TITLE II—COMMITTEE ON COMMERCE

Subtitle A—Restructuring Medicaid

SEC. 2001. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the "Medicaid Restructuring Act of 1996".

SEC. 2002. FINDING; GOALS FOR MEDICAID RESTRUCTURING.

(a) FINDING.—The Congress finds that the National Governors' Association on February 6, 1996, adopted unanimously and on a bipartisan basis goals to guide the restructuring of the medicaid program.

(b) GOALS FOR RESTRUCTURING.—The following are the 4 primary goals so adopted:

(1) The basic health care needs of the nation's most vulnerable populations must be guaranteed.

(2) The growth in health care expenditures must be brought under control.

(3) States must have maximum flexibility in the design and implementation of cost-effective systems of care.

(4) States must be protected from unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters.

SEC. 2003. RESTRUCTURING THE MEDICAID PROGRAM.

The Social Security Act is amended by inserting after title XIV the following new title:

"TITLE XV—PROGRAM OF MEDICAL ASSISTANCE FOR LOW-INCOME INDIVIDUALS AND FAMILIES

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"SEC. 1500. PURPOSE; STATE PLANS.

"(a) PURPOSE.—The purpose of this title is to provide funds to States to enable them to provide medical assistance to low-income individuals and families in a more effective, efficient, and responsive manner.

"(b) STATE PLAN REQUIRED.—A State is not eligible for payment under section 1512 unless the State has submitted to the Secretary under part C a plan (in this title referred to as a 'State plan') that—

"(1) sets forth how the State intends to use the funds provided under this title to provide medical assistance to needy individuals and families consistent with the provisions of this title, and

"(2) is approved under such part.

"(c) CONTINUED APPROVAL.—An approved State plan shall continue in effect unless and until—

"(1) the State amends the plan under section 1527,

"(2) the State terminates participation under this title under section 1528, or

"(3) the Secretary finds substantial noncompliance of the plan with the requirements of this title under section 1529.

"(d) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under part B.

"(e) EFFECTIVE DATE.—No State is eligible for payments under section 1512 for any calendar quarter beginning before October 1, 1996.

"PART A—ELIGIBILITY AND BENEFITS

"SEC. 1501. GUARANTEED ELIGIBILITY AND BENEFITS.

"(a) GUARANTEED COVERAGE AND BENEFITS FOR CERTAIN POPULATIONS.—

"(1) IN GENERAL.—Each State plan shall provide for making medical assistance available for benefits in the guaranteed benefit package (as defined in paragraph (2)) to individuals within each of the following categories:

"(A) POOR PREGNANT WOMEN.—Pregnant women with family income below 133 percent of the poverty line.

"(B) CHILDREN UNDER 6.—Children under 6 years of age whose family income does not exceed 133 percent of the poverty line.

"(C) CHILDREN 6 TO 12.—Children over 5 years of age, but under 13 years of age, whose family income does not exceed 100 percent of the poverty line.

"(D) DISABLED INDIVIDUALS.—As elected by the State under paragraph (3), either—

"(i) disabled individuals (as defined by the State) who meet the income and resource standards established under the plan, or

"(ii) individuals who are under 65 years of age, who are disabled (as determined under section 1614(a)(3)), and who, using the methodology provided for determining eligibility for payment of supplemental security income benefits under title XVI, meet the income and resource standards for payment of such benefits.

"(E) POOR ELDERLY INDIVIDUALS.—Subject to paragraph (4), elderly individuals who, using the methodology provided for determining eligibility for payment of supplemental security income benefits under title XVI, meet the income and resource standards for payment of such benefits.

"(F) CHILDREN RECEIVING FOSTER CARE OR ADOPTION ASSISTANCE.—Subject to paragraph (5), children who meet the requirements for receipt of foster care maintenance payments or adoption assistance under title IV.

"(G) CERTAIN LOW-INCOME FAMILIES.—Subject to paragraph (6), individuals and members of families who meet current AFDC income and resource standards (as defined in paragraph (6)(C)) in the State, determined using the methodology for determining eligibility for aid under the State plan under part A or part E of title IV (as in effect as of May 1, 1996).

"(2) GUARANTEED BENEFITS PACKAGE.—In this title, the term 'guaranteed benefit package' means benefits (in an amount, duration, and scope specified under the State plan) for at least the following categories of services:

"(A) Inpatient and outpatient hospital services.

"(B) Physicians' surgical and medical services.

"(C) Laboratory and x-ray services.

"(D) Nursing facility services.

"(E) Home health care.

"(F) Federally-qualified health center services and rural health clinic services.

"(G) Immunizations for children (in accordance with a schedule for immunizations established by the Health Department of the State in consultation with the State agency responsible for the administration of the plan).

"(H) Prepregnancy family planning services and supplies (as specified by the State).

"(I) Prenatal care.

"(J) Pediatric and family nurse practitioner services and nurse midwife services.

"(K) EPSDT services (as defined in section 1571(e)) for individuals who are under the age of 21.

A State may establish criteria, including utilization review, and cost effectiveness of alternative covered services, for purposes of specifying the amount, duration, and scope of benefits provided under the State plan.

"(3) STATE ELECTION OF DISABLED INDIVIDUALS TO BE GUARANTEED COVERAGE.—

"(A) IN GENERAL.—Each State shall specify in its State plan, before the beginning of each Federal fiscal year, whether to guarantee coverage of disabled individuals under the plan under the option described in paragraph (1)(D)(i) or under the option described in paragraph (1)(D)(ii). An election under this paragraph shall continue in effect for the subsequent fiscal year unless the election is changed before the beginning of the fiscal year.

"(B) CONSEQUENCES OF ELECTION.—

"(i) STATE FLEXIBLE DEFINITION OPTION.—If a State elects the option described in paragraph (1)(D)(i) for a fiscal year—

"(I) the State plan must provide under section 1502(c) for a set aside of funds for disabled individuals for the fiscal year, and

"(II) disabled individuals are not taken into account in determining a State supplemental umbrella allotment under section 1511(g).

"(ii) SSI DEFINITION OPTION.—If a State elects the option described in paragraph (1)(D)(ii) for a fiscal year—

"(I) section 1502(c) shall not apply for the fiscal year, and

"(II) the State is eligible for an increase under section 1511(g) in its outlay allotment for the fiscal year based on an increase in the number of guaranteed and optional disabled individuals covered under the plan.

"(4) CONTINUATION OF SPECIAL ELIGIBILITY STANDARDS FOR SECTION 209(b) STATES.—

"(A) IN GENERAL.—A section 209(b) State (as defined in subparagraph (B)) may elect to treat any reference in paragraph (1)(E) to 'elderly individuals who meet the income and resource standards for the payment of supplemental security income benefits under title XVI' as a reference to 'elderly individuals who meet the standards described in the first sentence of section 1902(f) (as in effect on the day before the date of the enactment of this title)'.

"(B) SECTION 209(b) STATE DEFINED.—In subparagraph (A), the term 'section 209(b) State' means a State to which section 1902(f) applied as of the day before the date of the enactment of this title.

(5) OPTION FOR APPLICATION OF CURRENT REQUIREMENTS FOR CERTAIN CHILDREN.—A State may elect to apply paragraph (1)(F) by treating any reference to 'requirements for receipt of foster care maintenance payments

or adoption assistance under title IV' as a reference to 'requirements for receipt of foster care maintenance payments or adoption assistance as in effect under its State plan under part E of title IV as of the date of the enactment of this title'.

"(6) SPECIAL RULES FOR LOW-INCOME FAMILIES.—

"(A) OPTIONAL USE OF LOWER NATIONAL AVERAGE STANDARDS.—In the case of a State in which the current AFDC income and resource standards are above the national average of the current AFDC income and resource standards for the 50 States and the District of Columbia, as determined and published by the Secretary, in applying paragraph (1)(G), the State may elect to substitute such national average income and resource standards for the current AFDC income and resource standards in that State.

"(B) OPTIONAL ELIGIBILITY BASED ON LINK TO OTHER ASSISTANCE.—

"(i) IN GENERAL.—Subject to clause (ii), in the case of a State which maintains a link between eligibility for aid or assistance under one or more parts of title IV and eligibility for medical assistance under this title, in applying paragraph (1)(G), the State may elect to treat any reference in such paragraph to 'individuals and members of families who meet current AFDC income and resource standards in the State' as a reference to 'members of families who are receiving assistance under a State plan under part A or E of title IV'.

"(ii) LIMITATION ON ELECTION.—A State may only make the election described in clause (i) if, and so long as, the State demonstrates to the satisfaction of the Secretary that the such election does not result in Federal expenditures under this title (taking into account any supplemental amounts provided pursuant to section 1511(g)) that are

greater than the Federal expenditures that would have been made under this title if the State had not made such election.

