Congressional Moderates' Position on Medicaid Reform

	House Coalition	Senate Moderates
FLEXIBILITY		
President's flexibility package -- Managed care and home and community services without Federal waivers. Flexibility on quality standards.	+	+
FINANCING		
'Dollars follow people'/economic downturn formula.	+	+
No reduction in state matching rate.	+	+
Provider tax protections.	+	+
ELIGIBILITY		
Coverage for kids 13-18 -- retains current law that phases in kids.	?	+
Federal definition of disability -- with welfare exclusion of alcoholics, chemical & substance abusers from mandatory coverage.	+	+
BENEFITS		
Retain 'adequacy' standards	+	+
Retain statewideness/comparability standards.	+	+
EPSDT--have Secretary designate benefits that are being abused.	+	+
ENFORCEMENT		
Repeal Boren amendment.	-	+
Federal right of action -- preserve Federal right of action for eligibility and benefits disputes.	?	?
STRUCTURE/SECOND TIER ISSUES		
Preserve current law protections by drafting off of Title XIX.	+	+
Quality assurance: managed care/nursing home standards, enforcement.	o	+
Family financial protections.	+	+
OVERALL SAVINGS Administration $59 billion; House Coalition $85 billion; Senate $62 billion.		

(+) indicates a position that is consistent with the Administration; (-) indiciates positon inconsistent with the Administration; (0) indicates partial support; (?) indicates unclear position.

(3/20/96)

Jen — new §§ added on Medicare eligibility & DHS.

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
A: OVERVIEW				
1. Program Structure	• Federal grant-in-aid program that entitles certain categories of children, families, disabled persons and elderly adults to coverage for a defined package of medical assistance benefits and services. Beneficiaries receive services through participating providers, which may include independent health professionals, clinics and institutions as well as federally qualified or state licensed health maintenance organizations. States have discretion with respect to eligibility, benefits, provider qualification and reimbursement matters but must administer their programs consistent with federal eligibility, benefit, and other requirements. • Medicaid is financed jointly by federal and state governments; states that participate in the program receive federal financial contributions for expenditures on behalf of eligible individuals. The minimum federal contributions for medical assistance are set at 50 percent. States determine the size of their programs, and federal contributions remain a fixed percentage of state expenditures regardless of states' expenditure levels.	• Revises Medicaid to increase state discretion over eligibility, benefits, provider participation and reimbursement, and other matters while retaining the program as an individual entitlement to a defined benefit package, as well as states' open ended entitlement to federal contributions toward their program, up to a per-capita maximum payment amount. • Continues joint state/federal financing of Medicaid and retains the minimum federal contribution at 50 percent. However, federal contributions toward medical assistance furnished to any particular beneficiary would be capped in accordance with a statutory formula.	• Replaces Medicaid with a block grant program that entitles states to a fixed amount of federal funds to help pay for medical assistance furnished to low-income individuals. Eliminates eligible individuals' federal entitlement to a defined set of benefits. States have the option to determine which groups of individuals, if any, will be entitled to benefits under state law. Other than childhood immunizations and family planning services defined by the state, there are no minimum service requirements. • Sets Federal payments to states at an aggregate amount and includes caps on the program's annual growth rate. Increases the minimum federal contribution to 60 percent.	• Replaces Medicaid with an open-ended entitlement program of grants to states. In exchange for funds, states are required to carry out more specific duties (known as "guarantees") toward certain classes of individuals than under MediGrant. However, no specific individual are entitled to a defined level of benefits as is the case under current law. States have complete discretion to set benefit levels and may utilize eligibility standards that are either more liberal or more restrictive than those required under current law. • Sets federal payments to states at an aggregate amount, with additional open-ended sums in the form of an "insurance umbrella" for states experiencing higher than anticipated growth because of "unanticipated needs." Increases the minimum federal contributions at 60 percent.
2. Authorizing Legislation and Effective Date	• Medicaid, codified at Title XIX of the Social Security Act, was enacted in 1965.	• Amends the program, effective October 1, 1996, while otherwise retaining its structure and content.	• Repeals Medicaid as of October 1, 1996, replacing it with a MediGrant program authorized under a new title, Title XXI.	• Repeals Medicaid, replacing it with a new title under the Social Security Act. Proposal is silent on effective date.
3. Federal Standards and State Flexibility	• Gives states flexibility to tailor their programs within a federal legal framework establishing minimum and maximum eligibility, benefit and provider qualification and compensation rules, and state expenditure requirements. • Allows beneficiaries free choice of provider. Allows states to offer voluntary managed care enrollment. Permits states to mandate managed care enrollment for one or more classes of beneficiaries through the waiver process in Section 1915(b) or Section 1115 of the Social Security Act. Establishes minimum provider qualification standards for managed care organizations that contract on a "full-risk" basis unless a state obtains a waiver under Section 1115. • Establishes performance standards and a federal enforcement scheme for long-term care institutions.	• Broadens state flexibility over eligibility, benefits, provider qualification, and provider compensation. • Broadens state flexibility to require enrollment in managed care plans without federal waivers and relaxes federal requirements for managed care plans operating on a "full risk" basis. • Does not revise current law.	• Gives states complete flexibility over eligibility, benefits and program structure. Reduces state expenditure requirements, and limits federal contribution levels to a defined aggregate limit over a seven-year period. • Repeals freedom of choice and qualification requirements for managed care organizations, with the exception of solvency requirements for certain classes of health plans as defined in state insurance law. Waivers are no longer needed to mandate enrollment in managed care plans. • Retains federal long-term care standards but permits states to develop their own enforcement schemes.	• Expands state flexibility, reduces state expenditure requirements, while potentially increasing federal financial contribution requirements • Repeals freedom of choice and provider qualification requirements for managed care organizations. Waivers are no longer needed to mandate enrollment in managed care plans • Retains federal long-term care standards but permits states to develop their own enforcement schemes.

