S. 2461

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

IN THE SENATE OF THE UNITED STATES

JUNE 11, 2014

Mr. ROCKEFELLER introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

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

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,

3 SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECU-
4 RITY ACT; REFERENCES; TABLE OF CON-
5 TENTS.

6 (a) Short Title.—This Act may be cited as the
7 “CHIP Extension Act of 2014”.

8 (b) Amendments to Social Security Act.—Ex-
9 cept as otherwise specifically provided, whenever in this
10 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 pro-
gram established under title XXI of the Social Secu-

rity Act (42 U.S.C. 1397aa et seq.) (whether imple-
mented under title XIX, XXI, or both, of the Social
Security Act).

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

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

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

Sec. 1. Short title; amendments to Social Security Act; references; table of con-
tents.
Sec. 2. Purposes.
Sec. 3. General effective date; exception for State legislation; reliance on law.

TITLE I—FINANCING

Sec. 101. Extension of CHIP.
Sec. 102. Continuation and update of performance incentives.
Sec. 103. Funds to address any Federal funding shortfalls for States.

TITLE II—ELIGIBILITY AND ENROLLMENT

Subtitle A—Coverage Continuity

Sec. 201. State option to increase upper age limit for children with special
health care needs.
Sec. 202. Improving coverage transitions from Medicaid or CHIP to coverage under a qualified health plan.
Sec. 203. Assuring coverage continuity for former foster care children.

Subtitle B—Enrollment Simplification and Improvements
Sec. 211. Automatic enrollment for newborns under CHIP.
Sec. 212. Express Lane Eligibility extension and application to pregnant women, foster children, and children with special health care needs.
Sec. 213. Outreach to targeted populations.

TITLE III—AFFORDABILITY
Sec. 301. Strengthened cost sharing protections under Medicaid and CHIP.

TITLE IV—BENEFITS
Sec. 401. Preventive health services.
Sec. 402. Timely immunization coverage.

TITLE V—ACCESS AND QUALITY
Subtitle A—Pediatric Quality Measures
Sec. 501. Extending the pediatric quality measures program.
Sec. 502. Improving the effectiveness of the pediatric quality measures.
Sec. 503. Annual State reports regarding State-specific quality of care measures applied under Medicaid or CHIP.
Sec. 504. Advisory panel regarding pediatric quality.
Sec. 505. Extending and expanding demonstration projects.

Subtitle B—Maternal, Infant, and Early Childhood Home Visiting Program
Sec. 511. Supporting evidence-based care coordination in communities.

Subtitle C—Comparative Study of Medicaid, CHIP, and Qualified Health Plans
Sec. 521. GAO study and report.

TITLE VI—BUDGETARY EFFECTS
Sec. 601. Budgetary effect of this Act.

1 SEC. 2. PURPOSES.
2 The purposes of this Act are to ensure the extension
3 of CHIP, safeguard child-specific health coverage for mil-
4 lions of children, and make improvements to promote chil-
5 dren’s access to cost-effective, high-quality health care.
SEC. 3. GENERAL EFFECTIVE DATE; EXCEPTION FOR STATE LEGISLATION; 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, 2015, and shall apply to child health assistance and medical assistance provided on or after that date.

(b) Exception for State Legislation.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) or a State child health plan under title XXI of such Act (42 U.S.C. 1397aa et seq.), which the Secretary determines requires State legislation in order for the respective plan to meet 1 or more additional requirements imposed by amendments made by this Act, the respective 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) Reliance on Law.—With respect to amendments made by this Act 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

SEC. 101. EXTENSION OF CHIP.

(a) Funding.—

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

(A) in paragraph (17), by striking “and” at the end;
(B) by striking paragraph (18) and inserting the following:

“(18) for fiscal year 2015, $21,061,000,000;”;

and

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

“(19) for fiscal year 2016, $19,300,000,000;
“(20) for fiscal year 2017, $20,300,000,000;
“(21) for fiscal year 2018, $21,300,000,000;

and

“(22) for fiscal year 2019, for purposes of making 2 semi-annual allotments—

“(A) $2,850,000,000 for the period beginning on October 1, 2018, and ending on March 31, 2019, and

“(B) $2,850,000,000 for the period beginning on April 1, 2019, and ending on September 30, 2019.”.

(2) PREVENTION OF DUPLICATE APPROPRIATIONS FOR FISCAL YEAR 2015.—Expenditures made under section 2104(a)(18) of the Social Security Act (42 U.S.C. 1387dd(a)(18)) pursuant to the amendments made by section 10203 of the Patient Protection and Affordable Care Act (Public Law 111–148) for fiscal year 2015 shall be charged to the appro-
appropriation provided by the amendment made by paragraph (1) to such section for that fiscal year.

(b) ALLOTMENTS.—

(1) IN GENERAL.—Section 2104(m) (42 U.S.C. 1397dd(m)) is amended—

(A) in paragraph (3)—

(i) by striking “2015” in the paragraph heading and inserting “2019”;

(ii) in subparagraph (A), by striking “paragraph (18)” and inserting “paragraph (22)”;

(iii) in subparagraph (B), by striking “paragraph (18)” and inserting “paragraph (22)”;

(iv) in subparagraph (C)—

(I) by striking “2014” each place it appears and inserting “2018”; and

(II) by striking “2015” and inserting “2019”; and

(v) in subparagraph (D)—

(I) in clause (i), by striking “the sum of—” and all that follows through “2009;” and inserting “the amount made available under subsection (a)(22)(A),”; and
(II) in subclause (II) of clause (ii), by striking "subsection (a)(18)(B)" and inserting "subsection (a)(22)(B)";

(B) in paragraph (4), by striking "2015" and inserting "2019";

(C) in paragraph (8)—

(i) by striking "2015" in the paragraph heading and inserting "2019"; and

(ii) by striking "for a period in fiscal year 2015" and inserting "for a period in fiscal year 2019"; and

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

“(9) Rebasings and Growth Factor Update Rules for Fiscal Years After Fiscal Year 2014.—Subject to paragraphs (3), (4), and (6), from the amount made available under subsection (a) for each fiscal year after fiscal year 2014, 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:

“(A) Rebasings in Odd-Numbered Fiscal Years.—If the fiscal year is an odd-numbered
fiscal year, the allotment of the 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 the preceding fiscal year (including any payments made to the State under subsections (n) and (o) for the preceding fiscal year as well as amounts redistributed to the State in the preceding fiscal year), multiplied by the allotment increase factor under paragraph (5) for the fiscal year.

“(B) GROWTH FACTOR UPDATE FOR EVEN-NUMBERED FISCAL YEARS.—If the fiscal year is an even-numbered fiscal year, the allotment of the State is equal to the sum of—

“(i) the amount of the State allotment for the preceding fiscal year; and

“(ii) the amount of any payments made to the State under subsections (n) and (o) for the preceding fiscal year, multiplied by the allotment increase factor under paragraph (5) for the fiscal year.”.

(2) ONE-TIME APPROPRIATION FOR FISCAL YEAR 2019.—Section 108 of the Children’s Health Insurance Program Reauthorization Act of 2009
(Public Law 111–3), as amended by section 10203(d)(2)(F) of the Patient Protection and Affordable Care Act (Public Law 111–148), is amended by striking “$15,361,000,000” and all that follows through the second sentence, and inserting “$16,700,000,000 to accompany the allotment made for the period beginning on October 1, 2018, and ending on March 31, 2019, under section 2104(a)(22)(A) of the Social Security Act (42 U.S.C. 1397dd(a)(22)(A)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (3) of section 2104(m) of such Act (42 U.S.C. 1397dd(m)) for the first 6 months of fiscal year 2019 in the same manner as allotments are provided under subsection (a)(22)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(22)(A).”.

