THE PRESIDENT'S MEDICAID REFORM PROPOSAL

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1. OVERVIEW

The President's Medicaid proposal achieves significant reform and offers:

- **Responsive and responsible Federal funding:**
  - Federal funding is not fixed but responds to unexpected costs due to recessions or increases in the number of aged or disabled beneficiaries.
  - Federal reductions are responsible, providing states with sufficient funds to maintain coverage for the millions of Americans who rely on Medicaid.

- **State flexibility:** The top concerns of the Governors have been addressed, including:
  - Repeal of the Boren Amendment regulating provider payments;
  - End to the burdensome waiver process for managed care and home and community-based waivers;
  - Eligibility simplification and expansions without waivers; and
  - Elimination of many unnecessary and duplicative administrative requirements.

2. FINANCING

The President has proposed to reform Medicaid financing through a **Per Capita Cap** and **Disproportionate Share Hospital (DSH) payment changes**.

- Responsiveness: A per capita cap maintains the responsiveness of Federal funding to states' unexpected costs.
    - Under the President's proposal, the Federal government shares in the unexpected costs due to recessions or increases in the number of aged or disabled beneficiaries.

- Responsible: The per capita cap and Disproportionate Share Hospital payment reductions achieve responsible levels of Federal savings.
    - The President's proposal provides states with sufficient Federal funds to maintain coverage for the millions of Americans who rely on Medicaid.

The following section reviews:

- Responsive and Responsible Federal Financing
- Per Capita Cap: What Is It
- Per Capita Cap: How Does It Work and Adapt to Enrollment Changes
- Per Capita Cap: Adapting to State Spending
- Disproportionate Share Hospital (DSH) Changes and Pool Payments

Responsive and Responsible Federal Financing

The President's proposal maintains the Federal commitment to share in states' Medicaid costs:

- Protection from recession. During a period of economic recession, enrollment will increase, causing state costs to rise. The Center on Budget and Policy Priorities estimates that Medicaid costs could increase by at least $26 billion over seven years if there is a recession similar to the one experienced in the early 1980s. Under a per capita cap, the Federal government shares in these unexpected costs.

- Protection from changes in Medicaid caseload. States may find themselves with greater proportions of costly persons such as seniors or people with disabilities. The per capita cap adapts to shifts in the types of beneficiaries covered by a state, increasing Federal payments to states if their patient population becomes sicker.

The President's proposal also takes a responsible and not a radical amount of savings from the Medicaid program.

- President's plan saves the Federal government $59 billion over seven years.

- Republicans' plan saves the Federal government $85 billion over seven years.

    - This is $26 billion -- or 44 percent -- higher than the savings proposed by the President.

    - Under the Republican plan, spending growth per beneficiary would average 2 percent over the period-- less than inflation and significantly below private spending growth per person (7 percent). By 2000, the rates are very low since the Republican cuts are backloaded, taking effect after the turn of the century.

    - By 2002, Federal funding to states will be inadequate and states will be forced to reduce payments, benefits and deny coverage for millions of Americans.

Per Capita Cap: What Is It

- A "per capita cap" is a policy that limits Federal Medicaid spending growth per beneficiary. Under this policy, Federal payments automatically adjust to a state's enrollment: if a state has an unexpected increase in enrollment, the Federal government will share in these increased costs. In other words, Federal money will flow with the number of needy persons a state serves.

  There are three components to the per capita limit on Federal funding:

  - Base spending: Each state's 1995 spending per beneficiary is calculated, excluding spending items such as payments for Medicare premiums and cost-sharing and Disproportionate Share Hospital payments. The spending per beneficiary is separated for the four major groups of Medicaid beneficiaries: seniors, people with disabilities, adults and children.

  - Index: Future year spending limits will be calculated by growing the average 1995 spending per beneficiary by a pre-set "index". The index updates the 1995 spending in proportion to the growth in the gross domestic product per person. In the President's proposal, the index averages approximately 5 percent between 1996 and 2002.

  - Actual enrollment: This indexed spending per beneficiary is then multiplied by the number of beneficiaries in each category in a given year. The category-specific limits are then added together to yields the maximum spending that the Federal government will match.

  Each state will have a single total limit, so it can use savings from one group to support expenditures for other groups or to expand benefits or coverage.

Per Capita Cap: How Does It Work and Adapt to Enrollment Changes

- To give an example of how the formula works, take a hypothetical state:

	1995 Spending per Beneficiary	2000 Limit per Beneficiary *	Enrollment in 2000	Total Limit (Millions)	Federal Limit (Millions)**
Elderly	$9,000	$11,487	1,000	$11.5	
Disabled	$8,000	$10,210	2,000	$20.4	
Adults	$2,000	$2,553	3,000	$7.7	
Children	$1,000	$1,276	6,000	$7.7	
Total				$47.2	**$23.6**

* Index is 5% per year, or 28% growth between 1995 and 2000.
** Assumes that the Federal medical assistance rate is 50%.

- In the year 2000, the maximum Federal matching payments for this state would be $23.6 million.

The cap adapts automatically to state enrollment changes

- If enrollment in these categories increases above the levels noted above, the total and Federal limit would increase automatically -- because the limit is calculated on a per person basis.

- If enrollment shifts to more expensive populations or enrollment grows faster than expected, then the total limit would increase automatically.

    - For example, if there are 500 more seniors than noted above, then the total limit would increase by $5.7 million (500 seniors times $11,487 limit per senior), and the Federal limit would increase by around $2.85 million.

Per Capita Cap: Adapting to State Spending

- If the state keeps spending per beneficiary below the limit for one or more categories of beneficiary, it has a number of options. For example, assume that the state kept spending for the elderly to $10,376 per elderly beneficiary ($1,000 below the limit per beneficiary). That would free up $1 million within the state's aggregate limit ($1,000 per enrollee times 1,000 seniors). The state could:

    - Spend above its per beneficiary limit for another group. For example, the state could spend $150 more per child -- a total of $1,426 per child -- for a total cost of $0.9 million ($150 per child times 6,000 children) and still remain within its aggregate limit.

    - Use the funds to expand eligibility to new groups whose income is within the 150 percent of poverty level (see Eligibility Flexibility).

    - Save the state share of the funds.

Disproportionate Share Hospital (DSH) Changes and Pool Payments

Disproportionate Share Hospital Payments Changes:

- Disproportionate Share Hospital (DSH) payments would be reduced and retargeted.
    - Financing: The current (1995) Federal payments to states would be gradually phased out, and a new DSH payment method would be phased in. Funding from a fixed Federal pool would be allotted to states on the basis of their share of low-income days for eligible hospitals.
    - Program Design: States would use the funds for hospitals that serve a high number of uninsured and Medicaid patients, and would have the flexibility to cover additional hospitals that they deem needy.