federal on long-term care standards and enforcement.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
A: OVERVIEW				
4. Federal Funding Levels	• CBO estimates total federal spending of $924.1 billion over the 7-year FY 1996 - FY 2002 period. The Federal share of Medicaid spending is projected to be 57 percent of total program spending over the FY 1996 - FY 2002 period [1] • CBO estimates that Medicaid will serve 36.7 million beneficiaries in FY 1996, rising to 46.8 million by FY 2005.[2] In 1995, CBO estimated a 10 percent annual rate of growth in federal Medicaid expenditures over the FY 1996-FY 2005 period, half of which is attributable to additional numbers of persons covered by the program.	• CBO estimates 7-year cost savings of $59 billion. • ANYTHING ABOUT GROWTH RATE TO ADD HERE?	• CBO estimates federal spending reductions of $133 billion over the 7-year period. • Growth rates are less than half the amount projected by CBO in 1995 as necessary to maintain current service levels to projected number of eligible persons. Provides no supplemental funds for increases in populations.	• No CBO estimates are available at this time. One study estimates that the Federal share of Medicaid spending would grow from 57 percent to 63 percent of total expenditures over the FY 1996 - FY 2002 period as a result of the continued open-ended federal funding nature of the program and the increase in the minimum federal contribution to 60 percent[3]. • ~~ANYTHING ABOUT GROWTH RATE TO ADD HERE?~~ Provides additional funds from an insurance umbrella to states which experience "unanticipated" growth in certain populations.

[1] Calculations by the Center on Budget and Policy Priorities, Washington D.C., 1996.

[2] According to CBO's December Preliminary Baseline.

[3] Center on Budget and Policy Priorities, op. cit

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
B. COVERAGE				
5. General Rules on Eligibility and Entitlement	• Federal law entitles certain categories of individuals to medical assistance on a mandatory basis and gives states the option of entitling other categories of individuals to coverage. Federal law specifies 27 separate categories of "mandatory categorically needy individuals" entitled to coverage. Low-income persons not falling into defined coverage categories are ineligible for federal contributions.	• Retains the individual entitlement to coverage for all existing mandatory coverage groups and adds a new optional low-income individual coverage category.	• Eliminates the federal entitlement to coverage for mandatory and optional groups. Provides states with full discretion to determine who is eligible for services, with no minimum eligibility standards and no requirement that the benefit be provided in the form of an individual entitlement.	• Eliminates the federal entitlement to a defined level of coverage for mandatory and optional groups. Revises the law to create state duties to "guarantee" at least some level of assistance to certain classes of persons but without requiring states to provide an individual federal entitlement in any person. Creates new options to assist additional classes of persons.
	• Requires states to extend coverage to all eligible persons in the state (the statewideness requirement). In addition, requires similar categories of eligible persons to be treated comparably with respect to eligibility standards (comparability requirement).	• Retains statewideness and comparability requirements.	• Eliminates statewideness and comparability requirements.	• Proposal is silent on treatment of statewideness and comparability requirements.
	• Federal law establishes standards for determining family income that takes into account certain individual and family living expenses. Limits state discretion to disregard certain types of income and resources. States may use more liberal standards and methodologies for children, pregnant women, and certain disabled and elderly persons under Section 1902(r)(2) of the Social Security Act.	• Retains existing standards and methodologies for most groups but restricts the use of more liberal standards and methodologies under Section 1902(r)(2).	• Permits states to develop standards and methodologies at their discretion.	• Proposal is silent on treatment of standards and methodologies.
a. Poverty Level Children	• Entitles children with poverty-level income (≤133 percent of the FPL for children under 6; ≤100 percent of the FPL for children ages 6 through 18 who were born after September 30, 1983) to coverage on a mandatory basis.	• Does not revise current law.	• Eliminates the federal entitlement to coverage.	• Eliminates the federal entitlement to coverage for a defined benefit package. Requires states to "guarantee" at least some assistance to the following classes of children: children up to age 6 with family incomes up to 133 percent of the FPL; and children ages 6 to 12 with family incomes up to 100 percent of the FPL. Eliminates any required level of assistance to children ages 12 through 18 with incomes up to 100 percent of the FPL.
	• States have the option to cover any child under a special provision codified at Section 1902(r)(2) through the use of more liberal financial eligibility criteria.	• Limits states' child coverage options to children with gross family incomes no greater than 150 percent of the federal poverty level. Does not revise option to cover infants up to 185 percent of poverty.	•States may assist any child with income up to 275 percent of the FPL.	• States may assist any child with income up to 275 percent of the FPL.
	• Children who are ineligible for Medicaid but who are uninsured are entitled to mandatory coverage for pediatric immunizations under the Vaccines for Children (VFC) program. All Indian children and children served by FQHCs and RHCs also are entitled to pediatric immunizations.	• Does not amend existing requirements under the VFC program.	• Eliminates the VFC program but requires that states furnish immunizations to children receiving assistance.	• Proposal is silent with respect to the VFC program.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
B. COVERAGE				
b. Poverty Level Pregnant Women	• Entitles pregnant women with poverty level income (≤ 133 percent of the FPL) to coverage on a mandatory basis for all "pregnancy related" services. • States have the option to cover any pregnant women under Section 1902(r)(2), using more liberal financial eligibility criteria.	• Does not revise current law. • Limits states' option to cover additional pregnant women to women with incomes up to 185 percent of FPL.	• Eliminates the federal entitlement to coverage for pregnant women. •States may use federal funds to assist pregnant women up to 275 percent of the FPL.	• Eliminates the federal entitlement to a defined benefit package but requires states to provide at least some level of assistance to poverty-level pregnant women. •States may use federal funds to assist pregnant women up to 275 percent of the FPL.
c. Aid to Families with Dependent Children (AFDC) Recipients (including Children Receiving Federal Foster Care and Adoption Assistance)	• Entitles AFDC recipients to Medicaid coverage on a mandatory basis. Mandates coverage for families receiving cash assistance and AFDC-related families (e.g., "deemed" AFDC recipients, persons losing AFDC coverage because of excess child support or work related income, and unemployed two-parent families eligible for but not receiving cash assistance). Children receiving federal foster care and adoption assistance under Title IV-E are treated as AFDC recipients and are entitled to mandatory coverage.	• Does not revise current law.	• Eliminates the federal entitlement to coverage for AFDC, AFDC-related children and adults and children receiving federal foster care and adoption assistance. States have full discretion regarding coverage.	• Eliminates the federal entitlement to a defined benefit package for AFDC families. Proposal is silent on treatment of AFDC-related families as well as children receiving federal adoption and foster care assistance. States must "guarantee" some level of assistance for AFDC families but may use other eligibility criteria adopted as a result of pending federal welfare reform legislation, if enacted.
d. Recipients of Supplemental Security Income (SSI)	• Mandates coverage of SSI recipients except in states using more restrictive eligibility standards that were in effect as of January 1, 1972.[4] Twelve states use more restrictive eligibility standards: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia.	• Does not revise existing requirements.	• Eliminates the federal entitlement to Medicaid coverage for SSI recipients. States have full discretion regarding coverage of persons with disabilities.	• Eliminates the individual federal entitlement for SSI recipients. Requires states to "guarantee" at least some level of assistance to persons with disabilities, as defined by the state.

