

(A) in subparagraph (B)(ii), by inserting “or that is described in section 412.22(h)(3)(i) of such title” before the period; and

(B) in subparagraph (C), by striking “the date of the enactment of this Act” and inserting “October 1, 2007 (or July 1, 2007, in the case of a satellite facility described in section 412.22(h)(3)(i) of title 42, Code of Federal Regulations)”.

(b) MORATORIUM.—Subsection (d)(3)(A) of such section is amended by striking “if the hospital or facility” and inserting “if the hospital or facility obtained a certificate of need for an increase in beds that is in a State for which such certificate of need is required and that was issued on or after April 1, 2005, and before December 29, 2007, or if the hospital or facility”.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective and apply as if included in the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173).

TITLE V—STATE FISCAL RELIEF

SEC. 5000. PURPOSES; TABLE OF CONTENTS.

(a) PURPOSES.—The purposes of this title are as follows:

(1) To provide fiscal relief to States in a period of economic downturn.

(2) To protect and maintain State Medicaid programs during a period of economic downturn, including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements.

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

TITLE V—STATE FISCAL RELIEF

Sec. 5000. Purposes; table of contents.

Sec. 5001. Temporary increase of Medicaid FMAP.

Sec. 5002. Temporary increase in DSH allotments during recession.

Sec. 5003. Extension of moratoria on certain Medicaid final regulations.

Sec. 5004. Extension of transitional medical assistance (TMA).

Sec. 5005. Extension of the qualifying individual (QI) program.

Sec. 5006. Protections for Indians under Medicaid and CHIP.

Sec. 5007. Funding for oversight and implementation.

Sec. 5008. GAO study and report regarding State needs during periods of national economic downturn.

SEC. 5001. TEMPORARY INCREASE OF MEDICAID FMAP.

(a) PERMITTING MAINTENANCE OF FMAP.—Subject to subsections (e), (f), and (g), if the FMAP determined without regard to this section for a State for—

(1) fiscal year 2009 is less than the FMAP as so determined for fiscal year 2008, the FMAP for the State for fiscal year 2008 shall be substituted for the State’s FMAP for fiscal year 2009, before the application of this section;

(2) fiscal year 2010 is less than the FMAP as so determined for fiscal year 2008 or fiscal year 2009 (after the application of paragraph (1)), the greater of such FMAP for the State for fiscal year 2008 or fiscal year 2009 shall be substituted

for the State's FMAP for fiscal year 2010, before the application of this section; and

(3) fiscal year 2011 is less than the FMAP as so determined for fiscal year 2008, fiscal year 2009 (after the application of paragraph (1)), or fiscal year 2010 (after the application of paragraph (2)), the greatest of such FMAP for the State for fiscal year 2008, fiscal year 2009, or fiscal year 2010 shall be substituted for the State's FMAP for fiscal year 2011, before the application of this section, but only for the first calendar quarter in fiscal year 2011.

(b) GENERAL 6.2 PERCENTAGE POINT INCREASE.—

(1) IN GENERAL.—Subject to subsections (e), (f), and (g) and paragraph (2), for each State for calendar quarters during the recession adjustment period (as defined in subsection (h)(3)), the FMAP (after the application of subsection (a)) shall be increased (without regard to any limitation otherwise specified in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))) by 6.2 percentage points.

(2) SPECIAL ELECTION FOR TERRITORIES.—In the case of a State that is not one of the 50 States or the District of Columbia, paragraph (1) shall only apply if the State makes a one-time election, in a form and manner specified by the Secretary and for the entire recession adjustment period, to apply the increase in FMAP under paragraph (1) and a 15 percent increase under subsection (d) instead of applying a 30 percent increase under subsection (d).

(c) ADDITIONAL RELIEF BASED ON INCREASE IN UNEMPLOYMENT.—

(1) IN GENERAL.—Subject to subsections (e), (f), and (g), if a State is a qualifying State under paragraph (2) for a calendar quarter occurring during the recession adjustment period, the FMAP for the State shall be further increased by the number of percentage points equal to the product of—

(A) the State percentage applicable for the State under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) after the application of subsection (a) and after the application of $\frac{1}{2}$ of the increase under subsection (b); and

(B) the applicable percent determined in paragraph (3) for the calendar quarter (or, if greater, for a previous such calendar quarter).