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

(A) in the subsection heading, by striking “2015” and inserting “2019”; and

(B) in paragraph (6)—

(i) in subparagraph (A), by striking “2015” and inserting “2019”; and
(ii) in the second sentence, by striking “or fiscal year 2014” and inserting “fiscal year 2014, fiscal year 2016, or fiscal year 2018”.

(c) Extension of Qualifying States Option.—Section 2105(g)(4) (42 U.S.C. 1397ee(g)(4)) is amended—

(1) in the paragraph heading, by striking “2015” and inserting “2019”; and

(2) in subparagraph (A), by striking “2015” and inserting “2019”.

SEC. 102. CONTINUATION AND UPDATE OF PERFORMANCE INCENTIVES.

(a) Extension Through Fiscal Year 2019.—Section 2105(a)(3) (42 U.S.C. 1397ee(a)(3)) is amended—

(1) in subparagraph (A), by striking “2013” and inserting “2019”; 

(2) in subparagraph (E)—

(A) in clause (ii)—

(i) by striking subclause (I) and inserting the following:

“(I) UNOBLIGATED NATIONAL ALLOTMENT.—As of December 31 of fiscal year 2009, and as of December 31 of each succeeding fiscal year
through fiscal year 2015, the portion, if any, of the amount appropriated under section 2104(a) for such fiscal year that is unobligated for allotment to a State under section 2104(m) for such fiscal year or set aside under subsection (a)(3) or (b)(2) of section 2111 for such fiscal year.”;

(ii) in subclause (II), by striking “2013” and inserting “2015”; and

(iii) in subclause (III), by striking “2013” and inserting “2015”;

(B) by redesignating clause (iii) as clause (iv); and

(C) by inserting after clause (ii), the following new clause:

“(iii) Appropriation for Fiscal Years 2016 through 2019.—Out of any money in the Treasury not otherwise appropriated, there are appropriated $750,000,000 for each of fiscal years 2016 through 2019 for making payments under this paragraph. Amounts appropriated for a fiscal year under this clause shall remain available for making payments under this
paragraph through December 31 of the following fiscal year. Any amount of such appropriations that remains unexpended or unobligated as of such date shall be transferred and made available on January 1 of such following fiscal year for making payments under section 2104(o).”; and

(3) in subparagraph (F)(iii), by striking “2013” and inserting “2019”.

(b) Updated Performance Incentive Criteria for Fiscal Years 2015 Through 2019.—Section 2105(a) (42 U.S.C. 1397ee(a)) is amended—

(1) in paragraph (3)(A), by inserting “or (5)” after “paragraph (4)”;

(2) in paragraph (4)—

(A) in the heading, by inserting “FOR FISCAL YEARS BEFORE FISCAL YEAR 2015” after “FOR CHILDREN”; and

(B) in the matter preceding subparagraph (A), by striking “for a fiscal year if” and inserting “for a fiscal year before fiscal year 2015 if”; and

(3) by adding at the end the following new paragraph:
“(5) Enrollment and retention provisions for children for fiscal years after fiscal year 2014.—

“(A) In general.—For purposes of paragraph (3)(A), a State meets the condition of this paragraph for a fiscal year after fiscal year 2014 if it is implementing at least 7 of the enrollment and retention provisions specified in subparagraph (B) (treating each clause of that subparagraph as a separate enrollment and retention provision) throughout the entire fiscal year and achieves a program rating of ‘effective’ or ‘highly effective’ under metrics established by the Secretary under subparagraph (C) for the fiscal year (beginning with the first fiscal year for which such metrics are established).

“(B) Enrollment and retention provisions.—The enrollment and retention provisions specified in this subparagraph are the following:

“(i) 12-month continuous eligibility.—The State has elected the option of continuous eligibility for a full 12 months under title XIX for all children described in section 1902(e)(12) and applies
such policy under its State child health plan under this title.

“(ii) EXPRESS LANE ELIGIBILITY.—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.

“(iii) PRESumptive eligibility.—The State is implementing section 1920A under title XIX as well as, pursuant to section 2107(e)(1), under this title.

“(iv) Elimination of CHIP Premiums.—In the case of any targeted low-income child or a targeted low-income pregnant woman, the State child health plan does not impose any enrollment fee, premium, or similar charge.

“(v) Premium Assistance for Employer-sponsored Plans.—The State has opted to offer a premium assistance subsidy for qualified employer-sponsored coverage by implementing section 1906A under title XIX or the option described in section 2105(c)(10) under this title.
“(vi) Comprehensive coverage for pregnant women.—If the State has elected to offer pregnancy-related assistance to targeted low-income women (as defined in section 2112(d)(2)) under section 2112, the State also has elected to include, as part of such pregnancy-related assistance and as part of the medical assistance provided to women under section 1902(e)(5) while pregnant and during the 60-day period described in such section—

“(I) dental services necessary to prevent disease and promote oral health, restore oral structure to health and function, and treat emergency conditions;

“(II) vision services, including vision screening and corrective lenses; and

“(III) all services covered under the State child health plan.

“(vii) Improved coverage for pregnant women.—If the State has elected to offer pregnancy-related assistance to targeted low-income women (as de-
fined in section 2112(d)(2)) under section 2112—

“(I) the State also has elected to provide that a pregnant woman who is determined to be eligible for pregnancy-related assistance under the amendment to the State child health plan under section 2112 shall remain eligible for those benefits until the end of a period (not to exceed 12 months) following the determination; and

“(II) the State is implementing section 1906A under title XIX.

“(viii) SUPPLEMENTAL DENTAL COVERAGE.—The State has elected to provide dental-only supplemental coverage under section 2110(b)(5).

“(ix) Raising CHIP Eligibility Age to Align with Medicaid Eligibility Age.—If the State has elected to provide eligibility as a child under the State plan under title XIX for an individual who has attained age 19 or 20, the State has elected to apply the same age under the State
plan under this title for purposes of eligibility as a child.

“(x) INCREASE IN INCOME ELIGIBILITY.—

“(I) UP TO AT LEAST 300 PERCENT OF THE POVERTY LINE.—The State has elected to extend eligibility for medical assistance under the State plan under title XIX or eligibility for child health assistance under the State child health plan to any otherwise eligible child whose family income does not exceed 300 percent of the poverty line for a family of the size involved.

“(II) RULE OF CONSTRUCTION.—Nothing in subclause (I) shall be construed as prohibiting a State from extending eligibility for medical assistance under the State plan under title XIX or eligibility for child health assistance under the State child health plan to any otherwise eligible child whose family income exceeds 300 percent of the poverty line.
“(xi) PROHIBITING LOCKOUT PERIODS.—The State child health plan permits an individual whose coverage under the plan has been terminated for failure to make premium payments to be immediately reenrolled upon payment of outstanding premiums, with coverage retroactive to the beginning of the most recent month for which an outstanding premium has been paid, and shall not impose any waiting period or enrollment fee as a condition of reenrollment.

“(xii) CHIP COVERAGE FOR CHILDREN OF STATE EMPLOYEES.—The State offers enrollment in the State child health plan for a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member’s employment with a public agency in accordance with section 2110(b)(6) and provides resources to help the family member so employed compare the coverage options for the family member’s child under the State health
benefits plan on the basis of cost and provider networks.

“(xiii) INTERAGENCY COORDINATION FOR JUVENILE JUSTICE YOUTH.—The State—

“(I) does not terminate (but may suspend) enrollment under a State plan for medical assistance for any individual under age 21 on the basis that the individual is an inmate of a public institution (as defined in section 435.1010 of title 42, Code of Federal Regulations);

“(II) informs such individual immediately upon release from such public institution that the individual’s eligibility for medical assistance is no longer suspended and the limitations on medical assistance under the subdivision (A) following paragraph (29) of section 1905(a) will no longer apply (unless and until there is a determination that the individual no longer meets the State or Federal eligibility
requirements for such medical assistance;

“(III) processes any application for medical assistance submitted by, or on behalf of any individual under age 21 who is an inmate of a public institution (as defined in section 435.1010 of title 42, Code of Federal Regulations) notwithstanding that the individual is such an inmate; and

“(IV) screens any individual under age 21 who is such an inmate for eligibility for medical assistance under title XIX or child health assistance under this title and assists those individuals who are identified as likely to be eligible for either such assistance in applying for either such assistance and enrolling in either such plan.

