CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS
NUMBER: 11-W-00206/4
TITLE: Medicaid Reform Section 1115 Demonstration
AWARDEE: Agency for Health Care Administration

XV. LOW INCOME POOL

91. **Low Income Pool Definition.** A Low Income Pool (LIP) will be established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5-year demonstration period.

92. **Availability of Low Income Pool Funds.** Funds in the LIP will become available upon implementation of Florida Medicaid Reform, which shall be no later than July 1, 2006, provided the pre-implementation milestones are met as discussed below in Section XVI "Low Income Pool Milestones."

93. **Reimbursement and Funding Methodology Document.** In order to define LIP permissible expenditures the State shall submit for CMS approval a Reimbursement and Funding Methodology document for the LIP expenditures and LIP parameters defining State authorized expenditures from the LIP and entities eligible to receive reimbursement. This is further defined in Section XVI, "Low Income Pool

Milestones." Any subsequent changes to the CMS approved document will need to be submitted as an amendment to the demonstration as defined in item six in Section III, "General Program Requirements."

94. **Low Income Pool Permissible Expenditures.** Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS

95. **Low Income Pool Expenditures - Non-Qualified Aliens.** LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens.

96. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care

services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-Federal share of funding for such expenditures will be defined in the Reimbursement and Funding Methodology Document as discussed in item 91 of this section and Section XVI, "Low Income Pool Milestones."

97. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid at cost and will be further defined in the Reimbursement and Funding Methodology Document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost and this requirement is further clarified with the submission of a corresponding State Plan Amendment, as outlined in the pre-implementation milestones in Section XVI, "Low Income Pool Milestones."

98. **Low Income Pool Permissible Non-Hospital Based Expenditures**. To ensure services are paid at cost, CMS and the State will agree upon cost-reporting strategies and define them in the Reimbursement and Funding Methodology document for expenditures for non-hospital based services.

99. **Permissible Sources of Funding Criteria.** At least, 120 days prior to the demonstration implementation the State must submit for CMS approval the source of non-Federal share used to access the LIP, as outlined in the pre-implementation milestones. The State shall not have access to these funds until the source of non-Federal share has been approved by CMS. CMS assures the State that it will review the sources of non-Federal share in a timely manner. Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes) shall be impermissible.

XVI. LOW INCOME POOL MILESTONES

100. **Pre-Implementation Milestones.** The availability of funds for the LIP in the amount of $1 billion is contingent upon the following items prior to implementation:
a. The State's submission and CMS approval of a Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement.
b. Florida's submission and CMS approval of a State Plan Amendment (SPA) that will terminate the current inpatient supplemental payment upper payment limit (UPL) program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Nothing herein

precludes the State from submitting a State Plan Amendment reinstituting inpatient hospital supplemental payments upon termination of this demonstration. The State agrees not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration.
c. The State shall submit a State Plan Amendment for CMS approval limiting the inpatient hospital payment for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96.
d. The State shall submit for CMS approval of all sources of non-Federal share funding to be used to access the LIP. The sources of the non-Federal share must be compliant with all Federal statutes and regulations.
e. The State's ability to access the restricted portion of funds at the time of implementation and for the duration of the demonstration shall be contingent upon the State's capacity to meet the following milestones outlined in this Section.

101. **Demonstration Year 1 Milestones.** The State agrees that within 6 months of implementation of the demonstration it will submit a final document including CMS comments on the Reimbursement and Funding Methodology document (referenced in item 91). The final document shall detail the payment mechanism for expenditures made from the LIP to pay for medical expenditures for the uninsured and qualified aliens including expenditures for 10 percent of the LIP used for other purposes as defined in paragraph 94. This document shall also include a reporting methodology for the number of individuals and types of services provided through the LIP. This methodology shall include a projection of these amounts for each current year of operation, and final reporting of historical demonstration periods. Providers with access to the LIP and services funded from the LIP shall be known as the provider access system. Any subsequent changes to the CMS approved document will need to be submitted as an amendment to the demonstration as defined in item six in Section III, "General Program Requirements."