[4] These states are known as "Section 209(b) states" because the option to use more restrictive standards was codified at Section 209(b) of the Social Security Amendments of 1972, which also created the SSI program.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
B. COVERAGE				
e. Low-Income Elderly Persons	• Entitles elderly persons who receive Supplemental Security Income (SSI) to full Medicaid benefits, except in states using more restrictive methodologies.[5]	• Does not revise current law.	• Eliminates the federal entitlement to coverage for elderly SSI recipients.	• Eliminates the federal entitlement to coverage but requires states to "guarantee" at least some level of assistance to elderly persons who meet SSI income and resource standards.
	• Entitles "qualified Medicare Beneficiaries (QMBs)" (family income ≤ 100 percent of the FPL and resources ≤ twice the SSI resource-eligibility standard) to coverage of Medicare premiums, coinsurance, and deductibles. Coverage for coinsurance and deductibles is at Medicare payment rates.	• Does not revise current law.	• Eliminates the federal entitlement to coverage for Medicare premiums and cost sharing assistance for QMBs.	• Eliminates the federal entitlement to mandatory coverage for QMBs but requires states to "guarantee" some level of assistance for cost-sharing only. States may limit cost sharing assistance to Medicaid payment levels rather than higher Medicare payment levels.
	• Entitles "Specified Low-Income Medicare Beneficiaries (SLIMBs)" (family income ≤ 120 percent of the FPL and resources ≤ twice the SSI resource-eligibility standard) to coverage of Medicare premiums only.	• Does not revise current law.	• Eliminates the federal entitlement for SLIMBs receiving assistance.	• Proposal is silent with respect to SLIMBs.
	• Permits states to cover individuals who are elderly and whose income does not exceed 100 percent of the FPL for full Medicaid benefits. Covered individuals are entitled to benefits.	• Does not revise current law.	• Eliminates the federal entitlement to coverage for individuals covered at state option.	• Eliminates the federal entitlement to a defined set of benefits for persons covered at state option.

[5] See footnote 4 and accompanying text.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
B. COVERAGE				
f. Individuals in Need of Long-Term Care and Their Children, Families, and Spouses	• Permits states to entitle individuals (whose incomes do not exceed three times the SSI payment level or who are medically needy and spend down to eligibility levels) to coverage in long-term care institutions. States may also entitle to coverage individuals in need of hospice and home and community based care who would qualify for Medicaid if institutionalized.	• Does not revise current law.	• Eliminates the federal entitlement to benefits for persons receiving long term care assistance for nursing facility, hospice, or home- and community-based care.	• Eliminates the federal entitlement to defined level of benefits for individuals receiving long term care assistance. States must "guarantee" at least some level of coverage among certain classes of individuals for certain long-term care-related services including home health care and nursing facility care.
	• Entitles spouses of long-term care residents to a monthly maintenance payment of 150 percent of the FPL. Permits spouses to retain assets of between $12,000 and $60,000. Prohibits states from charging adult children for parents' care.	• Does not revise current law.	• Continues spousal monthly maintenance support in the case of individuals receiving assistance. Permits states to charge children with family income above the state median for their parents' care.	• Proposal is silent on maintenance payments for non-institutionalized spouses or contributions from children of elderly relatives.
	• Limits states' authority to impose liens on homes of nursing home residents in the event that they are occupied by spouses, family members or children	• Does not revise current law	• Permits states to impose liens on homes occupied by spouses or minor or disabled adult children.	• Proposal is silent on imposition of liens on homes occupied by spouses, relatives or children.
	• Families with severely disabled children generally may not be charged for the long term care of children who have resided out of the home for 30 days or longer.	• Does not revise current law.	• Permits states to impose charges on families whose children are receiving long term institutional or home and community care.	• Proposal is silent on states' ability to charge families for long term care of minor disabled children.
	•States may obtain waivers to furnish home and community care but may not use federal funds to pay for room and board.	•Revises current law to permit states to furnish home and community care without waivers.	• Eliminates states' obligation to obtain waivers to furnish home and community care and permits states to furnish more types of long-term care than currently recognized under federal law (e.g., custodial level care).	• Eliminates states' obligation to obtain waivers to furnish home and community care and permits states to furnish more types of long-term care than currently recognized under federal law (e.g., custodial level care)
g. Persons with Disabilities	• Entitles disabled persons who receive Supplemental Security Income to full Medicaid benefits in most states.[6]	• Does not revise current law.	• Eliminates the federal entitlement to coverage for persons with disabilities who receive assistance from the state.	• Eliminates the federal entitlement to a defined benefit package for disabled persons who receive medical assistance. States must "guarantee" some level of assistance for persons with disabilities; states have the discretion to define disability.
	• Entitles disabled QMBs to Medicaid coverage for Medicare premiums, deductibles and copayments at the Medicare payment rate.	• Does not revise current law.	• Eliminates the federal entitlement among disabled QMBs to Medicare premium and cost sharing assistance.	• Eliminates the federal entitlement to premium and cost sharing assistance for disabled QMBs. States must furnish some level of assistance for Medicare cost sharing but only up to Medicaid payment levels. Proposal is silent on coverage of Medicare premiums.
	• Entitles disabled SLIMBs to Medicare premium payments.	• Does not revise current law.	• Eliminates the federal entitlement among disabled SLIMBs to Medicare premium payments.	• Proposal is silent on treatment of SLIMBs.