Pool Payments:

- Three pools of grant funding would be created to ease the transition to the reformed Medicaid program.
    - **Undocumented Persons Pool:** A $3.5 billion pool to help the 15 states with the largest numbers of undocumented persons would be created. This 100 percent Federal pool would be in effect from 1997 to 2001, and would be allocated to states in proportion to their share of the nation's undocumented persons. It would be used by states for emergency care for these persons.
    - **Federally Qualified Health Centers and Rural Health Clinics Pool:** As part of the proposed changes to promote state flexibility, the mandate for states to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) on a cost basis would be repealed. To ease the change in funding for these facilities, a program would be created with $500 million in Federal funds in each year beginning in 1997.
    - **Transition Pool:** For 1997 through 1999, $3.5 billion in Federal funds would be given to states to enable a smooth transition to the reformed Medicaid program.

3. FLEXIBILITY

The President's Medicaid proposal significantly increases states' flexibility to design and managed their own Medicaid programs.

- The President's plan addresses the top concerns of the Governors:
  - Repeal of the Boren Amendment regulating provider payments;
  - End to the burdensome waiver process for managed care and home- and community-based waivers;
  - Eligibility simplification and expansions without waivers; and
  - Elimination of many unnecessary and duplicative administrative requirements.

The following section describes new state flexibility in the following areas:

- Provider Payment Flexibility
- Managed Care Flexibility
- Eligibility and Benefits Flexibility
- Administrative Flexibility

Provider Payment Flexibility

The President's plan gives states greater flexibility in setting provider payment rates:

- **Boren Amendment is Repealed**: (NGA Recommendation) The proposal repeals the Boren Amendment, allowing states greater discretion in establishing their provider payment rates. Under the Boren Amendment, states were required states to pay hospitals and nursing homes "adequate" and "reasonable" rates. Because of its ambiguity, this requirement led to many costly lawsuits for states.

- **Cost-Based Reimbursement for Clinics is Repealed:** (NGA Recommendation) States will no longer be required to pay Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that are not Indian Health Service facilities on a cost basis beginning in FY 1999.

- **Burdensome Standards for Obstetrician and Pediatrician Payments are Eliminated:** (NGA Recommendation) States currently must file extensive documentation relating to their payments for these providers. Under the proposal, states could set their own payment standards for obstetricians and pediatricians and would be freed from the paperwork burden that can range from 30 pages to 300 pages.

- **Requirement to Pay for Private Insurance When Cost Effective is Repealed:** (NGA Recommendation) Under current law, states are required to enroll individuals in private insurance in certain situations, when private insurance is more cost effective. States will have the option to continue purchasing group insurance and negotiate their own rates.

Managed Care Flexibility

Under the President's proposal, states will have new flexibility to implement and operate Medicaid managed care programs.

- **Elimination of Need for a Waiver:** (NGA Recommendation) States will be able to implement managed care programs without the need for Federal waivers, so long as beneficiaries have a choice of plans, except in rural areas. States will be permitted to enroll Medicaid beneficiaries into their health plans for up to six months and to guarantee Medicaid eligibility during this enrollment period.

- **Outdated Quality Standards are Repealed:** (NGA Recommendation) The 75/25 enrollment composition rule will be eliminated.

  Quality of care will be assured through state-designed quality improvement programs -- which follow Federal guidelines -- that ensure that managed care providers maintain reasonable access to quality health care.

- **Federal Contract Review is Eliminated**: The Federal government will no longer review states' contracts with managed care plans that exceed $100,000.

- **HMO Copayments are Allowed:** (NGA Recommendation) States will be able to require HMO enrollees to make nominal copayments, consistent with their ability to require copayments in fee-for-service settings.

Eligibility and Benefits Flexibility

The President's proposal maintains the Federal entitlement and keeps Medicaid basic benefits intact. It builds upon this base to offer states options for simplifying and expanding eligibility and designing community-based long-term care programs.

- **Eligibility Expansions are Allowed Without Waivers:** If states are able to manage costs below their per capita limits, they may add any new eligibility group at their discretion. This means that if states want to expand coverage, they may do so without a waiver and to any group of low-income people. The only limits on this flexibility are that the new beneficiaries' income is less than 150 percent of the poverty level, and the expansion does not result in spending above the per capita limit.

    - In the example of the how a per capita cap would work, the state could, under one scenario, spend $1,000 less than its limit per senior ($10,476). With 1,000 senior enrollees, that would free up $1 million within the state's aggregate limit ($1,000 per enrollee times 1,000 senior enrollees).

    - With this $1 million, the state could choose to add 500 individuals with spending of $2,000 per person and still be within their limit.

- **Eligibility Expansions can be Scaled Back:** (NGA Recommendation) Under current law, a state that chooses to cover pregnant women and children above the mandatory levels cannot reverse that decision. This mandate is repealed, so states can return to the minimum level.

- **Home and Community-Based Care Programs are Allowed Without Waivers:** (NGA Recommendation) States will be able to provide home and community-based services to their elderly and disabled Medicaid enrollees without the administrative burden of seeking Federal waivers.

Administrative Flexibility

The President's plan repeals and simplifies Federal administrative requirements for the Medicaid program.

- **Certain Personnel and Program Requirements are Repealed:** The current Federal mandates to document the establishment and maintenance of merit-based personnel standards, and to use professional medical personnel in administration and supervision, are duplicative and are repealed. Also repealed is the obligation to enter into cooperative agreements with other state agencies.

- **Data Requirements are Streamlined**: Medicaid Management Information System (MMIS) requirements for the use of standardized claims formats and standardized HCFA reporting requirements will be simplified and reduced. The Medicaid Eligibility Quality Control (MEQC) system will also be reformed. States will no longer have to go through the entire determination, adjudication, and cost accounting process every six months.

- **Nursing Home Resident Duplicative Reviews are Eliminated:** (NGA Recommendation) Required annual resident review in nursing homes will be repealed. States will conduct reviews when indicated.

- **Permissible Sites for Nurse-Aide Training are Broadened:** (NGA Recommendation) States will be able to conduct nurse-aide training in certain rural nursing homes, which currently are not considered permissible training sites.

- **Certain Federal Provider Qualifications Requirements are Repealed:** (NGA Recommendation) Special minimum qualifications for obstetricians and pediatricians will be repealed.

EXAMPLES OF FLEXIBILITY IN PRESIDENT CLINTON'S PER CAPITA CAP MEDICAID PLAN

OVERVIEW

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- Reforming Medicaid Eligibility Quality Control (MEQC)
- Revise and Simplify Medicaid Management Information System Requirements
- Provider Qualifications for Obstetricians and Pediatricians
- Elimination of Requirements to Pay for Private Health Insurance
- Elimination of Personnel Requirements
- Elimination of Requirements for Cooperative Agreements
- Elimination of Requirements for Preadmission Screening and Annual Resident Review (PASARR)

EXAMPLES OF STATE FLEXIBILITY IN PRESIDENT CLINTON'S PER CAPITA CAP MEDICAID PROPOSAL

I. IMPLEMENTING MANAGED CARE

REPEAL OF REQUIREMENT FOR FEDERAL WAIVERS FOR MANAGED CARE

Administration Proposal:

The Administration's proposal would allow states to implement managed care programs without the need for Federal waivers. States could implement managed care programs with a state plan amendment.

