may elect to continue to provide such assistance or coverage through fiscal year 2010, 2011, or 2012, subject to the same terms and conditions that applied under the applicable existing waiver, unless otherwise modified in subparagraph (B).

"(B) TERMS AND CONDITIONS.—

"(i) BLOCK GRANT SET ASIDE FROM STATE ALLOTMENT.—If the State makes an election under subparagraph (A), the Secretary shall set aside for the State for each such fiscal year an amount equal to the Federal share of 110 percent of the State's projected expenditures under the applicable existing waiver for providing child health assistance or health benefits coverage to all parents of targeted low-income children enrolled under such waiver for the fiscal year (as certified by the State and submitted to the Secretary by not later than August 31 of the preceding fiscal year). In the case of fiscal year 2012, the set aside for any State shall be computed separately for each period described in subparagraphs (A) and (B) of section 2104(a)(15) and any reduction in the allotment

for either such period under section 2104(i)(4) shall be allocated on a pro rata basis to such set aside.

"(ii) PAYMENTS FROM BLOCK GRANT.—The Secretary shall pay the State from the amount set aside under clause (i) for the fiscal year, an amount for each quarter of such fiscal year equal to the applicable percentage determined under clause (iii) or (iv) for expenditures in the quarter for providing child health assistance or other health benefits coverage to a parent of a targeted low-income child.

"(iii) ENHANCED FMAP ONLY IN FISCAL YEAR 2010 FOR STATES WITH SIGNIFICANT CHILD OUTREACH OR THAT ACHIEVE CHILD COVERAGE BENCHMARKS; FMAP FOR ANY OTHER STATES.—For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2010 is equal to—

"(I) the enhanced FMAP determined under section 2105(b) in the case of a State that meets the outreach or coverage benchmarks described in any of subparagraph (A), (B), or (C) of paragraph (3) for fiscal year 2009; or

"(II) the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) in the case of any other State.

"(iv) AMOUNT OF FEDERAL MATCHING PAYMENT IN 2011 OR 2012.—For purposes of clause (ii), the applicable percentage for any quarter of fiscal year 2011 or 2012 is equal to—

"(I) the REMAP percentage if—

"(aa) the applicable percentage for the State under clause (iii) was the enhanced FMAP for fiscal year 2009; and

"(bb) the State met either of the coverage benchmarks described in subparagraph (B) or (C) of paragraph (3) for the preceding fiscal year; or

"(II) the Federal medical assistance percentage (as so determined) in the case of any State to which subclause (I) does not apply.

For purposes of subclause (I), the REMAP percentage is the percentage which is the sum of such Federal medical assistance percentage and a number of percentage points equal to one-half of the difference between such Federal medical assistance percentage and such enhanced FMAP.

"(v) NO FEDERAL PAYMENTS OTHER THAN FROM BLOCK GRANT SET ASIDE.—No payments shall be made to a State for expenditures described in clause (ii) after the total amount set aside under clause (i) for a fiscal year has been paid to the State.

"(vi) NO INCREASE IN INCOME ELIGIBILITY LEVEL FOR PARENTS.—No payments shall be made to a State from the amount set aside under clause (i) for a fiscal year for expenditures for providing child health assistance or health benefits coverage to a parent of a targeted low-income child whose family income exceeds

the income eligibility level applied under the applicable existing waiver to parents of targeted low-income children on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

"(3) OUTREACH OR COVERAGE BENCHMARKS.—For purposes of paragraph (2), the outreach or coverage benchmarks described in this paragraph are as follows:

"(A) SIGNIFICANT CHILD OUTREACH CAMPAIGN.—The State—

"(i) was awarded a grant under section 2113 for fiscal year 2009;

"(ii) implemented 1 or more of the enrollment and retention provisions described in section 2105(a)(4) for such fiscal year; or

"(iii) has submitted a specific plan for outreach for such fiscal year.

"(B) HIGH-PERFORMING STATE.—The State, on the basis of the most timely and accurate published estimates of the Bureau of the Census, ranks in the lowest ⅓ of States in terms of the State's percentage of low-income children without health insurance.

"(C) STATE INCREASING ENROLLMENT OF LOW-INCOME CHILDREN.—The State qualified for a performance bonus payment under section 2105(a)(3)(B) for the most recent fiscal year applicable under such section.

"(4) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting a State from submitting an application to the Secretary for a waiver under section 1115 of the State plan under title XIX to provide medical assistance to a parent of a targeted low-income child that was provided child health assistance or health benefits coverage under an applicable existing waiver.

"(c) APPLICABLE EXISTING WAIVER.—For purposes of this section—

"(1) IN GENERAL.—The term 'applicable existing waiver' means a waiver, experimental, pilot, or demonstration project under section 1115, grandfathered under section 6102(c)(3) of the Deficit Reduction Act of 2005, or otherwise conducted under authority that—

"(A) would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to—

"(i) a parent of a targeted low-income child;

"(ii) a nonpregnant childless adult; or

"(iii) individuals described in both clauses (i) and (ii); and

"(B) was in effect during fiscal year 2007.

"(2) DEFINITIONS.—

"(A) PARENT.—The term 'parent' includes a caretaker relative (as such term is used in carrying out section 1931) and a legal guardian.

"(B) NONPREGNANT CHILDLESS ADULT.—The term 'nonpregnant childless adult' has the meaning given such term by section 2107(f).".

(2) CONFORMING AMENDMENTS.—

(A) Section 2107(f) (42 U.S.C. 1397gg(f)) is amended—

(i) by striking ", the Secretary" and inserting ":

"(1) The Secretary";

(ii) in the first sentence, by inserting "or a parent (as defined in section 2111(c)(2)(A)), who is not pregnant, of a targeted low-income child" before the period;

(iii) by striking the second sentence; and

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

"(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007 that would waive or modify the requirements of section 2111.".

(B) Section 6102(c) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 131) is amended by striking "Nothing" and inserting "Subject to section 2111 of the Social Security Act, as added by section 112 of the Children's Health Insurance Program Reauthorization Act of 2007, nothing".

(b) GAO STUDY AND REPORT.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of whether—

(A) the coverage of a parent, a caretaker relative (as such term is used in carrying out section 1931), or a legal guardian of a targeted low-income child under a State health plan under title XXI of the Social Security Act increases the enrollment of, or the quality of care for, children, and

(B) such parents, relatives, and legal guardians who enroll in such a plan are more likely to enroll their children in such a plan or in a State plan under title XIX of such Act.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall report the results of the study to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives, including recommendations (if any) for changes in legislation.

SEC. 113. ELIMINATION OF COUNTING MEDICAID CHILD PRESUMPTIVE ELIGIBILITY COSTS AGAINST TITLE XXI ALLOTMENT.

(a) IN GENERAL.—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]".

(b) 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 flush sentence:

"The term 'qualified provider' also includes a qualified entity, as defined in section 1920A(b)(3).".

SEC. 114. LIMITATION ON MATCHING RATE FOR STATES THAT PROPOSE TO COVER CHILDREN WITH EFFECTIVE FAMILY INCOME THAT EXCEEDS 300 PERCENT OF THE POVERTY LINE.

(a) FMAP APPLIED TO EXPENDITURES.—Section 2105(c) (42 U.S.C. 1397ee(c)) is amended by adding at the end the following new paragraph:

"(8) LIMITATION ON MATCHING RATE FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE PROVIDED TO CHILDREN WHOSE EFFECTIVE FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.—

"(A) FMAP APPLIED TO EXPENDITURES.—Except as provided in subparagraph (B), for fiscal years beginning with fiscal year 2008, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to any expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose effective family income would exceed 300 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.

"(B) EXCEPTION.—Subparagraph (A) shall not apply to any State that, on the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, has an approved State plan amendment or waiver to provide, or has enacted a State law to submit a State plan amendment to provide, expenditures described in such subparagraph under the State child health plan.".

(b) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as—

(1) changing any income eligibility level for children under title XXI of the Social Security Act; or

(2) changing the flexibility provided States under such title to establish the income eligibility level for targeted low-income children under a State child health plan and the methodologies used by the State to determine income or assets under such plan.

SEC. 115. STATE AUTHORITY UNDER MEDICAID.

(a) STATE AUTHORITY TO EXPAND INCOME OR RESOURCE ELIGIBILITY LEVELS FOR CHILDREN.—Nothing in this Act, the amendments made by this Act, or title XIX of the Social Security Act, including paragraph (2)(B) of section 1905(u) of such Act, shall be construed as limiting the flexibility afforded States under such title to increase the income or resource eligibility levels for children under a State plan or waiver under such title.

(b) STATE AUTHORITY TO RECEIVE PAYMENTS UNDER MEDICAID FOR PROVIDING MEDICAL ASSISTANCE TO CHILDREN ELIGIBLE AS

A RESULT OF AN INCOME OR RESOURCE ELIGIBILITY LEVEL EXPANSION.—A State may, notwithstanding the fourth sentence of subsection (b) of section 1905 of the Social Security Act (42 U.S.C. 1396d) or subsection (u) of such section—

(1) cover individuals described in section 1902(a)(10)(A)(ii)(IX) of the Social Security Act and thereby receive Federal financial participation for medical assistance for such individuals under title XIX of the Social Security Act; or

(2) receive Federal financial participation for expenditures for medical assistance under Medicaid for children described in paragraph (2)(B) or (3) of section 1905(u) of such Act based on the Federal medical assistance percentage, as otherwise determined based on the first and third sentences of subsection (b) of section 1905 of the Social Security Act, rather than on the basis of an enhanced FMAP (as defined in section 2105(b) of such Act).

SEC. 116. PREVENTING SUBSTITUTION OF CHIP COVERAGE FOR PRIVATE COVERAGE.

(a) FINDINGS.—

(1) Congress agrees with the President that low-income children should be the first priority of all States in providing child health assistance under CHIP.

(2) Congress agrees with the President and the Congressional Budget Office that the substitution of CHIP coverage for private coverage occurs more frequently for children in families at higher income levels.

(3) Congress agrees with the President that it is appropriate that States that expand CHIP eligibility to children at higher income levels should have achieved a high level of health benefits coverage for low-income children and should implement strategies to address such substitution.

(4) Congress concludes that the policies specified in this section (and the amendments made by this section) are the appropriate policies to address these issues.

(b) ANALYSES OF BEST PRACTICES AND METHODOLOGY IN ADDRESSING CROWD-OUT.—

(1) GAO REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives and the Secretary a report describing the best practices by States in addressing the issue of CHIP crowd-out. Such report shall include analyses of—

(A) the impact of different geographic areas, including urban and rural areas, on CHIP crowd-out;

(B) the impact of different State labor markets on CHIP crowd-out;

(C) the impact of different strategies for addressing CHIP crowd-out;

(D) the incidence of crowd-out for children with different levels of family income; and

(E) the relationship (if any) between changes in the availability and affordability of dependent coverage under employer-sponsored health insurance and CHIP crowd-out.

(2) IOM REPORT ON METHODOLOGY.—The Secretary shall enter into an arrangement with the Institute of Medicine under which the Institute submits to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives and the Secretary, not later than 18 months after the date of the enactment of this Act, a report on—

(A) the most accurate, reliable, and timely way to measure—

(i) on a State-by-State basis, the rate of public and private health benefits coverage among low-income children with family income that does not exceed 200 percent of the poverty line; and

(ii) CHIP crowd-out, including in the case of children with family income that exceeds 200 percent of the poverty line; and

(B) the least burdensome way to gather the necessary data to conduct the measurements described in subparagraph (A).

Out of any money in the Treasury not otherwise appropriated, there are hereby appropriated $2,000,000 to carry out this paragraph for the period ending September 30, 2009.

(3) INCORPORATION OF DEFINITIONS.—In this section, the terms "CHIP crowd-out", "children", "poverty line", and "State" have the meanings given such terms for purposes of CHIP.

(4) DEFINITION OF CHIP CROWD-OUT.—Section 2110(c) (42 U.S.C. 1397jj(c)) is amended by adding at the end the following:

"(9) CHIP CROWD-OUT.—The term 'CHIP crowd-out' means the substitution of—

"(A) health benefits coverage for a child under this title, for

"(B) health benefits coverage for the child other than under this title or title XIX.".

(c) DEVELOPMENT OF BEST PRACTICE RECOMMENDATIONS.—Section 2107 (42 U.S.C. 1397gg) is amended by adding at the end the following:

"(g) DEVELOPMENT OF BEST PRACTICE RECOMMENDATIONS.—Within 6 months after the date of receipt of the reports under subsections (a) and (b) of section 116 of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary, in consultation with States, including Medicaid and CHIP directors in States, shall publish in the Federal Register, and post on the public website for the Department of Health and Human Services—

"(1) recommendations regarding best practices for States to use to address CHIP crowd-out; and

"(2) uniform standards for data collection by States to measure and report—

"(A) health benefits coverage for children with family income below 200 percent of the poverty line; and

"(B) on CHIP crowd-out, including for children with family income that exceeds 200 percent of the poverty line.

The Secretary, in consultation with States, including Medicaid and CHIP directors in States, may from time to time update the best practice recommendations and uniform standards set published under paragraphs (1) and (2) and shall provide for publication and posting of such updated recommendations and standards.".

(d) REQUIREMENT TO ADDRESS CHIP CROWD-OUT; SECRETARIAL REVIEW.—Section 2106 (42 U.S.C. 1397ff) is amended by adding at the end the following:

"(f) REQUIREMENT TO ADDRESS CHIP CROWD-OUT; SECRETARIAL REVIEW.—

"(1) IN GENERAL.—Each State that, on or after the best practice application date described in paragraph (3), submits a plan amendment (or waiver request) to provide for eligibility for child health assistance under the State child health plan for higher income children described in section 2105(c)(9)(D) (relating to children whose effective family income exceeds 300 percent of the poverty line) shall include with such plan amendment or request a description of how the State—

"(A) will address CHIP crowd-out for such children; and

"(B) will incorporate recommended best practices referred to in such paragraph.

"(2) APPLICATION TO CERTAIN STATES.—Each State that, as of the best practice application date described in paragraph (3), has a State child health plan that provides (whether under the plan or through a waiver) for eligibility for child health assistance for children referred to in paragraph (1) shall submit to the Secretary, not later than 6 months after the date of such application, a State plan amendment describing how the State—

"(A) will address CHIP crowd-out for such children; and

"(B) will incorporate recommended best practices referred to in such paragraph.

"(3) BEST PRACTICE APPLICATION DATE.—The best practice application date described in this paragraph is the date that is 6 months after the date of publication of recommendations regarding best practices under section 2107(g)(1).

"(4) SECRETARIAL REVIEW.—The Secretary shall—

"(A) review each State plan amendment or waiver request submitted under paragraph (1) or (2);

"(B) determine whether the amendment or request incorporates recommended best practices referred to in paragraph (3);

"(C) determine whether the State meets the enrollment targets required under reference section 2105(c)(9)(C); and

"(D) notify the State of such determinations.".

(e) LIMITATION ON PAYMENTS FOR STATES COVERING HIGHER INCOME CHILDREN.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 114(a), is amended by adding at the end the following new subsection:

"(9) LIMITATION ON PAYMENTS FOR STATES COVERING HIGHER INCOME CHILDREN.—

"(A) DETERMINATIONS.—

"(i) IN GENERAL.—The Secretary shall determine, for each State that is a higher income eligibility State as of April 1 of 2010 and each subsequent year, whether the State meets the target rate of coverage of low-income children required under subparagraph (C) and shall notify the State in that month of such determination.

"(ii) DETERMINATION OF FAILURE.—If the Secretary determines in such month that a higher income eligibility State does not meet such target rate of coverage, subject to subparagraph (E), no payment shall be made as of October 1 of such year on or after October 1, 2010, under this section for child health assistance provided for higher-income children (as defined in subparagraph (D)) under the State child health plan unless and until the State establishes it is in compliance with such requirement.

"(B) HIGHER INCOME ELIGIBILITY STATE.—A higher income eligibility State described in this clause is a State that—

"(i) applies under its State child health plan an eligibility income standard for targeted low-income children that exceeds 300 percent of the poverty line; or

"(ii) because of the application of a general exclusion of a block of income that is not determined by type of expense or type of income, applies an effective income standard under the State child health plan for such children that exceeds 300 percent of the poverty line.

"(C) REQUIREMENT FOR TARGET RATE OF COVERAGE OF LOW-INCOME CHILDREN.—

"(i) IN GENERAL.—The requirement of this subparagraph for a State is that the rate of health benefits coverage (both private and public) for low-income children in the State is not statistically significantly (at a p=0.05 level) less than the target rate of coverage specified in clause (ii).