"(C) CURRENT AFDC INCOME AND RESOURCE STANDARDS DEFINED.—In this subsection, the term 'current AFDC income and resource standards' means, with respect to a State, the income and resource standards for the payment of assistance under the State plan under part A or E of title IV (as in effect as of May 1, 1996).

"(D) STATE OPTION TO CONTINUE TO PROVIDE MEDICAL ASSISTANCE DURING THE TRANSITION FROM WELFARE TO WORK.—Nothing in this title shall be construed as preventing a State from continuing to provide medical assistance under a State plan under this title to an individual or a member of such individual's family who—

"(i) is eligible for medical assistance under this title as a result of a link between eligibility for such medical assistance and aid or assistance under one or more parts of title IV or any other program of assistance based on need; and

"(ii) because of hours of, or income from, employment is no longer eligible for such aid or assistance.

"(7) METHODOLOGY.—Family income shall be determined for purposes of subparagraphs (A) through (C) of paragraph (1) in the same manner (and using the same methodology) as income was determined under the State medicaid plan under section 1902(l) (as in effect as of May 1, 1996).

"(b) GUARANTEED COVERAGE OF MEDICARE PREMIUMS AND COST-SHARING FOR CERTAIN MEDICARE BENEFICIARIES.—

"(1) GUARANTEED ELIGIBILITY.—Each State plan shall provide—

"(A) for making medical assistance available for required medicare cost-sharing (as defined in paragraph (2)) for qualified medicare beneficiaries described in paragraph (3);

"(B) for making medical assistance available for payment of medicare premiums under section 1818A for qualified disabled and working individuals described in paragraph (4); and

"(C) for making medical assistance available for payment of medicare premiums under section 1839 for individuals who would be qualified medicare beneficiaries described in paragraph (3) but for the fact that their income exceeds 100 percent, but is less than 120 percent, of the poverty line for a family of the size involved.

"(2) REQUIRED MEDICARE COST-SHARING DEFINED.—

"(A) IN GENERAL.—In this subsection, the term 'required medicare cost-sharing' means, with respect to an individual, costs incurred for medicare cost-sharing described in paragraphs (1) through (4) of section 1571(e) (and, at the option of a State, section 1571(e)(5))) without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan.

"(B) LIMITATION ON OBLIGATION FOR CERTAIN COST-SHARING ASSISTANCE.—In the case of medical assistance furnished under this title for medicare cost-sharing described in paragraph (2), (3), or (4) of section 1571(e) relating to the furnishing of a service or item to a medicare beneficiary, nothing in this title shall be construed as preventing a State plan—

"(i) from limiting the assistance to the amount (if any) by which (I) the amount that is otherwise payable under the plan for the item or service for eligible individuals who are not such medicare beneficiaries (or, if payments for such items or services

are made on a capitated basis, an amount reasonably related or derived from such capitated payment amount), exceeds (II) amount of payment (if any) made under title XVIII with respect to the service or item, and

"(ii) if the amount described in subclause (II) of clause (i) exceeds the amount described in subclause (I) of such clause, from treating the amount paid under title XVIII as payment in full and not requiring or providing for any additional medical assistance under this subsection.

"(3) QUALIFIED MEDICARE BENEFICIARY DEFINED.—In this subsection, the term 'qualified medicare beneficiary' means an individual—

"(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A),

"(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (5)) does not exceed 100 percent of the poverty line applicable to a family of the size involved, and

"(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

"(4) QUALIFIED DISABLED AND WORKING INDIVIDUAL DEFINED.—In this subsection, the term 'qualified disabled and working individual' means an individual—

"(A) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A;

"(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 200 percent of the poverty line applicable to a family of the size involved;

"(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under title XVI; and

"(D) who is not otherwise eligible for medical assistance under this title.

"(5) INCOME DETERMINATIONS.—

"(A) IN GENERAL.—In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under title II for a transition month (as defined in subparagraph (B)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year.

"(B) TRANSITION MONTH DEFINED.—For purposes of subparagraph (A), the term 'transition month' means each month in a year through the month following the month in which the annual revision of the poverty line is published.

"SEC. 1502. OTHER PROVISIONS RELATING TO ELIGIBILITY AND BENEFITS.

"(a) OPTIONAL ELIGIBILITY GROUPS FOR WHICH UMBRELLA SUPPLEMENTAL FUNDING IS AVAILABLE.—In addition to the guaranteed coverage categories described in section 1501(a)(1), the following are population groups with respect to which supplemental allotments may be made under section 1511(g), but only if (for the individual involved) medical assist-

ance is made available under the State plan for the guaranteed benefit package (as defined in section 1501(a)(2)):

"(1) CERTAIN POOR CHILDREN OVER 12 YEARS OF AGE.—Children born after September 30, 1983, under 12 years of age, but under 19 years of age, and whose family income does not exceed 100 percent of the poverty line.

"(2) CERTAIN DISABLED INDIVIDUALS.—Individuals (not described in section 1501(a)(1)(D)(ii)) who are disabled (as determined under section 1614(a)(3)), covered under the State plan, and meet the eligibility standards for coverage under the State medicaid plan under title XIX (as in effect as of May 1, 1996).

"(3) CERTAIN ELDERLY INDIVIDUALS.—Elderly individuals (not described in section 1501(a)(1)(E)) who are covered under the State plan and who meet the eligibility standards for coverage under the State medicaid plan under title XIX (as in effect as of May 1, 1996) other than solely on the basis of being an individual described in section 1902(a)(10)(E).

Family income under paragraph (1) and eligibility under paragraphs (2) and (3) shall be determined using the methodologies that are not more restrictive than the methodologies used under the State medicaid plan as in effect as of May 1, 1996.

"(b) OTHER PROVISIONS RELATING TO GENERAL ELIGIBILITY AND BENEFITS.—

"(1) GENERAL DESCRIPTION.—Each State plan shall include a description (consistent with this title) of the following:

"(A) ELIGIBILITY GUIDELINES FOR THE NON-GUARANTEED, NON-UMBRELLA POPULATION.—The general eligibility guidelines of the plan for eligible low-income individuals who are not covered under subsection (a) or (b) of section 1501 or under subsection (a) of this section.

"(B) SCOPE OF ASSISTANCE.—The amount, duration, and scope of health care services and items cov-

ered under the plan, including differences among different eligible population groups.

"(C) DELIVERY METHOD.—The State's approach to delivery of medical assistance, including a general description of—

"(i) the use (or intended use) of vouchers, fee-for-service, or managed care arrangements (such as capitated health care plans, case management, and case coordination); and

"(ii) utilization control systems.

"(D) FEE-FOR-SERVICE BENEFITS.—To the extent that medical assistance is furnished on a fee-for-service basis—

"(i) how the State determines the qualifications of health care providers eligible to provide such assistance; and

"(ii) how the State determines rates of reimbursement for providing such assistance.

"(E) COST-SHARING.—Beneficiary cost-sharing (if any), including variations in such cost-sharing by population group or type of service and financial responsibilities of parents of recipients who are children and the spouses of recipients.

"(F) UTILIZATION INCENTIVES.—Incentives or requirements (if any) to encourage the appropriate utilization of services.

"(G) SUPPORT FOR CERTAIN HOSPITALS.—

"(i) IN GENERAL.—With respect to hospitals described in clause (ii) located in the State, a description of the extent to which provisions are made for expenditures for items and services furnished by such hospitals and covered under the State plan.

"(ii) HOSPITALS DESCRIBED.—A hospital described in this clause is a short-term acute care general hospital or a children's hospital, the low-in-

come utilization rate of which exceeds the lesser of—

"(I) 1 standard deviation above the mean low-income utilization rate for hospitals receiving payments under a State plan in the State in which such hospital is located, or

"(II) 1¼ standard deviations above the mean low-income utilization rate for hospitals receiving such payments in the 50 States and the District of Columbia.

"(iii) LOW-INCOME UTILIZATION RATE.—For purposes of clause (ii), the term 'low-income utilization rate' means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of patient days attributable to patients who (for such days) were eligible for medical assistance under a State plan or were uninsured in a period, and the denominator of which is the total number of the hospital's patient days in that period.

"(iv) PATIENT DAYS.—For purposes of clause (iii), the term 'patient day' includes each day in which—

"(I) an individual, including a newborn, is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere; or

"(II) an individual makes one or more outpatient visits to the hospital.

"(2) CONDITIONS FOR GUARANTEES AND RELATION OF GUARANTEES TO FINANCING.—The guarantees of States required under subsection (a) and (b) of section 1501 and subsection (d) of this section are subject to the limitations on payment to the States provided under section 1511 (including the provisions of subsection (g), relating to

supplemental umbrella allotments). In submitting a plan under this title, a State voluntarily agrees to accept payment amounts provided under such section as full payment from the Federal Government in return for providing for the benefits (including the guaranteed benefit package) under this title.