“(xiv) EXTENDED COVERAGE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—The State has elected to extend eligibility for child health assistance under the State child health plan (whether imple-
mented under this title, title XIX, or both) to individuals under age 26 with special health care needs by implementing the option described in section 2110(c)(1)(B).

“(C) METRICS FOR EVALUATING PROGRAM EFFECTIVENESS.—The Secretary shall establish metrics for evaluating the effectiveness of the State program established under this title (whether implemented under this title, title XIX, or both). Such metrics shall include a system for rating States as ‘effective’, ‘highly effective’, or ‘in need of improvement’.”.

SEC. 103. FUNDS TO ADDRESS ANY FEDERAL FUNDING SHORTFALLS FOR STATES.

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

“(o) FUND TO ALLEVIATE CHIP SHORTFALLS.—

“(1) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a fund which shall be known as the ‘CHIP Shortfall Fund’ (in this subsection referred to as the ‘Fund’). Amounts in the Fund shall be available without further appropriations for payments under this subsection and shall remain available until expended.
“(2) Deposits into fund.—

“(A) Initial appropriation.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Fund $3,860,000,000 for fiscal year 2016.

“(B) Transfers.—Notwithstanding any other provision of this title, the following amounts shall also be available, without fiscal year limitation, for making payments from the Fund:

“(i) Unobligated national allotment for fiscal years beginning with fiscal year 2016.—As of January 1 of fiscal year 2017, and as of January 1 of each succeeding fiscal year, the portion, if any, of the amount appropriated under subsection (a) for the preceding fiscal year that is unobligated for allotment to a State under subsection (m) for such preceding fiscal year.

“(ii) Unexpended allotments not used for redistribution.—As of November 15 of fiscal year 2016 and each succeeding fiscal year, the total amount of
allotments made to States under subsection (a) for the second preceding fiscal year that is not expended or redistributed under subsection (f) during the period in which such allotments are available for obligation.

“(iii) Unexpended Child Enrollment Contingency Funds.—As of October 1, 2015, any unobligated amount in the Child Enrollment Contingency Fund under subsection (n).

“(iv) Unexpended Performance Incentive Funds.—As of January 1, 2017, and as of January 1 of each succeeding calendar year, the portion, if any, of the amount appropriated under subparagraph (E)(iii) of section 2105(a)(3) for the preceding fiscal year that is not expended or obligated under such section for such preceding fiscal year.

“(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 shall constitute a part of the Fund.

“(3) Shortfall Fund Payments.—

“(A) Payments to Shortfall States.—

For each of fiscal years 2016 through 2020, if the Secretary determines that a State is a shortfall State described in paragraph (4) for that fiscal year, the Secretary shall pay the State from the Fund, in addition to any other payments made to a State under this title for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year.

“(B) Amount Described.—With respect to a State and a fiscal year, the amount described in this subparagraph is the amount of projected expenditures for the State under this title for the fiscal year that exceeds the sum determined under paragraph (4) for the State and fiscal year.

“(C) Proportional Reduction.—If the sum of the amounts otherwise payable under this paragraph for a fiscal year exceeds the amount available in the Fund for the fiscal year, the amount to be paid under this para-
graph to each State for the fiscal year shall be
reduced proportionally.

“(D) 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 re-
liable data regarding the expenditures under
the State child health plan in order to accu-
rately determine the commonwealth’s or terri-
tory’s eligibility for, and amount of payment,
under this paragraph.

“(4) Shortfall states described.—For
purposes of paragraph (3), with respect to a fiscal
year, a shortfall State is a State for which the Sec-
retary estimates on the basis of the most recent data
available to the Secretary, that the projected expend-
itures for the State for the fiscal year under this
title (whether the State plan is implemented under
this title, title XIX, or both) will exceed the sum
of—

“(A) 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;

“(B) the amount (if any) that will be redistributed to the State under subsection (f) for the fiscal year;

“(C) the amount (if any) of the child enrollment contingency fund payment under subsection (n) for the fiscal year; and

“(D) the amount of the State’s allotment for the fiscal year.

“(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the determinations made under this subsection with respect to a State and 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.”.

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

(1) in paragraph (1)—

(A) by striking “shortfall States” and inserting “redistribution States”; and

(B) by striking “shortfall described” and inserting “deficit described”; and
(2) in paragraph (2)—

(A) in the paragraph heading, by striking “SHORTFALL” and inserting “REDISTRIBUTION”;

(B) in subparagraph (A), by striking “shortfall State” and inserting “redistribution State”; and

(C) in subparagraph (B)—

(i) by striking “shortfalls” and inserting “deficits”; and

(ii) by striking “shortfall State” and inserting “redistribution State”.

TITLE II—ELIGIBILITY AND ENROLLMENT

Subtitle A—Coverage Continuity

SEC. 201. STATE OPTION TO INCREASE UPPER AGE LIMIT
FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS.

Section 2110(c)(1) (42 U.S.C. 2110(c)(1)) is amended—

(1) by striking “The term” and inserting the following:

“(A) IN GENERAL.—Subject to subparagraph (B), the term”; and

(2) by adding at the end the following:
“(B) CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—At State option, such term includes an individual under 26 years of age who has or is at an increased risk of a chronic physical, developmental, behavioral, or emotional condition and who also requires health and related services of a type or amount beyond that required by children typically.”.

SEC. 202. IMPROVING COVERAGE TRANSITIONS FROM MEDICAID OR CHIP TO COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) STATE COORDINATION REQUIREMENT.—Section 2105(d)(3)(B) (42 U.S.C. 1397ee(d)(3)(B)) is amended—

(1) in the subparagraph heading, by striking “SHORTFALLS” and inserting "SHORTFALLS; COORDINATION REQUIREMENTS FOR TRANSITIONING TO OR FROM EXCHANGE COVERAGE”;

(2) in the first sentence, by striking “In the event” and inserting the following:

“(i) EXCHANGE COVERAGE AS A RESULT OF FUNDING SHORTFALLS.—In the event”; and

(3) by adding at the end the following:

“(ii) COORDINATION REQUIREMENTS FOR TRANSITIONING TO OR FROM EX-
CHANGE COVERAGE.—The State shall establish procedures to eliminate gaps in coverage and to assist a child’s and pregnant woman’s transition from coverage under the State plan under title XIX or the State child health plan under this title (whether implemented under this title, title XIX, or both) to coverage under a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered through an Exchange and from coverage under a qualified health plan to coverage under the State plan under title XIX or the State child health plan under this title. Such procedures—

“(I) shall provide for coverage for the child’s or pregnant woman’s medical home, regardless of whether the medical home providers are participating providers under the State plan under title XIX or the State child health plan under this title, for a transitional time to be determined under regulations promulgated by the Secretary;
“(II) in the case of a child or pregnant woman with a chronic or complex condition, shall provide that the State plan under title XIX, or the State child health plan under this title (as applicable) shall permit the child or pregnant woman to continue to receive treatment from a non-network provider for a transitional period as determined under regulations promulgated by the Secretary;

“(III) shall require that if the benefits available and cost-sharing imposed under a qualified health plan available to the child or pregnant woman (as applicable) are not comparable to the benefits and coverage available to the child or pregnant woman under the State plan under title XIX or the State child health plan under this title (as applicable) the child or pregnant woman shall remain enrolled in the State plan under title XIX or the State child health plan under this title for so long as the
child or pregnant woman is otherwise eligible for coverage under the title 
XIX or XXI State plans; and

“(IV) shall establish a system under which the State shall record all transitions of children and pregnant women from coverage under the State plan under title XIX or the State child health plan under this title to coverage under a qualified health plan and from coverage under a qualified health plan to coverage under the State plan under title XIX or the State child health plan under this title and submit a report to the Secretary each fiscal quarter that includes data on the number of children and pregnant women who made such transitions in the preceding fiscal quarter.”.