"(ii) TARGET RATE.—The target rate of coverage specified in this clause is the average rate (determined by the Secretary) of health benefits coverage (both private and public) as of January 1, 2010, among the 10 of the 50 States and the District of Columbia with the highest percentage of health benefits coverage (both private and public) for low-income children.

"(iii) STANDARDS FOR DATA.— In applying this subparagraph, rates of health benefits coverage for States shall be determined using the uniform standards identified by the Secretary under section 2107(g)(2).

"(D) HIGHER-INCOME CHILD.—For purposes of this paragraph, the term 'higher income child' means, with respect to a State child health plan, a targeted low-income child whose family income—

"(i) exceeds 300 percent of the poverty line; or

"(ii) would exceed 300 percent of the poverty line if there were not taken into account any general exclusion described in subparagraph (B)(ii).

"(E) NOTICE AND OPPORTUNITY TO COMPLY WITH TARGET RATE.—If the Secretary makes a determination described in subparagraph (A)(ii) in April of a year, the Secretary—

"(i) shall provide the State with the opportunity to submit and implement a corrective action plan for

the State to come into compliance with the requirement of subparagraph (C) before October 1 of such year;

"(ii) shall not effect a denial of payment under subparagraph (A) on the basis of such determination before October 1 of such year; and

"(iii) shall not effect such a denial if the Secretary determines that there is a reasonable likelihood that the implementation of such a correction action plan will bring the State into compliance with the requirement of subparagraph (C).".

(f) TREATMENT OF MEDICAL SUPPORT ORDERS.—Section 2102(b) (42 U.S.C. 1397bb(c)) is amended by adding at the end the following:

"(5) TREATMENT OF MEDICAL SUPPORT ORDERS.—

"(A) IN GENERAL.—Nothing in this title shall be construed to allow the Secretary to require that a State deny eligibility for child health assistance to a child who is otherwise eligible on the basis of the existence of a valid medical support order being in effect.

"(B) STATE ELECTION.—A State may elect to limit eligibility for child health assistance to a targeted low-income child on the basis of the existence of a valid medical support order on the child's behalf, but only if the State does not deny such eligibility for a child on such basis if the child asserts that the order is not being complied with for any of the reasons described in subparagraph (C) unless the State demonstrates that none of such reasons applies in the case involved.

"(C) REASONS FOR NONCOMPLIANCE.—The reasons described in this subparagraph for noncompliance with a medical support order with respect to a child are that the child is not being provided health benefits coverage pursuant to such order because—

"(i) of failure of the noncustodial parent to comply with the order;

"(ii) of the failure of an employer, group health plan or health insurance issuer to comply with such order; or

"(iii) the child resides in a geographic area in which benefits under the health benefits coverage are generally unavailable.".

(g) EFFECTIVE DATE OF AMENDMENTS; CONSISTENCY OF POLICIES.—The amendments made by this section shall take effect as if enacted on August 16, 2007. The Secretary may not impose (or continue in effect) any requirement, prevent the implementation of any provision, or condition the approval of any provision under any State child health plan, State plan amendment, or waiver request on the basis of any policy or interpretation relating to CHIP crowd-out or medical support order other than under the amendments made by this section.

TITLE II—OUTREACH AND ENROLLMENT

Subtitle A—Outreach and Enrollment Activities

SEC. 201. GRANTS AND ENHANCED ADMINISTRATIVE FUNDING FOR OUTREACH AND ENROLLMENT.

(a) GRANTS.—Title XXI (42 U.S.C. 1397aa et seq.), as amended by section 107, is amended by adding at the end the following:

"SEC. 2113. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT.

"(a) OUTREACH AND ENROLLMENT GRANTS; NATIONAL CAMPAIGN.—

"(1) IN GENERAL.—From the amounts appropriated under subsection (g), subject to paragraph (2), the Secretary shall award grants to eligible entities during the period of fiscal years 2008 through 2012 to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

"(2) TEN PERCENT SET ASIDE FOR NATIONAL ENROLLMENT CAMPAIGN.—An amount equal to 10 percent of such amounts shall be used by the Secretary for expenditures during such period to carry out a national enrollment campaign in accordance with subsection (h).

"(b) PRIORITY FOR AWARD OF GRANTS.—

"(1) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

"(A) propose to target geographic areas with high rates of—

"(i) eligible but unenrolled children, including such children who reside in rural areas; or

"(ii) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

"(B) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

"(2) TEN PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (g) shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

"(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

"(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

"(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness

of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

"(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

"(4) an assurance that the eligible entity shall—

"(A) conduct an assessment of the effectiveness of such activities against the performance measures;

"(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments; and

"(C) in the case of an eligible entity that is not the State, provide the State with enrollment data and other information as necessary for the State to make necessary projections of eligible children and pregnant women.

"(d) DISSEMINATION OF ENROLLMENT DATA AND INFORMATION DETERMINED FROM EFFECTIVENESS ASSESSMENTS; ANNUAL REPORT.—The Secretary shall—

"(1) make publicly available the enrollment data and information collected and reported in accordance with subsection (c)(4)(B); and

"(2) submit an annual report to Congress on the outreach and enrollment activities conducted with funds appropriated under this section.

"(e) MAINTENANCE OF EFFORT FOR STATES AWARDED GRANTS; NO STATE MATCH REQUIRED.—In the case of a State that is awarded a grant under this section—

"(1) the State share of funds expended for outreach and enrollment activities under the State child health plan shall not be less than the State share of such funds expended in the fiscal year preceding the first fiscal year for which the grant is awarded; and

"(2) no State matching funds shall be required for the State to receive a grant under this section.

"(f) DEFINITIONS.—In this section:

"(1) ELIGIBLE ENTITY.—The term 'eligible entity' means any of the following:

"(A) A State with an approved child health plan under this title.

"(B) A local government.

"(C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.

"(D) A Federal health safety net organization.

"(E) A national, State, local, or community-based public or nonprofit private organization, including organizations that use community health workers or community-based doula programs.

"(F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300x–65) relating to a grant award to nongovernmental entities.

"(G) An elementary or secondary school.

"(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term 'Federal health safety net organization' means—

"(A) a Federally-qualified health center (as defined in section 1905(l)(2)(B));

"(B) a hospital defined as a disproportionate share hospital for purposes of section 1923;

"(C) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

"(D) any other entity or consortium that serves children under a federally funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the Head Start and Early Head Start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

"(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms 'Indian', 'Indian tribe', 'tribal organization', and 'urban Indian organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

"(4) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

"(A) by serving as a liaison between communities and health care agencies;

"(B) by providing guidance and social assistance to community residents;

"(C) by enhancing community residents' ability to effectively communicate with health care providers;

"(D) by providing culturally and linguistically appropriate health or nutrition education;

"(E) by advocating for individual and community health or nutrition needs; and

"(F) by providing referral and followup services.

"(g) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $100,000,000 for the period of fiscal years 2008 through 2012, for the purpose of awarding grants under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

"(h) NATIONAL ENROLLMENT CAMPAIGN.—From the amounts made available under subsection (a)(2), the Secretary shall develop and implement a national enrollment campaign to improve the enrollment of underserved child populations in the programs established under this title and title XIX. Such campaign may include—

"(1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

"(2) the integration of information about the programs established under this title and title XIX in public health awareness campaigns administered by the Secretary;

"(3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

"(4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

"(5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency; and

"(6) such other outreach initiatives as the Secretary determines would increase public awareness of the programs under this title and title XIX.".

(b) ENHANCED ADMINISTRATIVE FUNDING FOR TRANSLATION OR INTERPRETATION SERVICES UNDER CHIP AND MEDICAID.—

(1) CHIP.—Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)), as amended by section 113, is amended—

(A) in the matter preceding subparagraph (A), by inserting "(or, in the case of expenditures described in subparagraph (D)(iv), the higher of 75 percent or the sum of the enhanced FMAP plus 5 percentage points)" after "enhanced FMAP"; and

(B) in subparagraph (D)—

(i) in clause (iii), by striking "and" at the end;

(ii) by redesignating clause (iv) as clause (v); and

(iii) by inserting after clause (iii) the following new clause:

"(iv) for translation or interpretation services in connection with the enrollment of, retention of, and use of services under this title by, individuals for whom English is not their primary language (as found necessary by the Secretary for the proper and efficient administration of the State plan); and".

(2) MEDICAID.—

(A) USE OF MEDICAID FUNDS.—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 of, retention of, and use of services under this title by, children of families for whom English is not the primary language; plus".

(B) USE OF COMMUNITY HEALTH WORKERS FOR OUTREACH ACTIVITIES.—

(i) IN GENERAL.—Section 2102(c)(1) of such Act (42 U.S.C. 1397bb(c)(1)) is amended by inserting "(through community health workers and others)" after "Outreach".

(ii) IN FEDERAL EVALUATION.—Section 2108(c)(3)(B) of such Act (42 U.S.C. 1397hh(c)(3)(B)) is amended by inserting "(such as through community health workers and others)" after "including practices".

SEC. 202. INCREASED OUTREACH AND ENROLLMENT OF INDIANS.

(a) IN GENERAL.—Section 1139 (42 U.S.C. 1320b–9) is amended to read as follows:

"SEC. 1139. IMPROVED ACCESS TO, AND DELIVERY OF, HEALTH CARE FOR INDIANS UNDER TITLES XIX AND XXI.

"(a) AGREEMENTS WITH STATES FOR MEDICAID AND CHIP OUTREACH ON OR NEAR RESERVATIONS TO INCREASE THE ENROLLMENT OF INDIANS IN THOSE PROGRAMS.—

"(1) IN GENERAL.—In order to improve the access of Indians residing on or near a reservation to obtain benefits under the Medicaid and State children's health insurance programs established under titles XIX and XXI, the Secretary shall encourage the State to take steps to provide for enrollment on or near the reservation. Such steps may include outreach efforts such as the outstationing of eligibility workers, entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach, education regarding eligibility and benefits, enrollment, and translation services when such services are appropriate.

"(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting arrangements entered into between States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations for such Service, Tribes, or Organizations to conduct administrative activities under such titles.

"(b) REQUIREMENT TO FACILITATE COOPERATION.—The Secretary, acting through the Centers for Medicare & Medicaid Services, shall take such steps as are necessary to facilitate cooperation with, and agreements between, States and the Indian Health Service, Indian Tribes, Tribal Organizations, or Urban Indian Organizations with respect to the provision of health care items and services to Indians under the programs established under title XIX or XXI.

"(c) DEFINITION OF INDIAN; INDIAN TRIBE; INDIAN HEALTH PROGRAM; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—In this section, the terms 'Indian', 'Indian Tribe', 'Indian Health Program', 'Tribal Organization', and 'Urban Indian Organization' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act.".

(b) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(c)(2) (42 U.S.C. 1397ee(c)(2)) is amended by adding at the end the following:

"(C) NONAPPLICATION TO CERTAIN EXPENDITURES.—The limitation under subparagraph (A) shall not apply with respect to the following expenditures:

"(i) EXPENDITURES TO INCREASE OUTREACH TO, AND THE ENROLLMENT OF, INDIAN CHILDREN UNDER THIS TITLE AND TITLE xix.—Expenditures for outreach activities to families of Indian children likely to be eligible for child health assistance under the plan or medical assistance under the State plan under title XIX (or under a waiver of such plan), to inform such families of the availability of, and to assist them in enrolling their children in, such plans, including such activities

conducted under grants, contracts, or agreements entered into under section 1139(a).".

SEC. 203. STATE OPTION TO RELY ON FINDINGS FROM AN EXPRESS LANE AGENCY TO CONDUCT SIMPLIFIED ELIGIBILITY DETERMINATIONS.

(a) APPLICATION UNDER MEDICAID AND CHIP PROGRAMS.—

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

"(13) EXPRESS LANE OPTION.—

"(A) IN GENERAL.—

"(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this title for a child (as defined in subparagraph (G)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (F)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this title. The State may rely on a finding from an Express Lane agency notwithstanding sections 1902(a)(46)(B) and 1137(d) and any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

"(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE.—If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this title and for child health assistance under title XXI, the State shall determine eligibility for assistance using its regular procedures.

"(II) NOTICE REQUIREMENT.—For any child who is found eligible for medical assistance under the State plan under this title or child health assistance under title XXI and who is subject to premiums based on an Express Lane agency's finding of such child's income level, the State shall provide notice that the child may qualify for lower premium payments if evaluated by the State using its regular policies and of the procedures for requesting such an evaluation.

"(III) COMPLIANCE WITH SCREEN AND ENROLL REQUIREMENT.—The State shall satisfy the requirements under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) before enrolling a child in child health assistance under title XXI. At its option, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

"(IV) VERIFICATION OF CITIZENSHIP OR NATIONALITY STATUS.—The State shall satisfy the requirements of section 1902(a)(46)(B) or 2105(c)(10), as applicable for verifications of citizenship or nationality status.

"(V) CODING.—The State meets the requirements of subparagraph (E).

"(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.—The State may apply the provisions of this paragraph when conducting initial determinations of eligibility,

redeterminations of eligibility, or both, as described in the State plan.

"(B) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

"(i) to limit or prohibit a State from taking any actions otherwise permitted under this title or title XXI in determining eligibility for or enrolling children into medical assistance under this title or child health assistance under title XXI; or

"(ii) to modify the limitations in section 1902(a)(5) concerning the agencies that may make a determination of eligibility for medical assistance under this title.

"(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

"(i) IN GENERAL.—With respect to a child whose eligibility for medical assistance under this title or for child health assistance under title XXI has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

"(ii) ESTABLISHING A SCREENING THRESHOLD.—

"(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this title.

"(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this title regardless of whether such child would otherwise satisfy such criteria.

"(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in section 2110(b)(4) and to satisfy the requirement under section 2110(b)(1)(C) (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is enrolled in child health assistance under title XXI, the State shall provide the parent, guardian, or custodial relative with the following:

"(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this title if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian,

or custodial relative can request that the State evaluate the child's eligibility for medical assistance under this title using such regular procedures.

"(bb) A description of differences between the medical assistance provided under this title and child health assistance under title XXI, including differences in cost-sharing requirements and covered benefits.

"(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

"(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under title XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

"(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under title XXI or for medical assistance under this title in accordance with this clause.

"(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this title or child health assistance under title XXI pursuant to subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll).

"(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

"(V) AVAILABILITY OF CHIP MATCHING FUNDS DURING TEMPORARY ENROLLMENT PERIOD.—Medical assistance for items and services that are provided to a child enrolled in title XXI during a temporary enrollment period under this clause shall be treated as child health assistance under such title.

"(D) OPTION FOR AUTOMATIC ENROLLMENT.—

"(i) IN GENERAL.—The State may initiate and determine eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan without a program application from, or on behalf of, the child based on data obtained from sources other than the child (or the child's family), but a child can only be automatically enrolled in the State Medicaid plan or the State CHIP plan if the child or the family affirmatively consents to being enrolled through affirmation and signature on an Express Lane agency application, if the requirement of clause (ii) is met.

"(ii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1912(a)) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

"(E) CODING; APPLICATION TO ENROLLMENT ERROR RATES.—

"(i) IN GENERAL.—For purposes of subparagraph (A)(iv), the requirement of this subparagraph for a State is that the State agrees to—

"(I) assign such codes as the Secretary shall require to the children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency for the duration of the State's election under this paragraph;

"(II) annually provide the Secretary with a statistically valid sample (that is approved by Secretary) of the children enrolled in such plans through reliance on such a finding by conducting a full Medicaid eligibility review of the children identified for such sample for purposes of determining an eligibility error rate (as described in clause (iv)) with respect to the enrollment of such children (and shall not include such children in any data or samples used for purposes of complying with a Medicaid Eligibility Quality Control (MEQC) review or a payment error rate measurement (PERM) requirement);

"(III) submit the error rate determined under subclause (II) to the Secretary;

"(IV) if such error rate exceeds 3 percent for either of the first 2 fiscal years in which the State elects to apply this paragraph, demonstrate to the satisfaction of the Secretary the specific corrective actions implemented by the State to improve upon such error rate; and

"(V) if such error rate exceeds 3 percent for any fiscal year in which the State elects to apply this paragraph, a reduction in the amount otherwise payable to the State under section 1903(a) for quarters for that fiscal year, equal to the total amount of erroneous excess payments determined for the fiscal year only with respect to the children included in the sample for the fiscal year that are in excess of a 3 percent error rate with respect to such children.