[6] See footnote 4 and accompanying text.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
B. COVERAGE				
h. Medically Needy Persons	• Permits states to entitle to coverage individuals who would qualify for cash welfare assistance but for excess income and resources and whose income and resources are insufficient to pay for the cost of medically necessary care. Medically needy coverage begins when individuals incur expenses for medical and remedial care sufficient to meet their spend-down obligations. Restricts medically needy eligibility to 133 percent of the AFDC payment level for a family with no other income.[1]	• Does not revise current law.	• Eliminates the federal entitlement to coverage for individuals receiving assistance as medically needy persons. Permits states to establish medically needy eligibility levels (after incurred expenses) up to 275 percent of the FPL.	• Eliminates the federal entitlement to coverage for individuals receiving assistance as medically needy persons. Proposal is silent with respect to medically needy eligibility levels.
i. Severely Impaired Workers and Welfare-to-Work Transitional Families	• Entitles ~~to coverage~~ severely impaired individuals who return to work and who lose SSI if necessary to permit their continued employment. → to continue coverage	• Does not revise current law	• Eliminates individual entitlement to coverage for severely impaired workers. Coverage for any level of assistance is at state discretion.	• Proposal is silent with regard to severely impaired workers
	• Entitles families who lose welfare because of increased earnings to 12 months of continued coverage.	• Does not revise current law.	• Eliminates federal entitlement to coverage for transitional workers and their families. Coverage for any level of assistance is at state discretion.	• Proposal is silent with regard to welfare-to-work transitional families.
j. Legal Residents and Undocumented Persons	• Most individuals who are legal residents are eligible for Medicaid if they meet categorical and financial eligibility requirements.	• Does not revise current law.	• Eliminates federal entitlement to coverage for legal residents who meet eligibility criteria. Permits states to deny coverage or reduce benefits to otherwise eligible persons who are legal residents.	• Proposal is silent on coverage of persons who are not lawfully present as well as legal residents.
	• Requires states to furnish emergency services to otherwise eligible individuals who do not reside in the U.S. under color of law.	• Does not revise current law.	• Retains coverage of emergency care for undocumented persons.[2] Establishes a $3.5 billion fund for care for undocumented persons with 100 percent FFP.	• Proposal is silent with respect to coverage of emergency services for undocumented persons. Makes available special grants for care of "illegal aliens" to "certain states."
k. Retroactive Eligibility	• Requires states to commence eligibility up to three months prior to the date of application in the case of individuals found eligible for assistance at an earlier date.	• Does not revise current law.	•Eliminates federal entitlement to retroactive coverage.	• Proposal is silent on retroactive coverage.
l. Eligibility of Residents of Institution for Mental Diseases (IMDs)	• Individuals who are residents of Institutions for Mental Diseases (IMDs) are ineligible for medical assistance unless the IMD is a community group home of 16 beds or fewer.	• Does not revise current law.	• Eliminates IMD exclusion.	• Proposal is silent on the IMD exclusion.

[1] In 1995, the average AFDC payment level was 35 percent of the FPL.