(b) Certification Requirement.—Section 2105(d)(3)(C) (42 U.S.C. 1397ee(d)(3)(C)) is amended—

(1) in the subparagraph heading, by striking “PEDIATRIC”;

(2) by striking “With respect to” and inserting the following:

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“(i) IN GENERAL.—With respect to;

(3) by inserting “and pregnant women” after “children” each place it appears;

(4) by striking “are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan” and inserting “meet the comparability standards described in clause (ii) and the continuous coverage requirements described in clause (iii)”; and

(5) by adding at the end the following new clauses:

“(ii) COMPARABILITY STANDARDS.—

The Secretary shall develop, in consultation with non-government stakeholder entities (including not less than 1 national non-profit organization focused on children’s advocacy), comparability standards for qualified health plans seeking certification under clause (i). Such standards must include standards for the following areas:

“(I) AFFORDABILITY.—The plan must be comparable to the State child health plan in terms of affordability, including premiums, deductibles, co-
payments, co-insurance, medical home maintenance costs, and the cost of purchasing supplementary coverage for health benefits and services that are covered under the State child health plan but are not covered under the qualified health plan.

“(II) Benefits.—The plan must be comparable to the State child health plan in terms of pediatric and pregnancy-related benefits.

“(III) Network Adequacy.—The plan must be comparable to the State child health plan in terms of access to appropriate providers of pediatric and pregnancy-related services, and must provide flexibility for children with special health care needs to remain in their medical home or seek appropriate pediatric sub-specialists.

“(iii) Continuous Coverage Requirements.—The Secretary shall require health plans seeking certification as qualified health plans for purposes of an Amer-
ican Health Benefits Exchange to ensure that—

“(I) with respect to a child or pregnant woman who is transitioning from coverage under a State child health plan or a State plan under title XIX—

“(aa) coverage under the qualified health plan shall be effective as of the 60-day period preceding the date on which the first premium payment is made for such coverage;

“(bb) coverage under the State child health plan or State plan under title XIX shall remain in effect during the 30-day period that precedes the 60-day period described in item (aa);

“(cc) the qualified health plan shall provide coverage for a child’s or a pregnant woman’s medical home, regardless of whether the medical home provider is within the network of the
plan, to allow the child or pregnant woman to finish a course of treatment for an acute illness or a treatment or surgery scheduled prior to the effective date for coverage under the plan under item (aa) or for a period of up to 90 days if, by the end of such period, the child or pregnant woman is enrolled with a medical home provider that is within the network of the plan; and

“(dd) in the case of a child or pregnant woman with a chronic or complex condition, the qualified health plan shall permit the child or pregnant woman to continue to receive treatment from a non-network provider for a transitional time that is not less than 90 days, or until the child or pregnant woman can be enrolled with an in-network provider;
“(II) similar requirements apply with respect to any child or pregnant woman who transitions from coverage under a qualified health plan to coverage under the State child health plan or the State plan under title XIX in accordance with subparagraph (B)(ii); and

“(III) a child or pregnant woman transitioning to or from coverage under the State child health plan or the State plan under title XIX and a qualified health plan is informed of the differences between the benefits available and cost-sharing imposed under the coverage the child or pregnant woman is transitioning from and into, and that the pregnant woman or the parent or guardian of the child has the option of electing to remain enrolled in whichever coverage is the most affordable or provides the best benefits for the child or pregnant woman for such period as the Secretary shall specify.”.
(c) **Prohibition on Transitioning CHIP-Eligible Children.**—No child who is eligible for coverage under CHIP shall be transitioned from a State child health plan to a qualified health plan unless that plan is certified under section 2105(d)(3)(C) of the Social Security Act (42 U.S.C. 1397ee(d)(3)(C)) (as amended by subsection (b)).

(d) **Minimum Essential Coverage.**—

(1) **In General.**—Section 5000A(f) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“(6) **Pregnancy-Related Assistance under CHIP.**—With respect to a targeted low-income pregnant woman (as defined in section 2112(d)(2) of the Social Security Act), notwithstanding paragraph (1)(A)(iii), the term ‘minimum essential coverage’, at the option of such a woman, shall not include pregnancy-related assistance (as defined in section 2112(d)(1) of the Social Security Act).”.

(2) **Effective Date.**—The amendment made by this subsection applies to taxable years beginning after December 31, 2014.
SEC. 203. ASSURING COVERAGE CONTINUITY FOR FORMER FOSTER CARE CHILDREN.


(1) in item (cc), by striking “responsibility of the State” and inserting “responsibility of a State”;

and

(2) in item (dd), by striking “the State plan under this title or under a waiver of the” and inserting “a State plan under this title or under a waiver of such a”.

(b) Effective Date.—The amendments made by this section shall take effect on the date of enactment of this Act.

Subtitle B—Enrollment Simplification and Improvements

SEC. 211. AUTOMATIC ENROLLMENT FOR NEWBORNS UNDER CHIP.

(a) In General.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended—

(1) by redesignating subparagraphs (E) through (O) as subparagraphs (F) through (P), respectively; and

(2) by inserting after subparagraph (D) the following new subparagraph:
“(E) Section 1902(e)(4) (relating to automatic coverage for newborns through age 1).”.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 212. EXPRESS LANE ELIGIBILITY EXTENSION AND APPLICATION TO PREGNANT WOMEN, FOSTER CHILDREN, AND CHILDREN WITH SPECIAL HEALTH CARE NEEDS.

(a) IN GENERAL.—Section 1902(e)(13) (42 U.S.C. 1396a(e)(13)) is amended—

(1) in subparagraph (A), by adding at the end the following new clause:

“(iii) State option to extend express lane eligibility to pregnant women.—At the option of the State, the State may apply the provisions of this paragraph with respect to determining eligibility under this title for a pregnant woman. In applying this paragraph in the case of a State electing such an option, any reference in this paragraph to a child with respect to this title (other than a reference to child health assistance) shall be
deemed to be a reference to a pregnant woman.”;

(2) in subparagraph (G), by adding at the end the following new sentence: “Notwithstanding the age limit specified in the preceding sentence, such term includes an individual described in subsection (a)(10)(A)(i)(IX) and, at the option of the State, an individual described in section 2110(c)(1)(B).”; and

(3) by striking subparagraph (I).

(b) Effective Date.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 213. OUTREACH TO TARGETED POPULATIONS.

(a) Outreach and Enrollment Grants.—Section 2113 (42 U.S.C. 1397mm) is amended—

(1) in subsection (a)(1), by striking “during the period of fiscal years 2009 through 2015”; and

(2) in subsection (g), by inserting “and $40,000,000 for each fiscal year thereafter,” after “2015,”.

(b) Outreach to Non-English Speakers and Other Populations.—

(1) National Enrollment Campaign Requirements.—Such section 2113 is amended—
(A) in subsection (h), by striking “Such campaign” and inserting “In addition to the requirements described in subsection (i), such campaign”; and

(B) by adding at the end the following subsection:

“(i) REQUIRED ELEMENTS OF NATIONAL ENROLLMENT CAMPAIGN.—Beginning with fiscal year 2015, each of the following initiatives shall be part of the national enrollment campaign:

“(1) INITIATIVE TO INCREASE ENROLLMENT AMONG INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.—An initiative to increase enrollment in the State child health plan under this title or the State plan under title XIX of children from families that speak a primary language other than English that shall include—

“(A) language services, including oral interpreting and written translation services, for individuals with limited proficiency in English; and

“(B) other culturally appropriate efforts to increase enrollment of such children.