- 43 States will no longer need to apply for waivers or waiver renewals. These States have initiated 162 requests -- either initial waivers or renewals -- over the last three years.
- States can implement managed care by submitting state plan amendments.
- This simplified process will save states the considerable administrative burden associated with preparing freedom-of-choice waiver requests.

Background:

Currently, states must apply for Federal waiver approval to implement Medicaid managed care programs. Waiver requests are administratively burdensome and repetitive -- freedom-of-choice waivers must be renewed every two years. States generally spend three to six months preparing freedom-of-choice waiver requests, although this effort varies widely depending on the scope and complexity of the program. All but five states with freedom of choice waivers have more than one such waiver, each of which requires separate processing. HCFA's review and approval process must be completed within 90 days; however, this time period may be extended substantially if the State must provide additional information. See attached table for affected states.

FREEDOM OF CHOICE WAIVER ACTIVITY
(1993-1996)

State	1915(b) Freedom of Choice Waivers	State	1915(b) Freedom of Choice Waivers	State	1915(b) Freedom of Choice Waivers
Alabama	2	Kentucky	4	North Dakota	3
Alaska		Louisiana	2	Ohio	3
Arizona		Maine	3	Oklahoma	1
Arkansas	5	Maryland	3	Oregon	3
California	18	Massachusetts	3	Pennsylvania	7
Colorado	5	Michigan	5	Rhode Island	
Connecticut	1	Minnesota	2	South Carolina	2
Delaware		Mississippi	4	South Dakota	3
D.C.	2	Missouri	4	Tennessee	
Florida	4	Montana	2	Texas	7
Georgia	5	Nebraska	2	Utah	3
Hawaii		Nevada	1	Vermont	
Idaho	2	New Hampshire		Virginia	3
Illinois		New Jersey	1	Washington	14
Indiana	2	New Mexico	3	West Virginia	5
Iowa	4	New York	8	Wisconsin	4
Kansas	2	North Carolina	5	Wyoming	1
				TOTAL	**162**

The numbers indicated include approved and pending new waivers, renewals, and modifications.

REPEAL OF MANAGED CARE CONTRACTING RULES

Administration Proposal

Under the Administration proposal, States will be able to contract with Medicaid-only managed care plans. States will also be able to enroll Medicaid beneficiaries into managed care plans for up to six months at a time. Some States -- Hawaii and Rhode Island -- have developed demonstration programs in order to implement managed care programs with these features.

- States will no longer need to apply for demonstration authority to receive waivers of these statutory provisions.
- States will be able to contract with a broader range of managed care entities.
- Six-month lock-in provisions will attract more managed care plans to contract with Medicaid programs.

Background

Currently, Medicaid managed care plans must maintain a commercial enrollment base of twenty-five percent. This requirement -- the "75/25 rule" -- prohibits States from contracting with Medicaid-only managed care plans. In addition, Medicaid beneficiaries must be able to disenroll from most managed care plans on a month-to-month basis, thus disrupting enrollment stability.

If these provisions were repealed, the programmatic elements (but not eligibility expansions) of some demonstration programs (Hawaii and Rhode Island) could be operated without demonstration waivers. Other demonstration States, such as Oregon, require more complicated waivers of Medicaid law and would therefore still need waiver authority to operate their demonstration programs.

ELIMINATION OF REQUIREMENT FOR FEDERAL REVIEW OF HMO CONTRACTS OVER $100,000

Administration Proposal:

Under the Administration's proposal, states will no longer need to seek Secretarial approval for HMO Contracts over $100,000.

- All States with pre-paid managed care programs will avoid unnecessary and duplicative Federal oversight of their contracting and rate-setting procedures.
- This new flexibility will save states time and effort.

Background:

Currently, states must obtain HCFA's approval of all contracts with HMOs that exceed $100,000 in expenditures. This prior approval requirement represents an unnecessary double-check on the state's contracting and rate-setting procedures. HCFA approval generally takes between two and forty-five days.

See attached chart for state-by-state contract numbers.

FEDERAL PRIOR APPROVAL OF MANAGED CARE CONTRACTS

Annual estimate of State-by-State contract approvals:

State	Number of Contracts
Alabama	0.00
Alaska	0.00
Arizona	7
Arkansas	0.00
California	16
Colorado	7
Connecticut	11
Delaware	4
D.C.	4
Florida	30
Georgia	0.00
Hawaii	5
Idaho	0.00
Illinois	7
Indiana	2

State	Number of Contracts
Iowa	8
Kansas	6
Kentucky	0.00
Louisiana	0.00
Maine	0 (6-8 next year)
Maryland	6
Massachusetts	11
Michigan	12
Minnesota	9
Mississippi	0.00
Missouri	6
Montana	2
Nebraska	7
Nevada	0 (4 next year)
New Hampshire	3
New Jersey	25
New Mexico	0.00

State	Number of Contracts
New York	130
North Carolina	1
North Dakota	0.00
Ohio	14
Oklahoma	12
Oregon	36
Pennsylvania	9
Puerto Rico	2
Rhode Island	5
South Carolina	0.00
South Dakota	0.00
Tennessee	12
Texas	1 (8 next year)
Utah	5
Vermont	0.00
Virginia	10
Washington	30

State	Number of Contracts
West Virginia	0.00
Wisconsin	11
Wyoming	0.00
ESTIMATED TOTAL	**466**

II. FLEXIBILITY IN PROGRAM PAYMENT

REPEAL OF THE BOREN AMENDMENT

Administration Proposal:

The Boren Amendment will be repealed, and replaced with a process for notifying the public about facility rates. Thus, states can establish hospital and nursing home payment rates without federal requirements.

- States will have flexibility to negotiate payment rates with providers.
- States would no longer be required to submit assurances of the adequacy of their payment rates to HHS.
- States will no longer face law suits from providers demanding higher payments.

Background:

Under current requirements, states are required to assure that payment rates for institutional facilities are reasonable and adequate to meet the costs that must be incurred by an efficiently and economically operated facility.

Since 1984, plaintiffs have filed at least 173 cases alleging that States have failed to comply with the Boren Amendment. Under the Administration's proposal, these suits would not be possible.

ELIMINATION OF SPECIAL PAYMENT REQUIREMENTS FOR OBSTETRICIANS AND PEDIATRICIANS

Administration Proposal:

The current burdensome requirements for data collection to document that states are meeting special payment rate requirements for obstetricians and pediatricians will be repealed.

- States will no longer have to collect and submit data on payment rates for obstetrical and pediatric services.
- States will no longer have to submit state plan amendments for the Ob/Peds information that can range from 30 pages to over 300 pages in size.

Background

States are required to report the following information by April 1 of each year:

- payment rates for obstetrical and pediatric services for the coming year;
- data to document that the states' rates are sufficient to ensure access to these services is comparable to the access enjoyed by the general population;
- data that document that payment rates to HMOs take into account fee-for service payment rates for ob/ped services;
- data on the average statewide payment rates.