(2) QUALIFYING CRITERIA.—

(A) IN GENERAL.—For purposes of paragraph (1), a State qualifies for additional relief under this subsection for a calendar quarter occurring during the recession adjustment period if the State is 1 of the 50 States or the District of Columbia and the State satisfies any of the following criteria for the quarter:

(i) The State unemployment increase percentage (as defined in paragraph (4)) for the quarter is at least 1.5 percentage points but less than 2.5 percentage points.

(ii) The State unemployment increase percentage for the quarter is at least 2.5 percentage points but less than 3.5 percentage points.

(iii) The State unemployment increase percentage for the quarter is at least 3.5 percentage points.

(B) MAINTENANCE OF STATUS.—If a State qualifies for additional relief under this subsection for a calendar quarter, it shall be deemed to have qualified for such relief for each subsequent calendar quarter ending before July 1, 2010.

(3) APPLICABLE PERCENT.—

(A) IN GENERAL.—For purposes of paragraph (1), subject to subparagraph (B), the applicable percent is—

(i) 5.5 percent, if the State satisfies the criteria described in paragraph (2)(A)(i) for the calendar quarter;

(ii) 8.5 percent if the State satisfies the criteria described in paragraph (2)(A)(ii) for the calendar quarter; and

(iii) 11.5 percent if the State satisfies the criteria described in paragraph (2)(A)(iii) for the calendar quarter.

(B) MAINTENANCE OF HIGHER APPLICABLE PERCENT.—

(i) HOLD HARMLESS PERIOD.—If the percent applied to a State under subparagraph (A) for any calendar quarter in the recession adjustment period beginning on or after January 1, 2009, and ending before July 1, 2010, (determined without regard to this subparagraph) is less than the percent applied for the preceding quarter (as so determined), the higher applicable percent shall continue in effect for each subsequent calendar quarter ending before July 1, 2010.

(ii) NOTICE OF LOWER APPLICABLE PERCENT.—The Secretary shall notify a State at least 60 days prior to applying any lower applicable percent to the State under this paragraph.

(4) COMPUTATION OF STATE UNEMPLOYMENT INCREASE PERCENTAGE.—

(A) IN GENERAL.—In this subsection, the “State unemployment increase percentage” for a State for a calendar quarter is equal to the number of percentage points (if any) by which—

(i) the average monthly unemployment rate for the State for months in the most recent previous 3-consecutive-month period for which data are available, subject to subparagraph (C); exceeds

(ii) the lowest average monthly unemployment rate for the State for any 3-consecutive-month period preceding the period described in clause (i) and beginning on or after January 1, 2006.

(B) AVERAGE MONTHLY UNEMPLOYMENT RATE DEFINED.—In this paragraph, the term “average monthly unemployment rate” means the average of the monthly number unemployed, divided by the average of the monthly civilian labor force, seasonally adjusted, as determined based on the most recent monthly publications of the Bureau of Labor Statistics of the Department of Labor.

(C) SPECIAL RULE.—With respect to—

(i) the first 2 calendar quarters of the recession adjustment period, the most recent previous 3-consecutive-month period described in subparagraph (A)(i)

shall be the 3-consecutive-month period beginning with October 2008; and

(ii) the last 2 calendar quarters of the recession adjustment period, the most recent previous 3-consecutive-month period described in such subparagraph shall be the 3-consecutive-month period beginning with December 2009, or, if it results in a higher applicable percent under paragraph (3), the 3-consecutive-month period beginning with January 2010.

(d) INCREASE IN CAP ON MEDICAID PAYMENTS TO TERRITORIES.—Subject to subsections (f) and (g), with respect to entire fiscal years occurring during the recession adjustment period and with respect to fiscal years only a portion of which occurs during such period (and in proportion to the portion of the fiscal year that occurs during such period), the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) shall each be increased by 30 percent (or, in the case of an election under subsection (b)(2), 15 percent). In the case of such an election by a territory, subsection (a)(1) of such section shall be applied without regard to any increase in payment made to the territory under part E of title IV of such Act that is attributable to the increase in FMAP effected under subsection (b) for the territory.