“(2) INITIATIVE TO INCREASE ENROLLMENT OF CHILDREN IN FAMILIES WITH COMPLEX OR MULT-
TIPLE COVERAGE SOURCES.—An initiative to identify and increase enrollment in the State child health plan under this title or the State plan under title XIX of children from families who have multiple coverage sources or other coverage complexities, including children in foster care and children subject to a medical child support order.”.

(2) INCREASED REIMBURSEMENT FOR STATE SPENDING ON LANGUAGE SERVICES.—

(A) MEDICAID.—Section 1903(a)(2)(E)

(42 U.S.C. 1396b(a)(2)(E)) is amended by striking “75 percent” and inserting “the higher of 90 percent or the sum of the enhanced FMAP (as defined in section 2105(b)) plus 5 percentage points (not to exceed 100 percent)”.

(B) CHIP.—Section 2105(a)(1) (42 U.S.C. 1397ee(a)(1)) is amended in the matter preceding paragraph (1), by striking “the higher of 75 percent or the sum of the enhanced FMAP plus 5 percentage points” and inserting “the higher of 90 percent or the sum of the enhanced FMAP plus 5 percentage points (not to exceed 100 percent)”.

(3) REQUIREMENT THAT MANAGED CARE ORGANIZATIONS PROVIDE LANGUAGE SERVICES TO EN-
ROLLEES.—Section 1932(b) (42 U.S.C. 1396u–2(b)) is amended by adding at the end the following new paragraph:

“(9) LANGUAGE SERVICES.—Each contract with a medicaid managed care organization under section 1903(m) shall require the organization to provide (at no cost to the individual) language services, including oral interpreting and written translation services, to any individual who is eligible for medical assistance under the State plan under this title and is enrolled with the organization and to a parent or guardian of such individual if such individual, parent, or guardian is in need of such services when interacting with the organization or with any provider receiving payment from the organization.”.

(4) TRANSLATION OF APPLICATIONS AND OTHER VITAL DOCUMENTS.—

(A) MEDICAID.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(i) by striking “and” at the end of paragraph (80);

(ii) by striking the period at the end of paragraph (81) and inserting “; and”;

and
(iii) by inserting after paragraph (81)

the following new paragraph:

“(82) provide for the translation of all docu-
ments and materials necessary to make application
for medical assistance under the plan, and such
other documents and materials as the Secretary may
specify, including any such documents and materials
that are available via a website, into the primary
language spoken by any limited English proficiency
group in the State with a population of at least
1000 individuals or that constitutes 5 percent of the
State population.”.

(B) CHIP.—Section 2107(c)(1), as
amended by section 221, is amended—

(i) by redesignating subparagraphs

(E) through (P) as subparagraphs (F)

through (Q), respectively; and

(ii) by inserting after subparagraph

(D) the following subparagraph:

“(E) Section 1902(a)(82) (relating to the
translation of documents and materials).”.

(c) PRIMARY LANGUAGE DATA COLLECTION.—

(1) DATA FROM ELIGIBLE ENTITIES.—Section

2113(c)(4)(B) (42 U.S.C. 1397mm(c)(4)(B)) is
amended by inserting “under this title and title
XIX, individual data on the primary language of enrollees under this title and title XIX (and for such enrollees who are minors or incapacitated, data on the primary language of their parents or guardians)” after “enrollment data”.

(2) ANNUAL REPORT.—

(A) CHIP.—Section 2108 (42 U.S.C. 1397hh) is amended—

(i) by redesignating the subsection (e) added by section 501(e)(2) of Public Law 111–3 as subsection (f); and

(ii) in paragraph (1) of the subsection (e) added by section 402 of Public Law 111–3, by inserting “and primary language” after “duration of benefits”.

(B) MEDICAID.—Section 1946(c) (42 U.S.C. 1396w–5(c)) is amended by inserting “demographic” before “data on health care disparities”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.
TITLE III—AFFORDABILITY

SEC. 301. STRENGTHENED COST SHARING PROTECTIONS UNDER MEDICAID AND CHIP.

(a) MEDICAID.—

(1) IN GENERAL.—Section 1916 (42 U.S.C. 1396o) is amended—

(A) in subsection (a)—

(i) in subparagraph (E) of paragraph (2), by striking “and” at the end;

(ii) in paragraph (3)—

(I) by inserting “subject to para-

graph (4),” before “any deduction”;

and

(II) by striking the period at the end and inserting “; and”; and

(iii) by adding at the end the fol-

lowing new paragraph:

“(4) the total annual aggregate amount of any

premium, enrollment fee, deduction, cost sharing, or

similar charge imposed under the plan with respect
to such individuals and their families shall not ex-
ceed 5 percent of the family income of the individual
involved, as applied on a quarterly or monthly basis
(as specified by the State).”;

(B) in subsection (b)—
(i) in subparagraph (E) of paragraph (2), by striking “and” at the end;

(ii) in paragraph (3)—

(I) by inserting “subject to paragraph (4)” before “any deduction”; and

(II) by striking the period at the end and inserting “; and”; and

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

“(4) the total annual aggregate amount of any premium, enrollment fee, deduction, cost sharing, or similar charge imposed under the plan with respect to such individuals and their families shall not exceed 5 percent of the family income of the individual involved, as applied on a quarterly or monthly basis (as specified by the State).”;

(C) in subsection (d), by inserting “, and provided that the total annual aggregate amount of any such premium, and any enrollment fee, deduction, cost sharing, or similar charge imposed under the plan with respect to such individuals and their families shall not exceed 5 percent of the family income of the individual involved, as applied on a quarterly or
monthly basis (as specified by the State)” before the period; and

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

“(k) COST SHARING TRACKING; SUSPENSION OF CHARGES; NOTIFICATION REQUIREMENTS.—

“(1) TRACKING.—If the State plan imposes premiums, enrollment fees, deductions, cost sharing, or similar charges under this section that, together with any such charges imposed under section 1916A, could cause families to have out-of-pocket expenses that exceed a total aggregate cost sharing limit imposed under subsection (a)(4) or (b)(4) for the month or quarter (as specified by the State), the State shall establish a process for tracking and aggregating such expenses (including expenses incurred for separately administered benefits) that—

“(A) does not rely on documentation provided by the individual or the family;

“(B) is communicated in a manner designed to ensure the privacy of patient-related information; and

“(C) allows for coordination with managed care entities (as defined in section
1932(a)(1)(B)) that are under contract with
the State.

“(2) SUSPENSION OF CHARGES.—When a fam-
ily reaches any limit for a period imposed on pre-
miums, deductions, cost sharing, or similar charges
under this section, no further premiums, deductions,
cost sharing, or similar charges (or any portions
thereof) shall be imposed on any individual in the
family who is eligible for and receiving medical as-
stance under the plan for the remainder of the pe-
riod.

“(3) NOTIFICATION REQUIREMENTS.—With re-
spect to a limit imposed on premiums, deductions,
cost sharing, or similar charges under this section
the State plan shall provide for the notification of
providers and each family to which such a limit ap-
plies—

“(A) of any such limit applicable to the
family;

“(B) when the family has incurred out-of-
pocket expenses up to any such limit; and

“(C) when a family reaches any such limit
for a period, that the limit has been reached
and that no further premiums, deductions, cost
sharing, or similar charges (or portions thereof)
shall be imposed on any individual in the family who is eligible for and receiving medical assistance under the plan for the remainder of such month or quarter.

“(4) REASSESSMENT PROCESS.—The State shall establish a process for families that include an individual who is eligible for and receiving medical assistance under the plan to request a reassessment of the family’s aggregate limit on premiums, deductions, cost sharing, or similar charges if the family has a change in circumstances, in accordance with criteria specified by the Secretary.

“(5) APPLICATION OF REQUIREMENTS.—The requirements of this subsection shall apply in the same manner to limits imposed under subsections (e), (d), (g), and (i).”.