"(ii) NO PUNITIVE ACTION BASED ON ERROR RATE.—The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State

on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

"(iii) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as relieving a State that elects to apply this paragraph from being subject to a penalty under section 1903(u), for payments made under the State Medicaid plan with respect to ineligible individuals and families that are determined to exceed the error rate permitted under that section (as determined without regard to the error rate determined under clause (i)(II)).

"(iv) ERROR RATE DEFINED.—In this subparagraph, the term 'error rate' means the rate of erroneous excess payments for medical assistance (as defined in section 1903(u)(1)(D)) for the period involved, except that such payments shall be limited to individuals for which eligibility determinations are made under this paragraph and except that in applying this paragraph under title XXI, there shall be substituted for references to provisions of this title corresponding provisions within title XXI.

"(F) EXPRESS LANE AGENCY.—

"(i) IN GENERAL.—In this paragraph, the term 'Express Lane agency' means a public agency that—

"(I) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making the determinations of one or more eligibility requirements described in subparagraph (A)(i);

"(II) is identified in the State Medicaid plan or the State CHIP plan; and

"(III) notifies the child's family—

"(aa) of the information which shall be disclosed in accordance with this paragraph;

"(bb) that the information disclosed will be used solely for purposes of determining eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan; and

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

"(IV) enters into, or is subject to, an interagency agreement to limit the disclosure and use of the information disclosed.

"(ii) INCLUSION OF SPECIFIC PUBLIC AGENCIES.—Such term includes the following:

"(I) A public agency that determines eligibility for assistance under any of the following:

"(aa) The temporary assistance for needy families program funded under part A of title IV.

"(bb) A State program funded under part D of title IV.

"(cc) The State Medicaid plan.

"(dd) The State CHIP plan.

"(ee) The Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.).

"(ff) The Head Start Act (42 U.S.C. 9801 et seq.).

"(gg) The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.).

"(hh) The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.).

"(ii) The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.).

"(jj) The Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11301 et seq.).

"(kk) The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.).

"(ll) The Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.).

"(II) A State-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the State.

"(III) A public agency that is subject to an inter-agency agreement limiting the disclosure and use of the information disclosed for purposes of determining eligibility under the State Medicaid plan or the State CHIP plan.

"(iii) EXCLUSIONS.—Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under title XX or a private, for-profit organization.

"(iv) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

"(I) exempting a State Medicaid agency from complying with the requirements of section 1902(a)(4) relating to merit-based personnel standards for employees of the State Medicaid agency and safeguards against conflicts of interest); or

"(II) authorizing a State Medicaid agency that elects to use Express Lane agencies under this subparagraph to use the Express Lane option to avoid complying with such requirements for purposes of making eligibility determinations under the State Medicaid plan.

"(v) ADDITIONAL DEFINITIONS.—In this paragraph:

"(I) STATE.—The term 'State' means 1 of the 50 States or the District of Columbia.

"(II) STATE CHIP AGENCY.—The term 'State CHIP agency' means the State agency responsible for administering the State CHIP plan.

"(III) STATE CHIP PLAN.—The term 'State CHIP plan' means the State child health plan established under title XXI and includes any waiver of such plan.

"(IV) STATE MEDICAID AGENCY.—The term 'State Medicaid agency' means the State agency responsible for administering the State Medicaid plan.

"(V) STATE MEDICAID PLAN.—The term 'State Medicaid plan' means the State plan established under title XIX and includes any waiver of such plan.

"(G) CHILD DEFINED.—For purposes of this paragraph, the term 'child' means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.

"(H) APPLICATION.—This paragraph shall not apply to with respect to eligibility determinations made after September 30, 2012.".

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

"(B) Section 1902(e)(13) (relating to the State option to rely on findings from an Express Lane agency to help evaluate a child's eligibility for medical assistance).".

(b) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct, by grant, contract, or interagency agreement, a comprehensive, independent evaluation of the option provided under the amendments made by subsection (a). Such evaluation shall include an analysis of the effectiveness of the option, and shall include—

(A) obtaining a statistically valid sample of the children who were enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency and determining the percentage of children who were erroneously enrolled in such plans;

(B) determining whether enrolling children in such plans through reliance on a finding made by an Express Lane agency improves the ability of a State to identify and enroll low-income, uninsured children who are eligible but not enrolled in such plans;

(C) evaluating the administrative costs or savings related to identifying and enrolling children in such plans through reliance on such findings, and the extent to which such costs differ from the costs that the State otherwise would have incurred to identify and enroll low-income, uninsured children who are eligible but not enrolled in such plans; and

(D) any recommendations for legislative or administrative changes that would improve the effectiveness of enrolling children in such plans through reliance on such findings.

(2) REPORT TO CONGRESS.—Not later than September 30, 2011, the Secretary shall submit a report to Congress on the results of the evaluation under paragraph (1).

(3) FUNDING.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary to carry out the evaluation under this subsection $5,000,000 for the period of fiscal years 2008 through 2011.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of such amount to conduct the evaluation under this subsection.

(c) ELECTRONIC TRANSMISSION OF INFORMATION.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

"(dd) ELECTRONIC TRANSMISSION OF INFORMATION.—If the State agency determining eligibility for medical assistance under this title or child health assistance under title XXI verifies an element

of eligibility based on information from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. 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). The requirements of subparagraphs (A) and (B) of section 1137(d)(2) may be met through evidence in digital or electronic form.".

(d) AUTHORIZATION OF INFORMATION DISCLOSURE.—

(1) IN GENERAL.—Title XIX is amended—

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

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

"SEC. 1939. AUTHORIZATION TO RECEIVE RELEVANT INFORMATION.

"(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data directly relevant 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, to the extent such conveyance meets the requirements of subsection (b).

"(b) REQUIREMENTS FOR CONVEYANCE.—Data or information may be conveyed pursuant to subsection (a) 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 or attempting to enroll 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 otherwise 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) PENALTIES FOR IMPROPER DISCLOSURE.—

"(1) CIVIL MONEY PENALTY.—A private entity described in the subsection (a) that publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal

law, any information obtained under this section is subject to a civil money penalty in an amount equal to $10,000 for each such unauthorized publication or disclosure. The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(2) CRIMINAL PENALTY.—A private entity described in the subsection (a) that willfully publishes, 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 $10,000 or imprisoned not more than 1 year, or both, for each such unauthorized publication or disclosure.

"(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 subsection (a)(2), is amended by adding at the end the following new subparagraph:

"(F) Section 1939 (relating to authorization to receive data directly relevant to eligibility determinations).".

(3) 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 apply or whose eligibility for medical assistance is being evaluated in accordance with section 1902(e)(13)(D))" 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".

(e) AUTHORIZATION FOR STATES ELECTING EXPRESS LANE OPTION TO RECEIVE CERTAIN DATA DIRECTLY RELEVANT TO DETERMINING ELIGIBILITY AND CORRECT AMOUNT OF ASSISTANCE.—The Secretary shall enter into such agreements as are necessary to permit a State that elects the Express Lane option under section 1902(e)(13) of the Social Security Act to receive data directly relevant to eligibility determinations and determining the correct amount of benefits under a State child health plan under CHIP or a State plan under Medicaid from the following:

(1) The National Directory of New Hires established under section 453(i) of the Social Security Act (42 U.S.C. 653(i)).

(2) Data regarding enrollment in insurance that may help to facilitate outreach and enrollment under the State Medicaid plan, the State CHIP plan, and such other programs as the Secretary may specify.

(f) EFFECTIVE DATE.—The amendments made by this section are effective on January 1, 2008.

Subtitle B—Reducing Barriers to Enrollment

SEC. 211. VERIFICATION OF DECLARATION OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID AND CHIP.

(a) STATE OPTION TO VERIFY DECLARATION OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID THROUGH VERIFICATION OF NAME AND SOCIAL SECURITY NUMBER.—

(1) ALTERNATIVE TO DOCUMENTATION REQUIREMENT.—

(A) IN GENERAL.—Section 1902 (42 U.S.C. 1396a), as amended by section 203(c), is amended—

(i) in subsection (a)(46)—

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

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

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

"(B) provide, with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, that the State shall satisfy the requirements of—

"(i) section 1903(x); or

"(ii) subsection (ee);"; and

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

"(ee)(1) For purposes of subsection (a)(46)(B)(ii), the requirements of this subsection with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, are, in lieu of requiring the individual to present satisfactory documentary evidence of citizenship or nationality under section 1903(x) (if the individual is not described in paragraph (2) of that section), as follows:

"(A) The State submits the name and social security number of the individual to the Commissioner of Social Security as part of the program established under paragraph (2).

"(B) If the State receives notice from the Commissioner of Social Security that the name or social security number of the individual is invalid—

"(i) the State makes a reasonable effort to identify and address the causes of such invalid match, including through typographical or other clerical errors, by contacting the individual to confirm the accuracy of the name or social security number, respectively, submitted, and by taking such additional actions as the Secretary, through regulation or other guidance, or the State may identify, and continues to provide the individual with medical assistance while making such effort; and

"(ii) in the case that the name or social security number of the individual remains invalid after such reasonable efforts, the State—

"(I) notifies the individual of such fact;

"(II) provides the individual with a period of 90 days from the date on which the notice required under subclause (I) is received by the individual to either present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3))

or cure the invalid determination with the Commissioner of Social Security (and continues to provide the individual with medical assistance during such 90-day period); and

"(III) disenrolls the individual from the State plan under this title within 30 days after the end of such 90-day period if no such documentary evidence is presented or if such invalid determination is not cured.

"(2)(A) Each State electing to satisfy the requirements of this subsection for purposes of section 1902(a)(46)(B) shall establish a program under which the State submits each month to the Commissioner of Social Security for verification the name and social security number of each individual newly enrolled in the State plan under this title that month who is not described in section 1903(x)(2).

"(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of Social Security—

"(i) to provide for the electronic submission and verification, through an on-line system or otherwise, of the name and social security number of an individual enrolled in the State plan under this title;

"(ii) to submit to the Commissioner the names and social security numbers of such individuals on a batch basis, provided that such batches are submitted at least on a monthly basis; or

"(iii) to provide for the verification of the names and social security numbers of such individuals through such other method as agreed to by the State and the Commissioner and approved by the Secretary, provided that such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in clause (i) or (ii).

"(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social security number to the State under subparagraph (A) and who is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) 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.

"(3)(A) The State agency implementing the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the percentage each month that the invalid names and numbers submitted bears to the total submitted for verification. For purposes of the previous sentence, a name or social security number of an individual shall be treated as invalid and included in the determination of such percentage only if—

"(i) the name or social security number, respectively, submitted by the individual does not match Social Security Administration records;

"(ii) the inconsistency between the name or number, respectively, so submitted and the Social Security Administration records could not be resolved by the State;

"(iii) the individual was provided with a reasonable period of time to resolve the inconsistency with the Social Security Administration or provide satisfactory documentation of citizenship and did not successfully resolve such inconsistency; and

"(iv) payment has been made for an item or service furnished to the individual under this title.

"(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 3 percent—

"(i) the State shall develop and adopt a corrective plan to review its procedures for verifying the identities of individuals seeking to enroll in the State plan under this title and to identify and implement changes in such procedures to improve their accuracy; and

"(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the State plan for the fiscal year for providing medical assistance to individuals who provided invalid information as the number of individuals with invalid information in excess of 3 percent of such total submitted bears to the total number of individuals with invalid information.

"(C) The Secretary may waive, in certain limited cases, all or part of the payment under subparagraph (B)(ii) if the State is unable to reach the allowable error rate despite a good faith effort by such State.

"(D) This paragraph shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year.

"(4) Nothing in this subsection shall affect the rights of any individual under this title to appeal any disenrollment from a State plan.".

(B) COSTS OF IMPLEMENTING AND MAINTAINING SYSTEM.—Section 1903(a)(3) (42 U.S.C. 1396b(a)(3)) is amended—

(i) by striking "plus" at the end of subparagraph (E) and inserting "and", and

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

"(F)(i) 90 percent of the sums expended during the quarter as are attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1902(ee) (including a system described in paragraph (2)(B) thereof), and

"(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies, plus".

(2) LIMITATION ON WAIVER AUTHORITY.—Notwithstanding any provision of section 1115 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.

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

(A) in subsection (i)(22), by striking "subsection (x)" and inserting "section 1902(a)(46)(B)"; and

(B) in subsection (x)(1), by striking "subsection (i)(22)" and inserting "section 1902(a)(46)(B)(i)".

(b) CLARIFICATION OF REQUIREMENTS RELATING TO PRESENTATION OF SATISFACTORY DOCUMENTARY EVIDENCE OF CITIZENSHIP OR NATIONALITY.—

(1) ACCEPTANCE OF DOCUMENTARY EVIDENCE ISSUED BY A FEDERALLY RECOGNIZED INDIAN TRIBE.—Section 1903(x)(3)(B) (42 U.S.C. 1396b(x)(3)(B)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following new clause:

"(v)(I) Except as provided in subclause (II), 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).

"(II) 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, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.".

(2) REQUIREMENT TO PROVIDE REASONABLE OPPORTUNITY TO PRESENT SATISFACTORY DOCUMENTARY EVIDENCE.—Section 1903(x) (42 U.S.C. 1396b(x)) is amended by adding at the end the following new paragraph:

"(4) 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)(i), 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.".

(3) CHILDREN BORN IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR MEDICAID.—

(A) CLARIFICATION OF RULES.—Section 1903(x) (42 U.S.C. 1396b(x)), as amended by paragraph (2), is amended—

(i) in paragraph (2)—

(I) in subparagraph (C), by striking "or" at the end;

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

(III) 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"; and

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

"(5) 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.".

(B) STATE REQUIREMENT TO ISSUE SEPARATE IDENTIFICATION NUMBER.—Section 1902(e)(4) (42 U.S.C. 1396a(e)(4)) is amended by adding at the end the following new sentence: "Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1903(v), the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth.".

(4) TECHNICAL AMENDMENTS.—Section 1903(x)(2) (42 U.S.C. 1396b(x)) is amended—

(A) in subparagraph (B)—

(i) by realigning the left margin of the matter preceding clause (i) 2 ems to the left; and

(ii) by realigning the left margins of clauses (i) and (ii), respectively, 2 ems to the left; and

(B) in subparagraph (C)—

(i) by realigning the left margin of the matter preceding clause (i) 2 ems to the left; and

(ii) by realigning the left margins of clauses (i) and (ii), respectively, 2 ems to the left.

(c) APPLICATION OF DOCUMENTATION SYSTEM TO CHIP.—

(1) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by sections 114(a) and 116(c), is amended by adding at the end the following new paragraph:

"(10) CITIZENSHIP DOCUMENTATION REQUIREMENTS.—

"(A) IN GENERAL.—No payment may be made under this section with respect to an individual who has, or is, declared to be a citizen or national of the United States for purposes of establishing eligibility under this title unless the State meets the requirements of section 1902(a)(46)(B) with respect to the individual.

"(B) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures described in clause (i) or (ii) of section 1903(a)(3)(F) necessary to comply with subparagraph (A) shall in no event be less than 90 percent and 75 percent, respectively.".

(2) NONAPPLICATION OF ADMINISTRATIVE EXPENDITURES CAP.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as amended by section 202(b), is amended by adding at the end the following:

"(ii) EXPENDITURES TO COMPLY WITH CITIZENSHIP OR NATIONALITY VERIFICATION REQUIREMENTS.—

Expenditures necessary for the State to comply with paragraph (9)(A).".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section shall take effect on October 1, 2008.

(B) TECHNICAL AMENDMENTS.—The amendments made by—

(i) paragraphs (1), (2), and (3) of subsection (b) shall take effect as if included in the enactment of section 6036 of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 80); and

(ii) paragraph (4) of subsection (b) shall take effect as if included in the enactment of section 405 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432; 120 Stat. 2996).

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on October 1, 2008, was determined to be ineligible for medical assistance under a State Medicaid plan, including any waiver of such plan, 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 subsection (b), 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.

(3) SPECIAL TRANSITION RULE FOR INDIANS.—During the period that begins on July 1, 2006, and ends on the effective date of final regulations issued under subclause (II) of section 1903(x)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by subsection (b)(1)(B)), an individual who is a member of a federally-recognized Indian tribe described in subclause (II) of that section who presents a document described in subclause (I) of such section that is issued by such Indian tribe, shall be deemed to have presented satisfactory evidence of citizenship or nationality for purposes of satisfying the requirement of subsection (x) of section 1903 of such Act.