[2] Contained in the welfare reform provisions of H.R. 2491.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
B. COVERAGE				
m. Eligibility of Inmates of Public Institutions	• Individuals who are inmates of public institutions (other than foster care facilities or facilities for out-of-home placement for children and youth) are ineligible for coverage.	• Does not revise current law.	• Proposal is silent with respect to inmates of public institutions.	• Proposal is silent with respect to inmates of public institutions.
n. Low-Income Individuals Other than Pregnant Women, Children, Elderly and Disabled Persons	• Prohibits federal contributions toward medical assistance for low-income individuals who do not fall into defined eligibility categories noted above. States may entitle such individuals to coverage only if they pay 100 percent of the cost of coverage. Certain states with Section 1115 waivers (e.g., Oregon, Tennessee and Hawaii) entitle low-income persons to federal Medicaid on a demonstration basis.	•Revises current law to add a new coverage option for any individual with gross income ≤ 150 percent of the FPL. Repeals authority of the Secretary to waive otherwise applicable eligibility limitations under Section 1115 demonstrations.	•Adds a new optional assistance category consisting of individuals with family incomes up to 275 percent of the FPL.	• Adds a new optional assistance category consisting of individuals with family incomes up to 275 percent of the federal poverty level.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
B. COVERAGE				
6. Benefits: General Rules	• Specifies certain benefits for all covered individuals other than medically needy persons: inpatient hospital care, outpatient hospital care, laboratory and x-ray services, nursing facility services, physician services, family planning services and supplies, services of federally qualified health centers and rural health clinics, Early and Periodic Screening Diagnosis and Treatment (EPSDT) services, services of nurse midwives and pediatric and family nurse practitioner services. Transportation is a mandatory type of assistance.	• Does not revise current law.	• Eliminates mandatory benefit rules except for immunizations for children and family planning services as defined by each state.	• Eliminates services of federally qualified health centers and rural health clinics as mandatory ~~services~~. benefits.
	• Permits states to cover other services including intermediate care facility services, preventive health services, services of clinics, rehabilitation services, prescribed drugs, prosthetic and orthopedic devices, case management services, services of licensed health practitioners, dental care, physical therapy and related services, inpatient psychiatric services for persons under age 21 and over 65, personal care services, community supported living arrangement services, and hospice services	• Does not revise current law.	• Permits states to provide assistance for any benefit identified in current law. Adds IMD services (see section 5 (I) supra) as well as medically related services.	• Retains all existing optional benefit groups but does not identify either FQHC or RHC services as an optional benefit. ~~Adds~~ Proposal is silent on coverage of IMD services.
	• Requires services to be covered at levels that are "sufficient in amount, duration and scope to reasonably achieve their purpose". Prohibits discrimination in coverage of a required service on the basis of a condition. Requires that limits in coverage be based on medical necessity.	• Does not revise current law.	• Eliminates the amount, duration, and scope, anti-discrimination, and medical necessity requirements. Prohibits states from imposing pre-existing condition exclusions on coverage.	• Eliminates the amount duration and scope, medical necessity and anti-discrimination requirements. Benefit coverage may be at any level.
	• Requires states to cover all medically necessary vaccines for children eligible for Medicaid, uninsured children, all Indian children and all children receiving care at FQHCs and RHCs.	• Does not revise current law.	• Eliminates program but requires states to cover immunizations for all children eligible for medical assistance.	• Proposal is silent on the Vaccines for Children Program.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
B. COVERAGE				
a. Early and Periodic Screening Diagnosis and Treatment (EPSDT)	• Entitles all children under age 21 to a special set of benefits known as Early and Periodic Screening Diagnosis and *Treatment (EPSDT). EPSDT benefits include periodic health* exams beginning at birth, interperiodic exams whenever needed, immunizations, vision, dental and hearing care and any medically necessary care to prevent or ameliorate any physical or mental condition disclosed during a periodic or interperiodic health exam. Services that are recognized under the federal Medicaid statute must be covered for children even if they are otherwise optional services for adults.	• Does not revise current law.	• Eliminates the EPSDT program except for immunizations of children eligible for medical assistance.	• Retains EPSDT services as covered services but permits states to limit treatment services to whatever classes and level of assistance is furnished to adults under a state's plan.
b. Pregnancy-Related Care	• Requires states to cover pregnancy-related services, defined as prenatal delivery and post-partum care, as well as services necessary to treat conditions arising from or that could complicate, a pregnancy.	• Does not revise existing law.	• Eliminates requirement to furnish pregnancy-related services.	• Limits service requirement to prenatal care and nurse midwife services; silent on other pregnancy-related services.
c. Long-Term Care in Nursing Homes and in Community Settings	• Requires states to cover nursing facility services and provides coverage options for a range of other long-term care services, (noted above in Section 6). States may furnish home and community based care services with federal waivers.	• Does not revise existing service mandates and options and eliminates requirement of a waiver for home and community based services	• Eliminates nursing facility services as a mandatory service and permits states to cover other forms of long term care services at whatever levels they choose.	• Retains nursing facility services as a mandatory class of service for which certain levels of service guarantees must be given. Permits states to cover long term care services, including nursing facility services at whatever level they choose.
d. Family Planning Services and Supplies	• Mandates coverage of family planning services and supplies, defined under federal rules and guidelines.	• Does not revise current law.	• Requires states to provide family planning services and supplies to eligible individuals but leaves definition to each state as well as the level of service coverage.	• Retains family planning services as a mandatory class of services but leaves amount of coverage to state discretion. Proposal is silent regarding whether states can substitute their own definition of family planning services.
e. Federally Qualified Health Center and Rural Health Clinic Services	• Requires states to furnish FQHC and RHC services which are defined as physician, nurse practitioner and physician assistant, psychology and social work services furnished by FQHCs[9] and RHCs	• Does not revise current law.	• Eliminates the FQHC and RHC service coverage requirement.	• Eliminates the FQHC and RHC service coverage requirement

[9]FQHCs include federally funded community and migrant health centers, entities that meet the requirements of the health center programs but do not receive federal funding, homeless health care programs under section 340(A) of the Public Health Service Act, Urban Indian Health Clinics, and Indian Tribal organization clinics.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
B. COVERAGE				
7. Premiums and Cost Sharing	• Permits nominal cost sharing for certain beneficiaries; prohibits cost sharing for children, pregnant women, and persons in need of emergency care. Long-term care institutional residents may not be required to make copayments out of their personal needs allowance ($30 per month).	• Does not revise current law.	• Permits nominal cost sharing on primary and preventive services for children and pregnant women, and allows cost sharing generally for other persons. Permits premiums except in cases of families with pregnant women and children and family incomes below 100 percent of the FPL. Allows cost sharing to discourage "inappropriate" use of emergency medical services or transportation	• Proposal is silent on cost sharing generally.
	• Requires states to pay Medicare premiums and cost sharing for QMBs and Medicare premiums for SLIMBs (see Section 5, supra). Payment of QMB premiums must be at Medicare level.	• Does not revise current law.	• Eliminates premium and cost sharing requirements for QMBs and SLIMBs.	• Proposal is silent on premium assistance for QMBs and treatment of SLIMBs (See Section 5, supra).
8. Access to Care	• Requires that provider payments be "sufficient to enlist enough providers so that care and services are available under the [state Medicaid] plan at least to the extent that such care and services are available to the general population in the geographic area." sufficient to ensure that Medicaid beneficiaries have reasonable access to care.	• Does not revise current law.	•Eliminates "equal access" provision.	• Proposal is silent with respect to "equal access" provision

