FACT SHEET ON MEDICAID HEALTH CARE-RELATED TAXES
October 9, 1997

Medicaid, enacted in 1965, is a Federally-guaranteed health insurance program for certain low-income individuals, primarily pregnant women, children, the elderly and the disabled. It is a state/Federal partnership where the Federal government sets broad eligibility standards and pays states a portion of their Medicaid costs. States must commit funds in order to receive Federal financial participation (FFP). The source of certain State funds has been contentious, as described below.

BACKGROUND

During the late 1980s, many States established new taxes that had the effect of increasing their Federal Medicaid funds without using additional State resources. Typically, States would raise funds from health care providers (through provider taxes or "donations"), then pay back those providers through increased Medicaid payments. Since the Federal government pays at least half of Medicaid payments, the provider taxes or donations would be repaid in large part by Federal matching payments. Using this mechanism, the State realized a net gain because it had to repay only part of the provider tax or donation it originally received.

The widespread use of these financing mechanisms contributed to the extraordinary increases in Federal Medicaid expenditures in the late 1980s and early 1990s. One report found that provider tax revenue rose from $400 million in 6 states in 1990 to $8.7 billion in 39 States in 1992. There was a similar increase in Federal Medicaid spending, which more than doubled between 1988 and 1992, with an average annual rate of over 20 percent. The number of people served by Medicaid did not rise by nearly so much.

In response to this unprecedented drain on the Federal Treasury, Congress passed "The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991" (Public Law 102-234). The first stand-alone piece of Medicaid legislation in the program's history, this law permits States to use revenue from health care-related taxes to claim Federal Medicaid matching payments only to the extent that these taxes are broad based (i.e., applied to all providers in a definable group); uniform (i.e., same for all providers within the group); and are not part of a "hold harmless" arrangement (i.e., the taxes are not devised to repay dollar-for-dollar the provider who was initially assessed). The law also precluded States from using provider donations, except in very limited circumstances. In addition, the law introduced limits on how much States could pay hospitals through the disproportionate share hospital (DSH) program — the primary way that States repaid their provider taxes or donations.

The final regulation for this law was published in 1993 after extensive consultation with the States and the National Governors' Association. The regulation defined which taxes are permissible, HCFA's methodology for determining permissibility of taxes, and a process for requesting waiver approval for tax programs that are either not broad based and/or uniform.

Since the regulation, HCFA has communicated with States — through letters, a national conference, and State contacts at the regional level — about the provider tax policies. However, given the complexity of health care financing, some issues intended to be resolved by the 1991 law, the 1993 regulations, and subsequent HCFA interpretations are still questioned by some States. This has led to a review by HCFA of its interpretations of these policies.

POLICY CLARIFICATIONS

Today, the results of HCFA's review of its interpretation of the provider tax law and regulations are being described in a State Medicaid Directors' letter and a *Federal Register* notice. HCFA has determined that several changes in its implementation of the Medicaid provider tax provisions are appropriate, as described in today's letter to State Medicaid Directors (dated October 9, 1997). First, HCFA will clarify its interpretation of taxes that are considered uniform. It will permit taxes on occupied beds or patient days to be considered uniform (previously, only taxes on all beds and all days were considered uniform). Second, the letter states that States do not need to submit a new waiver request for a tax subject to an existing waiver if there is a uniform change in the tax rate. The letter also reminds States that they may suggest additional classes of providers to qualify as "broad based" and that they should submit quarterly reports on their provider taxes and donations. These clarifications have resulted in the determination that certain taxes in 10 States are permissible and require no further review.

In addition, HCFA will publish in the October 15, 1997 *Federal Register* a correcting amendment to the provider tax regulation regarding its interpretation of the uniformity test. It corrects the threshold for allowable tax programs based on regional variations, enacted and in effect prior to November 24, 1992. The correction is to conform the regulation to HCFA and Congress's intent to recognize such taxes as generally redistributive.

PLANS FOR ENDING THE USE OF IMPERMISSIBLE TAXES

In its effort to apply the law and end the use of impermissible provider taxes, HCFA will open discussions with the States individually to understand better their specific provider taxes and their issues resulting from the current law.