(e) SCOPE OF APPLICATION.—The increases in the FMAP for a State under this section shall apply for purposes of title XIX of the Social Security Act and shall not apply with respect to—

(1) disproportionate share hospital payments described in section 1923 of such Act (42 U.S.C. 1396r-4);

(2) payments under title IV of such Act (42 U.S.C. 601 et seq.) (except that the increases under subsections (a) and (b) shall apply to payments under part E of title IV of such Act (42 U.S.C. 670 et seq.) and, for purposes of the application of this section to the District of Columbia, payments under such part shall be deemed to be made on the basis of the FMAP applied with respect to such District for purposes of title XIX and as increased under subsection (b));

(3) payments under title XXI of such Act (42 U.S.C. 1397aa et seq.);

(4) any payments under title XIX of such Act that are based on the enhanced FMAP described in section 2105(b) of such Act (42 U.S.C. 1397ee(b)); or

(5) any payments under title XIX of such Act that are attributable to expenditures for medical assistance provided to individuals made eligible under a State plan under title XIX of the Social Security Act (including under any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) because of income standards (expressed as a percentage of the poverty line) for eligibility for medical assistance that are higher than the income standards (as so expressed) for such eligibility as in effect on July 1, 2008, (including as such standards were proposed to be in effect under a State law enacted but not effective as of such date or a State plan amendment or waiver request under title XIX of such Act that was pending approval on such date).

(f) STATE INELIGIBILITY; LIMITATION; SPECIAL RULES.—

(1) MAINTENANCE OF ELIGIBILITY REQUIREMENTS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a State is not eligible for an increase in its FMAP under subsection (a), (b), or (c), or an increase in a cap amount under subsection (d), if eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

(B) STATE REINSTATEMENT OF ELIGIBILITY PERMITTED.—Subject to subparagraph (C), a State that has restricted eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of such Act (42 U.S.C. 1315)) after July 1, 2008, is no longer ineligible under subparagraph (A) beginning with the first calendar quarter in which the State has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008.

(C) SPECIAL RULES.—A State shall not be ineligible under subparagraph (A)—

(i) for the calendar quarters before July 1, 2009, on the basis of a restriction that was applied after July 1, 2008, and before the date of the enactment of this Act, if the State prior to July 1, 2009, has reinstated eligibility standards, methodologies, or procedures that are no more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on July 1, 2008; or

(ii) on the basis of a restriction that was directed to be made under State law as in effect on July 1, 2008, and would have been in effect as of such date, but for a delay in the effective date of a waiver under section 1115 of such Act with respect to such restriction.

(2) COMPLIANCE WITH PROMPT PAY REQUIREMENTS.—

(A) APPLICATION TO PRACTITIONERS.—

(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, no State shall be eligible for an increased FMAP rate as provided under this section for any claim received by a State from a practitioner subject to the terms of section 1902(a)(37)(A) of the Social Security Act (42 U.S.C. 1396a(a)(37)(A)) for such days during any period in which that State has failed to pay claims in accordance with such section as applied under title XIX of such Act.

(ii) REPORTING REQUIREMENT.—Each State shall report to the Secretary, on a quarterly basis, its compliance with the requirements of clause (i) as such requirements pertain to claims made for covered services during each month of the preceding quarter.

(iii) WAIVER AUTHORITY.—The Secretary may waive the application of clause (i) to a State, or the

reporting requirement imposed under clause (ii), during any period in which there are exigent circumstances, including natural disasters, that prevent the timely processing of claims or the submission of such a report.

(iv) APPLICATION TO CLAIMS.—Clauses (i) and (ii) shall only apply to claims made for covered services after the date of enactment of this Act.

(B) APPLICATION TO NURSING FACILITIES AND HOSPITALS.—

(i) IN GENERAL.—Subject to clause (ii), the provisions of subparagraph (A) shall apply with respect to a nursing facility or hospital, insofar as it is paid under title XIX of the Social Security Act on the basis of submission of claims, in the same or similar manner (but within the same timeframe) as such provisions apply to practitioners described in such subparagraph.

(ii) GRACE PERIOD.—Notwithstanding clause (i), no period of ineligibility shall be imposed against a State prior to June 1, 2009, on the basis of the State failing to pay a claim in accordance with such clause.