SEC. 212. REDUCING ADMINISTRATIVE BARRIERS TO ENROLLMENT.

Section 2102(b) (42 U.S.C. 1397bb(b)) is amended—

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

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

"(4) REDUCTION OF ADMINISTRATIVE BARRIERS TO ENROLLMENT.—

"(A) IN GENERAL.—Subject to subparagraph (B), the plan shall include a description of the procedures used to reduce administrative barriers to the enrollment of children and pregnant women who are eligible for medical assistance under title XIX or for child health assistance or health benefits coverage under this title. Such procedures shall be established and revised as often as the

State determines appropriate to take into account the most recent information available to the State identifying such barriers.

"(B) DEEMED COMPLIANCE IF JOINT APPLICATION AND RENEWAL PROCESS THAT PERMITS APPLICATION OTHER THAN IN PERSON.—A State shall be deemed to comply with subparagraph (A) if the State's application and renewal forms and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children and pregnant women 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.".

SEC. 213. MODEL OF INTERSTATE COORDINATED ENROLLMENT AND COVERAGE PROCESS.

(a) IN GENERAL.—In order to assure continuity of coverage of low-income children under the Medicaid program and the State Children's Health Insurance Program (CHIP), not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with State Medicaid and CHIP directors and organizations representing program beneficiaries, shall develop a model process for the coordination of the enrollment, retention, and coverage under such programs of children who, because of migration of families, emergency evacuations, natural or other disasters, public health emergencies, educational needs, or otherwise, frequently change their State of residency or otherwise are temporarily located outside of the State of their residency.

(b) REPORT TO CONGRESS.—After development of such model process, the Secretary of Health and Human Services shall submit to Congress a report describing additional steps or authority needed to make further improvements to coordinate the enrollment, retention, and coverage under CHIP and Medicaid of children described in subsection (a).

TITLE III—REDUCING BARRIERS TO PROVIDING PREMIUM ASSISTANCE

Subtitle A—Additional State Option for Providing Premium Assistance

SEC. 301. ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE.

(a) CHIP.—

(1) IN GENERAL.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by sections 114(a), 116(c), and 211(c), is amended by adding at the end the following:

"(11) STATE OPTION TO OFFER PREMIUM ASSISTANCE.—

"(A) IN GENERAL.—A State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer-sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and

have access to such coverage in accordance with the requirements of this paragraph. No subsidy shall be provided to a targeted low-income child under this paragraph unless the child (or the child's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of child health assistance.

"(B) QUALIFIED EMPLOYER-SPONSORED COVERAGE.—

"(i) IN GENERAL.—Subject to clause (ii), in this paragraph, the term 'qualified employer-sponsored coverage' means a group health plan or health insurance coverage offered through an employer—

"(I) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act;

"(II) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

"(III) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

"(ii) EXCEPTION.—Such term does not include coverage consisting of—

"(I) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

"(II) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

"(C) PREMIUM ASSISTANCE SUBSIDY.—

"(i) IN GENERAL.—In this paragraph, the term 'premium assistance subsidy' means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer-sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan (subject to the limitations imposed under section 2103(e), including the requirement to count the total amount of the employee contribution required for enrollment of the employee and the child in such coverage toward the annual aggregate cost-sharing limit applied under paragraph (3)(B) of such section).

"(ii) STATE PAYMENT OPTION.—A State may provide a premium assistance subsidy either as reimbursement to an employee for out-of-pocket expenditures or, subject to clause (iii), directly to the employee's employer.

"(iii) EMPLOYER OPT-OUT.—An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee. In the event of such a notification, an employer shall withhold the total amount of the employee contribution required for enrollment of the employee and the child in the qualified employer-sponsored coverage and the State shall pay the premium assistance subsidy directly to the employee.

"(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

"(D) APPLICATION OF SECONDARY PAYOR RULES.—The State shall be a secondary payor for any items or services provided under the qualified employer-sponsored coverage for which the State provides child health assistance under the State child health plan.

"(E) REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

"(i) IN GENERAL.—Notwithstanding section 2110(b)(1)(C), the State shall provide for each targeted low-income child enrolled in qualified employer-sponsored coverage, supplemental coverage consisting of—

"(I) items or services that are not covered, or are only partially covered, under the qualified employer-sponsored coverage; and

"(II) cost-sharing protection consistent with section 2103(e).

"(ii) RECORD KEEPING REQUIREMENTS.—For purposes of carrying out clause (i), a State may elect to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified employer-sponsored coverage and collect or not collect all or any portion of such expenditures from the parent of the child.

"(F) APPLICATION OF WAITING PERIOD IMPOSED UNDER THE STATE.—Any waiting period imposed under the State child health plan prior to the provision of child health assistance to a targeted low-income child under the State plan shall apply to the same extent to the provision of a premium assistance subsidy for the child under this paragraph.

"(G) OPT-OUT PERMITTED FOR ANY MONTH.—A State shall establish a process for permitting the parent of a targeted low-income child receiving a premium assistance subsidy to disenroll the child from the qualified employer-sponsored coverage and enroll the child in, and receive child health assistance under, the State child health plan, effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child.

"(H) APPLICATION TO PARENTS.—If a State provides child health assistance or health benefits coverage to parents of a targeted low-income child in accordance with

section 2111(b), the State may elect to offer a premium assistance subsidy to a parent of a targeted low-income child who is eligible for such a subsidy under this paragraph in the same manner as the State offers such a subsidy for the enrollment of the child in qualified employer-sponsored coverage, except that—

"(i) the amount of the premium assistance subsidy shall be increased to take into account the cost of the enrollment of the parent in the qualified employer-sponsored coverage or, at the option of the State if the State determines it cost-effective, the cost of the enrollment of the child's family in such coverage; and

"(ii) any reference in this paragraph to a child is deemed to include a reference to the parent or, if applicable under clause (i), the family of the child.

"(I) ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE.—

"(i) IN GENERAL.—A State may establish an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least 1 employee who is a pregnant woman eligible for assistance under the State child health plan (including through the application of an option described in section 2112(f)) or a member of a family with at least 1 targeted low-income child and to provide a premium assistance subsidy under this paragraph for enrollment in coverage made available through such pool.

"(ii) ACCESS TO CHOICE OF COVERAGE.—A State that elects the option under clause (i) shall identify and offer access to not less than 2 private health plans that are health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2) for employees described in clause (i).

"(iii) CLARIFICATION OF PAYMENT FOR ADMINISTRATIVE EXPENDITURES.—Nothing in this subparagraph shall be construed as permitting payment under this section for administrative expenditures attributable to the establishment or operation of such pool, except to the extent that such payment would otherwise be permitted under this title.

"(J) NO EFFECT ON PREMIUM ASSISTANCE WAIVER PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906 or 1906A, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect prior to the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007.

"(K) NOTICE OF AVAILABILITY.—If a State elects to provide premium assistance subsidies in accordance with this paragraph, the State shall—

"(i) include on any application or enrollment form for child health assistance a notice of the availability

of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer-sponsored coverage;

"(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

"(iii) establish such other procedures as the State determines necessary to ensure that parents are fully informed of the choices for receiving child health assistance under the State child health plan or through the receipt of premium assistance subsidies.

"(L) APPLICATION TO QUALIFIED EMPLOYER-SPONSORED BENCHMARK COVERAGE.—If a group health plan or health insurance coverage offered through an employer is certified by an actuary as health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2), the State may provide premium assistance subsidies for enrollment of targeted low-income children in such group health plan or health insurance coverage in the same manner as such subsidies are provided under this paragraph for enrollment in qualified employer-sponsored coverage, but without regard to the requirement to provide supplemental coverage for benefits and cost-sharing protection provided under the State child health plan under subparagraph (E).

"(M) SATISFACTION OF COST-EFFECTIVENESS TEST.—Premium assistance subsidies for qualified employer-sponsored coverage offered under this paragraph shall be deemed to meet the requirement of subparagraph (A) of paragraph (3).".

(2) DETERMINATION OF COST-EFFECTIVENESS FOR PREMIUM ASSISTANCE OR PURCHASE OF FAMILY COVERAGE.—

(A) IN GENERAL.—Section 2105(c)(3)(A) (42 U.S.C. 1397ee(c)(3)(A)) is amended by striking "relative to" and all that follows through the comma and inserting "relative to

"(i) the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide comparable coverage of the targeted low-income child involved or the family involved (as applicable); or

"(ii) the aggregate amount of expenditures that the State would have made under the State child health plan, including administrative expenditures, for providing coverage under such plan for all such children or families.".

(B) NONAPPLICATION TO PREVIOUSLY APPROVED COVERAGE.—The amendment made by subparagraph (A) shall not apply to coverage the purchase of which has been approved by the Secretary under section 2105(c)(3) of the Social Security Act prior to the date of enactment of this Act.

(b) MEDICAID.—Title XIX is amended by inserting after section 1906 the following new section:

"PREMIUM ASSISTANCE OPTION FOR CHILDREN

"SEC. 1906A. (a) IN GENERAL.—A State may elect to offer a premium assistance subsidy (as defined in subsection (c)) for qualified employer-sponsored coverage (as defined in subsection (b)) to all individuals under age 19 who are entitled to medical assistance under this title (and to the parent of such an individual) who have access to such coverage if the State meets the requirements of this section.

"(b) QUALIFIED EMPLOYER-SPONSORED COVERAGE.—

"(1) IN GENERAL.—Subject to paragraph (2)), in this paragraph, the term 'qualified employer-sponsored coverage' means a group health plan or health insurance coverage offered through an employer—

"(A) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act;

"(B) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

"(C) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

"(2) EXCEPTION.—Such term does not include coverage consisting of—

"(A) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

"(B) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

"(3) TREATMENT AS THIRD PARTY LIABILITY.—The State shall treat the coverage provided under qualified employer-sponsored coverage as a third party liability under section 1902(a)(25).

"(c) PREMIUM ASSISTANCE SUBSIDY.—In this section, the term 'premium assistance subsidy' means the amount of the employee contribution for enrollment in the qualified employer-sponsored coverage by the individual under age 19 or by the individual's family. Premium assistance subsidies under this section shall be considered, for purposes of section 1903(a), to be a payment for medical assistance.

"(d) VOLUNTARY PARTICIPATION.—

"(1) EMPLOYERS.—Participation by an employer in a premium assistance subsidy offered by a State under this section shall be voluntary. An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee.

"(2) BENEFICIARIES.—No subsidy shall be provided to an individual under age 19 under this section unless the individual (or the individual's parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of medical assistance. State may not require, as a condition of an individual under age 19 (or the individual's parent) being or remaining eligible for medical assistance under

this title, apply for enrollment in qualified employer-sponsored coverage under this section.

"(3) OPT-OUT PERMITTED FOR ANY MONTH.—A State shall establish a process for permitting the parent of an individual under age 19 receiving a premium assistance subsidy to disenroll the individual from the qualified employer-sponsored coverage.

"(e) REQUIREMENT TO PAY PREMIUMS AND COST-SHARING AND PROVIDE SUPPLEMENTAL COVERAGE.—In the case of the participation of an individual under age 19 (or the individual's parent) in a premium assistance subsidy under this section for qualified employer-sponsored coverage, the State shall provide for payment of all enrollee premiums for enrollment in such coverage and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this title (exceeding the amount otherwise permitted under section 1916 or, if applicable, section 1916A). The fact that an individual under age 19 (or a parent) elects to enroll in qualified employer-sponsored coverage under this section shall not change the individual's (or parent's) eligibility for medical assistance under the State plan, except insofar as section 1902(a)(25) provides that payments for such assistance shall first be made under such coverage.".

(c) 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 any State premium assistance programs for which Federal matching payments are made under title XIX or XXI of the Social Security Act, including under waiver authority, and shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives on the results of such study.

SEC. 302. OUTREACH, EDUCATION, AND ENROLLMENT ASSISTANCE.

(a) REQUIREMENT TO INCLUDE DESCRIPTION OF OUTREACH, EDUCATION, AND ENROLLMENT EFFORTS RELATED TO PREMIUM ASSISTANCE SUBSIDIES IN STATE CHILD HEALTH PLAN.—Section 2102(c) (42 U.S.C. 1397bb(c)) is amended by adding at the end the following new paragraph:

"(3) PREMIUM ASSISTANCE SUBSIDIES.—In the case of a State that provides for premium assistance subsidies under the State child health plan in accordance with paragraph (2)(B), (3), or (10) of section 2105(c), or a waiver approved under section 1115, outreach, education, and enrollment assistance for families of children likely to be eligible for such subsidies, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and for employers likely to provide coverage that is eligible for such subsidies, including the specific, significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan.".

(b) NONAPPLICATION OF 10 PERCENT LIMIT ON OUTREACH AND CERTAIN OTHER EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)(C)), as amended by section 301(c)(2), is amended by adding at the end the following new clause:

"(iv) EXPENDITURES FOR OUTREACH TO INCREASE THE ENROLLMENT OF CHILDREN UNDER THIS TITLE AND TITLE xix THROUGH PREMIUM ASSISTANCE SUBSIDIES.—

Expenditures for outreach activities to families of children likely to be eligible for premium assistance subsidies in accordance with paragraph (2)(B), (3), or (10), or a waiver approved under section 1115, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and to employers likely to provide qualified employer-sponsored coverage (as defined in subparagraph (B) of such paragraph), but not to exceed an amount equal to 1.25 percent of the maximum amount permitted to be expended under subparagraph (A) for items described in subsection (a)(1)(D).".

Subtitle B—Coordinating Premium Assistance With Private Coverage

SEC. 311. SPECIAL ENROLLMENT PERIOD UNDER GROUP HEALTH PLANS IN CASE OF TERMINATION OF MEDICAID OR CHIP COVERAGE OR ELIGIBILITY FOR ASSISTANCE IN PURCHASE OF EMPLOYMENT-BASED COVERAGE; COORDINATION OF COVERAGE.

(a) AMENDMENTS TO INTERNAL REVENUE CODE OF 1986.—Section 9801(f) of the Internal Revenue Code of 1986 (relating to special enrollment periods) is amended by adding at the end the following new paragraph:

"(3) SPECIAL RULES RELATING TO MEDICAID AND CHIP.—

"(A) IN GENERAL.—A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

"(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan not later than 60 days after the date of termination of such coverage.

"(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

"(B) EMPLOYEE OUTREACH AND DISCLOSURE.—

"(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

"(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this clause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

"(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024).

"(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2007, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.".

(b) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT.—

(A) IN GENERAL.—Section 701(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)) is amended by adding at the end the following new paragraph:

"(3) SPECIAL RULES FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

"(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

"(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

"(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

"(B) COORDINATION WITH MEDICAID AND CHIP.—

"(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

"(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents.

"(II) MODEL NOTICE.—Not later than 1 year after the date of enactment of the Children's Health Insurance Program Reauthorization Act of

2007, the Secretary and the Secretary of Health and Human Services, in consultation with Directors of State Medicaid agencies under title XIX of the Social Security Act and Directors of State CHIP agencies under title XXI of such Act, shall jointly develop national and State-specific model notices for purposes of subparagraph (A). The Secretary shall provide employers with such model notices so as to enable employers to timely comply with the requirements of subparagraph (A). Such model notices shall include information regarding how an employee may contact the State in which the employee resides for additional information regarding potential opportunities for such premium assistance, including how to apply for such assistance.

"(III) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b).

"(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2007, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.".

(B) CONFORMING AMENDMENT.—Section 102(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1022(b)) is amended—

(i) by striking "and the remedies" and inserting ", the remedies"; and

(ii) by inserting before the period the following: ", and if the employer so elects for purposes of complying with section 701(f)(3)(B)(i), the model notice applicable to the State in which the participants and beneficiaries reside".

(C) WORKING GROUP TO DEVELOP MODEL COVERAGE COORDINATION DISCLOSURE FORM.—

(i) MEDICAID, CHIP, AND EMPLOYER-SPONSORED COVERAGE COORDINATION WORKING GROUP.—

(I) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services and the Secretary of Labor shall jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group (in this subparagraph referred to as the "Working Group"). The purpose of the Working Group shall be to develop the model coverage coordination disclosure form described in subclause (II) and to identify the impediments to the effective coordination of coverage available to families that include employees of employers that maintain group health plans and members who are eligible for medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

(II) MODEL COVERAGE COORDINATION DISCLOSURE FORM DESCRIBED.—The model form described in this subclause is a form for plan administrators of group health plans to complete for purposes of permitting a State to determine the availability and cost-effectiveness of the coverage available under such plans to employees who have family members who are eligible for premium assistance offered under a State plan under title XIX or XXI of such Act and to allow for coordination of coverage for enrollees of such plans. Such form shall provide the following information in addition to such other information as the Working Group determines appropriate:

(aa) A determination of whether the employee is eligible for coverage under the group health plan.