The data collection and analysis required to fulfill these requirements involve, on average, at least 5 people in each state Medicaid agency. In addition, staff from State licensing boards and provider offices are called upon to help states review and define data. Preparation of the final report alone takes, on average, 2 weeks. State plan amendments for the Ob/Peds information range from 30 pages to over 300 pages in size depending on the state.

III. FLEXIBILITY IN PROGRAM ELIGIBILITY

INCOME LEVEL FOR INFANTS AND PREGNANT WOMEN

Administration Proposal:

The 33 States that choose to cover pregnant women and infants above the minimum 133% of the Federal Poverty Level (FPL) will be given the option to lower this income eligibility threshold back to the minimum level. Currently, once a State chooses to expand Medicaid coverage to include populations at an income level above 133% FPL, they are prohibited from lowering the income threshold back to 133% FPL.

Background

States that used a percentage of poverty for eligibility level for pregnant women and infants that was above the minimum percentage required before OBRA 89 are currently prohibited from reducing that percentage.

The attached chart provides additional details on the affected states.

INCOME AND ELIGIBILITY LEVELS: INFANTS AND PREGNANT WOMEN

State	Percent of Poverty	Affected by Proposal
Alabama	133	
Alaska	133	
Arizona	140	x
Arkansas	133	
California	200*	x
Colorado	133	
Connecticut	185	x
Delaware	185	x
D.C.	185	x
Florida	185	x
Georgia	185	
Hawaii	300**	x
Idaho	133	
Illinois	133	
Indiana	150	x
Iowa	185	x
Kansas	150	x

State	Percent of Poverty	Affected by Proposal
Kentucky	185	x
Louisiana	133	
Maine	185	x
Maryland	185	x
Massachusetts	185	x
Michigan	185	x
Minnesota	275*	x
Mississippi	185	x
Missouri	185	x
Montana	133	
Nebraska	150	
Nevada	133	
New Hampshire	185	x
New Jersey	185	x
New Mexico	185	x
New York	185	x
North Carolina	185	x
North Dakota	133	

State	Percent of Poverty	Affected by Proposal
Ohio	133	
Oklahoma	150	x
Oregon	133	
Pennsylvania	185	x
Rhode Island	250**	
South Carolina	185	x
South Dakota	133	
Tennessee	185	x
Texas	185	x
Utah	133	
Vermont	225*	x
Virginia	133	
Washington	200*	x
West Virginia	150	x
Wisconsin	185	x
Wyoming	133	x

* States with effective income levels above the nominal statutory maximum use the authority in section 1902(r)(2) to disregard higher than usual amounts of income.

** States using higher income level as part of demonstration under section 1115.

IV. FLEXIBILITY IN PROGRAM BENEFITS

ENABLING STATES TO REQUIRE HEALTH MAINTENANCE ORGANIZATION ENROLLEES TO MAKE NOMINAL COPAYMENTS

Administration Proposal:

The Administration's proposal would allow States and health plans to require nominal copayments from Medicaid beneficiaries who are enrolled in HMOs to the extent that copayments could be imposed if the beneficiary were not enrolled in an HMO. For example, states could not require children to make copayments, nor charge copayments for pregnancy-related services or emergency services.

- States and health plans would have the flexibility to control unnecessary utilization better,
- States could reduce their capitation payments based on plans' anticipated copayment revenues, and
- Plans would still be required to provide services, regardless of enrollees' ability to make a copayment.

Background:

Currently, states cannot require categorically-eligible Medicaid beneficiaries who enroll in HMOs to make any type of cost-sharing payment, including copayments. This restriction prohibits States and Medicaid-contracting health plans from using all available tools to control unnecessary utilization of and payment for services.

ELIMINATION OF REQUIREMENT FOR FEDERAL WAIVERS FOR HOME AND COMMUNITY BASED SERVICES PROGRAMS

Administration Proposal:

States will be able to provide home and community-based services to their elderly and disabled Medicaid enrollees without the administrative burden of seeking Federal waivers.

- 49 States with a total of 517 home and community-based waiver programs will no longer need to obtain federal approval and renewal authority.
- States can provide tailored home and community-based services simply by submitting a state plan amendment.
- This simplification will save states approximately 6 months preparing new and renewal home and community-based waiver requests.

Background:

Currently, states must apply for Federal waiver approval to provide home and community-based services to elderly and disabled Medicaid beneficiaries. Waiver requests are administratively burdensome and repetitive because initial waiver approvals only last three years and must be renewed every five years. States spend approximately 180 hours to prepare each new and renewal home and community-based waiver request and approximately forty hours preparing an amendment to approved waivers. All 49 states with HCBS waivers have more than one such waiver, with separate processing requirements for each.

See attached chart for affected states.

HOME AND COMMUNITY-BASED WAIVER ACTIVITY
(1993-1996)

STATE	1915(C)HOME AND COMMUNITY-BASED WAIVERERS	STATE	1915(C) HOME AND COMMUNITY-BASED WAIVERS	STATE	1915(C)HOME AND COMMUNITY-BASED WAIVERS
Alabama	12	Kentucky	6	North Dakota	4
Alaska	12	Louisiana	12	Ohio	13
Arizona		Maine	12	Oklahoma	9
Arkansas	10	Maryland	8	Oregon	2
California	10	Massachusetts	3	Pennsylvania	14
Colorado	18	Michigan	12	Rhode Island	6
Connecticut	7	Minnesota	17	South Carolina	13
Delaware	7	Mississippi	6	South Dakota	8
D.C.		Missouri	11	Tennessee	15
Florida	17	Montana	5	Texas	22
Georgia	7	Nebraska	12	Utah	7
Hawaii	4	Nevada	9	Vermont	7
Idaho	4	New Hampshire	7	Virginia	7
Illinois	15	New Jersey	18	Washington	16
Indiana	24	New Mexico	4	West Virginia	3
Iowa	23	New York	15	Wisconsin	16
Kansas	7	North Carolina	13	Wyoming	8
				TOTAL	517

The numbers indicated include approved and pending new waivers, renewals, and modifications.

V. FLEXIBILITY IN STATE ADMINISTRATION

REFORMING MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC)

Administration Proposal:

The Administration's proposal reduces the complex accounting and individualized cost accounting currently required under MEQC, by requiring that states address only the numbers of ineligibles and the average cost per ineligible in the appropriate group.

- Details of spending on each ineligible case will not have to be documented, and
- Disallowances will not be distorted and excessively inflated when the ineligible sample includes a very few very high cost cases.

All states will benefit from this reduction in individualized tracking. Though only a few States have excessive error rates (the national average has hovered around 2 percent for several years), all states are currently required to go through the entire determination, adjudication, cost accounting process every six months.

Background:

Federal matching funds are disallowed to the extent that a State makes excessive errors in determining ineligible persons to be eligible for Medicaid or understates the amount of medical bill that a person must be responsible for before becoming eligible. "Excessive" means erroneous payments in excess of 3 percent of total payments. In certain circumstances, disallowances may be waived (e.g., if excessive errors are explained by events beyond the State's control).