(3) STATE'S APPLICATION TOWARD RAINY DAY FUND.—A State is not eligible for an increase in its FMAP under subsection (b) or (c), or an increase in a cap amount under subsection (d), if any amounts attributable (directly or indirectly) to such increase are deposited or credited into any reserve or rainy day fund of the State.

(4) NO WAIVER AUTHORITY.—Except as provided in paragraph (2)(A)(iii), the Secretary may not waive the application of this subsection or subsection (g) under section 1115 of the Social Security Act or otherwise.

(5) LIMITATION OF FMAP TO 100 PERCENT.—In no case shall an increase in FMAP under this section result in an FMAP that exceeds 100 percent.

(6) TREATMENT OF CERTAIN EXPENDITURES.—With respect to expenditures described in section 2105(a)(1)(B) of the Social Security Act (42 U.S.C. 1397ee(a)(1)(B)), as in effect before April 1, 2009, that are made during the period beginning on October 1, 2008, and ending on March 31, 2009, any additional Federal funds that are paid to a State as a result of this section that are attributable to such expenditures shall not be counted against any allotment under section 2104 of such Act (42 U.S.C. 1397dd).

(g) REQUIREMENTS.—

(1) STATE REPORTS.—Each State that is paid additional Federal funds as a result of this section shall, not later than September 30, 2011, submit a report to the Secretary, in such form and such manner as the Secretary shall determine, regarding how the additional Federal funds were expended.

(2) ADDITIONAL REQUIREMENT FOR CERTAIN STATES.—In the case of a State that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures under the State Medicaid plan required under section 1902(a)(2) of the Social Security Act (42 U.S.C. 1396a(a)(2)), the State is not eligible for an increase in its FMAP under subsection (b) or (c), or an increase in a cap amount under subsection (d), if it requires that such political subdivisions

pay for quarters during the recession adjustment period a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentage that would have been required by the State under such plan on September 30, 2008, prior to application of this section.

(h) DEFINITIONS.—In this section, except as otherwise provided:

(1) FMAP.—The term “FMAP” means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as determined without regard to this section except as otherwise specified.

(2) POVERTY LINE.—The term “poverty line” has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

(3) RECESSION ADJUSTMENT PERIOD.—The term “recession adjustment period” means the period beginning on October 1, 2008, and ending on December 31, 2010.

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

(5) STATE.—The term “State” has the meaning given such term in section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(i) SUNSET.—This section shall not apply to items and services furnished after the end of the recession adjustment period.

(j) LIMITATION ON FMAP CHANGE.—The increase in FMAP effected under section 614 of the Children’s Health Insurance Program Reauthorization Act of 2009 shall not apply in the computation of the enhanced FMAP under title XXI or XIX of the Social Security Act for any period (notwithstanding subsection (i)).

SEC. 5002. TEMPORARY INCREASE IN DSH ALLOTMENTS DURING RECESSION.

Section 1923(f)(3) of the Social Security Act (42 U.S.C. 1396r-4(f)(3)) is amended—

(1) in subparagraph (A), by striking “paragraph (6)” and inserting “paragraph (6) and subparagraph (E)”; and

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

“(E) TEMPORARY INCREASE IN ALLOTMENTS DURING RECESSION.—

“(i) IN GENERAL.—Subject to clause (ii), the DSH allotment for any State—

“(I) for fiscal year 2009 is equal to 102.5 percent of the DSH allotment that would be determined under this paragraph for the State for fiscal year 2009 without application of this subparagraph, notwithstanding subparagraphs (B) and (C);

“(II) for fiscal year 2010 is equal to 102.5 percent of the DSH allotment for the State for fiscal year 2009, as determined under subclause (I); and

“(III) for each succeeding fiscal year is equal to the DSH allotment for the State under this paragraph determined without applying subclauses (I) and (II).

“(ii) APPLICATION.—Clause (i) shall not apply to a State for a year in the case that the DSH allotment for such State for such year under this paragraph determined without applying clause (i) would grow higher than the DSH allotment specified under clause (i) for the State for such year.”.

SEC. 5003. EXTENSION OF MORATORIA ON CERTAIN MEDICAID FINAL REGULATIONS.