(bb) The name and contract information of the plan administrator of the group health plan.

(cc) The benefits offered under the plan.

(dd) The premiums and cost-sharing required under the plan.

(ee) Any other information relevant to coverage under the plan.

(ii) MEMBERSHIP.—The Working Group shall consist of not more than 30 members and shall be composed of representatives of—

(I) the Department of Labor;

(II) the Department of Health and Human Services;

(III) State directors of the Medicaid program under title XIX of the Social Security Act;

(IV) State directors of the State Children's Health Insurance Program under title XXI of the Social Security Act;

(V) employers, including owners of small businesses and their trade or industry representatives and certified human resource and payroll professionals;

(VI) plan administrators and plan sponsors of group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974);

(VII) health insurance issuers; and

(VIII) children and other beneficiaries of medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

(iii) COMPENSATION.—The members of the Working Group shall serve without compensation.

(iv) ADMINISTRATIVE SUPPORT.—The Department of Health and Human Services and the Department of Labor shall jointly provide appropriate administrative support to the Working Group, including technical assistance. The Working Group may use the services and facilities of either such Department, with or without reimbursement, as jointly determined by such Departments.

(v) REPORT.—

(I) REPORT BY WORKING GROUP TO THE SECRETARIES.—Not later than 18 months after the date of the enactment of this Act, the Working Group shall submit to the Secretary of Labor and the Secretary of Health and Human Services the model form described in clause (i)(II) along with a report containing recommendations for appropriate measures to address the impediments to the effective coordination of coverage between group health plans and the State plans under titles XIX and XXI of the Social Security Act.

(II) REPORT BY SECRETARIES TO THE CONGRESS.—Not later than 2 months after receipt of the report pursuant to subclause (I), the Secretaries shall jointly submit a report to each House of the Congress regarding the recommendations contained in the report under such subclause.

(vi) TERMINATION.—The Working Group shall terminate 30 days after the date of the issuance of its report under clause (v).

(D) EFFECTIVE DATES.—The Secretary of Labor and the Secretary of Health and Human Services shall develop the initial model notices under section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974, and the Secretary of Labor shall provide such notices to employers, not later than the date that is 1 year after the date of enactment of this Act, and each employer shall provide the initial annual notices to such employer's

employees beginning with the first plan year that begins after the date on which such initial model notices are first issued. The model coverage coordination disclosure form developed under subparagraph (C) shall apply with respect to requests made by States beginning with the first plan year that begins after the date on which such model coverage coordination disclosure form is first issued.

(E) ENFORCEMENT.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended—

(i) in subsection (a)(6), by striking "or (8)" and inserting "(8), or (9)"; and

(ii) in subsection (c), by redesignating paragraph (9) as paragraph (10), and by inserting after paragraph (8) the following:

"(9)(A) The Secretary may assess a civil penalty against any employer of up to $100 a day from the date of the employer's failure to meet the notice requirement of section 701(f)(3)(B)(i)(I). For purposes of this subparagraph, each violation with respect to any single employee shall be treated as a separate violation.

"(B) The Secretary may assess a civil penalty against any plan administrator of up to $100 a day from the date of the plan administrator's failure to timely provide to any State the information required to be disclosed under section 701(f)(3)(B)(ii). For purposes of this subparagraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.".

(2) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—Section 2701(f) of the Public Health Service Act (42 U.S.C. 300gg(f)) is amended by adding at the end the following new paragraph:

"(3) SPECIAL RULES FOR APPLICATION IN CASE OF MEDICAID AND CHIP.—

"(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

"(i) TERMINATION OF MEDICAID OR CHIP COVERAGE.—The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

"(ii) ELIGIBILITY FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHIP.—The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration

project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

"(B) COORDINATION WITH MEDICAID AND CHIP.—

"(i) OUTREACH TO EMPLOYEES REGARDING AVAILABILITY OF MEDICAID AND CHIP COVERAGE.—

"(I) IN GENERAL.—Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(f)(3)(B)(i)(II)).

"(II) OPTION TO PROVIDE CONCURRENT WITH PROVISION OF PLAN MATERIALS TO EMPLOYEE.—An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 104(b) of the Employee Retirement Income Security Act of 1974.

"(ii) DISCLOSURE ABOUT GROUP HEALTH PLAN BENEFITS TO STATES FOR MEDICAID AND CHIP ELIGIBLE INDIVIDUALS.—In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2007, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section

2105(c) of the Social Security Act or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.".

TITLE IV—STRENGTHENING QUALITY OF CARE AND HEALTH OUTCOMES

SEC. 401. CHILD HEALTH QUALITY IMPROVEMENT ACTIVITIES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.

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

"SEC. 1139A. CHILD HEALTH QUALITY MEASURES.

"(a) DEVELOPMENT OF AN INITIAL CORE SET OF HEALTH CARE QUALITY MEASURES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—

"(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall identify and publish for general comment an initial, recommended core set of child health quality measures for use by State programs administered under titles XIX and XXI, health insurance issuers and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

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

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

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

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

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

"(ii) treatments to correct or ameliorate the effects of physical and mental conditions, including chronic conditions, in infants, young children, school-age children, and adolescents.

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

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

"(4) ENCOURAGE VOLUNTARY AND STANDARDIZED REPORTING.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary, in consultation with States, shall develop a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measurement set to voluntarily report information regarding the quality of pediatric health care under titles XIX and XXI.

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

"(6) REPORTS TO CONGRESS.—Not later than January 1, 2010, and every 3 years thereafter, the Secretary shall report to Congress on—

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

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

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

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

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

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

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

"(8) DEFINITION OF CORE SET.—In this section, the term 'core set' means a group of valid, reliable, and evidence-based quality measures that, taken together—

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

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

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

"(b) ADVANCING AND IMPROVING PEDIATRIC QUALITY MEASURES.—

"(1) ESTABLISHMENT OF PEDIATRIC QUALITY MEASURES PROGRAM.—Not later than January 1, 2010, the Secretary shall establish a pediatric quality measures program to—

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

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

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

"(2) EVIDENCE-BASED MEASURES.—The measures developed under the pediatric quality measures program shall, at a minimum, be—

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

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

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

"(D) periodically updated; and

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

"(3) PROCESS FOR PEDIATRIC QUALITY MEASURES PROGRAM.—In identifying gaps in existing pediatric quality measures and establishing priorities for development and advancement of such measures, the Secretary shall consult with—

"(A) States;

"(B) pediatricians, children's hospitals, and other primary and specialized pediatric health care professionals

(including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

"(C) dental professionals, including pediatric dental professionals;

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

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

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

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

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

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

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

"(B) award grants and contracts for—

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

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

"(iii) the updating of such measures as necessary.

"(5) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning no later than January 1, 2012, and annually thereafter, the Secretary shall publish recommended changes to the core measures described in subsection (a) that shall reflect the testing, validation, and consensus process for the development of pediatric quality measures described in subsection paragraphs (1) through (4).

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

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

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

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

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

"(B) State-specific information on the quality of health care furnished to children under such plans, including information collected through external quality reviews of managed care organizations under section 1932 of the Social Security Act (42 U.S.C. 1396u–4) and benchmark plans under sections 1937 and 2103 of such Act (42 U.S.C. 1396u–7, 1397cc).

"(2) PUBLICATION.—Not later than September 30, 2009, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

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

"(1) IN GENERAL.—During the period of fiscal years 2008 through 2012, the Secretary shall award not more than 10 grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving the quality of children's health care provided under title XIX or XXI, including projects to—

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

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

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

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

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

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

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

"(3) AUTHORITY FOR MULTISTATE PROJECTS.—A demonstration project conducted with a grant awarded under this subsection may be conducted on a multistate basis, as needed.

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

"(e) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—

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

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

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

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

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

"(2) ELIGIBILITY ENTITIES.—For purposes of this subsection, an eligible entity is any of the following:

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

"(B) A local or tribal educational agency.

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

"(D) A Federally-qualified health center.

"(E) A local health department.

"(F) A health care provider.

"(G) A community-based organization.

"(H) Any other entity determined appropriate by the Secretary, including a consortia or partnership of entities described in any of subparagraphs (A) through (G).

"(3) USE OF FUNDS.—An eligible entity awarded a grant under this subsection shall use the funds made available under the grant to—

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

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

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

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

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

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

"(I) after hours physical activity programs; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"(i) community-based organizations;

"(ii) local governments;

"(iii) local educational agencies;

"(iv) the private sector;

"(v) State or local departments of health;

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

"(vii) health care providers;

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

"(ix) other entities determined appropriate by the Secretary.

"(5) PROGRAM DESIGN.—

"(A) INITIAL DESIGN.—Not later than 1 year after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary shall design the demonstration project. The demonstration should draw upon promising, innovative models and incentives to reduce behavioral risk factors. The Administrator of the Centers for Medicare & Medicaid Services shall consult with the Director of the Centers for Disease Control and Prevention, the Director of the Office of Minority Health, the heads of other agencies in the Department of Health and Human Services, and such professional

organizations, as the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

"(B) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2007, the Secretary shall award 1 grant that is specifically designed to determine whether programs similar to programs to be conducted by other grantees under this subsection should be implemented with respect to the general population of children who are eligible for child health assistance under State child health plans under title XXI in order to reduce the incidence of childhood obesity among such population.

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

"(7) DEFINITIONS.—In this subsection:

"(A) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'Federally-qualified health center' has the meaning given that term in section 1905(l)(2)(B).

"(B) 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).

"(C) SELF-ASSESSMENT.—The term 'self-assessment' means a form that—

"(i) includes questions regarding—

"(I) behavioral risk factors;

"(II) needed preventive and screening services; and

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

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

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

"(D) ONGOING SUPPORT.—The term 'ongoing support' means—

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

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

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

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

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

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

"(8) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2008 through 2012.

"(f) DEVELOPMENT OF MODEL ELECTRONIC HEALTH RECORD FORMAT FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—

"(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in the State plan under title XIX or the State child health plan under title XXI that is—

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

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

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

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

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

"(g) STUDY OF PEDIATRIC HEALTH AND HEALTH CARE QUALITY MEASURES.—

"(1) IN GENERAL.—Not later than July 1, 2009, the Institute of Medicine shall study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments aimed at ameliorating or correcting physical, mental, and developmental conditions in children. In conducting such study and preparing such report, the Institute of Medicine shall—

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

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

"(C) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health

status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment; and

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

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

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

"(i) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2008 through 2012, $45,000,000 for the purpose of carrying out this section (other than subsection (e)). Funds appropriated under this subsection shall remain available until expended.".

(b) INCREASED MATCHING RATE FOR COLLECTING AND REPORTING ON CHILD HEALTH MEASURES.—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) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) 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".

SEC. 402. IMPROVED AVAILABILITY OF PUBLIC INFORMATION REGARDING ENROLLMENT OF CHILDREN IN CHIP AND MEDICAID.

(a) INCLUSION OF PROCESS AND ACCESS MEASURES IN ANNUAL STATE REPORTS.—Section 2108 (42 U.S.C. 1397hh) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking "The State" and inserting "Subject to subsection (e), the State"; and

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

"(e) INFORMATION REQUIRED FOR INCLUSION IN STATE ANNUAL REPORT.—The State shall include the following information in the annual report required under subsection (a):

"(1) Eligibility criteria, enrollment, and retention data (including data with respect to continuity of coverage or duration of benefits).

"(2) Data regarding the extent to which the State uses process measures with respect to determining the eligibility

of children under the State child health plan, including measures such as 12-month continuous eligibility, self-declaration of income for applications or renewals, or presumptive eligibility.

"(3) Data regarding denials of eligibility and redeterminations of eligibility.

"(4) Data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

"(5) If the State provides child health assistance in the form of premium assistance for the purchase of coverage under a group health plan, data regarding the provision of such assistance, including the extent to which employer-sponsored health insurance coverage is available for children eligible for child health assistance under the State child health plan, the range of the monthly amount of such assistance provided on behalf of a child or family, the number of children or families provided such assistance on a monthly basis, the income of the children or families provided such assistance, the benefits and cost-sharing protection provided under the State child health plan to supplement the coverage purchased with such premium assistance, the effective strategies the State engages in to reduce any administrative barriers to the provision of such assistance, and, the effects, if any, of the provision of such assistance on preventing the coverage provided under the State child health plan from substituting for coverage provided under employer-sponsored health insurance offered in the State.

"(6) To the extent applicable, a description of any State activities that are designed to reduce the number of uncovered children in the State, including through a State health insurance connector program or support for innovative private health coverage initiatives.".

(b) STANDARDIZED REPORTING FORMAT.—

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

(2) TRANSITION PERIOD FOR STATES.—Each State that is required to submit a report under subsection (a) of section 2108 of the Social Security Act that includes the information required under subsection (e) of such section may use up to 3 reporting periods to transition to the reporting of such information in accordance with the standardized format specified by the Secretary under paragraph (1).

(c) ADDITIONAL FUNDING FOR THE SECRETARY TO IMPROVE TIMELINESS OF DATA REPORTING AND ANALYSIS FOR PURPOSES OF DETERMINING ENROLLMENT INCREASES UNDER MEDICAID AND CHIP.—

(1) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, $5,000,000 to the Secretary for fiscal year 2008 for the purpose of improving the timeliness of the data reported and analyzed from the Medicaid Statistical Information System (MSIS) for purposes of providing more timely data on enrollment and eligibility of children under Medicaid and CHIP and to provide

guidance to States with respect to any new reporting requirements related to such improvements. Amounts appropriated under this paragraph shall remain available until expended.

(2) REQUIREMENTS.—The improvements made by the Secretary under paragraph (1) shall be designed and implemented (including with respect to any necessary guidance for States to report such information in a complete and expeditious manner) so that, beginning no later than October 1, 2008, data regarding the enrollment of low-income children (as defined in section 2110(c)(4) of the Social Security Act (42 U.S.C. 1397jj(c)(4)) of a State enrolled in the State plan under Medicaid or the State child health plan under CHIP with respect to a fiscal year shall be collected and analyzed by the Secretary within 6 months of submission.

(d) GAO STUDY AND REPORT ON ACCESS TO PRIMARY AND SPECIALITY SERVICES.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study of children's access to primary and specialty services under Medicaid and CHIP, including—

(A) the extent to which providers are willing to treat children eligible for such programs;

(B) information on such children's access to networks of care;

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

(D) the extent to which care coordination is provided for children's care under Medicaid and CHIP; and

(E) as appropriate, information on the degree of availability of services for children under such programs.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives on the study conducted under paragraph (1) that includes recommendations for such Federal and State legislative and administrative changes as the Comptroller General determines are necessary to address any barriers to access to children's care under Medicaid and CHIP that may exist.

SEC. 403. APPLICATION OF CERTAIN MANAGED CARE QUALITY SAFEGUARDS TO CHIP.

(a) IN GENERAL.—Section 2103(f) of Social Security Act (42 U.S.C. 1397bb(f)) is amended by adding at the end the following new paragraph:

"(3) COMPLIANCE WITH MANAGED CARE REQUIREMENTS.—The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contract years for health plans beginning on or after July 1, 2008.

TITLE V—IMPROVING ACCESS TO BENEFITS

SEC. 501. DENTAL BENEFITS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 2103 (42 U.S.C. 1397cc) is amended—

(A) in subsection (a)—

(i) in the matter before paragraph (1), by striking "subsection (c)(5)" and inserting "paragraphs (5) and (7) of subsection (c)"; and

(ii) in paragraph (1), by inserting "at least" after "that is"; and

(B) in subsection (c)—

(i) by redesignating paragraph (5) as paragraph (7); and

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

"(5) DENTAL BENEFITS.—

"(A) IN GENERAL.—The child health assistance provided to a targeted low-income child shall include coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

"(B) PERMITTING USE OF DENTAL BENCHMARK PLANS BY CERTAIN STATES.—A State may elect to meet the requirement of subparagraph (A) through dental coverage that is equivalent to a benchmark dental benefit package described in subparagraph (C).

"(C) BENCHMARK DENTAL BENEFIT PACKAGES.—The benchmark dental benefit packages are as follows:

"(i) FEHBP CHILDREN'S DENTAL COVERAGE.—A dental benefits plan under chapter 89A of title 5, United States Code, that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

"(ii) STATE EMPLOYEE DEPENDENT DENTAL COVERAGE.—A dental benefits plan that is offered and generally available to State employees in the State involved and that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.