REVISE AND SIMPLIFY MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) REQUIREMENTS

Administration proposal:

States would have new flexibility to design, structure, and operate their Medicaid Management Information Systems within general federal parameters rather being required to comply with the detailed systems design requirements and planning documentation requirements in effect today.

- All states will be able to operate MMIS systems that are more tailored to State circumstances and thus more cost-effective.
- The Secretary will retain appropriate oversight authority and the ability to enforce general Federal parameters, but the States will not be hamstrung by a Medicaid equivalent of "mandatory sentencing."
- Because current financial penalties for non-compliance will be repealed, HCFA's on-site reviews of State MMIS systems would be less frequent and less intrusive. States would no longer need to dedicate several staff members to month-long preparations for these reviews.

Background:

Currently, as a requirement for federal administrative matching, all States must operate a Medicaid Management Information System that meets highly detailed Federal requirements. Compliance is continuously and rigorously monitored. Non-compliance results in financial penalties, which are elaborated in considerable statutory detail.

PROVIDER QUALIFICATIONS FOR OBSTETRICIANS AND PEDIATRICIANS

Administration Proposal:

The administration proposal would eliminate the detailed minimum provider qualifications that specify requirements that must be met by physicians serving pregnant women and children.

The requirements that would be eliminated are difficult for practitioners in large urban and underserved rural states to meet. This proposal would make state licensure requirements the only qualification requirements practitioners serving pregnant women and children would have to meet.

Background:

Section 1903(I) establishes provider qualifications for physicians serving pregnant women and children. Physicians must be certified in family practice or pediatrics, affiliated with an FQHC, have admitting privileges at a hospital participating in a State plan, a member of the National Health Service Corps, or certified by the Secretary as qualified to provide physicians' services to pregnant women.

Implications of the current policy are significant.

-- New York estimated that only 1/3 of its physician provider population would remain eligible to treat pregnant women and children.

-- Rural states e.g., Montana have indicated that the only source of physician care in some counties is from physicians who do not meet one of the qualifications.

-- New Mexico conducted a quick review of disciplinary actions under licensure and found that all of the involved physicians met the Medicaid standards.

-- The AMA estimates that approximately one third of the nation's physicians are not board certified.

ELIMINATION OF REQUIREMENTS TO PAY FOR PRIVATE HEALTH INSURANCE

Administration proposal:

The current Federal requirements in this area would be repealed. States will have the option to purchase health insurance for their Medicaid population under flexible terms of negotiation with insurers. States will be free to negotiate benefit packages, premiums, and cost sharing rates (deductible and co-payments). States would continue to have the option to continue such "buy-out" kinds of programs -- particularly cost-effective "buy-out" arrangements.

Background:

Currently, states must pay premiums and all other cost-sharing obligations for a private insurance plan for Medicaid eligibles when this strategy provides cost-effective coverage.

Free of federal restrictions, states should be able to do a better job of restraining costs by moving people into private insurance. This is because Federal requirements require states to consider all cost-sharing related to private insurance. Because private plan deductibles and coinsurance amounts typically exceed the Medicaid rate for the same services, this requirement restricts the number of cases where a "buy-out" would be cost-effective. Also, the requirement is virtually impossible for states to administer since every plan may has different payment rules.

ELIMINATION OF PERSONNEL REQUIREMENTS

Administration proposal:

Prescriptive Federal personnel standards and requirements that currently must be met by states would be replaced with a simple requirement that states provide methods of administration which are necessary for the proper and efficient operation of the plan. The detailed state plan requirements and documentation currently required would be eliminated.

Background:

Federal statute and regulations mandate in some detail that states must provide methods of administration for the establishment and maintenance of merit system-based personnel standards, and states must use professional medical personnel for administration and supervision. Many of these federal requirements are duplicative of state requirements and processes. States are required to provide considerable documentation for this portion of their state plan.

ELIMINATION OF REQUIREMENT FOR COOPERATIVE AGREEMENTS

Administration Proposal:

The current requirements for entering into cooperative agreements with numerous other state agencies would be repealed. Also repealed would be any requirements that states provide documentation, as a part of their state plan, that the agreements are in place and current.

The repeal of these requirements would alleviate considerable administrative burden for states, and would allow flexibility to pursue management of Medicaid withing the circumstances within each state's administrative practices and circumstances.

Background:

Section 1902(a) requires that a State Plan must "provide for entering into cooperative arrangements" with other State agencies. Some States have interpreted this to mean they must submit state plan amendments with the actual agreements every time an agreement is established or there is a change to an existing agreement. The requirement, however, is for states only to indicate in their State plan that agreements exist and identify which agencies the agreements are with. States are not required to submit the actual agreements.

ELIMINATION OF REQUIREMENTS FOR PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR)

Administration proposal:

Replace the requirement for an annual resident review for all residents, with a requirement that States conduct an annual resident review on an exception basis. Under the Administration proposal, reviews would be conducted only when the NF resident assessment indicates a significant change in the physical or mental condition of the resident.

This would provide considerable administrative flexibility to focus scarce resources on those residents whose condition indicates there is a need for additional intervention and assessment. This proposal relieves the states of burdensome, costly, annual reviews of every resident which duplicate, in large part, the required evaluations and add little value to meeting the needs of residents.

Background:

States are required to perreform resident assessments promptly after admission, after a significant change in physical or mental condition and no less often than annually thereafter for all mentally retarded or mentally ill individuals residing in facilities.

Although each state administers their reviews differently, the state of Washington can be looked to as a case example. In 1991, Washington conducted 400 annual resident reviews at a cost of $750,000. Under the administration's proposal, the State of Washington's burden would be reduced significantly because duplicative reviews would be eliminated. However, the actual reduction cannot be quantified.