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
C. TREATMENT OF PROVIDERS				
9. Provider Qualification and Patient Freedom of Choice	• Requires that Medicaid agencies permit participation by any qualified provider unless state obtains federal waivers under Section 1915(b) or Section 1115 to limit participation by qualified providers and use "selective contracting" for managed care and other services. • Requires that beneficiaries have a free choice of provider unless freedom of choice is waived by Secretary under Section 1915(b) (reviewed below under "Managed Care") or as part of a Section 1115 managed care demonstration. Requires states to maintain freedom of choice for family planning services even when free choice of provider requirements are otherwise waived under Section 1915(b)	• Permits states to selectively purchase certain types of managed care services from qualified providers without a waiver; proposal is silent regarding whether selective contracting can be used for other services without a waiver • Permits states to eliminate freedom of choice in certain circumstances without obtaining federal waivers. Retains family planning freedom of choice provision.	• Permits states to exclude qualified providers for all forms of managed care or other selective contracting purposes without obtaining federal waivers. • Permits states to eliminate freedom of choice for all services, including family planning, without federal waivers.	• Permits states to exclude qualified providers from all forms of managed care systems without waivers. Proposal is silent with respect to selective purchasing of services from qualified providers other than managed care. • Permits states to eliminate freedom of choice for all services, including family planning, without federal waivers.
10. Reimbursement of Hospitals, Nursing Facilities and Certain Other Institutional and Long-Term Care Providers	• State payments to hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), and home and community care services must be reasonable and adequate to meet the cost of efficiently provided care as required under the "Boren Amendment". Medicare upper payment limits apply. • Requires hospice programs to be paid in accordance with Medicare payment methodologies including Medicare upper payment limits. Provisions do not apply under HCFA [illegible] to institutions that are participating providers in risk-based managed care plans.	• Repeals the Boren amendment for hospitals, nursing homes and other institutional providers. • Does not revise current law.	• Repeals all provider payment rules. • Repeals hospice payment rules.	• Repeals both upper and minimum payment rules for hospitals, nursing facilities and ICF/MR (i.e., Boren Amendment and "Boren-like" statutory provisions). Proposal is silent on payments for home and community care. • Proposal is silent on payments for hospice services but provides for repeal of other "Boren-like statutory requirements."
11. Support for Hospitals Serving Large Number of Low-Income Patients	• Requires additional payments (known as "disproportionate share (DSH)" payments) to hospitals serving a high volume of low-income and publicly-insured patients. Mandatory DSH hospitals have Medicaid utilization rates more than one standard deviation above the average Medicaid utilization rate for participating hospitals in the state or a low-income utilization rate greater than 25 percent. Permits states to establish more liberal criteria for DSH payments and include additional classes of facilities in their programs	• Reduces DSH payments and re-targets them to hospitals serving a large number of low-income and publicly insured patients. Proposal is silent on minimum rules for re-targeting as well as minimum classes of DSH facilities	• Eliminates all DSH payment requirements and folds DSH payments into each state's baseline allocation.	• Eliminates all DSH payment requirements and folds DSH payments into each state's baseline allocation.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
C. TREATMENT OF PROVIDERS				
12. Treatment of Federally Qualified Health Centers and Rural Health Clinics	• Federally qualified health center (FQHCs) and rural health clinic (RHCs) services are mandatory. FQHCs and RHCs receive cost-based reimbursement. Special rules apply to FQHCs and RHCs that participate in risk- based managed care systems that permit them to elect cost-based reimbursement.	• Eliminates reasonable cost reimbursement for RHCs and FQHCs after 1998 and replaces payment provisions with a new program of direct supplemental payments to ~~clinics~~ providers.	• Contains no similar provisions concerning coverage of services or reasonable cost payment. Eliminates rules for FQHCs and RHCs that participate in managed care. Establishes a state maintenance of effort (MOE) payment requirement that states may waive in urban medically underserved areas. Requirement ends in 1998. Provision limits a state's MOE to 85 percent of total payments for FQHC and RHC services between FY 1992 and FY 1994.[10]	• Repeals reasonable cost payment requirements following a two-year phase-out. However, FQHC and RHC service coverage requirements are eliminated immediately; as a result, the phase-out program status is unclear.
13. Payment for Obstetrical and Pediatric Care	• States must submit data on obstetrical and pediatric payment levels to ensure that payments are sufficient to enlist adequate providers.	• Eliminates the obstetrical and pediatric payment provision	• Eliminates the obstetrical and pediatric payment provisions.	• Proposal is silent regarding obstetrical and pediatric payment levels.