(a) FINAL REGULATIONS RELATING TO OPTIONAL CASE MANAGEMENT SERVICES AND ALLOWABLE PROVIDER TAXES.—Section 7001(a)(3)(A) of the Supplemental Appropriations Act, 2008 (Public Law 110–252) is amended by striking “April 1, 2009” and inserting “July 1, 2009”.

(b) FINAL REGULATION RELATING TO SCHOOL-BASED ADMINISTRATION AND SCHOOL-BASED TRANSPORTATION.—Section 206 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), as amended by section 7001(a)(2) of the Supplemental Appropriations Act, 2008 (Public Law 110–252), is amended by inserting “(July 1, 2009, in the case of the final regulation relating to school-based administration and school-based transportation)” after “April 1, 2009,”.

(c) FINAL REGULATION RELATING TO OUTPATIENT HOSPITAL FACILITY SERVICES.—Notwithstanding any other provision of law, with respect to expenditures for services furnished during the period beginning on December 8, 2008, and ending on June 30, 2009, the Secretary of Health and Human Services shall not 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 implement the final regulation relating to clarification of the definition of outpatient hospital facility services under the Medicaid program published on November 7, 2008 (73 Federal Register 66187).

(d) SENSE OF CONGRESS.—It is the sense of Congress that the Secretary of Health and Human Services should not promulgate as final regulations any of the following proposed Medicaid regulations:

(1) COST LIMITS FOR CERTAIN PROVIDERS.—The proposed regulation published on January 18, 2007, (72 Federal Register 2236) (and the purported final regulation published on May 29, 2007 (72 Federal Register 29748) and determined by the United States District Court for the District of Columbia to have been “improperly promulgated”, *Alameda County Medical Center, et al., v. Leavitt, et al.*, Civil Action No. 08-0422, Mem. at 4 (D.D.C. May 23, 2008)).

(2) PAYMENTS FOR GRADUATE MEDICAL EDUCATION.—The proposed regulation published on May 23, 2007 (72 Federal Register 28930).

(3) REHABILITATIVE SERVICES.—The proposed regulation published on August 13, 2007 (72 Federal Register 45201).

SEC. 5004. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA).

(a) 18-MONTH EXTENSION.—

(1) IN GENERAL.—Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are

each amended by striking “September 30, 2003” and inserting “December 31, 2010”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on July 1, 2009.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a)(1), by inserting “but subject to paragraph (5)” after “Notwithstanding any other provision of this title”;

(2) by adding at the end of subsection (a) the following:

“(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.”; and

(3) in subsection (b)(1), by inserting “but subject to subsection (a)(5)” after “Notwithstanding any other provision of this title”.

(c) REMOVAL OF REQUIREMENT FOR PREVIOUS RECEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of such Act (42 U.S.C. 1396r–6(a)(1)), as amended by subsection (b)(1), is further amended—

(1) by inserting “subparagraph (B) and” before “paragraph (5)”;

(2) by redesignating the matter after “REQUIREMENT.—” as a subparagraph (A) with the heading “IN GENERAL.—” and with the same indentation as subparagraph (B) (as added by paragraph (3)); and

(3) by adding at the end the following:

“(B) STATE OPTION TO WAIVE REQUIREMENT FOR 3 MONTHS BEFORE RECEIPT OF MEDICAL ASSISTANCE.—A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for fewer than three months or that had applied for and was eligible for such aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.”.

(d) CMS REPORT ON ENROLLMENT AND PARTICIPATION RATES UNDER TMA.—Section 1925 of such Act (42 U.S.C. 1396r–6), as amended by this section, is further amended by adding at the end the following new subsection:

“(g) COLLECTION AND REPORTING OF PARTICIPATION INFORMATION.—

“(1) COLLECTION OF INFORMATION FROM STATES.—Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State’s child health plan under title XXI. Such information shall be submitted at the same time and frequency in which other enrollment information under this title is submitted to the Secretary.

“(2) ANNUAL REPORTS TO CONGRESS.—Using the information submitted under paragraph (1), the Secretary shall submit

to Congress annual reports concerning enrollment and participation rates described in such paragraph.”

(e) EFFECTIVE DATE.—The amendments made by subsections (b) through (d) shall take effect on July 1, 2009.

SEC. 5005. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking “December 2009” and inserting “December 2010”.