"(3) SECONDARY PAYMENT.—Nothing in this section shall be construed as preventing a State from denying benefits to an individual to the extent such benefits are available to the individual under the medicare program under title XVIII or under another public or private health care insurance program.

"(4) RESIDENCY REQUIREMENT.—In the case of an individual who—

"(A) is described in section 1501(a)(1),

"(B) changed residence from another State to the State, and

"(C) has resided in the State for less than 180 days,

the State may limit the benefits provided to such individual in the guaranteed benefits package under paragraph (2) of section 1501(a) to the amount, duration, and scope of benefits available under the State plan of the individual's previous State of residence.

"(c) SET-ASIDE OF FUNDS FOR THE LOW-INCOME DISABLED.—

"(1) IN GENERAL.—In the case of a State that has elected the option described in section 1501(a)(1)(D)(i) for a fiscal year, the State plan shall provide that the percentage of funds expended under the plan for medical assistance for eligible low-income individuals who are not elderly individuals and who are eligible for such assistance on the basis of a disability, including being blind, for the fiscal year is not less than the minimum low-income-disabled percentage specified in paragraph (2) of the total funds ex-

pended under the plan for medical assistance for the fiscal year.

"(2) MINIMUM LOW-INCOME-DISABLED PERCENTAGE.—The minimum low-income-disabled percentage specified in this paragraph for a State is equal to 90 percent of the percentage of the expenditures under title XIX for medical assistance in the State during Federal fiscal year 1995 which was attributable to expenditures for medical assistance for benefits furnished to individuals whose coverage (at such time) was on a basis directly related to disability status, including being blind.

"(3) COMPUTATIONS.—States shall calculate the minimum percentage under paragraph (2) in a reasonable manner consistent with reports submitted to the Secretary for the fiscal years involved and medical assistance attributable to the exception provided under section 1903(v)(2) shall not be considered to be expenditures for medical assistance.

"(d) TRANSITIONAL PAYMENT FOR FEDERALLY-QUALIFIED HEALTH CENTER SERVICES AND RURAL HEALTH CLINIC SERVICES.—Each State plan shall provide that, for Federally-qualified health center services and rural health clinic services (as defined in section 1571(f)) furnished under the plan during the first 8 calendar quarters in which the plan is in effect and for which payment is made under the plan, payment shall be made for such services at a rate based on 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on the same methodology used under section 1833(a)(3).

"(e) PREEXISTING CONDITION EXCLUSIONS.—Notwithstanding any other provision of this title—

"(1) a State plan may not deny or exclude coverage of any item or service for an eligible individual for benefits under the State plan for such item or service on the basis of a preexisting condition; and

"(2) if a State contracts or makes other arrangements (through the eligible individual or through another entity) with a capitated health care organization, insurer, or other entity, for the provision of items or services to eligible individuals under the State plan and the State permits such organization, insurer, or other entity to exclude coverage of a covered item or service on the basis of a preexisting condition, the State shall provide, through its State plan, for such coverage (through direct payment or otherwise) for any such covered item or service denied or excluded on the basis of a preexisting condition.

"(f) SOLVENCY STANDARDS FOR CAPITATED HEALTH CARE ORGANIZATIONS.—

"(1) IN GENERAL.—A State may not contract with a capitated health care organization, as defined in section 1504(c)(1), for the provision of medical assistance under a State plan under which the organization is—

"(A) at full financial risk, as defined by the State, unless the organization meets solvency standards established by the State for private health maintenance organizations, or

"(B) is not at such risk, unless the organization meets solvency standards that are established under the State plan.

"(2) TREATMENT OF PUBLIC ENTITIES.—Paragraph (1) shall not apply to an organization that is a public entity or if the solvency of such organization is guaranteed by the State.

"(3) TRANSITION.—In the case of a capitated health care organization that as of the date of the enactment of this title has entered into a contract with a State for the provision of medical assistance under title XIX under which the organization assumes full financial risk and is receiving capitation payments, paragraph (1) shall not apply to such organization until 3 years after the date of the enactment of this title.

"SEC. 1503. LIMITATIONS ON PREMIUMS AND COST-SHARING.

"(a) LIMITATION ON PREMIUMS.—

"(1) NONE FOR GUARANTEED POPULATION.—The State plan shall not impose any enrollment fee, premium, or similar charge for eligible individuals described in subsection (a) or (b) of section 1501 or section 1502(a).

"(2) INCOME-RELATED FOR OTHER POPULATIONS.—The State plan may impose an enrollment fee, premium, or similar charge for eligible individuals not described in paragraph (1) if it is related to the individual's income (and does not exceed 2 percent of the individual's gross income).

"(b) LIMITATION ON COST-SHARING.—Subject to subsection (c)—

"(1) GUARANTEED POPULATIONS.—With respect to individuals covered under subsection (a) or (b) of section 1501 or section 1502, the State may not impose any cost-sharing with respect to items and services unless the amount is nominal in amount. For purposes of this paragraph, an amount is nominal if it does not exceed 6 percent of the amount otherwise payable, or, if greater, 50 cents.

"(2) OTHER POPULATIONS.—With respect to individuals not described in paragraph (1), the State may not impose any cost-sharing with respect to items and services unless such cost sharing is pursuant to a public cost-sharing schedule and such cost-sharing is not in excess of the average, nominal cost-sharing imposed in the State for health plans offered by health maintenance organizations (and similar organizations) for the same or similar items and services, as determined by the State insurance commissioner.

"(c) CERTAIN COST-SHARING PERMITTED.—

"(1) IN GENERAL.—Subject to paragraph (2), a State may—

"(A) impose additional cost-sharing to discourage the inappropriate use of emergency medical services de-

livered through a hospital emergency room, a medical transportation provider, or otherwise;

"(B) impose additional cost-sharing differentially in order to encourage the use of primary and preventive care and discourage unnecessary or less economical care; and

"(C) from imposing additional cost-sharing based on the failure to participate in employment training programs, drug or alcohol abuse treatment, counseling programs, or other programs promoting personal responsibility.

"(2) LIMITATION.—The additional cost-sharing imposed under paragraph (1) may not result—

"(A) in the case of an individual described in subsection (b)(1), in aggregate cost-sharing that exceeds the maximum amount of cost-sharing that may be imposed under subsection (b)(2) (determined without regard to this subsection); or

"(B) in the case of an individual described in subsection (b)(2), in aggregate cost-sharing that exceeds twice the maximum amount of cost-sharing that may be imposed under such subsection (determined without regard to this subsection).

"(d) PROHIBITION ON BALANCE BILLING.—An individual eligible for benefits for items and services under the State plan who is furnished such an items or service by a provider under the plan may not be billed by the provider for such item or service, other than such amount of cost-sharing as is permitted with this section.".

"(e) COST-SHARING DEFINED.—In this section, the term 'cost-sharing' includes copayments, deductibles, coinsurance, and other charges for the provision of health care services.

"SEC. 1504. DESCRIPTION OF PROCESS FOR DEVELOPING CAPITATION PAYMENT RATES.

"(a) IN GENERAL.—If a State contracts (or intends to contract) with a capitated health care organization (as defined

in subsection (c)(1)) under which the State makes a capitation payment (as defined in subsection (c)(2)) to the organization for providing or arranging for the provision of medical assistance under the State plan for a group of services, including at least inpatient hospital services and physicians' services, the plan shall include a description of the following:

"(1) USE OF ACTUARIAL SCIENCE.—The extent and manner in which the State uses actuarial science—

"(A) to analyze and project health care expenditures and utilization for individuals enrolled (or to be enrolled) in such an organization under the State plan, and

"(B) to develop capitation payment rates, including a brief description of the general methodologies used by actuaries.

"(2) QUALIFICATIONS OF ORGANIZATIONS.—The general qualifications, including any accreditation, State licensure or certification, or provider network standards, required by the State for participation of capitated health care organizations under the State plan.

"(3) DISSEMINATION PROCESS.—The process used by the State under subsection (b) and otherwise to disseminate, before entering into contracts with capitated health care organizations, actuarial information to such organizations on the historical fee-for-service costs (or, if not available, other recent financial data associated with providing covered services) and utilization associated with individuals described in paragraph (1)(A).

"(b) PUBLIC NOTICE AND COMMENT.—Under the State plan the State shall provide a process for providing, before the beginning of each contract year—

"(1) public notice of—

"(A) the amounts of the capitation payments (if any) made under the plan for the contract year preceding the public notice, and

"(B)(i) the information described under subsection (a)(1) with respect to capitation payments for the contract year involved, or (ii) amounts of the capitation payments the State expects to make for the contract year involved,

unless such information is designated as proprietary and not subject to public disclosure under State law, and

"(2) an opportunity for receiving public comment on the amounts and information for which notice is provided under paragraph (1).