The Administration's goal is to end the use of impermissible taxes as soon as possible. To achieve rapid and full compliance, it is willing to work with States to resolve impermissible tax liabilities. The Administration believes that this will be facilitated by legislation that codifies the tests to determine that a tax is permissible and concentrates in the Department greater authority to work with States to resolve impermissible tax liabilities in return for States coming into full compliance. In the development of this legislation, the Administration will work with States, the National Governors' Association, and Congress to address the concerns States have raised with respect to current law. If, however, legislation is not enacted by August 1998, the Secretary will move forward to complete the process already begun to apply with full force the current law.

It is our hope that States will be responsive and cooperative so we can resolve these issues in a mutually satisfactory way.

Copied
VP
Bowles
Reed
Sperling
Jennings

THE PRESIDENT HAS SEEN
10-10-97

THE WHITE HOUSE

WASHINGTON

October 9, 1997

Looks pretty good too (strongly feel we must forgive the past taxes — as of 1/1/98 back)

MEMORANDUM TO THE PRESIDENT

cc: Vice President, Erskine Bowles, Bruce Reed, Gene Sperling

FROM: Chris Jennings

RE: **NEW YORK AND THE PROVIDER TAX ISSUE**

Today, DHHS announced the results of its policy review of Medicaid provider taxes and its policy changes regarding New York. In brief, they announced (1) policy clarifications that clarify that certain provider taxes previously in question, including New York's regional tax, are permissible; and (2) support for legislation that expedites identifying impermissible taxes and ending their use. This is the culmination of an intensive process that involved HHS, OMB, DPC/NEC, Legislative and Intergovernmental Affairs, the Office of the Vice President and other senior staff.

BACKGROUND

Financing scheme and the law limiting it. During the late 1980s, many States established financing schemes that had the effect of increasing their Federal Medicaid funds without using additional State resources. Typically, States would raise funds from health care providers (through provider taxes or "donations"), then pay back those providers through increased Medicaid payments. Since the Federal government pays at least half of Medicaid payments, the provider taxes or donations would be repaid in large part by Federal matching payments. Using this mechanism, the State was left with a net gain because it only had to repay part of the provider tax or donation it originally received.

Because provider taxes and donations were effectively siphoning off potentially billions of dollars from the Federal Treasury, the Congress limited states' use of these schemes in a bill enacted by President Bush in 1991. The subsequent regulatory interpretation of these limits was, as you know, negotiated with ~~the states and the~~ National Governors' Association in 1993.

States' continued reliance on impermissible provider taxes and our enforcement record. Despite the new law and the regulations, many states continued to use provider taxes that at least appeared to be out of compliance. To date, these possibly impermissible taxes total an estimated $2 to 4 billion and, in the future, could cost billions more. In response, HCFA issued letters and discussed its concerns about certain taxes with states, but -- for a variety of reasons -- never took any final action. Unfortunately, this has meant that a number of states continue using these taxes, believing that HCFA might never enforce the law, or that if they did, they could seek recourse through the White House or the Congress.

The New York provision in the balanced budget. To ensure that New York would never be vulnerable to Medicaid provider tax enforcement actions, Senator Moynihan and Senator D'Amato successfully added a provision to the Balanced Budget Act to exempt all of its provider taxes (it has dozens), both retrospectively and prospectively, from disallowances. Both in writing and orally we repeatedly objected to this provision. Moreover, we provided alternative statutory language that would have forgiven about $1 billion. As you know, however, the Senators (through their staff) rejected our offer and insisted on their original provisions.

Line-item veto and New York's reaction. In announcing the line-time veto on August 11, we raised concerns about the cost and ramifications of singling out as permissible one state's provider taxes. Although our actions were generally viewed as responsible and defensible by those who know the program and/or who are budget experts, the same clearly cannot be said of New York's political establishment. The Governor's office, the New York Congressional delegation, the Mayor, providers and unions reacted strongly and negatively to the veto. Among a host of complaints, they charged that they were singled out and were never made aware that this provision could be subject to the line-tem veto. Most recently they have criticized us for our delay in getting back to them and our willingness to support fixes for the other two vetoed provisions without addressing their problem.