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) of such Act (42 U.S.C. 1396u–3(g)) is amended—

(1) in paragraph (2)—

(A) by striking “and” at the end of subparagraph (K);

(B) in subparagraph (L), by striking the period at the end and inserting a semicolon; and

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

“(M) for the period that begins on January 1, 2010, and ends on September 30, 2010, the total allocation amount is \$412,500,000; and

“(N) for the period that begins on October 1, 2010, and ends on December 31, 2010, the total allocation amount is \$150,000,000.”; and

(2) in paragraph (3), in the matter preceding subparagraph

(A), by striking “or (L)” and inserting “(L), or (N)”.

SEC. 5006. PROTECTIONS FOR INDIANS UNDER MEDICAID AND CHIP.

(a) PREMIUMS AND COST SHARING PROTECTION UNDER MEDICAID.—

(1) IN GENERAL.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended—

(A) in subsection (a), in the matter preceding paragraph

(1), by striking “and (i)” and inserting “, (i), and (j)”;

and

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

“(j) NO PREMIUMS OR COST SHARING FOR INDIANS FURNISHED ITEMS OR SERVICES DIRECTLY BY INDIAN HEALTH PROGRAMS OR THROUGH REFERRAL UNDER CONTRACT HEALTH SERVICES.—

“(1) NO COST SHARING FOR ITEMS OR SERVICES FURNISHED TO INDIANS THROUGH INDIAN HEALTH PROGRAMS.—

“(A) IN GENERAL.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this title.

“(B) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such title, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost

sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

“(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this title who is an Indian.”

(2) CONFORMING AMENDMENT.—Section 1916A(b)(3) of such Act (42 U.S.C. 1396o–1(b)(3)) is amended—

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

“(vii) An Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.”; and (B) in subparagraph (B), by adding at the end the following new clause:

“(x) Items and services furnished to an Indian directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.”.

(b) TREATMENT OF CERTAIN PROPERTY FROM RESOURCES FOR MEDICAID AND CHIP ELIGIBILITY.—

(1) MEDICAID.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by sections 203(c) and 211(a)(1)(A)(ii) of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by adding at the end the following new subsection:

“(ff) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this title:

“(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe’s reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

“(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

“(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

“(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.”.

(2) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 203(a)(2),

203(d)(2), 214(b), 501(d)(2), and 503(a)(1) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), is amended—

(A) by redesignating subparagraphs (C) through (I), as subparagraphs (D) through (J), respectively; and

(B) by inserting after subparagraph (B), the following new subparagraph:

“(C) Section 1902(ff) (relating to disregard of certain property for purposes of making eligibility determinations).”

(c) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Section 1917(b)(3) of the Social Security Act (42 U.S.C. 1396p(b)(3)) is amended—

(1) by inserting “(A)” after “(3)”; and

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

“(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this title for Indians.”

(d) RULES APPLICABLE UNDER MEDICAID AND CHIP TO MANAGED CARE ENTITIES WITH RESPECT TO INDIAN ENROLLEES AND INDIAN HEALTH CARE PROVIDERS AND INDIAN MANAGED CARE ENTITIES.—

(1) IN GENERAL.—Section 1932 of the Social Security Act (42 U.S.C. 1396u-2) is amended by adding at the end the following new subsection:

“(h) SPECIAL RULES WITH RESPECT TO INDIAN ENROLLEES, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—

“(1) ENROLLEE OPTION TO SELECT AN INDIAN HEALTH CARE PROVIDER AS PRIMARY CARE PROVIDER.—In the case of a non-Indian Medicaid managed care entity that—

“(A) has an Indian enrolled with the entity; and

“(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1903(m) or under section 1905(t)(3) shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

“(2) ASSURANCE OF PAYMENT TO INDIAN HEALTH CARE PROVIDERS FOR PROVISION OF COVERED SERVICES.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require any such entity, as a condition of receiving payment under such contract, to satisfy the following requirements:

“(A) DEMONSTRATION OF ACCESS TO INDIAN HEALTH CARE PROVIDERS AND APPLICATION OF ALTERNATIVE PAYMENT ARRANGEMENTS.—Subject to subparagraph (C), to—

“(i) demonstrate that the number of Indian health care providers that are participating providers with respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those Indian enrollees who are eligible to receive services from such providers; and

“(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered Medicaid managed care services provided to those Indian enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

The Secretary shall establish procedures for applying the requirements of clause (i) in States where there are no or few Indian health providers.