"(c) DEFINITIONS.—In this title:

"(1) CAPITATED HEALTH CARE ORGANIZATION.—The term 'capitated health care organization' means a health maintenance organization or any other entity (including a health insuring organization, managed care organization, prepaid health plan, integrated service network, or similar entity) which under State law is permitted to accept capitation payments for providing (or arranging for the provision of) a group of items and services including at least inpatient hospital services and physicians' services.

"(2) CAPITATION PAYMENT.—The term 'capitation payment' means, with respect to payment, payment on a prepaid capitation basis or any other risk basis to an entity for the entity's provision (or arranging for the provision) of a group of items and services, including at least inpatient hospital services and physicians' services.

"SEC. 1505. PREVENTING SPOUSAL IMPOVERISHMENT.

"(a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title which is inconsistent with them.

"(2) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(3) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d), except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse,

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, ½ of the income shall be considered available to each of them, and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, ½ of the joint interest shall be considered available to each spouse).

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title; and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse,

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, ½ of the income shall be considered available to each of them, and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, ½ of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subpara-

graph (D), ½ of the income shall be considered to be available to the institutionalized spouse and ½ to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

"(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of the first continuous period of institutionalization of the institutionalized spouse)—

"(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

"(ii) a spousal share which is equal to ½ of such total value.

"(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment,

the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for medical assistance under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) (as of the time of application for medical assistance).

"(3) ASSIGNMENT OF SUPPORT RIGHTS.—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

"(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse,

"(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment, or

"(C) the State determines that denial of eligibility would work an undue hardship.

"(4) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR MEDICAL ASSISTANCE ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which

an institutionalized spouse is determined to be eligible for medical assistance under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(5) RESOURCES DEFINED.—In this section, the term 'resources' does not include—

"(A) resources excluded under subsection (a) or (d) of section 1613, and

"(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined or redetermined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance (described in paragraph (2)(A)), in an amount not less than the amount specified in paragraph (2)(C).

"(B) A community spouse monthly income allowance (as defined in paragraph (3)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (4)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse as provided under paragraph (6).

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) PERSONAL NEEDS ALLOWANCE.—

"(A) IN GENERAL.—The State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the plan) a monthly personal needs allowance—

"(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

"(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in subparagraph (C).

"(B) INSTITUTIONALIZED INDIVIDUAL OR COUPLE DEFINED.—In this paragraph, the term 'institutionalized individual or couple' means an individual or married couple—

"(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

"(ii) who is or are determined to be eligible for medical assistance under the State plan.

"(C) MINIMUM ALLOWANCE.—The minimum monthly personal needs allowance described in this subparagraph is $40 for an institutionalized individual and $80 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

"(3) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—

"(A) IN GENERAL.—In this section (except as provided in subparagraph (B)), the community spouse monthly income allowance for a community spouse is an amount by which—

"(i) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (4)) for the spouse, exceeds

"(ii) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(B) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(4) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (B), is equal to or exceeds—

"(i) 150 percent of 1/12 of the poverty line applicable to a family unit of 2 members, plus

"(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph

(A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

"(5) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (4)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (4)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

"(6) TREATMENT OF INCURRED EXPENSES.—With respect to the post-eligibility treatment of income under this section, there shall be disregarded reparation payments made by the Federal Republic of Germany and, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

"(A) medicare and other health insurance premiums, deductibles, or coinsurance, and

"(B) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.

"(e) NOTICE AND FAIR HEARING.—

"(1) NOTICE.—Upon—

"(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under the State plan respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) FAIR HEARING.—

"(A) IN GENERAL.—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance;

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(3)(A)(ii));

"(iii) the computation of the spousal share of resources under subsection (c)(1);

"(iv) the attribution of resources under subsection (c)(2); or

"(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing under the State plan with respect to such determination if an application for benefits under this title has been made on

behalf of the institutionalized spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

"(B) REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(3)(A)(i), an amount adequate to provide such additional income as is necessary.

"(C) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

"(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to any other provision of the State plan to the contrary, transfer an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into ac-

count such time as may be necessary to obtain a court order under paragraph (3).

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greatest of—

"(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g)),

"(iii) the amount established under subsection (e)(2), or

"(iv) the amount transferred under a court order under paragraph (3);

exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, any provisions under the plan relating to transfers or disposals of assets for less than fair market value shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse or a family member (as defined in subsection (d)(1)).

"(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between Sep-

tember 1988 and the September before the calendar year involved.

"(h) DEFINITIONS.—In this section:

"(1) INSTITUTIONALIZED SPOUSE.—The term 'institutionalized spouse' means an individual—

"(A)(i) who is in a medical institution or nursing facility, or

"(ii) at the option of the State (I) who would be eligible under the State plan under this title if such individual was in a medical institution, (II) with respect to whom there has been a determination that but for the provision of home or community-based services such individual would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the plan, and (III) who will receive home or community-based services pursuant the plan; and

"(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) COMMUNITY SPOUSE.—The term 'community spouse' means the spouse of an institutionalized spouse.

"SEC. 1506. PREVENTING FAMILY IMPOVERISHMENT.

"(a) RESPONSIBILITIES FOR LONG-TERM AND INSTITUTIONAL CARE GENERALLY.—A State plan may not—

"(1) require an adult child or any other individual (other than the applicant or recipient of services or the spouse of such an applicant or recipient) to contribute to the cost of covered nursing facility services, other long-term care services, and hospital and other institutional services under the plan; and

"(2) take into account with respect to such services the financial responsibility of any individual for any appli-

cant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program).

"(b) LIMITATIONS ON LIENS.—

"(1) IN GENERAL.—No lien may be imposed against the property of any individual prior to the individual's death on account of medical assistance paid or to be paid on the individual's behalf under a State plan, except—

"(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual; or

"(B) in the case of the real property of an individual—

"(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs, and

"(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

"(2) EXCEPTION.—No lien may be imposed under paragraph (1)(B) on such individual's home if—

"(A) the spouse of such individual,

"(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614, or

"(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

"(3) DISSOLUTION UPON RETURN HOME.—Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

"SEC. 1507. STATE FLEXIBILITY.

"(a) STATE FLEXIBILITY IN BENEFITS, GEOGRAPHICAL COVERAGE AREA, AND SELECTION OF PROVIDERS.—The State under its State plan may—

"(1) specify those items and services for which medical assistance is provided (consistent with guarantees under subsections (a) and (b) of section 1501), the providers which may provide such items and services, and the amount and frequency of providing such items and services (consistent with the requirements of section 1502(d));

"(2) specify the extent to which the same medical assistance will be provided in all geographical areas or political subdivisions of the State, so long as medical assistance is made available in all such areas or subdivisions;

"(3) specify the extent to which the medical assistance made available to any individual eligible for medical assistance is comparable in amount, duration, or scope to the medical assistance made available to any other such individual; and

"(4) specify the extent to which an individual eligible for medical assistance with respect to an item or service may choose to obtain such assistance from any institution, agency, or person qualified to provide the item or service.

"(b) STATE FLEXIBILITY WITH RESPECT TO MANAGED CARE.—Nothing in this title shall be construed—

"(1) to limit a State's ability to contract with, on a capitated basis or otherwise, health care plans or individual health care providers for the provision or arrangement of medical assistance,

"(2) to limit a State's ability to contract with health care plans or other entities for case management services or for coordination of medical assistance, or

"(3) to restrict a State from establishing capitation rates on the basis of competition among health care plans or negotiations between the State and one or more health care plans.

"SEC. 1508. PRIVATE RIGHTS OF ACTION.

"(a) LIMITATION ON FEDERAL CAUSES OF ACTION.—Except as provided in this section, no person or entity may bring an action against a State in Federal court based on its failure to comply with any requirement of this title.

"(b) STATE CAUSES OF ACTION.—

"(1) ADMINISTRATIVE AND JUDICIAL PROCEDURES.—A State plan shall provide for—

"(A) an administrative procedure whereby an individual alleging a denial of eligibility for benefits or a denial of benefits under the State plan may receive a hearing regarding such denial, and

"(B) judicial review, through a private right of action in a State court by an individual or class of individuals, regarding such a denial, but a State may require exhaustion of administrative remedies before such an action may be taken.

The administrative procedure under subparagraph (A) shall include impartial decision makers and a fair process and timely decisions.

"(2) WRIT OF CERTIORARI.—An individual or class may file a petition for certiorari before the Supreme Court of the United States in a case of a denial of benefits under the State plan to review a determination of the highest court of a State regarding such denial.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a State to provide a private right of action in State court by a provider, health plan, or a class of providers or health plans.