(2) STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST SHARING.—Section 1916A(b) (42 U.S.C. 1396o–1(b)) is amended—

(A) in paragraphs (1)(B)(ii) and (2)(A), by inserting “or section 1916” after “subsection (e) or (e)” in each place it appears; and

(B) by adding at the end the following new paragraph:
“(7) Cost sharing tracking; suspension of charges; notification requirements.—

“(A) Tracking.—If the State plan imposes premiums or cost sharing under this section that, together with cost sharing imposed under section 1916, could cause families to have out-of-pocket expenses that exceed the total aggregate limit imposed under paragraph (1) or (2) of this subsection for a month or quarter (as specified by the State), the State shall establish a process for tracking and aggregating such expenses (including expenses for separately administered benefits) that—

“(i) does not rely on documentation provided by the individual or the family;

“(ii) is communicated in a manner designed to ensure the privacy of patient-related information; and

“(iii) allows for coordination with managed care entities (as defined in section 1932(a)(1)(B)) that are under contract with the State.

“(B) Suspension of charges.—When a family reaches any limit for a period imposed on premiums or cost sharing under this section,
no further premiums or cost sharing (or any portions thereof) shall be imposed on any individual in the family who is eligible for and receiving medical assistance under the plan for the remainder of the period.

“(C) Notification Requirements.—
With respect to a limit imposed on premiums or cost sharing under paragraph (1) or (2) of this subsection the State plan shall provide for the notification of providers and each family to which such a limit applies—

“(i) of any such limit applicable to the family;

“(ii) when the family has incurred out-of-pocket expenses up to any such limit; and

“(iii) when a family reaches such a limit for a period, that the limit has been reached and that no further premiums or cost sharing (or portions thereof) shall be imposed on any individual in the family who is eligible for and receiving medical assistance under the plan for the remainder of such month or quarter.
“(D) REASSESSMENT PROCESS.—The State shall establish a process for families that include an individual who is eligible for and receiving medical assistance under the plan to request a reassessment of the family’s aggregate limit on premiums, deductions, cost sharing, or similar charges if the family has a change in circumstances, in accordance with criteria specified by the Secretary.”.

(3) MANAGED CARE ORGANIZATIONS.—Section 1932(a)(5) (42 U.S.C. 1396u–2(a)(5)) is amended by adding at the end the following new subparagraph:

“(E) COORDINATION WITH PROVIDERS ON COST SHARING.—The State shall require that a managed care entity with a contract with the State, as a condition of such contract, comply with the requirements of sections 1916 and 1916A (as applicable), for such individuals who are enrolled with the organization or entity and coordinate with the State with respect to tracking and aggregating an enrollee’s family’s out-of-pocket expenses for premiums, deductions, cost sharing, or similar charges.”.
(4) CONFORMING AMENDMENTS.—Section 1916A(a)(2)(B) (42 U.S.C. 1396o–1(a)(2)(B)) is amended—

(A) by inserting “and the tracking, suspension, and notification requirements under subsection (b)(7)” before “shall apply”; and

(B) by inserting “and requirements” after “limitations”.

(b) CHIP.—

(1) IN GENERAL.—Section 2103(e) (42 U.S.C. 1397cc(e)) is amended—

(A) by striking paragraphs (2) and (4);

(B) by redesignating paragraph (3) as paragraph (2);

(C) in paragraph (2) (as so redesignated)—

(i) by striking subparagraph (B);

(ii) by redesignating subparagraph (C) as subparagraph (D); and

(iii) by inserting after subparagraph (A) the following new subparagraphs:

“(B) NO COST SHARING FOR PREGNANCY-RELATED ASSISTANCE.—The State child health plan may not impose deductions, cost sharing,
or similar charges with respect to pregnancy-related assistance.

“(C) Application of Medicaid cost sharing limits.—Subject to subparagraphs (A) and (B) and paragraph (3), the State child health plan may only impose deductions, cost sharing, or similar charges to the extent that such charges do not exceed the nominal limits set under section 1916(a)(3).”; and

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

“(3) Additional requirements.—

“(A) In general.—Subject to paragraph (2)(A), any premiums, deductions, cost sharing, or similar charges imposed under the State child health plan for medical or dental benefits may be imposed on a sliding scale related to income, except that the total annual aggregate cost sharing imposed for such benefits with respect to all individuals in a family that includes a targeted low-income child or a targeted low-income pregnant woman under this title shall not exceed 5 percent of such family’s income for the year involved.
“(B) Dental-only supplemental coverage.—With respect to dental-only supplemental coverage offered under section 2110(b)(5), the total annual aggregate cost sharing imposed for such coverage shall not exceed 5 percent of a family's income for the year involved, minus the amount the family is required to pay during such year in premiums, deductions, cost sharing, or similar charges for health care services for children in the family enrolled in a group health plan or health insurance coverage offered through an employer.

“(C) Tracking of expenses; suspension of charges; notice; reassessments.—If the State child health plan imposes premiums, deductions, cost sharing, or similar charges that could cause families that include a targeted low-income child or a targeted low-income pregnant woman to have out-of-pocket expenses that exceed the aggregate cost sharing limit imposed under subparagraph (A) for the year, the State shall—

“(i) establish a process for tracking and aggregating such expenses (including
expenses incurred for separately adminis-
tered benefits) that—

“(I) does not rely on documenta-
tion provided by the targeted low-in-
come child, the targeted low-income
pregnant woman, or the family;

“(II) is communicated in a man-
ner designed to ensure the privacy of
patient-related information; and

“(III) allows for coordination
with managed care entities and man-
aged care organizations that are
under contract with the State;

“(ii) when a family reaches the aggre-
gate cost-sharing limit for a year imposed
under subparagraph (A), not impose any
further premiums or cost sharing (or any
portions thereof) on any targeted low-in-
come child or targeted low-income preg-
nant woman in the family for the remain-
der of the year;

“(iii) notify providers and each family
that includes a targeted low-income child
or a targeted low-income pregnant
woman—
“(I) of the annual aggregate limits on out-of-pocket expenses applicable to the family;

“(II) when the family has incurred out-of-pocket expenses up to the annual aggregate family limit imposed under subparagraph (A); and

“(III) when a family reaches the aggregate out-of-pocket expenses limit for a year, that the limit has been reached and that no further premiums, deductions, cost sharing, or similar charges (or portions thereof) shall be imposed on any targeted low-income child or targeted low-income pregnant woman in the family for the remainder of such year; and

“(iv) establish a process for families that include a targeted low-income child or a targeted low-income pregnant woman to request a reassessment of the family’s annual aggregate limit on premiums, deductions, cost sharing, or similar charges if the family has a change in circumstances,
in accordance with criteria specified by the Secretary.”.

(2) MANAGED CARE ORGANIZATIONS.—Section 2103(f) (42 U.S.C. 1397ee(f)) is amended by adding at the end following new paragraph:

“(4) COORDINATION WITH PROVIDERS ON COST SHARING.—The State shall require that a managed care entity or a managed care organization with a contract with the State, as a condition of such contract, comply with the requirements of 2103(e) and coordinate with the State with respect to in tracking and aggregating an enrollee’s family’s out-of-pocket expenses for cost sharing as required under subsection (e)(3)(C).”.

(c) CONFORMING AMENDMENTS.—

(1) Section 2105(c)(10)(C)(i) (42 U.S.C. 1397ee(c)(10)(C)(i)) is amended by striking “paragraph (3)(B) of”.

(2) Section 2112(b)(6) (42 U.S.C. 1397ll(b)(6)) is amended by striking “paragraph (3)(B) of”.

TITLE IV—BENEFITS

SEC. 401. PREVENTIVE HEALTH SERVICES.