7-YEAR STATE TOTALS

Including Aliens Fund Allocations and non-Per Capita Supplemental Allocations

	House Floor	Senate Floor	Conference Formula	MediGrant II Formula	MediGrant II minus Conference
AL	12,668,142,230	12,864,348,427	12,864,348,427	13,665,345,135	800,996,708
AK	1,480,117,901	1,659,800,474	1,659,800,474	1,762,503,840	102,703,366
AZ	11,589,517,898	11,511,439,455	11,658,336,443	12,451,658,925	793,322,482
AR	8,117,060,109	8,573,602,836	8,573,602,836	9,107,436,919	533,834,083
CA	78,706,115,491	77,693,216,737	80,310,282,158	86,349,397,134	6,039,114,976
CO	6,236,058,035	6,342,964,250	6,367,455,344	6,862,650,788	495,195,444
CT	11,093,676,363	10,649,830,019	11,093,676,363	11,277,686,075	184,009,712
DE	1,342,469,608	1,719,690,612	1,719,690,612	1,826,099,795	106,409,183
DC	3,629,369,813	3,802,091,067	3,802,091,067	3,865,155,975	63,064,908
FL	30,869,381,269	31,262,055,451	33,045,129,389	35,333,353,698	2,288,224,309
GA	20,314,358,936	20,239,809,189	20,348,284,125	21,850,792,059	1,502,507,934
HI	2,288,248,065	2,450,176,852	2,450,176,852	2,490,817,693	40,640,841
ID	2,410,987,953	2,444,845,871	2,448,490,433	2,600,716,892	152,226,459
IL	27,273,533,390	28,850,803,391	29,056,303,847	31,614,009,361	2,557,705,514
IN	16,068,694,812	15,841,325,652	16,068,694,812	16,719,245,020	650,550,208
IA	6,870,884,877	6,873,944,016	6,873,944,016	7,152,239,531	278,295,515
KS	5,828,745,014	5,873,717,650	5,873,717,650	6,132,506,975	258,789,325
KY	13,374,434,382	13,297,903,704	13,374,434,382	14,207,191,515	832,757,133
LA	28,728,525,233	18,817,999,188	18,817,999,188	19,019,896,090	201,896,902
ME	5,264,114,507	5,155,030,527	5,264,114,507	5,351,429,853	87,315,346
MD	10,964,263,199	11,192,882,451	11,266,050,649	11,780,454,388	514,403,739
MA	21,765,171,500	19,835,170,224	21,815,266,920	22,212,066,111	396,799,191
MI	27,900,043,998	28,518,258,518	28,518,258,518	29,913,528,014	1,395,269,496
MN	12,722,300,804	13,120,993,108	13,601,788,179	13,827,399,694	225,611,515
MS	10,942,910,965	10,819,809,354	11,100,000,018	11,790,104,287	690,104,269
MO	15,192,679,647	15,337,876,193	15,337,876,193	16,477,169,838	1,139,293,645
MT	2,479,559,424	2,589,524,929	2,602,779,931	2,781,874,199	179,094,268
NE	3,552,378,091	3,662,386,215	3,662,386,215	3,751,844,814	89,458,599
NV	2,268,737,513	2,021,779,281	2,538,737,513	2,679,788,454	141,050,941

Colmac

	House Floor	Senate Floor	Conference Formula	MediGrant II Formula	MediGrant II minus Conference
NH	4,260,317,982	2,541,744,000	2,541,744,000	2,552,724,000	10,980,000
NJ	21,487,598,282	21,645,927,777	21,775,062,637	22,226,340,687	451,278,050
NM	5,280,952,628	5,576,877,642	5,605,163,411	5,967,438,267	362,274,856
NY	97,115,702,068	97,831,290,654	98,331,131,620	100,310,878,826	1,979,747,206
NC	20,418,103,739	21,298,136,897	21,298,136,897	22,515,745,600	1,217,608,703
ND	1,979,474,902	1,984,803,587	1,984,803,587	2,065,159,484	80,355,897
OH	32,641,759,233	32,948,194,248	33,200,000,033	34,544,120,832	1,344,120,799
OK	8,015,894,810	7,895,692,023	8,015,894,810	8,514,255,460	498,360,650
OR	7,330,985,186	8,959,695,944	8,981,960,575	9,360,602,246	378,641,671
PA	35,303,479,533	35,910,431,644	36,174,447,057	37,956,085,328	1,781,638,271
RI	3,915,115,700	4,137,811,786	4,137,811,786	4,206,445,261	68,633,475
SC	13,735,849,428	13,554,847,197	13,740,558,833	14,596,112,650	855,553,817
SD	2,005,501,364	2,162,869,900	2,162,869,900	2,302,067,441	139,197,541
TN	18,152,506,121	20,738,915,886	20,738,915,886	22,080,375,230	1,341,459,344
TX	54,781,582,369	54,156,902,513	55,272,604,685	59,809,760,919	4,537,156,234
UT	4,011,960,482	4,096,351,789	4,103,175,964	4,360,534,513	257,358,549
VT	1,617,361,605	1,867,610,068	1,919,175,467	2,004,690,075	85,514,608
VA	9,795,883,067	9,729,787,744	9,834,846,171	10,645,918,844	811,072,673
WA	13,061,603,791	13,121,913,869	13,405,310,816	13,650,964,390	245,653,574
WV	9,263,658,741	9,520,506,641	9,520,506,641	9,905,949,743	385,443,102
WI	13,548,954,321	14,069,093,279	14,069,093,279	14,638,688,486	569,595,207
WY	983,684,922	1,067,319,275	1,076,511,828	1,143,123,080	66,611,252

TOTALS

780,650,411,301	777,840,000,004	790,003,442,944	830,212,344,434	40,208,901,490

(Excludes funding for territories.)

Option, $50 Billion Savings, Excludes Illegal Alien Funds & Supplemental Per Capita Allotments, Scenario29