"(c) SECRETARIAL RELIEF.—

"(1) IN GENERAL.—The Secretary may bring an action in Federal court against a State and on behalf of an individual or class of individuals in order to assure that a State provides benefits to individuals and classes of individuals as guaranteed under subsection (a) or (b) of section 1501 under its State plan.

"(2) NO PRIVATE RIGHT.—No action may be brought in any court against the Secretary based on the Secretary's bringing, or failure to bring, an action under paragraph (1).

"(3) CONSTRUCTION.—Nothing in this title shall be construed as authorizing the Secretary to bring an action on behalf of a provider, health plan, or a class of providers or health plans.

"PART B—PAYMENTS TO STATES

"SEC. 1511. ALLOTMENT OF FUNDS AMONG STATES.

"(a) ALLOTMENTS.—

"(1) COMPUTATION.—The Secretary shall provide for the computation of State obligation and outlay allotments in accordance with this section for each fiscal year beginning with fiscal year 1997. Nothing in this part shall be construed as authorizing payment under this part to any State for fiscal year 1996.

"(2) LIMITATION ON OBLIGATIONS.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the Secretary shall not enter into obligations with any State under this title for a fiscal year in excess of the sum of the following allotments for the State for the fiscal year:

"(i) BASE OBLIGATION ALLOTMENT.—The amount of the base obligation allotment for that State for the fiscal year under paragraph (4).

"(ii) SUPPLEMENTAL ALLOTMENT FOR CERTAIN ALIENS.—The amount of any supplemental allotment for that State for the fiscal year under subsection (f).

"(iii) SUPPLEMENTAL PER BENEFICIARY UMBRELLA ALLOTMENT.—The amount of any supplemental per beneficiary umbrella allotment for that State for the fiscal year under subsection (g).

"(iv) SUPPLEMENTAL ALLOTMENT FOR INDIAN HEALTH SERVICES.—The amount of any supplemental allotment for that State for the fiscal year under subsection (h).

The sum of the base obligation allotments for all States in any fiscal year (excluding amounts carried over under subparagraph (B) and excluding changes in allotments effected under paragraph (4)(D)) shall not exceed the aggregate limit on new base obligation authority specified in paragraph (3) for that fiscal year.

"(B) ADJUSTMENTS.—

"(i) CARRYOVER OF BASE ALLOTMENT PERMITTED.—Subject to clauses (ii), if the amount of obligations entered into under this part with a State for quarters in a fiscal year is less than the amount of the obligation allotment under this section to the State for the fiscal year, the amount of the difference (less any amount computed under clause (iii)) shall be added to the amount of the

State obligation allotment otherwise provided under this section for the succeeding fiscal year.

"(ii) NO CARRYOVER PERMITTED FOR STATES RECEIVING SUPPLEMENTAL UMBRELLA ALLOTMENTS.—Clause (i) shall not apply, insofar as it permits a carryover for a State from a particular year to the next year, if in the particular year the State receives a supplemental umbrella allotment under subsection (g).

"(iii) NO CARRYOVER OF ALIEN AND INDIAN SUPPLEMENTAL ALLOTMENTS.—The amount of any carryover under clause (i) from a fiscal year shall be reduced by the amount (if any) by which the amount of the outlays for expenditures described in subsection (f) or (h) for the fiscal year is less than the amount of any supplemental allotment provided under the respective subsection for the State and fiscal year involved.

"(C) REDUCTION FOR NEW OBLIGATIONS UNDER TITLE XIX IN FISCAL YEAR 1997.—The amount of the base obligation allotment otherwise provided under this section for fiscal year 1997 for a State shall be reduced by the amount of the obligations entered into with respect to the State under section 1903(a) during such fiscal year.

"(D) NO EFFECT ON PRIOR YEAR OBLIGATIONS.—Subparagraph (A) shall not apply to or affect obligations for a fiscal year prior to fiscal year 1997.

"(E) OBLIGATION.—For purposes of this section, the Secretary's establishment of an estimate under section 1512(b) of the amount a State is entitled to receive for a quarter (taking into account any adjustments described in such subsection) beginning during or after fiscal year 1997 shall be treated as the obligation of such amount for the State as of the first day of the quarter.

"(F) RELATION TO GUARANTEES.—The Federal Government's obligations for payments under this title are limited as provided under subparagraph (A) and are only subject to adjustment based on any guarantee provided under section 1501 as provided under subsection (g).

"(3) AGGREGATE LIMIT ON NEW BASE OBLIGATION AUTHORITY.—

"(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (C), the 'aggregate limit on new base obligation authority', for a fiscal year, is the base pool amount under subsection (b) for the fiscal year, divided by the payout adjustment factor (described in subparagraph (B)) for the fiscal year.

"(B) PAYOUT ADJUSTMENT FACTOR.—For purposes of this subsection, the 'payout adjustment factor'—

"(i) for fiscal year 1997 is 0.950,

"(ii) for fiscal year 1998 is 0.986, and

"(iii) for a subsequent fiscal year is 0.998.

"(C) TRANSITIONAL ADJUSTMENT FOR PRE-FISCAL YEAR 1997-OBLIGATION OUTLAYS.—In order to account for pre-fiscal year 1997-obligation outlays described in paragraph (4)(C)(iv), in determining the aggregate limit on new obligation authority under subparagraph (A) for fiscal year 1997, the pool amount for such fiscal year is equal to—

"(i) the pool amount for such year, reduced by

"(ii) $12,000,000,000.

"(4) BASE OBLIGATION ALLOTMENTS.—

"(A) GENERAL RULE FOR 50 STATES AND THE DISTRICT OF COLUMBIA.—Except as provided in this paragraph, the 'base obligation allotment' for any of the 50 States or the District of Columbia for a fiscal year (beginning with fiscal year 1997) is an amount that bears the same ratio to the base outlay allotment

under subsection (c)(2) for such State or District (not taking into account any adjustment due to an election under subsection (c)(4)) for the fiscal year as the ratio of—

"(i) the aggregate limit on new base obligation authority (less the total of the obligation allotments under subparagraph (B)) for the fiscal year, to

"(ii) the base pool amount (less the sum of the base outlay allotments for the territories) for such fiscal year.

"(B) TERRITORIES.—The base obligation allotment for each of the Commonwealths and territories for a fiscal year is the base outlay allotment for such Commonwealth or Territory (as determined under subsection (c)(5)) for the fiscal year divided by the payout adjustment factor for the fiscal year (as defined in paragraph (3)(B)).

"(C) TRANSITIONAL RULE FOR FISCAL YEAR 1997.—

"(i) IN GENERAL.—The obligation amount for fiscal year 1997 for any State (including the District of Columbia, a Commonwealth, or Territory) is determined according to the formula: A=(B-C)/D, where—

"(I) 'A' is the base obligation amount for such State,

"(II) 'B' is the base outlay allotment of such State for fiscal year 1997, as determined under subsection (c),

"(III) 'C' is the amount of the pre-enactment-obligation outlays (as established for such State under clause (ii)), and

"(IV) 'D' is the payout adjustment factor for such fiscal year (as defined in paragraph (3)(B)).

"(ii) PRE-FISCAL YEAR 1997-OBLIGATION OUTLAY AMOUNTS.—Not later than November 1, 1996, the Secretary shall estimate (based on the best data available) and publish in the Federal Register the amount of the pre-fiscal year 1997-obligation outlays (as defined in clause (iv)) for each State (including the District of Columbia, Commonwealths, and Territories). The total of such amounts shall equal the dollar amount specified in paragraph (3)(C)(ii).

"(iii) AGREEMENT.—The submission of a State plan by a State under this title is deemed to constitute the State's acceptance of the obligation allotment limitations under this subsection, including the formula for computing the amount of the base obligation allotment and any supplemental obligation allotments.

"(iv) PRE-FISCAL YEAR 1997-OBLIGATION OUTLAYS DEFINED.—In this subsection, the term 'pre-fiscal year 1997-obligation outlays' means, for a State, the outlays of the Federal Government that result from obligations that have been incurred under title XIX with respect to the State before October 1, 1996, but for which payments to States have not been made as of such date.

"(D) ADJUSTMENT TO REFLECT ADOPTION OF ALTERNATIVE GROWTH FORMULA.—Any State that has elected an alternative growth formula under subsection (e)(4) which increases or decreases the dollar amount of an outlay allotment for a fiscal year is deemed to have increased or decreased, respectively, its obligation amount for such fiscal year by the amount of such increase or decrease.

"(E) TRANSITIONAL CORRECTION FOR FISCAL YEAR 1997.—

"(i) IN GENERAL.—The base obligation amount for fiscal year 1998 for any State described in clause (ii) shall be increased by the amount by which the amount described in clause (ii)(I) exceeds the amount described in clause (ii)(II), divided by the payout adjustment factor specified in paragraph (3)(B) for fiscal year 1997. The increase under this clause shall be paid to a State in the first quarter of fiscal year 1998.