"(iii) COVERAGE OFFERED THROUGH COMMERCIAL DENTAL PLAN.—A dental benefits plan that has the largest insured commercial, non-medicaid enrollment of dependent covered lives of such plans that is offered in the State involved.".

(2) ASSURING ACCESS TO CARE.—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".

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to coverage of items and services furnished on or after October 1, 2008.

(b) DENTAL EDUCATION FOR PARENTS OF NEWBORNS.—The Secretary shall develop and implement, through entities that fund

or provide perinatal care services to targeted low-income children under a State child health plan under title XXI of the Social Security Act, a program to deliver oral health educational materials that inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit within their newborn's first year of life.

(c) PROVISION OF DENTAL SERVICES THROUGH FQHCS.—

(1) MEDICAID.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by striking "and" at the end of paragraph (69);

(B) by striking the period at the end of paragraph (70) and inserting "; and"; and

(C) by inserting after paragraph (70) the following new paragraph:

"(71) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services.".

(2) CHIP.—Section 2107(e)(1) (42 U.S.C. 1397g(e)(1)), as amended by subsections (a)(2) and (d)(2) of section 203, is amended by inserting after subparagraph (B) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

"(C) Section 1902(a)(71) (relating to limiting FQHC contracting for provision of dental services).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2008.

(d) REPORTING INFORMATION ON DENTAL HEALTH.—

(1) MEDICAID.—Section 1902(a)(43)(D)(iii) (42 U.S.C. 1396a(a)(43)(D)(iii)) is amended by inserting "and other information relating to the provision of dental services to such children described in section 2108(e)" after "receiving dental services,".

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

"(e) INFORMATION ON DENTAL CARE FOR CHILDREN.—

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

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

"(B) For children within each such age grouping, information of the type contained in questions 12(a)–(c) of CMS Form 416 (that consists of the number of enrolled targeted low income children who receive any, preventive, or restorative dental care under the State plan).

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

"(2) INCLUSION OF INFORMATION ON ENROLLEES IN MANAGED CARE PLANS.—The information under paragraph (1) shall include information on children who are enrolled in managed care plans and other private health plans and contracts with such plans under this title shall provide for the reporting of such information by such plans to the State.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall be effective for annual reports submitted for years beginning after date of enactment.

(e) IMPROVED ACCESSIBILITY OF DENTAL PROVIDER INFORMATION TO ENROLLEES UNDER MEDICAID AND CHIP.—The Secretary shall—

(1) work with States, pediatric dentists, and other dental providers (including providers that are, or are affiliated with, a school of dentistry) to include, not later than 6 months after the date of the enactment of this Act, on the Insure Kids Now website (http://www.insurekidsnow.gov/) and hotline (1–877–KIDS–NOW) (or on any successor websites or hotlines) a current and accurate list of all such dentists and providers within each State that provide dental services to children enrolled in the State plan (or waiver) under Medicaid or the State child health plan (or waiver) under CHIP, and shall ensure that such list is updated at least quarterly; and

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

(f) INCLUSION OF STATUS OF EFFORTS TO IMPROVE DENTAL CARE IN REPORTS ON THE QUALITY OF CHILDREN'S HEALTH CARE UNDER MEDICAID AND CHIP.—Section 1139A(a), as added by section 401(a), is amended—

(1) in paragraph (3)(B)(ii), by inserting "and, with respect to dental care, conditions requiring the restoration of teeth, relief of pain and infection, and maintenance of dental health" after "chronic conditions"; and

(2) in paragraph (6)(A)(ii), by inserting "dental care," after "preventive health services,".

(g) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall provide for a study that examines—

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

(B) children's access to oral health care, including preventive and restorative services, under Medicaid and CHIP, including—

(i) the extent to which dental providers are willing to treat children eligible for such programs;

(ii) information on such children's access to networks of care, including such networks that serve special needs children; and

(iii) geographic availability of oral health care, including preventive and restorative services, under such programs; and

(C) the feasibility and appropriateness of using qualified mid-level dental health providers, in coordination with dentists, to improve access for children to oral health services and public health overall.

(2) REPORT.—Not later than 18 months year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include recommendations for such Federal and State legislative and administrative changes

as the Comptroller General determines are necessary to address any barriers to access to oral health care, including preventive and restorative services, under Medicaid and CHIP that may exist.

SEC. 502. MENTAL HEALTH PARITY IN CHIP PLANS.

(a) ASSURANCE OF PARITY.—Section 2103(c) (42 U.S.C. 1397cc(c)), as amended by section 501(a)(1)(B), is amended by inserting after paragraph (5), the following:

"(6) MENTAL HEALTH SERVICES PARITY.—

"(A) IN GENERAL.—In the case of a State child health plan that provides both medical and surgical benefits and mental health or substance abuse benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance abuse benefits are no more restrictive than the financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

"(B) DEEMED COMPLIANCE.—To the extent that a State child health plan includes coverage with respect to an individual described in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), such plan shall be deemed to satisfy the requirements of subparagraph (A).".

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

(1) in subsection (a), as amended by section 501(a)(1)(A)(i), in the matter preceding paragraph (1), by inserting ", (6)," after "(5)"; and

(2) in subsection (c)(2), by striking subparagraph (B) and redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

SEC. 503. APPLICATION OF PROSPECTIVE PAYMENT SYSTEM FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) APPLICATION OF PROSPECTIVE PAYMENT SYSTEM.—

(1) IN GENERAL.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)), as amended by section 501(c)(2) is amended by inserting after subparagraph (C) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

"(D) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services provided on or after October 1, 2008.

(b) TRANSITION GRANTS.—

(1) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary for fiscal year 2008, $5,000,000, to remain available until expended, for the purpose of awarding grants to States with State child health plans under CHIP that are operated separately from the State Medicaid plan under title XIX of

the Social Security Act (including any waiver of such plan), or in combination with the State Medicaid plan, for expenditures related to transitioning to compliance with the requirement of section 2107(e)(1)(D) of the Social Security Act (as added by subsection (a)) to apply the prospective payment system established under section 1902(bb) of the such Act (42 U.S.C. 1396a(bb)) to services provided by Federally-qualified health centers and rural health clinics.

(2) MONITORING AND REPORT.—The Secretary shall monitor the impact of the application of such prospective payment system on the States described in paragraph (1) and, not later than October 1, 2010, shall report to Congress on any effect on access to benefits, provider payment rates, or scope of benefits offered by such States as a result of the application of such payment system.

SEC. 504. PREMIUM GRACE PERIOD.

(a) IN GENERAL.—Section 2103(e)(3) (42 U.S.C. 1397cc(e)(3)) is amended by adding at the end the following new subparagraph:

"(C) PREMIUM GRACE PERIOD.—The State child health plan—

"(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

"(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice—

"(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health plan; and

"(II) of the individual's right to challenge the proposed termination pursuant to the applicable Federal regulations.

For purposes of clause (i), the term 'new coverage period' means the month immediately following the last month for which the premium has been paid.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to new coverage periods beginning on or after January 1, 2009.

SEC. 505. DEMONSTRATION PROJECTS RELATING TO DIABETES PREVENTION.

There is authorized to be appropriated $15,000,000 during the period of fiscal years 2008 through 2012 to fund demonstration projects in up to 10 States over 3 years for voluntary incentive programs to promote children's receipt of relevant screenings and improvements in healthy eating and physical activity with the aim of reducing the incidence of type 2 diabetes. Such programs may involve reductions in cost-sharing or premiums when children receive regular screening and reach certain benchmarks in healthy eating and physical activity. Under such programs, a State may also provide financial bonuses for partnerships with entities, such as schools, which increase their education and efforts with respect to reducing the incidence of type 2 diabetes and may also devise incentives for providers serving children covered under this title and title XIX to perform relevant screening and counseling

regarding healthy eating and physical activity. Upon completion of these demonstrations, the Secretary shall provide a report to Congress on the results of the State demonstration projects and the degree to which they helped improve health outcomes related to type 2 diabetes in children in those States.

SEC. 506. CLARIFICATION OF COVERAGE OF SERVICES PROVIDED THROUGH SCHOOL-BASED HEALTH CENTERS.

Section 2103(c) (42 U.S.C. 1397cc(c)), as amended by section 501(a)(1)(B), is amended by adding at the end the following new paragraph:

"(8) AVAILABILITY OF COVERAGE FOR ITEMS AND SERVICES FURNISHED THROUGH SCHOOL-BASED HEALTH CENTERS.—Nothing in this title shall be construed as limiting a State's ability to provide child health assistance for covered items and services that are furnished through school-based health centers.".

TITLE VI—PROGRAM INTEGRITY AND OTHER MISCELLANEOUS PROVISIONS

Subtitle A—Program Integrity and Data Collection

SEC. 601. PAYMENT ERROR RATE MEASUREMENT ("PERM").

(a) EXPENDITURES RELATED TO COMPLIANCE WITH REQUIREMENTS.—

(1) ENHANCED PAYMENTS.—Section 2105(c) (42 U.S.C. 1397ee(c)), as amended by section 301(a), is amended by adding at the end the following new paragraph:

"(12) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations) shall in no event be less than 90 percent.".

(2) EXCLUSION OF FROM CAP ON ADMINISTRATIVE EXPENDITURES.—Section 2105(c)(2)(C) (42 U.S.C. 1397ee(c)(2)C)), as amended by section 302(b)), is amended by adding at the end the following:

"(iv) PAYMENT ERROR RATE MEASUREMENT (PERM) EXPENDITURES.—Expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations).".

(b) FINAL RULE REQUIRED TO BE IN EFFECT FOR ALL STATES.—Notwithstanding parts 431 and 457 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act), the Secretary shall not calculate or publish any national or State-

specific error rate based on the application of the payment error rate measurement (in this section referred to as "PERM") requirements to CHIP until after the date that is 6 months after the date on which a final rule implementing such requirements in accordance with the requirements of subsection (c) is in effect for all States. Any calculation of a national error rate or a State specific error rate after such final rule in effect for all States may only be inclusive of errors, as defined in such final rule or in guidance issued within a reasonable time frame after the effective date for such final rule that includes detailed guidance for the specific methodology for error determinations.

(c) REQUIREMENTS FOR FINAL RULE.—For purposes of subsection (b), the requirements of this subsection are that the final rule implementing the PERM requirements shall—

(1) include—

(A) clearly defined criteria for errors for both States and providers;

(B) a clearly defined process for appealing error determinations by—

(i) review contractors; or

(ii) the agency and personnel described in section 431.974(a)(2) of title 42, Code of Federal Regulations, as in effect on September 1, 2007, responsible for the development, direction, implementation, and evaluation of eligibility reviews and associated activities; and

(C) clearly defined responsibilities and deadlines for States in implementing any corrective action plans; and

(2) provide that the payment error rate determined for a State shall not take into account payment errors resulting from the State's verification of an applicant's self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant's self-declaration or self-certification satisfies the requirements for such process applicable under regulations promulgated by the Secretary or otherwise approved by the Secretary.

(d) OPTION FOR APPLICATION OF DATA FOR STATES IN FIRST APPLICATION CYCLE UNDER THE INTERIM FINAL RULE.—After the final rule implementing the PERM requirements in accordance with the requirements of subsection (c) is in effect for all States, a State for which the PERM requirements were first in effect under an interim final rule for fiscal year 2007 may elect to accept any payment error rate determined in whole or in part for the State on the basis of data for that fiscal year or may elect to not have any payment error rate determined on the basis of such data and, instead, shall be treated as if fiscal year 2010 were the first fiscal year for which the PERM requirements apply to the State.

(e) HARMONIZATION OF MEQC AND PERM.—

(1) REDUCTION OF REDUNDANCIES.—The Secretary shall review the Medicaid Eligibility Quality Control (in this subsection referred to as the "MEQC") requirements with the PERM requirements and coordinate consistent implementation of both sets of requirements, while reducing redundancies.

(2) STATE OPTION TO APPLY PERM DATA.—A State may elect, for purposes of determining the erroneous excess payments for medical assistance ratio applicable to the State for a fiscal

year under section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) to substitute data resulting from the application of the PERM requirements to the State after the final rule implementing such requirements is in effect for all States for data obtained from the application of the MEQC requirements to the State with respect to a fiscal year.

(3) STATE OPTION TO APPLY MEQC DATA.—For purposes of satisfying the requirements of subpart Q of part 431 of title 42, Code of Federal Regulations, as in effect on September 1, 2007, relating to Medicaid eligibility reviews, a State may elect to substitute data obtained through MEQC reviews conducted in accordance with section 1903(u) of the Social Security Act (42 U.S.C. 1396b(u)) for data required for purposes of PERM requirements, but only if the State MEQC reviews are based on a broad, representative sample of Medicaid applicants or enrollees in the States.

(f) IDENTIFICATION OF IMPROVED STATE-SPECIFIC SAMPLE SIZES.—The Secretary shall establish State-specific sample sizes for application of the PERM requirements with respect to State child health plans for fiscal years beginning with fiscal year 2009, on the basis of such information as the Secretary determines appropriate. In establishing such sample sizes, the Secretary shall, to the greatest extent practicable—

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

(2) maintain State flexibility to manage such programs.

SEC. 602. 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 (4); and

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

"(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 determine the child population growth factor under section 2104(i)(5)(B) and any other data necessary for carrying out this title.

"(C) Include 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 with respect to the purposes described in subparagraph (B).

"(E) On the basis of the assessment required under subparagraph (D), recommend to the Secretary of Health and Human Services whether American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in subparagraph (B).

"(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.

"(3) AUTHORITY FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES TO TRANSITION TO THE USE OF ALL, OR SOME COMBINATION OF, ACS ESTIMATES UPON RECOMMENDATION OF THE SECRETARY OF COMMERCE.—If, on the basis of the assessment required under paragraph (2)(D), the Secretary of Commerce recommends to the Secretary of Health and Human Services that American Community Survey estimates should be used in lieu of, or in some combination with, Current Population Survey estimates for the purposes described in paragraph (2)(B), the Secretary of Health and Human Services, in consultation with the States, may provide for a period during which the Secretary may transition from carrying out such purposes through the use of Current Population Survey estimates to the use of American Community Survey estimates (in lieu of, or in combination with the Current Population Survey estimates, as recommended), provided that any such transition is implemented in a manner that is designed to avoid adverse impacts upon States with approved State child health plans under this title.".

SEC. 603. UPDATED FEDERAL EVALUATION OF CHIP.

Section 2108(c) (42 U.S.C. 1397hh(c)) is amended by striking paragraph (5) and inserting the following:

"(5) SUBSEQUENT EVALUATION USING UPDATED INFORMATION.—

"(A) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent subsequent evaluation of 10 States with approved child health plans.

"(B) SELECTION OF STATES AND MATTERS INCLUDED.—Paragraphs (2) and (3) shall apply to such subsequent evaluation in the same manner as such provisions apply to the evaluation conducted under paragraph (1).

"(C) SUBMISSION TO CONGRESS.—Not later than December 31, 2010, the Secretary shall submit to Congress the results of the evaluation conducted under this paragraph.

"(D) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2009 for the purpose of conducting the evaluation authorized under this paragraph. Amounts appropriated under this subparagraph shall remain available for expenditure through fiscal year 2011.".

SEC. 604. ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.

Section 2108(d) (42 U.S.C. 1397hh(d)) is amended to read as follows:

"(d) ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.—For the purpose of evaluating and auditing the program established under this title, or title XIX, the Secretary, the Office of Inspector General, and the Comptroller General shall have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of Federal funds under this title and that are in the possession, custody, or control of States receiving Federal funds under this title or political subdivisions thereof, or any grantee or contractor of such States or political subdivisions.".

SEC. 605. NO FEDERAL FUNDING FOR ILLEGAL ALIENS.

Nothing in this Act allows Federal payment for individuals who are not legal residents.