“(B) PROMPT PAYMENT.—To agree to make prompt payment (consistent with rule for prompt payment of providers under section 1932(f)) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (C) applies, that the entity is required to pay in accordance with that subparagraph.

“(C) APPLICATION OF SPECIAL PAYMENT REQUIREMENTS FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—

“(i) FEDERALLY-QUALIFIED HEALTH CENTERS.—

“(I) MANAGED CARE ENTITY PAYMENT REQUIREMENT.—To agree to pay any Indian health care provider that is a federally-qualified health center under this title but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.

“(II) CONTINUED APPLICATION OF STATE REQUIREMENT TO MAKE SUPPLEMENTAL PAYMENT.—Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1902(bb)(5) regarding the State plan requirement to make any supplemental payment due under such section to a federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless

of whether the federally-qualified health center is or is not a participating provider with the entity).

“(ii) PAYMENT RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—If the amount paid by a managed care entity to an Indian health care provider that is not a federally-qualified health center for services provided by the provider to an Indian enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian health care provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

“(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as waiving the application of section 1902(a)(30)(A) (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

“(3) SPECIAL RULE FOR ENROLLMENT FOR INDIAN MANAGED CARE ENTITIES.—Regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities, an Indian Medicaid managed care entity may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

“(4) DEFINITIONS.—For purposes of this subsection:

“(A) INDIAN HEALTH CARE PROVIDER.—The term ‘Indian health care provider’ means an Indian Health Program or an Urban Indian Organization.

“(B) INDIAN MEDICAID MANAGED CARE ENTITY.—The term ‘Indian Medicaid managed care entity’ means a managed care entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C)) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

“(C) NON-INDIAN MEDICAID MANAGED CARE ENTITY.—The term ‘non-Indian Medicaid managed care entity’ means a managed care entity that is not an Indian Medicaid managed care entity.

“(D) COVERED MEDICAID MANAGED CARE SERVICES.—The term ‘covered Medicaid managed care services’ means, with respect to an individual enrolled with a managed care entity, items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

“(E) MEDICAID MANAGED CARE PROGRAM.—The term ‘Medicaid managed care program’ means a program under sections 1903(m), 1905(t), and 1932 and includes a managed care program operating under a waiver under section 1915(b) or 1115 or otherwise.”.

(2) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(1)), as amended by subsection (b)(2), is amended—

(A) by redesignating subparagraph (J) as subparagraph (K); and

(B) by inserting after subparagraph (I) the following new subparagraph:

“(J) Subsections (a)(2)(C) and (h) of section 1932.”.

(e) CONSULTATION ON MEDICAID, CHIP, AND OTHER HEALTH CARE PROGRAMS FUNDED UNDER THE SOCIAL SECURITY ACT INVOLVING INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.—

(1) CONSULTATION WITH TRIBAL TECHNICAL ADVISORY GROUP (TTAG).—The Secretary of Health and Human Services shall maintain within the Centers for Medicaid & Medicare Services (CMS) a Tribal Technical Advisory Group (TTAG), which was first established in accordance with requirements of the charter dated September 30, 2003, and the Secretary of Health and Human Services shall include in such Group a representative of a national urban Indian health organization and a representative of the Indian Health Service. The inclusion of a representative of a national urban Indian health organization in such Group shall not affect the nonapplication of the Federal Advisory Committee Act (5 U.S.C. App.) to such Group.

(2) SOLICITATION OF ADVICE UNDER MEDICAID AND CHIP.—

(A) MEDICAID STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 501(d)(1) of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), (42 U.S.C. 1396a(a)) is amended—

(i) in paragraph (71), by striking “and” at the end;

(ii) in paragraph (72), by striking the period at the end and inserting “; and”; and

(iii) by inserting after paragraph (72), the following new paragraph:

“(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

“(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

“(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this title.”.