"(ii) STATES DESCRIBED.—A State described in this clause is a State for which—

"(I) the amount of the pre-fiscal year 1997-obligation outlays (as established for such State under subparagraph (C)(ii)), exceeded

"(II) the outlays of the Federal Government during fiscal year 1997 that are attributable to obligations that were incurred under title XIX with respect to the State before October 1, 1996, but for which payments to States had not been made as of such date.

"(5) SEQUENCE OF OBLIGATIONS.—For purposes of carrying out this title, payments under section 1512 to a State eligible for a supplemental outlay allotment that are attributable to—

"(A) expenditures for medical assistance described in the second sentence of subsection (f)(1) or the second sentence of subsection (h)(1) shall first be counted toward the supplemental outlay allotment provided under subsection (f) or (h), respectively, rather than toward the base outlay allotment otherwise provided under this section; or

"(B) subsection (g) (relating to the umbrella fund) shall first be counted toward the allotment provided other than under such subsection, and then to such subsection.

"(b) BASE POOL OF AVAILABLE FUNDS.—

"(1) IN GENERAL.—For purposes of this section, the 'base pool amount' under this subsection for—

"(A) fiscal year 1996 is $96,601,037,894,

"(B) fiscal year 1997 is $103,447,755,053,

"(C) fiscal year 1998 is $108,430,173,129,

"(D) fiscal year 1999 is $113,652,562,483,

"(E) fiscal year 2000 is $119,126,480,999,

"(F) fiscal year 2001 is $124,864,043,230,

"(G) fiscal year 2002 is $130,877,947,213, and

"(H) each subsequent fiscal year is the pool amount under this paragraph for the previous fiscal year increased by the lesser of 4.82 percent or the annual percentage increase in the gross domestic product for the 12-month period ending in June before the beginning of that subsequent fiscal year.

"(2) NATIONAL GROWTH PERCENTAGE.—For purposes of this section for a fiscal year (beginning with fiscal year 1997), the 'national growth percentage' is the percentage by which—

"(A) the base pool amount under paragraph (1) for the fiscal year, exceeds

"(B) such base pool amount for the previous fiscal year.

"(c) STATE BASE OUTLAY ALLOTMENTS.—

"(1) FISCAL YEAR 1996.—

"(A) IN GENERAL.—For each of the 50 States and the District of Columbia, the amount of the State base outlay allotment under this subsection for fiscal year 1996 is, subject to paragraph (4), determined in accordance with the following table:

"State or District:	Outlay allotment (in dollars):
Alabama	1,517,652,207
Alaska	204,933,213
Arizona	1,385,781,297
Arkansas	1,011,457,933
California	8,946,838,461
Colorado	757,492,679
Connecticut	1,463,011,635
Delaware	212,327,763

"State or District:	Outlay allotment (in dollars):
District of Columbia	501,412,091
Florida	3,715,624,180
Georgia	2,426,320,602
Hawaii	323,124,375
Idaho	278,329,686
Illinois	3,467,274,342
Indiana	1,952,467,267
Iowa	835,235,895
Kansas	713,700,869
Kentucky	1,577,828,832
Louisiana	2,622,000,000
Maine	694,220,790
Maryland	1,369,699,847
Massachusetts	2,870,346,862
Michigan	3,465,182,886
Minnesota	1,793,776,356
Mississippi	1,261,781,330
Missouri	1,849,248,945
Montana	312,212,472
Nebraska	463,900,417
Nevada	257,896,453
New Hampshire	560,000,000
New Jersey	2,854,621,241
New Mexico	634,756,945
New York	12,901,793,038
North Carolina	2,587,883,809
North Dakota	241,168,563
Ohio	4,034,049,690
Oklahoma	911,198,775
Oregon	1,088,670,440
Pennsylvania	4,454,423,400
Rhode Island	545,686,262
South Carolina	1,621,021,815
South Dakota	262,804,959
Tennessee	2,519,934,251
Texas	6,351,909,343
Utah	484,274,254
Vermont	248,158,729
Virginia	1,144,962,509
Washington	1,763,460,996
West Virginia	1,156,813,157
Wisconsin	1,709,500,642
Wyoming	132,915,390.

"(2) FOR SUBSEQUENT FISCAL YEARS.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the amount of the State base outlay allotment under this subsection for one of the 50 States and the District of Columbia for a fiscal year

(beginning with fiscal year 1997) is equal to the product of—

"(i) the needs-based amount determined under subparagraph (B) for such State or District for the fiscal year, and

"(ii) the adjustment factor described in subparagraph (C) for the fiscal year.

"(B) NEEDS-BASED AMOUNT.—The needs-based amount under this subparagraph for a State or the District of Columbia for a fiscal year is equal to the product of—

"(i) the State's or District's aggregate expenditure need for the fiscal year (as determined under subsection (d)), and

"(ii) the State's or District's old Federal medical assistance percentage (as defined in section 1512(d)) for the fiscal year (or, in the case of fiscal year 1997, the Federal medical assistance percentage determined under section 1905(b) for fiscal year 1996).

"(C) ADJUSTMENT FACTOR.—The adjustment factor under this subparagraph for a fiscal year is such proportion so that, when it is applied under subparagraph (A)(ii) for the fiscal year (taking into account the floors and ceilings under paragraph (3)), the total of the base outlay allotments under this subsection for all the 50 States and the District of Columbia for the fiscal year (not taking into account any increase in a base outlay allotment for a fiscal year attributable to the election of an alternative growth formula under paragraph (4)) is equal to the amount by which (i) the base pool amount for the fiscal year (as determined under subsection (b)), exceeds (ii) the sum of the base outlay allotments provided under paragraph (5) for the Commonwealths and Territories for the fiscal year.

"(3) FLOORS AND CEILINGS.—

"(A) FLOORS.—Subject to the ceiling established under subparagraph (B), in no case shall the amount of the State base outlay allotment under paragraph (2) for a fiscal year be less than the greatest of the following:

"(i) IN GENERAL.—Beginning with fiscal year 1998, 0.24 percent of the pool amount for the fiscal year.

"(ii) FLOOR BASED ON PREVIOUS YEAR'S OUTLAY ALLOTMENT.—Subject to clause (iii)—

"(I) for fiscal year 1997, 103.5 percent of the amount of the State base outlay allotment under this subsection for fiscal year 1996,

"(II) for fiscal year 1998, 103 percent of the amount of the State base outlay allotment under this subsection for fiscal year 1997,

"(III) for fiscal year 1999, 102.5 percent of the amount of the State base outlay allotment under this subsection for fiscal year 1998,

"(IV) for fiscal year 2000, 102.25 percent of the amount of the State base outlay allotment under this subsection for fiscal year 1999, and

"(V) for each of fiscal years 2001 and 2002, 102 percent of the amount of the State base outlay allotment under this subsection for the previous fiscal year.

"(iii) FLOOR BASED ON OUTLAY ALLOTMENT GROWTH RATE IN FIRST YEAR.—Beginning with fiscal year 1998, in the case of a State for which the outlay allotment under this subsection for fiscal year 1997 exceeded its outlay allotment under this subsection for the previous fiscal year by more than 95 percent of the national growth percentage for

fiscal year 1997, 90 percent of the national growth percentage for the fiscal year involved.

"(B) CEILINGS.—

"(i) IN GENERAL.—Subject to clause (ii), in no case shall the amount of the State base outlay allotment under paragraph (2) for a fiscal year be greater than the product of—

"(I) the State base outlay allotment under this subsection for the State for the preceding fiscal year, and

"(II) the applicable percent (specified in clause (ii) or (iii)) for the fiscal year involved.

"(ii) GENERAL RULE FOR APPLICABLE PERCENT.—For purposes of clause (i), subject to clause (iii), the 'applicable percent' for fiscal year 1997 is 126.98 percent and for a subsequent fiscal year is 133 percent of the national growth percentage for the fiscal year.

"(iii) SPECIAL RULE.—For a fiscal year after fiscal year 1997, in the case of a State (among the 50 States and the District of Columbia) that is one of the 10 States with the lowest Federal spending per resident-in-poverty rates (as determined under clause (iv)) for the fiscal year, the 'applicable percent' is 150 percent of the national growth percentage for the fiscal year.

"(iv) DETERMINATION OF FEDERAL SPENDING PER RESIDENT-IN-POVERTY RATE.—For purposes of clause (iii), the 'Federal spending per resident-in-poverty rate' for a State for a fiscal year is equal to—

"(I) the State's outlay allotment under this subsection for the previous fiscal year (determined without regard to paragraph (4)), divided by

"(II) the average annual number of residents of the State in poverty (as defined in subsection (d)(2)) with respect to the fiscal year.