Subtitle B—Miscellaneous Health Provisions

SEC. 611. DEFICIT REDUCTION ACT TECHNICAL CORRECTIONS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EPSDT SERVICES FOR ALL CHILDREN IN BENCHMARK BENEFIT PACKAGES UNDER MEDICAID.—Section 1937(a)(1) (42 U.S.C. 1396u–7(a)(1)), as inserted by section 6044(a) of the Deficit Reduction Act of 2005 (Public Law 109–171, 120 Stat. 88), is amended—

(1) in subparagraph (A)—

(A) in the matter before clause (i)—

(i) by striking "Notwithstanding any other provision of this title" and inserting "Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability) and any other provision of this title which would be directly contrary to the authority under this section and subject to subsection (E)"; and

(ii) by striking "enrollment in coverage that provides" and inserting "coverage that";

(B) in clause (i), by inserting "provides" after "(i)"; and

(C) by striking clause (ii) and inserting the following:

"(ii) for any individual described in section 1905(a)(4)(B) who is eligible under the State plan in accordance with paragraphs (10) and (17) of section 1902(a), consists of the items and services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43).";

(2) in subparagraph (C)—

(A) in the heading, by striking "**WRAP-AROUND**" and inserting "**ADDITIONAL**"; and

(B) by striking "wrap-around or"; and

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

"(E) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

"(i) requiring a State to offer all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2);

"(ii) preventing a State from offering all or any of the items and services required by subparagraph (A)(ii) through an issuer of benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); or

"(iii) 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 1902(a)(43) whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.".

(b) CORRECTION OF REFERENCE TO CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—Section 1937(a)(2)(B)(viii) (42 U.S.C. 1396u–7(a)(2)(B)(viii), as inserted by section 6044(a) of the Deficit Reduction Act of 2005, is amended by striking "aid or assistance is made available under part B of title IV to children in foster care and individuals" and inserting "child welfare services are made available under part B of title IV on the basis of being a child in foster care or".

(c) TRANSPARENCY.—Section 1937 (42 U.S.C. 1396u–7), as inserted by section 6044(a) of the Deficit Reduction Act of 2005, is amended by adding at the end the following:

"(c) PUBLICATION OF PROVISIONS AFFECTED.—With respect to a State plan amendment to provide benchmark benefits in accordance with subsections (a) and (b) that is approved by the Secretary, the Secretary shall publish on the Internet website of the Centers for Medicare & Medicaid Services, a list of the provisions of this title that the Secretary has determined do not apply in order to enable the State to carry out the plan amendment and the reason for each such determination on the date such approval is made, and shall publish such list in the Federal Register and not later than 30 days after such date of approval.".

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

SEC. 612. REFERENCES TO TITLE XXI.

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.

SEC. 613. PROHIBITING INITIATION OF NEW HEALTH OPPORTUNITY ACCOUNT DEMONSTRATION PROGRAMS.

After the date of the enactment of this Act, the Secretary of Health and Human Services may not approve any new demonstration programs under section 1938 of the Social Security Act (42 U.S.C. 1396u–8).

SEC. 614. COUNTY MEDICAID HEALTH INSURING ORGANIZATIONS; GAO REPORT ON MEDICAID MANAGED CARE PAYMENT RATES.

(a) IN GENERAL.—Section 9517(c)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1396b note), as added by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and as amended by section 704 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, is amended—

(1) in subparagraph (A), by inserting ", in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Ventura County, and in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Merced County" after "described in subparagraph (B)"; and

(2) in subparagraph (C), by striking "14 percent" and inserting "16 percent".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

(c) GAO REPORT ON ACTUARIAL SOUNDNESS OF MEDICAID MANAGED CARE PAYMENT RATES.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit a report to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives analyzing the extent to which State payment rates for medicaid managed care organizations under title XIX of the Social Security Act are actuarially sound.

SEC. 615. ADJUSTMENT IN COMPUTATION OF MEDICAID FMAP TO DISREGARD AN EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION.

(a) IN GENERAL.—Only for purposes of computing the FMAP (as defined in subsection (e)) for a State for a fiscal year (beginning with fiscal year 2006) and applying the FMAP under title XIX of the Social Security Act, any significantly disproportionate employer pension or insurance fund contribution described in subsection (b) shall be disregarded in computing the per capita income of such State, but shall not be disregarded in computing the per capita income for the continental United States (and Alaska) and Hawaii.

(b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER PENSION AND INSURANCE FUND CONTRIBUTION.—

(1) IN GENERAL.—For purposes of this section, a significantly disproportionate employer pension and insurance fund contribution described in this subsection with respect to a State is any identifiable employer contribution towards pension or other employee insurance funds that is estimated to accrue to residents of such State for a calendar year (beginning with calendar year 2003) if the increase in the amount so estimated exceeds 25 percent of the total increase in personal income in that State for the year involved.

(2) DATA TO BE USED.—For estimating and adjustment a FMAP already calculated as of the date of the enactment of this Act for a State with a significantly disproportionate employer pension and insurance fund contribution, the Secretary shall use the personal income data set originally used in calculating such FMAP.

(3) SPECIAL ADJUSTMENT FOR NEGATIVE GROWTH.—If in any calendar year the total personal income growth in a State is negative, an employer pension and insurance fund contribution for the purposes of calculating the State's FMAP for a calendar year shall not exceed 125 percent of the amount of such contribution for the previous calendar year for the State.

(c) HOLD HARMLESS.—No State shall have its FMAP for a fiscal year reduced as a result of the application of this section.

(d) REPORT.—Not later than May 15, 2008, the Secretary shall submit to the Congress a report on the problems presented by the current treatment of pension and insurance fund contributions in the use of Bureau of Economic Affairs calculations for the FMAP and for Medicaid and on possible alternative methodologies to mitigate such problems.

(e) FMAP DEFINED.—For purposes of this section, the term "FMAP" means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396(d)).

SEC. 616. MORATORIUM ON CERTAIN PAYMENT RESTRICTIONS.

Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to May 28, 2008, take any action (through promulgation of regulation, issuance of regulatory guidance, use of federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to restrict coverage or payment under title XIX of the Social Security Act for rehabilitation services, or school-based administration, transportation, or medical services if such restrictions are more restrictive in any aspect than those applied to such coverage or payment as of July 1, 2007.

SEC. 617. MEDICAID DSH ALLOTMENTS FOR TENNESSEE AND HAWAII.

(a) TENNESSEE.—The DSH allotments for Tennessee for each fiscal year beginning with fiscal year 2008 under subsection (f)(3) of section 1923 of the Social Security Act (42 U.S.C. 1396r–4) are deemed to be $30,000,000. The Secretary of Health and Human Services may impose a limitation on the total amount of payments made to hospitals under the TennCare Section 1115 waiver only to the extent that such limitation is necessary to ensure that a hospital does not receive payment in excess of the amounts described in subsection (f) of such section or as necessary to ensure that the waiver remains budget neutral.

(b) HAWAII.—Section 1923(f)(6) (42 U.S.C. 1396r–4(f)(6)) is amended—

(1) in the paragraph heading, by striking "FOR FISCAL YEAR 2007"; and

(2) in subparagraph (B)—

(A) in clause (i), by striking "Only with respect to fiscal year 2007" and inserting "With respect to each of fiscal years 2007 and 2008";

(B) by redesignating clause (ii) as clause (iv); and

(C) by inserting after clause (i), the following new clauses:

"(ii) TREATMENT AS A LOW-DSH STATE.—With respect to fiscal year 2009 and each fiscal year thereafter, notwithstanding the table set forth in paragraph

(2), the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clauses (ii) and (iii) of paragraph (5)(B).

"(iii) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this section do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.".

SEC. 618. CLARIFICATION TREATMENT OF REGIONAL MEDICAL CENTER.

(a) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in subsection (b), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

(b) CENTER DESCRIBED.—A center described in this subsection is a publicly-owned regional medical center that—

(1) provides level 1 trauma and burn care services;

(2) provides level 3 neonatal care services;

(3) is obligated to serve all patients, regardless of ability to pay;

(4) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States;

(5) provides services as a tertiary care provider for patients residing within a 125-mile radius; and

(6) meets the criteria for a disproportionate share hospital under section 1923 of such Act (42 U.S.C. 1396r–4) in at least one State other than the State in which the center is located.

SEC. 619. EXTENSION OF SSI WEB-BASED ASSET DEMONSTRATION PROJECT TO THE MEDICAID PROGRAM.

(a) IN GENERAL.—Beginning on October 1, 2012, the Secretary of Health and Human Services shall provide for the application to asset eligibility determinations under the Medicaid program under title XIX of the Social Security Act of the automated, secure, web-based asset verification request and response process being applied for determining eligibility for benefits under the Supplemental Security Income (SSI) program under title XVI of such Act under a demonstration project conducted under the authority of section 1631(e)(1)(B)(ii) of such Act (42 U.S.C. 1383(e)(1)(B)(ii)).

(b) LIMITATION.—Such application shall only extend to those States in which such demonstration project is operating and only for the period in which such project is otherwise provided.

(c) RULES OF APPLICATION.—For purposes of carrying out subsection (a), notwithstanding any other provision of law, information obtained from a financial institution that is used for purposes of eligibility determinations under such demonstration project with respect to the Secretary of Health and Human Services under the SSI program may also be shared and used by States for purposes of eligibility determinations under the Medicaid program. In applying section 1631(e)(1)(B)(ii) of the Social Security Act under this subsection, references to the Commissioner of Social Security and benefits under title XVI of such Act shall be treated as including a reference to a State described in subsection (b) and medical assistance under title XIX of such Act provided by such a State.

Subtitle C—Other Provisions

SEC. 621. SUPPORT FOR INJURED SERVICEMEMBERS.

(a) SHORT TITLE.—This section may be cited as the "Support for Injured Servicemembers Act".

(b) SERVICEMEMBER FAMILY LEAVE.—

(1) DEFINITIONS.—Section 101 of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611) is amended by adding at the end the following:

"(14) ACTIVE DUTY.—The term 'active duty' means duty under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code.

"(15) COVERED SERVICEMEMBER.—The term 'covered servicemember' means a member of the Armed Forces, including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy, is otherwise in medical hold or medical holdover status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

"(16) MEDICAL HOLD OR MEDICAL HOLDOVER STATUS.—The term 'medical hold or medical holdover status' means—

"(A) the status of a member of the Armed Forces, including a member of the National Guard or a Reserve, assigned or attached to a military hospital for medical care; and

"(B) the status of a member of a reserve component of the Armed Forces who is separated, whether pre-deployment or post-deployment, from the member's unit while in need of health care based on a medical condition identified while the member is on active duty in the Armed Forces.

"(17) NEXT OF KIN.—The term 'next of kin', used with respect to an individual, means the nearest blood relative of that individual.

"(18) SERIOUS INJURY OR ILLNESS.—The term 'serious injury or illness', in the case of a member of the Armed Forces, means an injury or illness incurred by the member in line of duty on active duty in the Armed Forces that may render

the member medically unfit to perform the duties of the member's office, grade, rank, or rating.".

(2) ENTITLEMENT TO LEAVE.—Section 102(a) of such Act (29 U.S.C. 2612(a)) is amended by adding at the end the following:

"(3) SERVICEMEMBER FAMILY LEAVE.—Subject to section 103, an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember shall be entitled to a total of 26 workweeks of leave during a 12-month period to care for the servicemember. The leave described in this paragraph shall only be available during a single 12-month period.

"(4) COMBINED LEAVE TOTAL.—During the single 12-month period described in paragraph (3), an eligible employee shall be entitled to a combined total of 26 workweeks of leave under paragraphs (1) and (3). Nothing in this paragraph shall be construed to limit the availability of leave under paragraph (1) during any other 12-month period.".

(3) REQUIREMENTS RELATING TO LEAVE.—

(A) SCHEDULE.—Section 102(b) of such Act (29 U.S.C. 2612(b)) is amended—

(i) in paragraph (1), in the second sentence—

(I) by striking "section 103(b)(5)" and inserting "subsection (b)(5) or (f) (as appropriate) of section 103"; and

(II) by inserting "or under subsection (a)(3)" after "subsection (a)(1)"; and

(ii) in paragraph (2), by inserting "or under subsection (a)(3)" after "subsection (a)(1)".

(B) SUBSTITUTION OF PAID LEAVE.—Section 102(d) of such Act (29 U.S.C. 2612(d)) is amended—

(i) in paragraph (1)—

(I) by inserting "(or 26 workweeks in the case of leave provided under subsection (a)(3))" after "12 workweeks" the first place it appears; and

(II) by inserting "(or 26 workweeks, as appropriate)" after "12 workweeks" the second place it appears; and

(ii) in paragraph (2)(B), by adding at the end the following: "An eligible employee may elect, or an employer may require the employee, to substitute any of the accrued paid vacation leave, personal leave, family leave, or medical or sick leave of the employee for leave provided under subsection (a)(3) for any part of the 26-week period of such leave under such subsection.".

(C) NOTICE.—Section 102(e)(2) of such Act (29 U.S.C. 2612(e)(2)) is amended by inserting "or under subsection (a)(3)" after "subsection (a)(1)".

(D) SPOUSES EMPLOYED BY SAME EMPLOYER.—Section 102(f) of such Act (29 U.S.C. 2612(f)) is amended—

(i) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), and aligning the margins of the subparagraphs with the margins of section 102(e)(2)(A);

(ii) by striking "In any" and inserting the following: "(1) IN GENERAL.—In any"; and

(iii) by adding at the end the following:

"(2) SERVICEMEMBER FAMILY LEAVE.—

"(A) IN GENERAL.—The aggregate number of workweeks of leave to which both that husband and wife may be entitled under subsection (a) may be limited to 26 workweeks during the single 12-month period described in subsection (a)(3) if the leave is—

"(i) leave under subsection (a)(3); or

"(ii) a combination of leave under subsection (a)(3) and leave described in paragraph (1).

"(B) BOTH LIMITATIONS APPLICABLE.—If the leave taken by the husband and wife includes leave described in paragraph (1), the limitation in paragraph (1) shall apply to the leave described in paragraph (1).".

(E) CERTIFICATION.—Section 103 of such Act (29 U.S.C. 2613) is amended by adding at the end the following:

"(f) CERTIFICATION FOR SERVICEMEMBER FAMILY LEAVE.—An employer may require that a request for leave under section 102(a)(3) be supported by a certification issued at such time and in such manner as the Secretary may by regulation prescribe.".

(F) FAILURE TO RETURN.—Section 104(c) of such Act (29 U.S.C. 2614(c)) is amended—

(i) in paragraph (2)(B)(i), by inserting "or under section 102(a)(3)" before the semicolon; and

(ii) in paragraph (3)(A)—

(I) in clause (i), by striking "or" at the end;

(II) in clause (ii), by striking the period and inserting "; or"; and

(III) by adding at the end the following:

"(iii) a certification issued by the health care provider of the servicemember being cared for by the employee, in the case of an employee unable to return to work because of a condition specified in section 102(a)(3).".

(G) ENFORCEMENT.—Section 107 of such Act (29 U.S.C. 2617) is amended, in subsection (a)(1)(A)(i)(II), by inserting "(or 26 weeks, in a case involving leave under section 102(a)(3))" after "12 weeks".

(H) INSTRUCTIONAL EMPLOYEES.—Section 108 of such Act (29 U.S.C. 2618) is amended, in subsections (c)(1), (d)(2), and (d)(3), by inserting "or under section 102(a)(3)" after "section 102(a)(1)".

(c) SERVICEMEMBER FAMILY LEAVE FOR CIVIL SERVICE EMPLOYEES.—

(1) DEFINITIONS.—Section 6381 of title 5, United States Code, is amended—

(A) in paragraph (5), by striking "and" at the end;

(B) in paragraph (6), by striking the period and inserting "; and"; and

(C) by adding at the end the following:

"(7) the term 'active duty' means duty under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code;

"(8) the term 'covered servicemember' means a member of the Armed Forces, including a member of the National Guard

or a Reserve, who is undergoing medical treatment, recuperation, or therapy, is otherwise in medical hold or medical holdover status, or is otherwise on the temporary disability retired list, for a serious injury or illness;

"(9) the term 'medical hold or medical holdover status' means—

"(A) the status of a member of the Armed Forces, including a member of the National Guard or a Reserve, assigned or attached to a military hospital for medical care; and

"(B) the status of a member of a reserve component of the Armed Forces who is separated, whether pre-deployment or post-deployment, from the member's unit while in need of health care based on a medical condition identified while the member is on active duty in the Armed Forces;

"(10) the term 'next of kin', used with respect to an individual, means the nearest blood relative of that individual; and

"(11) the term 'serious injury or illness', in the case of a member of the Armed Forces, means an injury or illness incurred by the member in line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.".

(2) ENTITLEMENT TO LEAVE.—Section 6382(a) of such title is amended by adding at the end the following:

"(3) Subject to section 6383, an employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember shall be entitled to a total of 26 administrative workweeks of leave during a 12-month period to care for the servicemember. The leave described in this paragraph shall only be available during a single 12-month period.