[10]Under current law, states may report payments for FQHC and RHC services either as payments for these particular classes of services or as payment for physician services, nurse practitioner services, clinic services, pharmacy services, etc. In states that do not report payment to FQHCs and RHCs under the "FQHC" and "RHC" category there would be no MOE, since the MOE is tied to state payments ~~under these particular service categories~~ specifically for "FQHC" + "RHC" claims of services

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	*Current Medicaid Program*	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the *Seven-Year Balanced Budget Act of 1995*	*National Governors' Association Proposal*
D. FINANCING				
14. Federal/State Financial Arrangements: In General	• Entitles states to an open-ended federal financial contribution, known as the Federal Medical Assistance Percentage (FMAP) toward the cost of state program expenditures. Federal *payments rise as state spending* increases to accommodate additional numbers of eligible persons and/or increases in the cost of medical care. • CBO projects that between FY 1995 and FY 2005 federal expenditures will grow at a 10 percent average annual rate, with total federal spending between FY 1996 and FY 2002 of $955 billion. Approximately one-half of the projected federal spending increase can be attributed to growth in the number of beneficiaries.	• Retains existing system of open-ended federal financial contribution in accordance with a statutory formula. However, federal contributions per enrollee are limited to a per capita *payment which is adjusted annually following the* 1995 base year. A state's per capita payment baseline reflects the state's historic expenditures on behalf of eligible populations. No federal per capita payments are available for low -income individuals added at state option (see Section 5(n), supra). • CBO projects $59 billion in savings from per capita caps and other reductions.	• Entitles states to a fixed annual federal contribution which increases annually in the aggregate in accordance with a statutory formula but which does not grow as enrollment increases. • CBO projects approximately $133 billion in savings.	• Entitles states to open-ended federal contributions as follows: each state would receive an annual aggregate lump sum payment reflecting a base year payment level adjusted in the out-years for changes in caseload and inflation. In addition, States would be able to obtain additional assistance under an "insurance umbrella" which would be available once actual population growth exceeds estimates and the state can show a "demonstrable need". • ~~Provides~~ CBO projections are available.
15. Federal *Contributions*	• Provides federal contributions for "medical assistance" payments, administrative costs, and contribution for state DSH programs, which are subject to separate aggregate limits. With the exception of DSH, the federal contribution toward medical assistance and program administration rise as state expenditures rise. • The minimum federal contribution for medical assistance is 50 percent.	• Imposes limits on per capita contributions for both medical assistance and administrative services. The allowable Medicaid growth limit for a state is 1 plus the average change in the nominal GDP plus an additional additive factor required to produce the level of savings required under the proposal. • Does not revise current law.	• Provides for base-year payments plus variable out-year growth rates that are designed to average out per capita expenditure levels among the states. • Increases the minimum federal contribution to 60 percent.	• Proposal does not include a formula for determining out-year growth rates. • Increases the minimum federal contribution to 60 percent.

for each of the fiscal years 1996 through 2002

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
D. FINANCING				
16. State Expenditure Requirements	• Requires states to spend their own funds from either general revenues or dedicated taxes in order to qualify for a federal contribution • Prohibits states from using provider donations to generate state expenditures and strictly limits the use of provider-specific taxes	• Does not revise current law.	• Requires states to make expenditures but caps state expenditure requirements at 40 percent. • Eliminates prohibitions and limitations on provider taxes and donations. • Requires states to "set aside" the following amounts for certain populations until FY 1998: 85 percent of total average expenditure between FY 1992 and FY 1994 for mandatory benefits for low-income families, low-income disabled persons and low-income elderly persons; and for Medicare premium assistance, 90 percent of amounts that were spent on mandatory premiums for QMBs and SLIMBs between FY 1993 and FY 1995. DSH payments attributable to inpatient hospital care for mandatory eligibles are excluded from set-aside. • Permits states to use "residual funds" (which equal 58 percent of total Medicaid expenditures) for additional medical assistance, "medically related" services (defined as any service related to states' objectives and goals) and administration (up to defined limits). • Permits states to waive set-asides if not necessary in the state's opinion.	• Requires states to make expenditures but caps state expenditure requirements at 40 percent. • Eliminates prohibitions and limitations on provider taxes and donations. • Requires states to spend 90 percent of total medical assistance funds paid in FY 1995 for persons with disabilities. Provides no other mandatory minimum set-aside rules. • Proposal is silent
17. Disproportionate Share Hospital Payments (DSH)	• Federal payments toward states' disproportionate share hospital programs are capped at an aggregate level per state. For FY 1994, the total federal DSH allocation was $18.5 billion.	• Reduces each state's aggregate federal DSH payment.	• Folds federal DSH payments into each state's "baseline" payment.	• Folds federal DSH payments into each state's baseline payment.
18. Contingency Funding	• Does not include contingency funding; payments are open-ended.	• No contingency payments even if cost per enrollee increases at rate faster than federal formula for federal contribution permits.	• No contingency fund even if number of beneficiaries increases faster than aggregate formula estimates.	• Provides an "Insurance Umbrella" which is available if actual population increases faster than estimates and if there is a "demonstrable need".
19. Financing Services for Undocumented Persons	• Federal financial participation is available for emergency services for undocumented persons who are otherwise eligible. No other funds are available.	• Creates new supplemental payment program for states with high numbers of undocumented persons. Proposal is silent with respect to formula and amount.	• Creates a $3.5 billion fund between FY 1996 and FY 2002 for the 15 states with the highest numbers of undocumented persons.	• Creates a special grant program of unspecified size to assist states meet the cost of serving "illegal aliens". No state expenditures are required.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
E. FEDERAL OVERSIGHT AND STATE FLEXIBILITY				
20. Managed Care	• States have the option to offer managed care enrollment to any group of beneficiaries on a voluntary basis.	• Does not revise existing law.	• Permits states full discretion to mandate managed care enrollment without waivers.	• Permits states full discretion to mandate managed care enrollment without waivers.
	• States may mandate managed care enrollment for one or more classes of beneficiaries through Section 1915(b) freedom of choice waivers, which permits states to require managed care enrollment.	• States may mandate enrollment into primary care case management systems or with risk based plans without obtaining a waiver as long as individuals are given a choice of arrangements and other requirements are met.	• Permits states full discretion to mandate managed care enrollment without waivers.	• Permits states full discretion to mandate managed care enrollment without waivers.
	• Minimum provider qualification standards apply to managed care organizations that contract on a "*full risk*" basis unless a state obtains Section 1115 waivers. No more than 75 percent of enrollees may be Medicare and Medicaid beneficiaries and HCFA must approve contracts in excess of $100,000. Six-month guaranteed enrollment is available only in the case of federally qualified or state licensed HMOs and CMPs.	• Eliminates the "75 percent" rule for full risk plans and all contract approval requirements. Extends 6-month guaranteed enrollment period to all managed care plan enrollees. See p. 27	• Eliminates all federal qualifications for managed care organizations *with the exception of solvency requirements for* certain classes of health plans as defined in state insurance laws. States may set minimum enrollment periods at their discretion.	• Eliminates all federal requirements for managed care organizations. *States may set minimum enrollment periods at* their discretion.
	• Does not apply special rules to the enrollment of Indians in managed care or the participation of IHS facilities. ~~IHS facilities are reimbursed at 100 percent federal financial participation rate for the medical assistance they furnish to Indians.~~	• Requires that IHS facilities be permitted to participate in managed care arrangements and that Indians continue to be given reasonable access to IHS services even if outside their plans. ~~IHS facilities continue to be reimbursed at a 100 percent federal financial participation rate.~~	• Does not impose special rules for Indians or IHS facilities. ~~However, facilities continue to be reimbursed at a 100 percent Federal financial participation rate for their services.~~	• Does not impose special rules for Indians or IHS facilities. ~~However, facilities continue to be reimbursed at a 100 percent Federal financial participation rate for the IHS services.~~
	• Managed care enrollees retain freedom of choice for family planning services.	• Does not revise current law.	• Repeals family planning freedom of choice provisions.	• Proposal is silent on family planning freedom of choice provision.
	• Federally qualified health centers and rural health clinics may continue to receive reasonable cost reimbursement even if they participate in risk based plans.	• Eliminates FQHC and RHC rights to reasonable cost reimbursement.	•. Eliminates FQHC and RHC rights to reasonable cost reimbursement.	•. Eliminates FQHC and RHC rights to reasonable cost reimbursement.
21. Nursing Home Care	• Requires nursing facilities that participate in Medicaid to meet extensive quality of care standards, with payment adjusted to assure coverage of the cost of compliance.	• Does not revise existing law and adds requirement for review of residents upon notice of a change in their condition.	• Retains nursing facility standards.	• Contains provisions pertaining to nursing facility standards which are similar to MediGrant.
	• Establishes minimum standards for non-institutionalized spouses of nursing home residents to protect against impoverishment. Minimum standards include monthly maintenance income levels and protected resource levels.	• Does not revise current law.	• Retains spousal impoverishment program for spouses of institutionalized beneficiaries; however, all rules regarding coverage of individuals for institutional benefits are repealed.	• Proposal is silent on existing law protections for spouses of institutionalized persons
	• Minimum federal monitoring and enforcement standards and procedures apply.	• Does not revise current law.	• Gives states discretion on methods of enforcement.	• Gives states discretion on methods of enforcement