(B) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(1)), as amended by subsections (b)(2) and (d) (2), is amended—

(i) by redesignating subparagraphs (B), (C), (D), (E), (F), (G), (H), (I), (J), and (K) as subparagraphs (D), (F), (B), (E), (G), (I), (H), (J), (K), and (L), respectively;

(ii) by moving such subparagraphs so as to appear in alphabetical order; and

(iii) by inserting after subparagraph (B) (as so redesignated and moved) the following new subparagraph:

“(C) Section 1902(a)(73) (relating to requiring certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).”.

(3) **RULE OF CONSTRUCTION.**—Nothing in the amendments made by this subsection shall be construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians.

(f) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on July 1, 2009.

SEC. 5007. FUNDING FOR OVERSIGHT AND IMPLEMENTATION.

(a) **OVERSIGHT.**—For purposes of ensuring the proper expenditure of Federal funds under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), there is appropriated to the Office of the Inspector General of the Department of Health and Human Services, out of any money in the Treasury not otherwise appropriated and without further appropriation, \$31,250,000 for fiscal year 2009, which shall remain available for expenditure until September 30, 2011, and shall be in addition to any other amounts appropriated or made available to such Office for such purposes.

(b) **IMPLEMENTATION OF INCREASED FMAP.**—For purposes of carrying out section 5001, there is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated and without further appropriation, \$5,000,000 for fiscal year 2009, which shall remain available for expenditure until September 30, 2011, and shall be in addition to any other amounts appropriated or made available to such Secretary for such purposes.

SEC. 5008. GAO STUDY AND REPORT REGARDING STATE NEEDS DURING PERIODS OF NATIONAL ECONOMIC DOWNTURN.

(a) **IN GENERAL.**—The Comptroller General of the United States shall study the period of national economic downturn in effect on the date of enactment of this Act, as well as previous periods of national economic downturn since 1974, for the purpose of developing recommendations for addressing the needs of States during such periods. As part of such analysis, the Comptroller General shall study the past and projected effects of temporary increases in the Federal medical assistance percentage under the Medicaid program with respect to such periods.

(b) **REPORT.**—Not later than April 1, 2011, the Comptroller General of the United States shall submit a report to the appropriate committees of Congress on the results of the study conducted under paragraph (1). Such report shall include the following:

(1) Such recommendations as the Comptroller General determines appropriate for modifying the national economic downturn assistance formula for temporary adjustment of the

Federal medical assistance percentage under Medicaid (also referred to as a “countercyclical FMAP”) described in GAO report number GAO–07–97 to improve the effectiveness of the application of such percentage in addressing the needs of States during periods of national economic downturn, including recommendations for—

(A) improvements to the factors that would begin and end the application of such percentage;

(B) how the determination of the amount of such percentage could be adjusted to address State and regional economic variations during such periods; and

(C) how the determination of the amount of such percentage could be adjusted to be more responsive to actual Medicaid costs incurred by States during such periods.

(2) An analysis of the impact on States during such periods of—

(A) declines in private health benefits coverage;

(B) declines in State revenues; and

(C) caseload maintenance and growth under Medicaid, the Children’s Health Insurance Program, or any other publicly-funded programs to provide health benefits coverage for State residents.

(3) Identification of, and recommendations for addressing, the effects on States of any other specific economic indicators that the Comptroller General determines appropriate.

TITLE VI—BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM

SEC. 6000. TABLE OF CONTENTS.

The table of contents of this title is as follows:

TITLE VI—BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM

Sec. 6000. Table of contents.

Sec. 6001. Broadband Technology Opportunities Program.

SEC. 6001. BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM.

(a) The Assistant Secretary of Commerce for Communications and Information (Assistant Secretary), in consultation with the Federal Communications Commission (Commission), shall establish a national broadband service development and expansion program in conjunction with the technology opportunities program, which shall be referred to as the Broadband Technology Opportunities Program. The Assistant Secretary shall ensure that the program complements and enhances and does not conflict with other Federal broadband initiatives and programs.

(b) The purposes of the program are to—

(1) provide access to broadband service to consumers residing in unserved areas of the United States;

(2) provide improved access to broadband service to consumers residing in underserved areas of the United States;

(3) provide broadband education, awareness, training, access, equipment, and support to—

(A) schools, libraries, medical and healthcare providers, community colleges and other institutions of higher education, and other community support organizations and