TODAY'S ACTIONS. The line-item veto of New York's special provider tax waiver provision accelerated a review process of these tax policies that was already underway at DHHS. This process has yielded two results. First, HCFA is issuing a set of policy clarifications in a letter to State Medicaid Directors. This letter clarifies how DHHS will implement the law and regulations on states' use of health care-related taxes for their share of Medicaid; this letter will be viewed as good news for at least nine states. HCFA also released a notice in the Federal Register containing a correcting amendment to the regulation to make it consistent with Congressional intent; this will make New York's regional tax permissible.

The State Medicaid Director's letter also includes an announcement of our support for legislation that (a) lays out in statute how to identify impermissible taxes; and (b) would provide enhanced authority to the Secretary **to forgive up to the entire amount of individual states' current liabilities if they come into full compliance with the law for future financing**. If, however, by a date certain -- August 1998 -- no legislation is passed, HCFA will aggressively enforce its current policies. (Attached is a one-page summary of our actions today.)

Need for legislation. The Administration's goal in these actions is to work with the states to end the impermissible use of provider taxes. Given the staggering size of the liabilities for some states, we agree that this is best accomplished through negotiation. Specifically, we are interested in trading reductions in some or all of states' retrospective liabilities for discontinued use of such taxes in the future. However, the administrative process that HCFA has at its disposal offers many opportunities for states to continue to stall (as they have done in the past). More importantly, final settlements must be approved by the Department of Justice which may take a hard line in terms of recouping retrospective liabilities. This could force states to look for a legislative "rifle shots" to fix their particular problem, or to go to court.

Consequently, we think that the best way to bring states to the negotiations is through reliance on a legislative strategy. By strengthening the Secretary's ability to negotiate, we avoid the uncertainty inherent in an ordinary administrative process. By stating what type of legislation we would support, we get ahead of the rifle shots and possibly prevent them, as well as to get the Congress invested (albeit reluctantly) in developing a mutual solution to the provider tax mess. And by offering to clarify our ways of identifying impermissible taxes, we may engage states that have concerns about our interpretation, thus possibly preventing suits. These incentives are reinforced by threat of a deadline for passage of such legislation (August 1998) that triggers an aggressive enforcement action by HCFA.

Reaction from New York. Today's briefing of both Governor Pataki's staff and the New York Congressional delegation seemed to go quite well. They appreciated the resolution on the states' regional tax and seemed to accept that our legislation approach was much preferable to an immediate administrative enforcement action. We explained to them that the law and our current regulations would have forced us to publicly state that some of their provider taxes appear to be impermissible. Having said this, they certainly would have preferred an action that retrospectively and prospectively forgiven any potential liability; in other words, they want the provisions we line-item vetoed. As such, as of this writing, it is unclear what public posture either the Governor or the Congressional delegation will take.

Reaction from other states. Although nine other states benefit from the new policy clarifications, it is news of our support for legislation that caught the states' attention at our NGA briefing. The dozen or so states that have widely used provider taxes appeared to view this positively. It is these states that we want to engage in discussion and eventually negotiations. However, it was unclear whether the remaining states that either ended their provider tax use or who never used them to begin with viewed our action as too conciliatory. We communicated to all the states that we have not -- and will not -- change our opposition to the use of provider taxes. We simply stated that we are looking for the most effective way to end all states' reliance on impermissible taxes.

Next steps. HCFA plans on immediately reaching out to the states to obtain updated information about the status of state provider taxes. There will probably be Congressional interest in knowing how we plan on pursuing our legislative strategy. John Hilley believes that we should have an Administration bill, but that we should not introduce it until we have had sufficient time to achieve more investment in the details of the bill from the Congress and the states. We will keep you apprised of developments.

SUMMARY: MEDICAID PROVIDER TAXES

- **What is being released.** Today, the Department of Health and Human Services (DHHS) has sent a letter to State Medicaid Directors. This letter clarifies how DHHS will implement the law and regulations on states' use of health care-related taxes for their share of Medicaid. There will also be a notice in the Federal Register containing a correcting amendment to the regulation to make it consistent with Congressional intent.