"(4) During the single 12-month period described in paragraph (3), an employee shall be entitled to a combined total of 26 administrative workweeks of leave under paragraphs (1) and (3). Nothing in this paragraph shall be construed to limit the availability of leave under paragraph (1) during any other 12-month period.".

(3) REQUIREMENTS RELATING TO LEAVE.—

(A) SCHEDULE.—Section 6382(b) of such title is amended—

(i) in paragraph (1), in the second sentence—

(I) by striking "section 6383(b)(5)" and inserting "subsection (b)(5) or (f) (as appropriate) of section 6383"; and

(II) by inserting "or under subsection (a)(3)" after "subsection (a)(1)"; and

(ii) in paragraph (2), by inserting "or under subsection (a)(3)" after "subsection (a)(1)".

(B) SUBSTITUTION OF PAID LEAVE.—Section 6382(d) of such title is amended by adding at the end the following: "An employee may elect to substitute for leave under subsection (a)(3) any of the employee's accrued or accumulated annual or sick leave under subchapter I for any part of the 26-week period of leave under such subsection.".

(C) NOTICE.—Section 6382(e) of such title is amended by inserting "or under subsection (a)(3)" after "subsection (a)(1)".

(D) CERTIFICATION.—Section 6383 of such title is amended by adding at the end the following:

"(f) An employing agency may require that a request for leave under section 6382(a)(3) be supported by a certification issued at such time and in such manner as the Office of Personnel Management may by regulation prescribe.".

SEC. 622. MILITARY FAMILY JOB PROTECTION.

(a) SHORT TITLE.—This section may be cited as the "Military Family Job Protection Act".

(b) PROHIBITION ON DISCRIMINATION IN EMPLOYMENT AGAINST CERTAIN FAMILY MEMBERS CARING FOR RECOVERING MEMBERS OF THE ARMED FORCES.—A family member of a recovering servicemember described in subsection (c) shall not be denied retention in employment, promotion, or any benefit of employment by an employer on the basis of the family member's absence from employment as described in that subsection, for a period of not more than 52 workweeks.

(c) COVERED FAMILY MEMBERS.—A family member described in this subsection is a family member of a recovering servicemember who is—

(1) on invitational orders while caring for the recovering servicemember;

(2) a non-medical attendee caring for the recovering servicemember; or

(3) receiving per diem payments from the Department of Defense while caring for the recovering servicemember.

(d) TREATMENT OF ACTIONS.—An employer shall be considered to have engaged in an action prohibited by subsection (b) with respect to a person described in that subsection if the absence from employment of the person as described in that subsection is a motivating factor in the employer's action, unless the employer can prove that the action would have been taken in the absence of the absence of employment of the person.

(e) DEFINITIONS.—In this section:

(1) BENEFIT OF EMPLOYMENT.—The term "benefit of employment" has the meaning given such term in section 4303 of title 38, United States Code.

(2) CARING FOR.—The term "caring for", used with respect to a recovering servicemember, means providing personal, medical, or convalescent care to the recovering servicemember, under circumstances that substantially interfere with an employee's ability to work.

(3) EMPLOYER.—The term "employer" has the meaning given such term in section 4303 of title 38, United States Code, except that the term does not include any person who is not considered to be an employer under title I of the Family and Medical Leave Act of 1993 (29 U.S.C. 2611 et seq.) because the person does not meet the requirements of section 101(4)(A)(i) of such Act (29 U.S.C. 2611(4)(A)(i)).

(4) FAMILY MEMBER.—The term "family member", with respect to a recovering servicemember, has the meaning given that term in section 411h(b) of title 37, United States Code.

(5) RECOVERING SERVICEMEMBER.—The term "recovering servicemember" means a member of the Armed Forces, including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy, or is otherwise in medical hold or medical holdover status, for an injury, illness, or disease incurred or aggravated while on active duty in the Armed Forces.

SEC. 623. OUTREACH REGARDING HEALTH INSURANCE OPTIONS AVAILABLE TO CHILDREN.

(a) DEFINITIONS.—In this section—

(1) the terms "Administration" and "Administrator" means the Small Business Administration and the Administrator thereof, respectively;

(2) the term "certified development company" means a development company participating in the program under title V of the Small Business Investment Act of 1958 (15 U.S.C. 695 et seq.);

(3) the term "Medicaid program" means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(4) the term "Service Corps of Retired Executives" means the Service Corps of Retired Executives authorized by section 8(b)(1) of the Small Business Act (15 U.S.C. 637(b)(1));

(5) the term "small business concern" has the meaning given that term in section 3 of the Small Business Act (15 U.S.C. 632);

(6) the term "small business development center" means a small business development center described in section 21 of the Small Business Act (15 U.S.C. 648);

(7) the term "State" has the meaning given that term for purposes of title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(8) the term "State Children's Health Insurance Program" means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.);

(9) the term "task force" means the task force established under subsection (b)(1); and

(10) the term "women's business center" means a women's business center described in section 29 of the Small Business Act (15 U.S.C. 656).

(b) ESTABLISHMENT OF TASK FORCE.—

(1) ESTABLISHMENT.—There is established a task force to conduct a nationwide campaign of education and outreach for small business concerns regarding the availability of coverage for children through private insurance options, the Medicaid program, and the State Children's Health Insurance Program.

(2) MEMBERSHIP.—The task force shall consist of the Administrator, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury.

(3) RESPONSIBILITIES.—The campaign conducted under this subsection shall include—

(A) efforts to educate the owners of small business concerns about the value of health coverage for children;

(B) information regarding options available to the owners and employees of small business concerns to make

insurance more affordable, including Federal and State tax deductions and credits for health care-related expenses and health insurance expenses and Federal tax exclusion for health insurance options available under employer-sponsored cafeteria plans under section 125 of the Internal Revenue Code of 1986;

(C) efforts to educate the owners of small business concerns about assistance available through public programs; and

(D) efforts to educate the owners and employees of small business concerns regarding the availability of the hotline operated as part of the Insure Kids Now program of the Department of Health and Human Services.

(4) IMPLEMENTATION.—In carrying out this subsection, the task force may—

(A) use any business partner of the Administration, including—

(i) a small business development center;

(ii) a certified development company;

(iii) a women's business center; and

(iv) the Service Corps of Retired Executives;

(B) enter into—

(i) a memorandum of understanding with a chamber of commerce; and

(ii) a partnership with any appropriate small business concern or health advocacy group; and

(C) designate outreach programs at regional offices of the Department of Health and Human Services to work with district offices of the Administration.

(5) WEBSITE.—The Administrator shall ensure that links to information on the eligibility and enrollment requirements for the Medicaid program and State Children's Health Insurance Program of each State are prominently displayed on the website of the Administration.

(6) REPORT.—

(A) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, and every 2 years thereafter, the Administrator shall submit to the Committee on Small Business and Entrepreneurship of the Senate and the Committee on Small Business of the House of Representatives a report on the status of the nationwide campaign conducted under paragraph (1).

(B) CONTENTS.—Each report submitted under subparagraph (A) shall include a status update on all efforts made to educate owners and employees of small business concerns on options for providing health insurance for children through public and private alternatives.

SEC. 624. SENSE OF SENATE REGARDING ACCESS TO AFFORDABLE AND MEANINGFUL HEALTH INSURANCE COVERAGE.

(a) FINDINGS.—The Senate finds the following:

(1) There are approximately 45 million Americans currently without health insurance.

(2) More than half of uninsured workers are employed by businesses with less than 25 employees or are self-employed.

(3) Health insurance premiums continue to rise at more than twice the rate of inflation for all consumer goods.

(4) Individuals in the small group and individual health insurance markets usually pay more for similar coverage than those in the large group market.

(5) The rapid growth in health insurance costs over the last few years has forced many employers, particularly small employers, to increase deductibles and co-pays or to drop coverage completely.

(b) SENSE OF THE SENATE.—The Senate—

(1) recognizes the necessity to improve affordability and access to health insurance for all Americans;

(2) acknowledges the value of building upon the existing private health insurance market; and

(3) affirms its intent to enact legislation this year that, with appropriate protection for consumers, improves access to affordable and meaningful health insurance coverage for employees of small businesses and individuals by—

(A) facilitating pooling mechanisms, including pooling across State lines, and

(B) providing assistance to small businesses and individuals, including financial assistance and tax incentives, for the purchase of private insurance coverage.

TITLE VII—REVENUE PROVISIONS

SEC. 701. INCREASE IN EXCISE TAX RATE ON TOBACCO PRODUCTS.

(a) CIGARS.—Section 5701(a) of the Internal Revenue Code of 1986 is amended—

(1) by striking "$1.828 cents per thousand ($1.594 cents per thousand on cigars removed during 2000 or 2001)" in paragraph (1) and inserting "$50.00 per thousand",

(2) by striking "20.719 percent (18.063 percent on cigars removed during 2000 or 2001)" in paragraph (2) and inserting "52.988 percent", and

(3) by striking "$48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001)" in paragraph (2) and inserting "$3.00 per cigar".

(b) CIGARETTES.—Section 5701(b) of such Code is amended—

(1) by striking "$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)" in paragraph (1) and inserting "$50.00 per thousand", and

(2) by striking "$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)" in paragraph (2) and inserting "$105.00 per thousand".

(c) CIGARETTE PAPERS.—Section 5701(c) of such Code is amended by striking "1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)" and inserting "3.13 cents".

(d) CIGARETTE TUBES.—Section 5701(d) of such Code is amended by striking "2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)" and inserting "6.26 cents".

(e) SMOKELESS TOBACCO.—Section 5701(e) of such Code is amended—

(1) by striking "58.5 cents (51 cents on snuff removed during 2000 or 2001)" in paragraph (1) and inserting "$1.50", and

(2) by striking "19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)" in paragraph (2) and inserting "50 cents".

(f) PIPE TOBACCO.—Section 5701(f) of such Code is amended by striking "$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)" and inserting "$2.8126 cents".

(g) ROLL-YOUR-OWN TOBACCO.—Section 5701(g) of such Code is amended by striking "$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)" and inserting "$8.8889 cents".

(h) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products (other than cigars described in section 5701(a)(2) of the Internal Revenue Code of 1986) and cigarette papers and tubes manufactured in or imported into the United States which are removed before January 1, 2008, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of such Code on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on January 1, 2008, for which such person is liable.

(3) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding tobacco products, cigarette papers, or cigarette tubes on January 1, 2008, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before April 1, 2008.

(4) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (commonly known as the Foreign Trade Zone Act, 48 Stat. 998, 19 U.S.C. 81a et seq.) or any other provision of law, any article which is located in a foreign trade zone on January 1, 2008, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of an officer of the United States Customs and Border Protection of the Department of Homeland Security pursuant to the 2d proviso of such section 3(a).

(5) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Any term used in this subsection which is also used in section 5702 of the Internal Revenue Code of 1986 shall have the same meaning as such term has in such section.

(B) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or the Secretary's delegate.

(6) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(7) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after December 31, 2007.

SEC. 702. ADMINISTRATIVE IMPROVEMENTS.

(a) PERMIT, REPORT, AND RECORD REQUIREMENTS FOR MANUFACTURERS AND IMPORTERS OF PROCESSED TOBACCO.—

(1) PERMITS.—

(A) APPLICATION.—Section 5712 of the Internal Revenue Code of 1986 is amended by inserting "or processed tobacco" after "tobacco products".

(B) ISSUANCE.—Section 5713(a) of such Code is amended by inserting "or processed tobacco" after "tobacco products".

(2) INVENTORIES AND REPORTS.—

(A) INVENTORIES.—Section 5721 of such Code is amended by inserting ", processed tobacco," after "tobacco products".

(B) REPORTS.—Section 5722 of such Code is amended by inserting ", processed tobacco," after "tobacco products".

(3) RECORDS.—Section 5741 of such Code is amended by inserting ", processed tobacco," after "tobacco products".

(4) MANUFACTURER OF PROCESSED TOBACCO.—Section 5702 of such Code is amended by adding at the end the following new subsection:

"(p) MANUFACTURER OF PROCESSED TOBACCO.—

"(1) IN GENERAL.—The term 'manufacturer of processed tobacco' means any person who processes any tobacco other than tobacco products.

"(2) PROCESSED TOBACCO.—The processing of tobacco shall not include the farming or growing of tobacco or the handling of tobacco solely for sale, shipment, or delivery to a manufacturer of tobacco products or processed tobacco.".

(5) CONFORMING AMENDMENT.—Section 5702(k) of such Code is amended by inserting ", or any processed tobacco," after "nontaxpaid tobacco products or cigarette papers or tubes".

(6) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2008.

(b) BASIS FOR DENIAL, SUSPENSION, OR REVOCATION OF PERMITS.—

(1) DENIAL.—Paragraph (3) of section 5712 of such Code is amended to read as follows:

"(3) such person (including, in the case of a corporation, any officer, director, or principal stockholder and, in the case of a partnership, a partner)—

"(A) is, by reason of his business experience, financial standing, or trade connections or by reason of previous or current legal proceedings involving a felony violation of any other provision of Federal criminal law relating to tobacco products, cigarette paper, or cigarette tubes, not likely to maintain operations in compliance with this chapter,

"(B) has been convicted of a felony violation of any provision of Federal or State criminal law relating to tobacco products, cigarette paper, or cigarette tubes, or

"(C) has failed to disclose any material information required or made any material false statement in the application therefor.".

(2) SUSPENSION OR REVOCATION.—Subsection (b) of section 5713 of such Code is amended to read as follows:

"(b) SUSPENSION OR REVOCATION.—

"(1) SHOW CAUSE HEARING.—If the Secretary has reason to believe that any person holding a permit—

"(A) has not in good faith complied with this chapter, or with any other provision of this title involving intent to defraud,

"(B) has violated the conditions of such permit,

"(C) has failed to disclose any material information required or made any material false statement in the application for such permit,

"(D) has failed to maintain his premises in such manner as to protect the revenue,

"(E) is, by reason of previous or current legal proceedings involving a felony violation of any other provision of Federal criminal law relating to tobacco products, cigarette paper, or cigarette tubes, not likely to maintain operations in compliance with this chapter, or

"(F) has been convicted of a felony violation of any provision of Federal or State criminal law relating to tobacco products, cigarette paper, or cigarette tubes,

the Secretary shall issue an order, stating the facts charged, citing such person to show cause why his permit should not be suspended or revoked.

"(2) ACTION FOLLOWING HEARING.—If, after hearing, the Secretary finds that such person has not shown cause why his permit should not be suspended or revoked, such permit shall be suspended for such period as the Secretary deems proper or shall be revoked.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(c) APPLICATION OF INTERNAL REVENUE CODE STATUTE OF LIMITATIONS FOR ALCOHOL AND TOBACCO EXCISE TAXES.—

(1) IN GENERAL.—Section 514(a) of the Tariff Act of 1930 (19 U.S.C. 1514(a)) is amended by striking "and section 520 (relating to refunds)" and inserting "section 520 (relating to refunds), and section 6501 of the Internal Revenue Code of 1986 (but only with respect to taxes imposed under chapters 51 and 52 of such Code)".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to articles imported after the date of the enactment of this Act.

(d) EXPANSION OF DEFINITION OF ROLL-YOUR-OWN TOBACCO.—

(1) IN GENERAL.—Section 5702(o) of the Internal Revenue Code of 1986 is amended by inserting "or cigars, or for use as wrappers thereof" before the period at the end.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to articles removed (as defined in section 5702(j) of the Internal Revenue Code of 1986) after December 31, 2007.

(e) TIME OF TAX FOR UNLAWFULLY MANUFACTURED TOBACCO PRODUCTS.—

(1) IN GENERAL.—Section 5703(b)(2) of such Code is amended by adding at the end the following new subparagraph:

"(F) SPECIAL RULE FOR UNLAWFULLY MANUFACTURED TOBACCO PRODUCTS.—In the case of any tobacco products, cigarette paper, or cigarette tubes produced in the United States at any place other than the premises of a manufacturer of tobacco products, cigarette paper, or cigarette tubes that has filed the bond and obtained the permit required under this chapter, tax shall be due and payable immediately upon manufacture.".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on the date of the enactment of this Act.

SEC. 703. TIME FOR PAYMENT OF CORPORATE ESTIMATED TAXES.

Subparagraph (B) of section 401(1) of the Tax Increase Prevention and Reconciliation Act of 2005 is amended by striking "114.75 percent" and inserting "113.75 percent".

Speaker of the House of Representatives.

Vice President of the United States and President of the Senate.

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