"(C) SPECIAL RULE.—

"(i) IN GENERAL.—Notwithstanding the preceding subparagraphs of this paragraph, the State base outlay allotment for—

"(I) Louisiana, subject to subclause (II), for each of the fiscal years 1997 through 2000, is $2,622,000,000,

"(II) Louisiana for fiscal year 1997 only, as otherwise determined, shall be increased by $37,048,207, and

"(III) Nevada for each of fiscal years 1997, 1998, and 1999, as otherwise determined, shall be increased by $90,000,000.

"(ii) EXCEPTION.—A State described in subclause (I) of clause (i) may apply to the Secretary for use of the State base outlay allotment otherwise determined under this subsection for any fiscal year, if such State notifies the Secretary not later than March 1 preceding such fiscal year that such State will be able to expend sufficient State funds in such fiscal year to qualify for such allotment.

"(iii) TREATMENT OF INCREASE AS SUPPLEMENTAL ALLOTMENT.—Any increase in an outlay allotment under clause (i)(II) or (i)(III) shall not be taken into account for purposes of determining—

"(I) the adjustment factor under paragraph (2) for fiscal year 1997,

"(II) any State base outlay allotment for a fiscal year after fiscal year 1997,

"(III) the base pool amount for a fiscal year after fiscal year 1997, or

"(IV) determination of the national growth percentage for any fiscal year.

"(4) ELECTION OF ALTERNATIVE GROWTH FORMULA.—

"(A) ELECTION.—In order to reduce variations in increases in outlay allotments over time, any of the 50 States or the District of Columbia may elect (by notice provided to the Secretary by not later than April 1, 1997) to adopt an alternative growth rate formula under this paragraph for the determination of the State's base outlay allotment in fiscal year 1997 and for the increase in the amount of such allotment in subsequent fiscal years.

"(B) FORMULA.—The alternative growth formula under this paragraph may be any formula under which a portion of the State base outlay allotment for fiscal year 1997 under paragraph (1) is deferred and applied to increase the amount of its base outlay allotment for one or more subsequent fiscal years, so long as the total amount of such increases for all such subsequent fiscal years does not exceed the amount of the base outlay allotment deferred from fiscal year 1997.

"(5) COMMONWEALTHS AND TERRITORIES.—

"(A) IN GENERAL.—The base outlay allotment for each of the Commonwealths and Territories for a fiscal year is the maximum amount that could have been certified under section 1108(c) (as in effect on the day before the date of the enactment of this title) with respect to the Commonwealth or Territory for the fiscal year with respect to title XIX, if the national growth percentage (as determined under subsection (b)(2)) for the fiscal year had been substituted (beginning with fiscal year 1997) for the percentage increase referred to in section 1108(c)(1)(B) (as so in effect).

"(B) DISREGARD OF ROUNDING REQUIREMENTS.—For purposes of subparagraph (A), the rounding requirements under section 1108(c) shall not apply.

"(C) LIMITATION ON TOTAL AMOUNT FOR FISCAL YEAR 1996.—Notwithstanding the provisions of subparagraph (A), the total amount of the base outlay allotments for the Commonwealths and Territories for fiscal year 1996 may not exceed $139,950,000.

"(d) STATE AGGREGATE EXPENDITURE NEED DETERMINED.—

"(1) IN GENERAL.—For purposes of subsection (c), the 'State aggregate expenditure need' for a State or the District of Columbia for a fiscal year is equal to the product of the following 4 factors:

"(A) PROGRAM NEED.—The program need for the State for the fiscal year, as determined under paragraph (2).

"(B) HEALTH CARE COST INDEX.—The health care cost index for the State (as determined under paragraph (3)) for the most recent fiscal year for which data are available.

"(C) PROJECTED INFLATION.—The CPI increase factor for the fiscal year (as defined in subsection (g)(4)(C)).

"(D) NATIONAL AVERAGE SPENDING PER RESIDENT IN POVERTY.—The national average spending per resident in poverty (as determined under paragraph (4)).

"(2) PROGRAM NEED.—

"(A) IN GENERAL.—In this subsection and subject to subparagraph (D), the 'program need' of a State for a fiscal year is equal to the sum, for each of the population groups described in subparagraph (B), of the product described in subparagraph (C) for that population group.

"(B) POPULATION GROUPS DESCRIBED.—The population groups described in this subparagraph are as follows:

"(i) INDIVIDUALS BETWEEN 60 AND 85.—Individuals who are least 60, but less than 85, years of age.

"(ii) INDIVIDUALS 85 OR OLDER.—Individuals who are 85 years of age or older.

"(iii) DISABLED INDIVIDUALS.—Individuals who are eligible for medical assistance because such individuals are blind or disabled and are not described in clause (i) or (ii).

"(iv) CHILDREN.—Individuals described in subsection (g)(2)(B).

"(v) OTHER INDIVIDUALS.—Individuals not described in a previous clause of this subparagraph.

"(C) PRODUCT DESCRIBED.—The product described in this subparagraph, with respect to a population group for a fiscal year for a State (or District), is the product of the following 2 factors for that group, year, and State (or District):

"(i) WEIGHTING FACTOR REFLECTING RELATIVE NEED FOR THE GROUP.—For all States, the national average per recipient expenditures under this title in the 50 States and the District of Columbia for individuals in such group, as determined under subparagraph (E), divided by the national average of such averages for all such groups (weighted by the number of recipients in each group).

"(ii) NUMBER OF NEEDY IN GROUP.—The product of—

"(I) for all groups, the average annual number of residents in poverty in such State or District (based on data made generally available by the Bureau of the Census from the

Current Population Survey) for the most recent 3-calendar-year period (ending before the fiscal year) for which such data are available; and

"(II) the proportion, of all individuals who received medical assistance under this title in such State or District, that were individuals in such group.

In clause (ii)(II), the term 'resident in poverty' means an individual whose family income does not exceed the poverty threshold (as such terms are defined by the Office of Management and Budget and are generally interpreted and applied by the Bureau of the Census for the year involved).

"(D) FLOORS AND CEILINGS ON PROGRAM NEED.—

"(i) IN GENERAL.—In no case shall the value of the program need for a State for a fiscal year be less than 90 percent, or be more than 115 percent, of the program need based on national averages (determined under clause (ii)) for that State for the fiscal year.

"(ii) PROGRAM NEED BASED ON NATIONAL AVERAGES.—For purposes of clause (i), the 'program need based on national average' for a fiscal year is equal to the sum of the product (for each of the population groups) of the following 3 factors (for that group, year, and State or District):

"(I) WEIGHTING FACTOR FOR GROUP.—The weighting factor for the group (described in subparagraph (C)(i)).

"(II) TOTAL NUMBER OF NEEDY IN STATE.—For all groups, the average annual number of residents in poverty in such State or District (as defined in subparagraph (C)(ii)(I)).

"(III) NATIONAL PROPORTION OF NEEDY IN GROUP.—The proportion, of all individuals

who received medical assistance under this title in all of the States and the District in all such groups, that were individuals in such group.

"(E) DETERMINATION OF NATIONAL AVERAGES AND PROPORTIONS.—The national averages per recipient and the proportions referred to in subparagraph (C)(ii) and (C)(iii), respectively, shall be determined by the Secretary using the most recent data available.

"(F) EXPENDITURE DEFINED.—For purposes of this paragraph, the term 'expenditure' means medical vendor payments by basis of eligibility as reported by HCFA Form 2082.

"(3) HEALTH CARE COST INDEX.—

"(A) IN GENERAL.—In this section, the 'health care cost index' for a State or the District of Columbia for a fiscal year is the sum of—

"(i) 0.15, and

"(ii) 0.85 multiplied by the ratio of (I) the annual average wages for hospital employees in such State or District for the fiscal year (as determined under subparagraph (B)), to (II) the annual average wages for hospital employees in the 50 States and the District of Columbia for such year (as determined under such subparagraph).

"(B) DETERMINATION OF ANNUAL AVERAGE WAGES OF HOSPITAL EMPLOYEES.—The Secretary shall provide for the determination of annual average wages for hospital employees in a State or the District of Columbia and, collectively, in the 50 States and the District of Columbia for a fiscal year based on the area wage data applicable to hospitals under section 1886(d)(2)(E) (or, if such data no longer exists, comparable data of hospital wages) for discharges occurring during the fiscal year involved.

"(4) NATIONAL AVERAGE SPENDING PER RESIDENT IN POVERTY.—For purposes of this subsection, the 'national average spending per resident in poverty'—

"(A) for fiscal year 1997 is equal to—

"(i) the sum (for each of the 50 States and the District of Columbia) of the total of the Federal and State expenditures under title XIX for calendar quarters in fiscal year 1994, increased by the percentage by which (I) the base pool amount for fiscal year 1997, exceeds (II) $83,213,431,458 (which represents Federal medicaid expenditures for such States and District for fiscal year 1994); divided by

"(ii) the sum of the number of residents in poverty (as defined in paragraph (2)(C)(ii)(I)) for all of the 50 States and the District of Columbia for fiscal year 1994; and

"(B) for a succeeding fiscal year is equal to the national average spending per resident in poverty under this paragraph for the preceding fiscal year increased by the national growth percentage (as defined in subsection (b)(2)) for the fiscal year involved.