  The State Medicaid Director letter also includes an announcement of our support for legislation that (a) codifies current regulations that contain the tests to determine that a tax is permissible; and (b) would concentrate authority in the Department to resolve impermissible tax liabilities if a state comes into full compliance by ending the use of impermissible taxes. This legislative approach may more expeditiously end the use of impermissible taxes. If, however, by August 1998 no legislation is passed, the Secretary will move forward to complete the process already begun to apply with full force the current law.

- **Why action is needed**? States' use of impermissible provider taxes poses a major threat to Medicaid's fiscal integrity. During the late 1980s, health care provider tax programs were used to increase Federal Medicaid funding without using additional state resources. These schemes contributed to the doubling of Federal Medicaid spending between 1988 and 1992.

  Today, a number of states continue to use potentially impermissible provider taxes. To maintain the integrity of the Medicaid program, we must be certain that the Federal Treasury is not impermissibly being tapped to underwrite costs that are the responsibilities of the states. To not do so would be unfair to those states (and their taxpayers) which are in compliance.

- **Why now?** This review, which has been on-going at DHHS for many months, has drawn increased attention recently due to the line-item veto of a Medicaid provider tax provision in the Balanced Budget Act. Under this provision, all of New York's over 30 provider taxes would be deemed approved. The President vetoed this provision because it was too broad and singled out a single state for special treatment. However, he promised that DHHS would intensify its review of its interpretation of the law for New York and all states. Today's action is a result of this review.

- **Impact on New York**. One of New York's major concerns have been that Medicaid regulations have not grandfathered the State's "regional" tax. Given evidence of Congressional intent for this tax treatment, the Administration will publish a correcting amendment to the regulation in the Oct.15 *Federal Register*. This action relieves New York of over $1 billion of provider tax liability.

  No final resolution on New York's other provider taxes has been reached. However, HCFA will be contacting New York and other states to gather further information on taxes.

- **Impact on other states**. 10 States will benefit from the clarification that the Department is providing today. States will be contacted with requests for additional information. It is our hope that all states and their representatives will work toward legislation that protects the Federal Treasury as well as treats States fairly as we move to ensure that all states are in compliance with the law (D.C., Alabama, Lousiana, Ohio, Mississippi, Montana, New York, South Carolina, Utah, Wisconsin).

File Pataki letter

216
C. Jennings

THE WHITE HOUSE

WASHINGTON

September 10, 1997

The Honorable George E. Patakі
Governor of New York
Albany, New York 12224

Dear George:

Thank you for writing to me regarding my decision to cancel the New York provider tax provision in the Balanced Budget Act of 1997. Please be assured that I did not exercise this authority lightly, and I understand that New York has significant concerns. My Administration is working to ameliorate these difficulties, and I have asked my budget director, Frank Raines, to contact you directly to discuss the issues involved in more detail.

As you know, the federal government has, over several administrations, opposed allowing certain provider taxes to be permissible for only one state or singling out any state for special treatment. I canceled the New York provider tax provision only after my staff had both articulated our opposition to this provision and offered alternative language that could have mitigated the impact of the potential tax disallowance on New York. Unfortunately, the Congressional negotiators rejected our offer. My only remaining option to address this issue was to use my line item veto authority to prevent a precedent that would have been both costly and poor policy.

The Health Care Financing Administration is assessing possible administrative approaches for New York and other states and will follow up with you expeditiously. I am confident that we are moving forward in a manner that will treat all states fairly and equitably.

Sincerely,

Bill Clinton

Renee ? Schilhab ?

R. S. For Mever

824 - 6412

888 479 - 7149

[illegible]

File "NY Waiver"

July 17, 1997

MEMORANDUM TO THE VICE PRESIDENT

FR: Chris Jennings

cc: Ron Klain, Don Gips, Mike Burton

RE: New York Medicaid Waiver

Yesterday, I met with representatives from a number of unions including, Gerry Shea of the AFL-CIO, and Alan Reuther at UAW as well as representatives from SEIU and AFSCME. At the meeting, the unions mentioned how pleased they were with the outcome of the New York 1115 Medicaid Demonstration, which will enroll 2.4 million New-Yorkers in managed care plans. This demonstration was made public by HHS on Monday.