(a) Preventive Health Services.—

(1) MEDICAID.—Section 1905 (42 U.S.C. 1396d) is amended—
(A) in subsection (a)(4)—

(i) by striking “and” before “(D)”; and

(ii) by inserting before the semicolon at the end the following new subparagraph:

“; and (E) preventive services described in subsection (ee)”;

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

“(ee) PREVENTIVE SERVICES.—

“(1) IN GENERAL.—For purposes of subsection (a)(4)(E), the preventive services described in this subsection are diagnostic, screening, and preventive services not otherwise described in subsection (a) or required by subsection (r) that the Secretary determines are appropriate for children or pregnant women entitled to medical assistance under this title, including—

“(A) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force;

“(B) with respect to pregnant women, immunizations that have in effect a recommendation from the Advisory Committee on Immunization...
zation Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

“(C) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

“(D) with respect to women, such additional preventive care and screenings not described in this paragraph as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

“(2) ADDITIONAL SERVICES.—Nothing in this subsection shall be construed to limit the application of any requirement of subsection (r) or to prohibit a State plan under this title from providing coverage for services in addition to those recommended by United States Preventive Services Task Force or to prohibit coverage of services.”.

(2) ELIMINATION OF COST-SHARING.—

(A) Subsections (a)(2)(D) and (b)(2)(D) of section 1916 (42 U.S.C. 1396o) are each amended by inserting “preventive services de-
scribed in section 1905(ee),” after “emergency services (as defined by the Secretary),”.

(B) Section 1916A(a)(1) (42 U.S.C. 1396o–1(a)(1)) is amended by inserting “, preventive services described in section 1905(ee),” after “subsection (c)”.

(3) INTERVAL PERIOD FOR INCLUSION OF NEW RECOMMENDATIONS IN STATE PLANS.—With respect to a recommendation issued on or after the date of enactment of this Act that adds new preventive services to the requirements described in subsection (ee) of section 1905 of the Social Security Act, the Secretary shall establish a maximum interval period, which shall not be longer than 6 months, between the date on which the recommendation is issued and the plan year for which a State plan for medical assistance under title XIX of the Social Security Act shall be required to include such preventive service.

(b) CHIP.—Section 2103 (42 U.S.C. 1397cc) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking “and (7)” and inserting “(7), and (8)” ; and

(2) in subsection (c) —
(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7), the following new paragraph:

“(8) PREVENTIVE SERVICES.—The child health assistance provided to a targeted low-income child and pregnancy-related assistance provided to a targeted low-income pregnant woman shall include coverage of preventive services for children or pregnant women required under a State plan under title XIX under subsections (a)(4)(E) and (ee) of section 1905 and no deductible, cost sharing or similar charge shall be imposed under the State child health plan with respect to such services.”.

SEC. 402. TIMELY IMMUNIZATION COVERAGE.

(a) COVERAGE FOR NEWLY APPROVED VACCINES WITHIN 30 DAYS.—

(1) IN GENERAL.—Section 1928(e) (42 U.S.C. 1396s(e)) is amended by adding at the end the following new sentence: “Each revision of the list established by such Advisory Committee shall apply to the purchase, delivery, and administration of pediatric vaccines under this section not later than 30 days after the date such Advisory Committee approves the revision.”.
CONFORMING AMENDMENT.—Section 2103(c)(1)(D) (42 U.S.C. 1397ce(c)(1)(D)) is amended by inserting “in accordance with the schedule referred to in section 1928(c)(2)(B)(i) for pediatric vaccines” after “immunizations”.

(b) TREATMENT OF CHIP-ELIGIBLE CHILDREN AS FEDERALLY VACCINE-ELIGIBLE CHILDREN.—Section 1928(b)(2) (42 U.S.C. 1396s(b)(2)) is amended—

(1) in subparagraph (A)(i), by inserting “or CHIP-eligible” after “medicaid-eligible”; and

(2) in subparagraph (B), by striking clause (i) and inserting the following:

“(i) The term ‘medicaid-eligible or CHIP-eligible child’ means, with respect to a child, a child who is entitled to medical assistance under a State plan approved under this title or a waiver of such plan, or who is eligible for child health assistance under a State child health plan approved under title XXI.”.

(c) CODING FOR VACCINE ADMINISTRATION.—Section 1928 (42 U.S.C. 1396s) is amended—

(1) by striking subsection (g) and inserting:

“(g) [Reserved].”; and
(2) in subsection (h)(6), by striking “a vaccine” and inserting “each vaccine component”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

TITLE V—ACCESS AND QUALITY
Subtitle A—Pediatric Quality Measures

SEC. 501. EXTENDING THE PEDIATRIC QUALITY MEASURES PROGRAM.

(a) In General.—Section 1139A(i) (42 U.S.C. 1320b–9a(i)) is amended by inserting “, and for each of fiscal years 2014 through 2019, $50,000,000,” after “$45,000,000”.

(b) Effective Date.—The amendment made by this section shall take effect on the date of enactment of this Act.

SEC. 502. IMPROVING THE EFFECTIVENESS OF THE PEDIATRIC QUALITY MEASURES.

(a) In General.—Section 1139A(b) (42 U.S.C. 1320b–9a(b)) is amended—

(1) in paragraph (4)—

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

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

“(C) establish a program to continue and enhance pediatric quality measures program centers of excellence, which may include developing centers of excellence with a particular emphasis on patient and family experience and pediatric populations that are small in size and may be most effectively addressed by aggregating data across multiple States, including pediatric populations with medical complexity and pediatric populations with rare conditions.”; and

(2) by amending paragraph (5) to read as follows:

“(5) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—

“(A) IN GENERAL.—The Secretary shall annually publish recommended changes to the core measures described in subsection (a) that—
“(i) are consistent with the purposes
of the pediatric quality measures program
established under paragraph (1);
“(ii) meet the conditions specified in
paragraph (2);
“(iii) were developed by the Secretary
in consultation with the entities specified
in subparagraphs (A) through (H) of para-
graph (3); and
“(iv) were developed, validated, or
tested through a grant awarded under
paragraph (4).
“(B) ADDITIONAL RECOMMENDED
CHANGES.—Beginning not later than 1 year
after the date of enactment of the CHIP Exten-
sion Act of 2014, the recommended changes
published under subparagraph (A) shall include
changes—
“(i) to measure the type of children’s
health insurance coverage or other health
benefits coverage available over time, in
addition to the presence, stability, and du-
ration of such health insurance coverage or
such health benefits coverage over time, for
purposes of examining enrollment changes
of a child from one type of coverage to another;

“(ii) to ensure that the measures reflect the care provided to the diverse pediatric population, including adolescents and children with special health care needs, and the management of acute and chronic conditions;

“(iii) to ensure that the measures reflect care provided in diverse health care settings, including both inpatient and ambulatory settings;

“(iv) to encourage the development, implementation, and stewardship of core measures that can be used at the State, hospital, practice, and plan levels, including a sustainable mechanism to maintain and disseminate such measures and collect and report data on such measures; and

“(v) to facilitate the adoption, dissemination, stewardship, and reporting of such measures as well as measures developed through the pediatric quality measures program at the State, hospital, practice, and plan levels and across different
health care delivery and coverage systems, including coverage provided through the Exchanges established under title I of the Patient Protection and Affordable Care Act.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 503. ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID OR CHIP.

(a) IN GENERAL.—Section 1139A(c) (42 U.S.C. 1320b–9a(c)) is amended by adding at the end the following new paragraph:

“(3) DATA COLLECTION AND REPORTING ON FULL SET OF CORE MEASURES.—Beginning not later than 5 years after the date of enactment of this paragraph, the information reported under paragraph (1) shall include State-specific information on the full set of pediatric core measures.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of enactment of this Act.
SEC. 504. ADVISORY PANEL REGARDING PEDIATRIC QUALITY.