State	Federal Medicaid Grant FY 1996	Conference Federal Medicaid Grant FY 1997	% Differ-Ence	Conference Federal Medicaid Grant FY 1998	% Differ-Ence	Conference Federal Medicaid Grant FY 1999	% Differ-Ence	Conference Federal Medicaid Grant FY 2000	% Differ-Ence	Conference Federal Medicaid Grant FY 2001	% Differ-Ence	Conference Federal Medicaid Grant FY 2002
Alabama	1,517,652,207	1,654,240,906	9.00	1,791,292,445	8.28	1,937,038,505	8.14	2,088,106,544	7.80	2,251,714,895	7.84	2,425,299,634
Alaska	204,933,213	212,105,875	3.50	229,678,550	8.28	248,356,031	8.14	267,735,393	7.80	288,713,668	7.84	310,970,609
Arizona	1,370,781,297	1,494,151,613	9.00	1,617,839,980	8.28	1,749,581,453	8.14	1,886,029,971	7.00	2,033,805,011	7.84	2,190,591,074
Arkansas	1,011,457,933	1,102,489,147	9.00	1,193,828,827	8.28	1,290,963,078	8.14	1,391,644,224	7.80	1,500,683,017	7.84	1,618,370,696
California	8,940,838,461	9,762,331,048	9.11	10,732,885,577	9.94	11,780,805,443	9.76	12,863,335,925	9.36	14,094,665,585	9.40	15,398,535,196
Colorado	757,492,679	825,667,020	9.00	894,072,375	8.28	966,817,351	8.14	1,042,218,540	7.80	1,120,879,368	7.84	1,210,518,924
Connecticut	1,463,011,635	1,514,217,042	3.50	1,563,429,096	3.25	1,610,331,969	3.00	1,658,641,928	3.00	1,708,401,186	3.00	1,759,653,221
Delaware	212,327,763	219,759,235	3.50	237,965,890	8.28	257,327,756	8.14	277,396,536	7.80	299,131,246	7.84	322,191,279
District of Columbia	501,412,091	518,961,515	3.50	535,827,764	3.25	551,902,597	3.00	568,459,675	3.00	585,513,465	3.00	603,078,869
Florida	3,715,624,180	4,054,298,449	9.11	4,457,389,980	9.94	4,892,571,354	9.76	5,350,452,489	9.36	5,850,518,031	9.40	6,395,015,397
Georgia	2,426,320,602	2,544,689,456	9.00	2,663,798,270	8.28	3,096,807,295	8.14	3,338,324,751	7.80	3,577,466,656	7.73	3,850,949,872
Hawaii	323,124,375	334,433,728	3.50	345,302,824	3.25	355,661,909	3.00	366,331,766	3.00	377,321,719	3.00	388,641,371
Idaho	278,329,686	303,699,071	9.11	333,892,322	9.94	366,492,352	9.76	400,791,277	9.36	438,474,971	9.40	479,037,313
Illinois	3,467,274,342	3,783,311,848	9.11	4,159,442,348	9.94	4,544,209,317	9.25	4,831,804,001	6.33	5,104,385,380	5.64	5,387,703,332
Indiana	1,952,467,267	2,128,189,321	9.00	2,255,137,922	5.97	2,387,247,995	5.86	2,521,297,739	5.62	2,663,533,183	5.64	2,811,372,092
Iowa	835,235,895	910,407,125	9.00	984,713,812	5.97	1,021,228,408	5.86	1,078,572,732	5.62	1,139,419,113	5.64	1,202,662,356
Kansas	713,700,869	777,933,947	9.00	824,338,478	5.97	872,913,129	5.89	928,158,380	5.93	980,519,316	5.64	1,034,942,857
Kentucky	1,577,828,832	1,719,833,427	9.00	1,862,319,215	8.28	2,013,844,271	8.14	2,170,902,328	7.80	2,340,997,935	7.84	2,521,465,506
Louisiana	2,822,000,000	2,822,000,000	0.00	2,822,000,000	0.00	2,822,000,000	0.00	2,822,000,000	0.00	2,827,440,234	7.84	3,045,407,650
Maine	694,220,790	718,518,518	3.50	741,870,370	3.25	764,126,481	3.00	787,050,275	3.00	810,661,783	3.00	834,981,637
Maryland	1,369,699,847	1,492,972,834	9.00	1,582,030,142	5.97	1,674,708,340	5.86	1,768,746,309	5.62	1,868,526,633	5.84	1,972,240,964
Massachusetts	2,870,346,862	2,970,809,002	3.50	3,067,360,295	3.25	3,159,381,104	3.00	3,254,162,537	3.00	3,351,787,413	3.00	3,452,341,035
Michigan	3,465,182,886	3,777,049,346	9.00	4,002,354,081	5.97	4,269,938,554	6.69	4,540,176,017	6.33	4,798,304,573	5.64	5,062,522,557
Minnesota	1,793,776,356	1,856,568,528	3.50	1,916,896,680	3.25	1,974,403,581	3.00	2,033,635,688	3.00	2,094,644,759	3.00	2,157,484,102
Mississippi	1,261,781,330	1,376,791,043	9.11	1,513,669,292	9.94	1,661,458,450	9.76	1,816,949,302	9.36	1,987,784,396	9.40	2,171,670,395
Missouri	1,849,248,945	2,015,681,350	9.00	2,187,677,724	8.28	2,490,258,317	8.14	2,684,343,294	7.80	2,887,879,776	5.64	2,837,070,038
Montana	312,212,472	340,311,595	9.00	368,505,933	8.28	398,488,914	8.14	429,566,737	7.80	453,800,226	5.64	478,988,322
Nebraska	463,900,417	490,892,894	5.82	506,848,813	3.25	522,052,370	3.00	537,713,940	3.00	553,845,306	3.00	570,460,666
Nevada	257,696,453	281,403,377	9.11	309,360,027	9.94	339,586,786	9.76	371,367,977	9.36	406,284,777	9.40	443,869,377
New Hampshire	360,000,000	360,000,000	0.00	360,000,000	0.00	360,000,000	0.00	360,000,000	0.00	370,800,000	3.00	381,924,000
New Jersey	2,854,621,241	2,954,532,984	3.50	3,050,556,306	3.25	3,142,071,965	3.00	3,236,334,124	3.00	3,333,424,146	3.00	3,433,425,872
New Mexico	634,756,945	692,614,208	9.11	761,472,747	9.94	835,620,173	9.76	914,042,206	9.36	999,983,266	9.40	1,092,489,509
New York	12,901,793,038	13,353,355,795	3.50	13,787,339,858	3.25	14,200,960,054	3.00	14,626,988,856	3.00	15,065,798,521	3.00	15,517,772,477
North Carolina	2,587,883,809	2,820,793,352	9.00	3,019,820,982	7.06	3,222,018,776	6.70	3,425,935,132	6.33	3,619,705,120	5.64	3,820,088,421
North Dakota	241,168,563	262,873,733	9.00	278,554,412	5.97	294,872,636	5.86	311,430,384	5.62	328,902,354	5.64	347,260,401
Ohio	4,034,049,690	4,397,114,162	9.00	4,659,406,378	5.97	4,932,362,861	5.86	5,209,335,923	5.62	5,503,203,763	5.64	5,808,658,655
Oklahoma	911,198,775	994,250,347	9.11	1,093,100,342	9.94	1,199,826,679	9.76	1,312,114,573	9.36	1,435,483,838	9.40	1,569,277,606
Oregon	1,088,670,440	1,186,650,780	9.00	1,257,436,674	5.97	1,331,098,538	5.86	1,405,842,559	5.62	1,485,151,578	5.64	1,567,584,637
Pennsylvania	4,454,423,400	4,828,262,492	8.39	5,116,273,132	5.97	5,415,993,700	5.86	5,720,113,700	5.62	6,042,807,018	5.64	6,378,211,886
Rhode Island	545,686,262	564,785,281	3.50	583,140,803	3.25	600,635,027	3.00	618,654,078	3.00	637,213,700	3.00	656,330,111
South Carolina	1,821,021,815	1,766,913,779	9.00	1,913,300,108	8.28	2,068,973,154	8.14	2,230,330,487	7.80	2,405,062,533	7.84	2,590,400,494
South Dakota	262,804,959	286,457,405	9.00	309,413,478	8.01	330,130,841	6.70	351,924,285	6.33	370,826,597	5.64	391,409,574
Tennessee	2,519,934,251	2,746,728,333	9.00	2,968,036,424	8.06	3,188,766,904	6.70	3,367,186,428	6.33	3,557,142,191	5.64	3,754,580,700
Texas	6,351,809,343	6,900,877,545	9.11	7,619,930,730	9.94	8,363,916,313	9.76	9,146,670,250	9.36	9,974,809,539	9.05	10,740,346,489
Utah	484,274,254	527,856,937	9.00	571,591,310	8.28	618,098,055	8.14	666,303,014	7.80	718,509,515	7.84	773,899,426
Vermont	246,158,729	256,844,284	3.50	265,191,724	3.25	281,207,101	6.04	298,751,369	6.24	317,478,359	6.27	337,057,889
Virginia	1,144,962,509	1,249,324,339	9.11	1,373,530,063	9.94	1,507,636,537	9.76	1,648,731,736	9.36	1,759,934,936	6.74	1,895,004,770
Washington	1,763,460,996	1,825,182,131	3.50	1,884,500,550	3.25	1,941,035,567	3.00	1,999,266,534	3.00	2,059,244,633	3.00	2,121,021,972
West Virginia	1,156,813,157	1,260,926,342	9.00	1,336,141,847	5.97	1,414,413,462	5.86	1,493,838,012	5.62	1,578,111,382	5.54	1,665,703,841
Wisconsin	1,709,500,642	1,863,355,700	9.00	1,974,506,713	5.97	2,090,176,901	5.86	2,207,544,947	5.62	2,332,080,934	5.54	2,461,522,648
Wyoming	132,915,390	137,567,429	3.50	148,964,898	8.28	161,085,006	8.14	173,647,393	7.80	187,253,639	7.84	201,689,025
Subtotal: States & D	96,246,087,894	103,170,980,616	7.19	110,009,037,500	6.63	117,159,625,395	6.51	124,479,995,496	6.24	132,282,649,773	6.27	140,440,787,147
Subtotal: Territories	139,950,000	150,019,383	7.19	159,962,500	6.63	170,374,604	6.51	181,004,504	6.24	192,350,227	6.27	204,212,853
U.S. Total	96,386,037,894	103,321,000,000	7.19	110,169,000,000	6.63	117,340,000,000	6.51	124,660,999,999	6.24	132,474,999,999	6.27	140,644,999,999