The unions are pleased with the New York Demonstration because it includes $250 million per year ($1.2 billion over five years) to help the health care work force make a smooth transition into managed care. Any transition into managed care such as this one has the potential to disrupt the health care delivery system and, in particular, the health care work force. Hospitals will be downsized and more community-oriented options will take their place and Hospital workers will need to be retrained so they can make this transition.

The unions expressed their concerns early on in this process about how HHS should take precautions to ensure that we minimized the impact of the transition. They are now happy that the $250 million per year will help health care workers be retrained.

Talking Points for Phone Call

- I understand that the AFL-CIO is pleased with the outcome of the New York 1115 Medicaid Demonstration which HHS made public on Tuesday. I know that Dennis Rivera worked particularly hard to ensure that this Demonstration was successful.

- We well understand that making significant changes in a state's Medicaid program has important implications for the health care work force. As New York makes the transition to managed care, hospitals will be downsizing and more community-oriented options will take their place. The health care work force will need assistance in making this transition.

- The Administration worked to ensure that this Demonstration included $250 million per year ($1.2 billion over five years) to help hospital workers adjust to this transition. Each qualifying hospital will submit to the state a plan for how it will use the funds from the demonstration to restructure its work force and make other changes to adapt to the managed care environment.

- We look forward to working with you as this process moves forward.

My Provider Tax File

September 12, 1997

NOTE TO OMB PROVIDER TAX MEETING PARTICIPANTS:

FYI, at the time these materials were distributed, ASPE was not in concurrence on several points. HCFA and ASPE are currently discussing their differences. If these differences are not resolved before today's meeting, it will be noted during the meeting that discussions on these points are still underway.

Rebecca Cardozo

R

cc: Anna Durand, OGC
Rich Tarplin, ASL
LaVarne Burton, ASMB
Gary Claxton, ASPE
Sally Richardson, HCFA
Nancy Ann Min DeParle, HCFA
Kathy King, HCFA
David Cade, HCFA
Claudia Cooley, ES
Jackie White, ES

TO: The Secretary
Through: DS ____
ES ____

FROM: The Administrator

SUBJECT: Status of Health Care Provider Tax Programs - Material for Briefing.

BACKGROUND

In 1991, an agreement was reached between the previous Administration and the States that resulted in the enactment of Public Law 102-234, the Medicaid Voluntary Contributions and Provider-Specific Tax Amendments of 1991.

This law became effective on January 1, 1992. It provides that:

- States are precluded from using provider donations, except in very limited circumstances.

- In order to be permissible, provider taxes must meet three criteria. These criteria are:

  The tax must be "broad-based;" i.e., it must tax all providers in a class designated either by law or by the Secretary in regulations.

  The tax must apply to all providers in a uniform way.

  The State may not hold the providers harmless for the tax costs.

- When the interim final regulations were published on November 24, 1992, there was widespread expression of concern by the States and the National Governors Association that the provisions of those regulations were inconsistent with the spirit of the agreement that had produced the new legislation. During his first month in office, the President promised the NGA that the regulations would be revised, and the Department immediately undertook extensive discussions with the NGA and States. On August 13, 1993, the Final Rule was published in the Federal Register.

We have identified a number of areas for which we have determined potential impermissible tax issues.

1) the **generally redistributive waiver test threshold** - waiver standard for provider tax programs which are not broad based and/or uniform specified at 42 CFR 433.68(e);

2) the **licensing fee** requirements (requirement that fees be broad based, uniform, and not hold taxpayers harmless) specified at 42 CFR 433.56(a)(19).

3) the **hold harmless** repayment provisions (requirement prohibiting States from returning tax dollars back to assessed providers) specified at 42 CFR 433.68(f); and,

4) the **classes of health care items or services** (permissible provider classes) specified at 42 CFR 433.56.

There are several actions that the department could take to clarify the law in this area and to resolve our differences with States.