102. **Demonstration Year 2 Milestones.** At the beginning of demonstration year 2, $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year one for a total of $1 billion.

The State will conduct a study to evaluate the cost-effectiveness of various provider access systems. The results of this study shall be disseminated to the provider access systems for the continuous improvement in the structure, scope and access to such systems.

During demonstration year 2, using the results of the study as a guideline, the State and CMS will define the scale of the provider access systems and the indicators used to measure the impact of such systems on the uninsured, which will be funded through the low-income pool for demonstration years 3 through 5.

By the end of demonstration year 2, the State will develop a plan for the continuous

improvement of provider access systems and evaluation of the impact of these systems on the uninsured to be implemented in demonstration year 3.

By the end of demonstration year 2, the State will develop a plan for the statewide implementation of the demonstration by the end of waiver year 5.

103. **Demonstration Year 3 Funding.** At the beginning of demonstration year 3, $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year 2 for a total of $1 billion

Demonstration Year 3 Milestone. The State shall implement the indicators established under the plan for continuous improvement of provider access systems for the uninsured as indicated in demonstration year 2.

104. **Demonstration Year 4.** At the beginning of demonstration year four $700 million will be available. An additional $300 million will be available at the completion of milestones as specified in demonstration year 3 for a total of $1 billion.

Demonstration Year 4 Milestone. The State shall identify the qualitative impact on the implemented indicators in demonstration year 3 on uninsured individuals. This analysis may require the State to adjust the indicators as necessary.

105. **Demonstration Year 5.** At the beginning of demonstration year 5, $700 million will be available. An additional $300 million will be available at the time the demonstration is operating on a statewide basis for a total of $1 billion.

XVII. OTHER DEMONSTRATION MILESTONES

106**. Other Demonstration Milestones.** The State agrees it must adhere to all of the timeframes and deliverables specified in the sections outlined below in order to be considered compliant with Section XVI, "Low Income Milestones:"

1. Section IV. General Reporting Requirements
a. Quarterly Reports
b. Annual Reports
2. Section V. Florida Medicaid Reform Demonstration Implementation
3. Section VIII. Choice Counseling
a. Developing Choice Counseling Materials
4. Section X. Employer Sponsored Insurance
a. Opt-Out Guidelines
5. Section XI. Enhanced Benefit Accounts Program
a. Enhanced Benefit Accounts Milestones
6. Section XIV. Evaluation
a. Submission of Draft Evaluation Design
b. Final Evaluation Design and Implementation
7. Section XVI. Low Income Pool Milestones

XVIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

107**. Quarterly Expenditure Reports.** The State shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under Section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide Federal Financial Participation (FFP) for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIX (Monitoring Budget Neutrality for the Demonstration).

108**. Reporting Expenditures Subject to the Budget Neutrality Cap.** The following describes the reporting of expenditures subject to the budget neutrality cap:

a) In order to track expenditures under this Demonstration, Florida shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which service was provided or for which capitation payments were made – incurred/accrual basis). Corrections for any incorrectly reported demonstration expenditures for previous demonstration years must be input within 3 months of the beginning of the Demonstration. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 108.c.

b) For each demonstration year at least three separate Form CMS-64.9 WAIVER and/or 64.9P WAIVER reports must be submitted reporting expenditures subject to the budget neutrality cap – more than three forms will be needed when there is more than one date of service year. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported on waiver forms. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 108.c.). The Florida Medicaid Reform eligibility groups (MEGs), for reporting purposes, include the following names and definitions:
MEG 1: SSI
MEG 2: TANF
MEG 3: Low Income Pool

c) For purposes of this section, the term “expenditures subject to the budget neutrality cap” shall include all Medicaid expenditures on behalf of the

individuals who are enrolled in this Demonstration (as described in item 106.b.of this section) and who are receiving the services subject to the budget neutrality cap, with the exception of the excluded services identified at the end of this paragraph. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and shall be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver. The excluded services are the following:

Excluded Services
AIDS Waiver (Waiver Services)
DD Waiver (Waiver Services)
Home Safe Net (Behavioral Services)
BHOS (Services Only)
ICF/DD Institutional Services
Family & Supported Living (W.S.)
Katie Beckett Model Waiver Services
Brain & Spinal Cord Waiver Services
School Based Admin Claiming
Healthy Start Waiver Services

d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS on Form CMS-64. In order to assure that the Demonstration is properly credited with premium collections, all premium collections from demonstration participants must be separated from other collections in the State's Medicaid program and reported in the narrative portion of the CMS-64 report as well as reported on line 9.D of the CMS-64 Summary Sheet.

e) Administrative costs shall not be included in the budget neutrality limit. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

109**. Reporting Member Months.** The following describes the reporting of member months subject to the budget neutrality cap:

a) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible

for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

b) The term "Demonstration eligibles" excludes unqualified aliens and generally refers to the following categories of enrollees, pursuant to the waiver specifications and expenditures included in budget neutrality, with the exceptions noted in paragraph 106.d:

MEG 1: SSI
MEG 2: TANF
MEG 3: Low Income Pool

c) For the purpose of monitoring the budget neutrality expenditure cap described in Section XIX, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined above. This information must be provided to CMS in conjunction with the quarterly progress report referred to in number 22 of Section IV. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.)

d) The excluded eligibles are the following:

Excluded Eligibles
Refugee Eligibles
Dual Eligibles
Medically Needy
PW above TANF Eligible (>27% FPL, SOBRA)
ICF/DD Eligibles
Unborn Children
State Mental Facilities (Over Age 65)
Family Planning Waiver Eligibles
Women w/ breast or cervical cancer
MediKids

110**. Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the Demonstration. Florida must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended.

CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

111**. Non-Federal Share of Funding Conditions and Availability of Federal financial payments (FFP).** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Section XIX:
1. Administrative costs associated with the direct administration of Florida Medicaid Reform at the appropriate FFP rate authorized under Medicaid.

2. Net expenditures and prior period adjustments of the Medicaid and Florida Medicaid Reform programs, which are paid in accordance with the approved State plan. CMS will provide FFP for medical assistance payments with dates of service and during the operation of the 1115 waiver.

3. The employee subsidy portion of the ESI, as subsidized by the State of Florida, provided that the employer or self-employed person contributes. In no instance shall the subsidy exceed the premium, which would be paid to a Medicaid capitated plan in the absence of the individual not opting out of Medicaid. The program is limited to enrollees eligible for Medicaid, as authorized under the current state plan.
4. Health insurance (individual, two-person, or family) purchased by a selfemployed person on his/her own behalf, will be treated as employersponsored insurance, and will be eligible for employer subsidies and employee subsidies which, are for FFP purposes, subject to the same limits

5. Net Expenditures associated with the Low Income Pool, as described in Section XV.

6. Net Expenditures associated with the Enhanced Benefits Accounts Program.

112**. State Certification of Funding.** The State shall certify State/local monies used as matching funds for the Demonstration and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

113**. MSIS Data Submission.** The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State shall

ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

XI. MONITORING BUDGET NEUTRALITY

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The Special Terms and Conditions specify the two independent financial caps on the amount of Federal Title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as defined in 106.c. of Section X of this document. Federal financial payments for the Medicaid Reform aspects of the demonstration are limited by a per member per month method cap and the payments for the Low Income Pool aspects are limited by an aggregate cap.

114. **Budget Neutrality Limit for the Low Income Pool.** Florida will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The Low Income Pool amount will be capped at $1 billion total computable for each year of the demonstration for a total of $5 billion. In each year, use of a specific amount of the Pool is restricted by the provisions of Paragraphs 100 through 105 of the terms and conditions. Unexpended funds from the restricted amount may not be used for purposes other than these provisions and may not be carried over to other years. For the balance of the Pool amount each year, any unexpended portion may be expended for Pool purposes in subsequent demonstration years subject to clause 94. The Federal share of the annual $1 billion total computable is the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures for the Low Income Pool MEG, subject to the previous conditions on what portions may be carried over from year to year. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