Eliminates annual resident review under PASARR

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
E. FEDERAL OVERSIGHT AND STATE FLEXIBILITY				
22. Enforcement of Federal Standards	• Permits Secretary to terminate participation of state in Medicaid in the event that a state either submits a plan or amendments that fails to satisfy federal requirements or operates its program in a manner that is inconsistent with federal standards.	• Does not revise current law.	• Permits Secretary to terminate state participation in the event that within 30 days of submission a state plan or amendment is determined to be inconsistent with federal requirements. Permits Secretary to also terminate state involvement if its administration of the program is in "substantial violation" of law.	• Permits Secretary to determine adequacy of state plan. Permits Federal intervention only when state fails to comply substantially with Federal statutes or its own plan.

A SIDE-BY-SIDE COMPARISON OF PROPOSALS TO REFORM THE MEDICAID PROGRAM

Issue	Current Medicaid Program	President Clinton's Proposal (FY 1997 Budget)	MediGrant Provisions of H.R. 2491, the Seven-Year Balanced Budget Act of 1995	National Governors' Association Proposal
F. LEGAL PROTECTIONS				
23. Beneficiary Protections	• Individuals who allege that a state agency has violated their right to coverage under the program have a federal right of action to enforce federal requirements in court. Federal courts have power to hear federal rights of action arising under the Medicaid statute and alleging a conflict between state policies and federally guaranteed rights.	• Does not revise current law.	• Individuals ~~are no longer are~~ entitled to coverage and therefore the individual federal right of action to enforce coverage rights is ~~not relevant~~. (Secretary will establish a complaint process so that individuals may notify the Secretary of a State's failure to provide medicaid assistance or administer the plan properly. If the Secretary determines that there is a pattern of complaints or that a particular finding of non-compliance is "egregious," the Secretary is required to notify the Governor of the state and Congress in the event that the state fails to respond to the notice in a reasonable time.	• ~~Individuals no longer have an entitlement to a defined benefit package. Proposal eliminates a federal right of action in individuals and requires that state PROVIDE A state-created right of action in state court only after exhaustion of administrative remedies.~~ State right of action for individuals is *limited* to claims involving eligibility. Proposal is silent on other federal claims including claims regarding access, quality and benefits.
24. Provider Protections	• Providers have a federal right of action to enforce rights granted under the Medicaid program.	• Does not revise current law.	• Repeals federal rights of action in providers and repeals federal provider rights.	• Repeals all rights of action in providers and ~~repeals~~ federal provider rights.