Post Conferen

State	% Differ-ence	Total Federal Medicaid Grant FY 1996 - 2002
Alabama	7.71	13,865,345,135
Alaska	7.71	1,762,503,840
Arizona	7.71	12,342,880,299
Arkansas	7.71	9,107,436,919
California	9.25	83,599,397,104
Colorado	7.71	6,820,660,055
Connecticut	3.00	11,277,686,075
Delaware	7.71	1,826,099,795
District of Columbia	3.00	3,865,156,975
Florida	9.25	34,718,849,881
Georgia	7.67	21,797,3[illegible],944
Hawaii	3.00	2,490,817,600
Idaho	9.25	2,600,716,892
Illinois	5.55	31,278,131,498
Indiana	5.55	16,719,245,070
Iowa	5.55	7,152,239,531
Kansas	5.55	6,132,506,975
Kentucky	7.71	14,207,191,515
Louisiana	7.71	16,982,847,883
Maine	3.00	5,351,429,853
Maryland	5.55	11,728,927,870
Massachusetts	3.00	22,176,188,248
Michigan	5.55	29,913,528,014
Minnesota	3.00	13,827,399,694
Mississippi	9.25	11,790,104,287
Missouri	5.55	16,477,1[illegible],838
Montana	5.55	2,781,874,199
Nebraska	3.00	3,645,712,406
Nevada	9.25	2,409,788,454
New Hampshire	3.00	2,552,724,000
New Jersey	3.00	22,004,966,541
New Mexico	9.25	5,931,178,725
New York	3.00	99,454,008,597
North Carolina	5.55	22,515,745,600
North Dakota	5.55	2,065,159,484
Ohio	5.55	34,644,120,832
Oklahoma	9.25	8,514,[illegible],400
Oregon	5.55	9,322,434,307
Pennsylvania	5.55	37,956,085,328
Rhode Island	3.00	4,206,445,261
South Carolina	7.71	14,5[illegible],650
South Dakota	5.55	2,302,057,441
Tennessee	5.55	22,080,375,230
Texas	7.67	59,128,463,[illegible]
Utah	7.71	4,350,534,513
Vermont	6.17	2,004,690,075
Virginia	7.67	19,579,[illegible],651
Washington	3.00	13,593,712,482
West Virginia	5.55	9,905,949,743
Wisconsin	5.55	14,638,686,476
Wyoming	7.71	1,143,[illegible],000
Subtotal States & D	6.17	823,799,163,821
Subtotal Territories	6.17	1,197,874,070
U S Total	6.17	824,997,037,891

rost Conference Option, Scenario 29

Scenario29

Supplemental Allotment for Emergency Health Care to Undocumented Aliens as Provided Under Conference Agreement

State	Undocumented Alien Count	Undocumented Alien % of 0 States	Supplemental Allotments FY 1998	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
California	1,441	45.83%	287,833,333	434,858,333	471,166,667	494,083,333	518,375,000	543,583,333	0
New York	449	14.28%	89,685,751	135,528,308	146,810,433	153,951,018	161,520,038	169,374,682	0
Texas	357	11.35%	71,309,160	107,758,588	116,729,008	122,406,489	128,424,618	134,669,847	0
Florida	322	10.24%	64,318,066	97,194,020	105,284,987	110,405,852	115,833,969	121,466,921	0
Illinois	176	5.60%	35,155,216	53,124,682	57,547,074	60,346,056	63,312,977	66,391,858	0
New Jersey	116	3.69%	23,170,483	35,013,995	37,928,753	39,773,537	41,729,008	43,758,270	0
Arizona	57	1.81%	11,385,496	17,205,153	18,637,405	19,543,893	20,504,771	21,501,908	0
Massachusetts	46	1.43%	8,988,550	13,583,015	14,713,740	15,429,389	16,187,977	16,975,191	0
Virginia	35	1.11%	6,991,004	10,564,567	11,444,020	12,000,636	12,590,649	13,202,926	0
Washington	30	0.95%	5,992,386	9,055,344	9,809,160	10,286,260	10,791,985	11,316,791	0
Georgia	28	0.89%	5,592,875	8,451,654	9,155,216	9,600,509	10,072,519	10,562,341	0
Maryland	27	0.86%	5,393,130	8,149,809	8,828,244	9,257,834	9,712,786	10,185,115	0
Colorado	22	0.70%	4,394,402	6,640,565	7,193,384	7,543,257	7,914,122	8,298,982	0
Oregon	20	0.64%	3,994,911	6,036,896	6,539,440	6,857,506	7,194,656	7,544,529	0
New Mexico	19	0.60%	3,795,165	5,735,051	6,212,468	6,514,631	6,834,924	7,167,303	0
Sum of States	3,144	100.00%	628,000,000	949,000,000	1,028,000,000	1,078,000,000	1,131,000,000	1,186,000,000	0
Percentage Change From Previous Year				51.11%	8.32%	4.86%	4.92%	4.86%	

Note: Projections for FY 1997 through FY 2000 assume no change in any State's share of undocumented aliens.

Total Outlays	97,014,037,894	104,270,000,000	111,197,000,000	118,418,000,000	125,791,999,999	133,660,999,999	140,644,999,999
Illegal Alien Funding	628,000,000	949,000,000	1,028,000,000	1,078,000,000	1,131,000,000	1,186,000,000	0
Formula Amounts	96,386,037,894	103,321,000,000	110,169,000,000	117,340,000,000	124,660,999,999	132,474,999,999	140,644,999,999

ESTIMATE

1996 Thru 2000 Total
2,750,000,000
868,870,229
681,297,710
614,503,617
335,877,663
221,374,046
108,778,676
85,877,663
65,793,893
57,251,908
53,435,115
51,526,718
41,984,733
38,167,939
36,259,542
6,000,000,000

$830,997,037,891
6,000,000,000
924,997,037,891