(a) IN GENERAL.—Section 1139A(g) (42 U.S.C. 1320b–9a(g)) is amended—

(1) in the subsection heading, by striking “STUDY OF” and inserting “STUDIES AND REPORTS ON”;

(2) by redesignating paragraph (2) as paragraph (4); and

(3) by inserting after paragraph (1) the following new paragraphs:

“(2) EXPERT PANEL.—The Secretary shall convene a panel, composed of health experts (including experts employed by the Federal Government and experts not so employed) to establish priorities and goals for child health as recommended in the report submitted under paragraph (1) by the Institute of Medicine. Such panel shall—

“(A) advise and make recommendations to the Secretary regarding changes that may be made to the core measures described in subsection (a);

“(B) establish standards for the timeliness and accuracy of data so collected and reported; and
“(C) review and make recommendations, on an annual basis, for strategies to enhance the timeliness, accuracy, and utility of the core measures.

“(3) COLLECTING AND REPORTING FULL SET OF CORE MEASURES.—Not later than 1 year after the date of enactment of this paragraph, the Secretary, in consultation with representatives of State agencies responsible for administering Medicaid and the State Children’s Health Insurance Program and representatives of relevant provider organizations, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report identifying—

“(A) strategies to address and overcome barriers to State collection of and reporting of the full set of pediatric core measures;

“(B) an analysis of the amount of Federal funding needed to incentivize States to collect and report on the full set of pediatric core measures; and

“(C) a standardized format and plan for States to collect and report on the full set of pediatric core measures.”.
(b) Effective Date.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 505. EXTENDING AND EXPANDING DEMONSTRATION PROJECTS.

(a) Strengthening Demonstration Projects for Improving the Quality of Children’s Health Care and the Use of Health Information Technology.—Section 1139A(d) (42 U.S.C. 1320b–9a(d)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A)—

(i) by inserting “, and during the period of fiscal years 2014 through 2019, the Secretary shall award not less than 10 grants,” after “10 grants”; and

(ii) by inserting “(including oral care)” after “health care”; and

(B) in subparagraph (C), by striking “or” at the end;

(C) in subparagraph (D), by striking the period at the end and inserting a semicolon; and
(D) by adding at the end the following new subparagraphs:

“(E) examine and address barriers to effective delivery of perinatal care and its impact on birth outcomes and subsequent pregnancies and children’s health;

“(F) implement and expand pediatric and perinatal learning and quality improvement collaboratives on the quality of children’s and pregnant women’s health care, including improving patient outcomes, reducing health costs, and addressing health disparities;

“(G) encourage and evaluate the use at the State level of payment reform and related policy proposals for purposes of promoting higher quality of care for children, including the shared savings program established under section 1899 and other methods of encouraging integrated care models; or

“(H) with respect to the model electronic health record format for children developed and disseminated under subsection (f)—

“(i) assess the extent to which the format has been incorporated into widely used electronic health record formats;
“(ii) implement standards and activities that result in increased use of such format; and

“(iii) evaluate the impact of the increased use of such format.”;

(2) in paragraph (2)—

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

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

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

“(C) with respect to grants awarded for projects described in paragraph (1)(F), such grants shall be awarded for projects that—

“(i) give priority to collaboratives that would have substantial impacts on the pediatric population by—

“(I) affecting a large percentage of such population or by substantially improving outcomes in a smaller population;

“(II) reducing the cost of health care for children, including children
with medically complex illnesses or chronic conditions;

“(III) having a high likelihood to reduce disparities in health status; or

“(IV) potentially having long-term health impacts by addressing childhood precursors to adult conditions; and

“(ii) encourage coordination with other sources of funding in the expansion of pediatric learning collaboratives, including by coordinating care and utilizing community health workers (as defined in section 399V(k) of the Public Health Service Act (42 U.S.C. 280g–11(k))).”; and

(3) in paragraph (4)—

(A) by inserting “For each of fiscal years 2009 through 2013,” before “$20,000,000”; and

(B) by adding at the end the following new sentence: “For each of fiscal years 2014 through 2019, $36,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.”.
(b) Extending Funding for Childhood Obesity Demonstration Projects.—Section 1139A(e)(8) (42 U.S.C. 1320b–9a(e)(8)) is amended by inserting “, and for the period of fiscal years 2015 through 2019, $25,000,000” after “2014”.

(c) Effective Date.—The amendments made by this section shall take effect on the date of enactment of this Act.

Subtitle B—Maternal, Infant, and Early Childhood Home Visiting Program

SEC. 511. SUPPORTING EVIDENCE-BASED CARE COORDINATION IN COMMUNITIES.

(a) In General.—Section 511(j)(1) (42 U.S.C. 711(j)(1)) is amended by striking subparagraph (F) and inserting the following:

“(F) $400,000,000 for each of fiscal years 2015 through 2019.”.

(b) Prevention of Duplicate Appropriations for Fiscal Year 2015.—Expenditures made pursuant to the amendments made by section 209 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93) for fiscal year 2015 shall be charged to the appropriation provided by the amendment made by subsection (a) for such fiscal year.
(c) **Effective Date.**—The amendment made by
this section shall take effect on the date of enactment of
this Act.

**Subtitle C—Comparative Study of**
**Medicaid, CHIP, and Qualified Health Plans**

**SEC. 521. GAO Study and Report.**

(a) **Study.**—The Comptroller General of the United
States shall conduct a study of each State in which indi-
viduals eligible for medical assistance under a State plan
under title XIX of the Social Security Act (42 U.S.C.
1396 et seq.) or for child health assistance under a State
child health plan under title XXI of the Social Security
Act (42 U.S.C. 1397aa et seq.) are provided such assist-
ance through enrollment in a qualified health plan or em-
ployer-sponsored insurance. Such study shall determine,
for each such State—

(1) the number of such individuals enrolled in
an employer-sponsored health plan to whom wrap-
around services are offered;

(2) the number of such individuals enrolled in
an employer-sponsored health plan who use wrap-
around services for any purpose during the plan
year;
(3) the average cost of wraparound services per individual enrolled in an employer-sponsored health plan who uses such services;

(4) the number of such individuals with “developmental disabilities” (as defined in section 102(8) of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002(8))), enrolled in an employer-sponsored health plan who used wrap-around benefits;

(5) the number of disabled individuals enrolled in an employer-sponsored health plan who use wrap-around benefits for habilitative services, rehabilitative services, or home health services;

(6) the number of such individuals enrolled in qualified health plans;

(7) average premiums and cost-sharing per such individual enrolled in a qualified health plan; and

(8) comparative data with respect to the benefits offered to such individuals under qualified health plans as compared to the benefits offered to such individuals under State plans under title XIX or XXI of the Social Security Act.

(b) REPORTS.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General of
the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the findings of the study conducted under subsection (a) that includes any recommendations or proposed legislation. Not later than 4 years after the date of enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate an updated report on the findings of the study conducted under subsection (a) that includes any recommendations or proposed legislation.

(c) DEFINITIONS.—For purposes of this section:

(1) QUALIFIED HEALTH PLAN.—The term “qualified health plan” means a health plan that is offered through an American Health Benefits Exchange established under the Patient Protection and Affordable Care Act (Public Law 111–148).

(2) WRAPAROUND SERVICES.—The term “wraparound services” means services provided by a State plan under title XIX or XXI of the Social Security Act that are provided as a supplement to items or services for which coverage is not offered or is limited under a qualified health plan or an employer-sponsored health plan.
TITLE VI—BUDGETARY EFFECTS

SEC. 601. BUDGETARY EFFECT OF THIS ACT.

The budgetary effects of this Act, for the purpose of complying with the Statutory Pay-As-You-Go Act of 2010, shall be determined by reference to the latest statement titled “Budgetary Effects of PAYGO Legislation” for this Act, submitted for printing in the Congressional Record by the Chairman of the Committee on the Budget of the House of Representatives, as long as such statement has been submitted prior to the vote on passage of this Act.