"(e) PUBLICATION OF OBLIGATION AND OUTLAY ALLOTMENTS.—

"(1) NOTICE OF PRELIMINARY ALLOTMENTS.—Not later than April 1 before the beginning of each fiscal year (beginning with fiscal year 1997), the Secretary shall initially compute, after consultation with the Comptroller General, and publish in the Federal Register notice of the proposed base obligation allotment, base outlay allotment, and supplemental allotments under subsections (f) and (h) for each State under this section (not taking into account subsection (a)(2)(B)) for the fiscal year. The Secretary shall include in the notice a description of the methodology and data used in deriving such allotments for the year.

"(2) REVIEW BY GAO.—The Comptroller General shall submit to Congress by not later than May 15 of each such fiscal year, a report analyzing such allotments and the extent to which they comply with the precise requirements of this section.

"(3) NOTICE OF FINAL ALLOTMENTS.—Not later than July 1 before the beginning of each such fiscal year, the Secretary, taking into consideration the analysis contained in the report of the Comptroller General under paragraph (2), shall compute and publish in the Federal Register notice of the final allotments under this section (both taking into account and not taking into account subsection (a)(2)(B)) for the fiscal year. The Secretary shall include in the notice a description of any changes in such allotments from the initial allotments published under paragraph (1) for the fiscal year and the reasons for such changes. Once published under this paragraph, the Secretary is not authorized to change such allotments.

"(4) GAO REPORT ON FINAL ALLOTMENTS.—The Comptroller General shall submit to Congress by not later than August 1 of each such fiscal year, a report analyzing the final allotments under paragraph (3) and the extent to which they comply with the precise requirements of this section.

"(5) TRANSITIONAL RULE FOR FISCAL YEAR 1997.—With respect to fiscal year 1997, the deadlines under the previous provisions of this subsection shall be extended by a number of days equal to the number of days between May 1, 1996, and the date of the enactment of this title.

"(f) SUPPLEMENTAL ALLOTMENT FOR CERTAIN HEALTH CARE SERVICES TO CERTAIN ALIENS.—

"(1) IN GENERAL.—For purposes of this section for each of fiscal years 1998 through 2002 in the case of a subsection (f) supplemental allotment eligible State, the amount of the supplemental allotment under this subsection is the amount provided under paragraph (2) for the State

for that year. Such amount may only be used for the purpose of providing medical assistance for care and services for aliens described in paragraph (1) of section 1513(f) and for which the exception described in paragraph (2) of such section applies. Section 1512(f)(4) shall apply to such assistance in the same manner as it applies to medical assistance described in such section.

"(2) SUPPLEMENTAL AMOUNT.—

"(A) IN GENERAL.—For purposes of paragraph (1), the supplemental amount for a subsection (f) supplemental allotment eligible State for a fiscal year is equal to the subsection (f) supplemental allotment ratio (as defined in subparagraph (C)) multiplied by the subsection (f) supplemental pool amount (specified in subparagraph (D)) for the fiscal year.

"(B) SUBSECTION (f) SUPPLEMENTAL ALLOTMENT ELIGIBLE STATE.—In this subsection, the term 'subsection (f) supplemental allotment eligible State' means one of the 15 States with the highest number of undocumented alien residents of all the States.

"(C) SUBSECTION (f) SUPPLEMENTAL ALLOTMENT RATIO.—In this paragraph, the 'subsection (f) supplemental allotment ratio' for a State is the ratio of—

"(i) the number of undocumented aliens residing in the State, to

"(ii) the sum of such numbers for all subsection (f) supplemental allotment eligible States.

"(D) SUBSECTION (f) SUPPLEMENTAL POOL AMOUNT.—In this paragraph, the 'subsection (f) supplemental pool amount'—

"(i) for fiscal year 1998 is $500,000,000,

"(ii) for fiscal year 1999 is $600,000,000,

"(iii) for fiscal year 2000 is $700,000,000,

"(iv) for fiscal year 2001 is $800,000,000, and

"(v) for fiscal year 2002 is $900,000,000.

"(E) DETERMINATION OF NUMBER.—

"(i) IN GENERAL.—The number of undocumented aliens residing in a State under this paragraph—

"(I) for fiscal year 1998 shall be determined based on estimates of the resident illegal alien population residing in each State prepared by the Statistics Division of the Immigration and Naturalization Service as of October 1992, and

"(II) for a subsequent fiscal year shall be determined based on the most recent updated estimate made under clause (ii).

"(ii) UPDATING ESTIMATE.—For each fiscal year beginning with fiscal year 1999, the Secretary, in consultation with the Commission of the Immigration and Naturalization Service, States, and outside experts, shall estimate the number of undocumented aliens residing in each of the 50 States and the District of Columbia.

"(g) SUPPLEMENTAL PER BENEFICIARY UMBRELLA ALLOTMENT FOR STATES WITH EXCESS GROWTH IN CERTAIN POPULATION GROUPS.—

"(1) IN GENERAL.—Subject to paragraphs (5) through (7), for purposes of this section the amount of the supplemental allotment under this subsection for a State for a fiscal year (beginning with fiscal year 1997) is the sum, for each supplemental allotment population group described in paragraph (2), of the product of the following:

"(A) EXCESS NUMBER OF INDIVIDUALS.—The excess number of individuals (if any, determined under paragraph (3)) for State and the fiscal year who are in the population group.

"(B) APPLICABLE PER BENEFICIARY AMOUNT.—The applicable per beneficiary amount (determined under paragraph (4)) for the State and fiscal year for the population group.

"(C) FMAP.—The old Federal medical assistance percentage (as defined in section 1512(d)) for the State and fiscal year.

"(2) SUPPLEMENTAL ALLOTMENT POPULATION GROUP.—In this subsection, each of the following shall be considered to be a separate 'supplemental allotment population group':

"(A) POOR PREGNANT WOMEN.—Individuals described in section 1501(a)(1)(A).

"(B) POOR CHILDREN.—Individuals (not described in subparagraph (C))—

"(i) described in subparagraph (B) or (C) of section 1501(a)(1),

"(ii) described in subparagraph (F) or (G) of section 1501(a)(1) who are under 21 years of age and who are not pregnant women, or

"(iii) described in section 1502(a) under paragraph (1) of that section.

"(C) POOR DISABLED INDIVIDUALS.—Only in the case of a State that has elected the option (of guaranteeing coverage of disabled individuals) described in section 1501(a)(1)(D)(ii) for the fiscal year (and, in the case of a fiscal year after fiscal year 1997, for the previous fiscal year), individuals—

"(i) who are described in such section; or

"(ii) who are described in section 1502(a) under paragraph (2) of that section.

"(D) POOR ELDERLY INDIVIDUALS.—Individuals who are—

"(i) described in section 1501(a)(1)(E); or

"(ii) described in section 1502(a) under paragraph (3) of that section.

"(E) QUALIFIED MEDICARE BENEFICIARIES.—Individuals described in section 1501(b)(1)(A) who are not described in subparagraph (D).

"(F) QUALIFIED DISABLED AND WORKING INDIVIDUALS.—Individuals described in section 1501(b)(1)(B) who are not described in subparagraph (D).

"(G) CERTAIN OTHER MEDICARE BENEFICIARIES.—Individuals described in section 1501(b)(1)(C) who are not described in subparagraph (D).

"(H) OTHER POOR ADULTS.—Individuals described in section 1501(a)(1)(G) who are not within a population group described in a previous subparagraph.

"(3) EXCESS NUMBER OF INDIVIDUALS.—

"(A) IN GENERAL.—In this subsection, the 'excess number of individuals', for a State for a fiscal year with respect to a supplemental allotment population group, is equal to the amount (if any) by which—

"(i) the number of full-year equivalent individuals in the population group for the State and fiscal year, exceeds

"(ii) the anticipated number of such individuals (as determined under subparagraph (B)) for the State and fiscal year in such group.

"(B) ANTICIPATED NUMBER.—

"(i) IN GENERAL.—In subparagraph (A)(ii), the 'anticipated number' of individuals for a State in a supplemental allotment population group for—

"(I) fiscal year 1997 is equal to the number of full-year equivalent individuals in such group enrolled in the State medicaid plan under title XIX in fiscal year 1996 increased by the percentage increase factor (described in clause (ii)) for fiscal year 1997; or

"(II) a subsequent fiscal year is equal to the number of full-year equivalent individuals in the population group for the State for the previous fiscal year increased by the percentage