115. **Budget Neutrality Limit under the Per Capita Cost Per Month Method.** The limit is determined by using a per capita cost per month (PCCM) method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire Demonstration. In this way, Florida will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing Florida at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

116. **Calculating the Per Capita Cost Per Month.** For the purpose of calculating the overall PCCM expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire

demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures for the SSI and TANF MEGs. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

a) **Projecting Service Expenditures.** Each yearly estimate of Medicaid Reform service expenditures will be the cost projections for the SSI and TANF MEGs defined below. The annual budget estimate for each MEG will be the product of the projected per capita cost per month (PCCM) cost for the MEG, times the actual number of eligible member months as reported to CMS by the State under the guidelines set forth in section X.
b) **Projected PCCM Cost.** Projected PCCM for each MEG has been calculated by using a pre-determined trend rates to convert the base year per capita costs into annual projected per capita costs for each year of the demonstration. Rates of 8 and 8 percent apply to the SSI and TANF MEGs respectively. The monthly equivalent growth rates are: .643403 and .643403 percent for each MEG and have been used to convert Base Year/State fiscal year (FFY) PCCM cost estimates to Demonstration Year (DY) estimates. The agreement to use these trend rates is based on analysis of State and National data.
The base year and projected DY PCCM amounts are the following (using July 1, 2006 as start date for the demonstration):

Time Period SSI MEG TANF MEG
Base Year $753.18 $158.35
DY 01 (SFY 2006-2007) $948.79 $199.48
DY 02 (SFY 2007-2008) $ 1,024.69 $215.44
DY 03 (SFY 2008-2009) $ 1,106.67 $232.68
DY 04 (SFY 2009-2010) $ 1,195.20 $251.29
DY 05 (SFY 2010-2011) $ 1,290.82 $271.39

c) Converting PCCM to an Alternative Start Date. Because the beginning demonstration may deviate from the expected start date, the following methodology may be used to produce revised DY estimates of PCCM amounts. Using the monthly equivalent growth rate, the appropriate number of monthly trend rates would be used to convert base year PCCM costs to PCCM costs for the first DY. After the first DY, the annual trend factor will be used to trend forward from one year to the next. (This procedure is described more fully in the sample calculations presented below.)

Sample Calculations
First Demonstration Year:
As an example, assume that a base year (SFY 2000) per capita cost for the enrolled population is $1,000, and the first year of the demonstration (DY 2001) is January 1, 2001, and ends December 31, 2001. DY 2001 is 18 months in time beyond SFY 2000; therefore, the monthly trend factor must be applied to trend SFY 2000 cost forward DY to 2001. Assume a trend rate of 5.2% and the associated monthly trend

of .42336%. Applying the monthly trend factor to bring the base year estimate forward to DY 2001 results in PCCM cost of $1079. ($1079 = $1000 x 1.00423336^{18})
Second and Subsequent Demonstration Years:
Since DY 2002 is 12 months beyond DY 2001, 12 months of growth factor are needed. Applying the 5.2 percent growth factor to the estimated DY 2001 PCCM cost of $1079 gives a DY 2002 PCCM cost of $1135.

117. **How the Limit will be Applied**. The limits as defined in paragraphs 93 and 94 will apply to actual expenditures for demonstration, as reported by the State under Section XVIII. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

118. **Impermissible DSH, Taxes or Donations**. The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through SMD letters, other memoranda on or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

119. **Expenditure Review** CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, the State will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in term and condition #22. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide for the PCCM budget limit, if the State exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

120. **Expenditure Review.** Expenditure through the low-income pool may not exceed the amounts determined by term and condition #93 – the annual contingent amount

of $300 million must not be exceeded during applicable demonstration years of 02-05. The non-contingent amount during demonstration years 02-05 may not exceed $700 million, except as permitted by rollover amounts as guided by the following:

Year	Non-Contingent Low Income Pool Expenditures	Cumulative Amount
Year 1	$1 billion, providing implementation requirements are met	$1 billion
Year 2	$700 million	$1.7 billion
Year 3	$700 million	$2.4 billion
Year 4	$700 million	$3.1 billion
Year 5	$700 million	$3.8 billion