HCFA proposes to take the following actions:

1) Revisions to Regulations

Correcting Amendment to Regulations

HCFA put a correcting amendment into clearance on September 11, 1997. The corrected regulation would reduce the generally redistributive waiver test threshold for tax programs based exclusively on regional variations, and enacted and in effect prior to November 24, 1992, from **.85** to **.7**. The correction is necessary to correct an error in the published regulation and conforms the regulatory language to HCFA's -- and Congress's -- original intent, i.e., to exempt New York's preexisting regional tax pool from the provisions of the statute.

Generally Redistributive Waiver Test

HCFA proposes to prospectively reduce the numerical threshold for the generally redistributive test from **1.0 (or .95)** to **.8 (or .75)**.

HCFA has evaluated 6 provider tax programs from 2 States that yielded a generally redistributive value of greater than .8 but less than 1.0. We believe tax programs which yielded a generally redistributive value in this range do not unduly burden the Medicaid program. The potentially unallowed FFP for these taxes is estimated to be $587 million through March 31, 1997.

Licensing Fees and User Fees

With regard to licensing fees, HCFA proposes to prospectively remove the $1,000 annual exception limit for licensing fees. However, the Governor (or his designee) must certify that the revenue generated from these fees was used to administer the licensing program.

With regard to user fees, HCFA proposes to consider them permissible prospectively if the Governor (or his designee) certifies that the revenue generated from these fees was used to administer the user fee program.

To the extent the licensing and user fees are used to administer the licensing and user fee programs, we believe these types of fees are not unduly burdensome to the Medicaid program.

Bad Classes

HCFA proposes to publish a regulation in the **Federal Register** which invites States to identify additional classes if States can demonstrate that the revenue of the class is not more than 50 percent from Medicaid and not more than 80 percent from Medicaid, Medicare, and other Federal programs combined; the class is clearly identifiable; and, the class is nationally recognized.

The statute and current regulation permit the addition of classes through regulation. This provides States with the vehicle to add classes to the extent they meet the above mentioned criteria.

2) Revisions to HCFA Policy Interpretation

Occupied Beds/Patient Days

HCFA will issue a State Medicaid Director letter advising States that we are revising our interpretation of uniformity. A tax based on occupied beds/patient days would be uniform and, therefore, would not require waiver approval. Previous policy required that all beds/days must be taxed to be considered uniform. The effect of this revision would be both retrospective and prospective. This would provide relief to 14 of the pending waiver requests from 9 States.

Change in Rate of Tax

HCFA will issue a State Medicaid Director letter advising States that we are revising our interpretation of waiver submission requirements. States may change the rate of a currently existing tax program without submitting a new waiver request. Previous policy required the approval of a waiver for each tax rate change. The effect of this revision would be both retrospective and prospective. This would provide relief to several States.

3) <u>Remaining Taxes Which Require Resolution</u>

Hold Harmless

There are seven (7) States whose provider tax programs violate the hold harmless provision of the statute. The hold harmless provisions are not waivable. HCFA believes these types of provider tax programs are impermissible. The potentially unallowed FFP for these tax programs is estimated to be $1.6 billion through March 31, 1997.

Generally Redistributive Waiver Test Results Below .8

At least two States impose provider tax programs which yield generally redistributive values of less than .8.

Retrospective and Prospective Bad Classes

At least two States impose provider taxes on classes which are not listed by statute and regulation and do not meet the criteria for addition to the list of classes.

Retrospective Generally Redistributive Waiver Test Results Between 1.0 and .8

While the revised regulation would permit certain taxes to be considered permissible <u>prospectively</u>, the Department Of Justice is currently researching HCFA's authority to make the proposed regulatory changes retroactive. We believe we will receive a response to this issue early next week.

Retrospective and Prospective Licensing and User Fees

While the revised regulation would permit certain taxes to be considered permissible <u>prospectively</u>, there may be other fees that do not meet the revised regulatory requirements and, therefore, would be impermissible. Also, the Department Of Justice is currently researching HCFA's authority to make the proposed regulatory changes retroactive. We believe we will receive a response to this issue early next week.

<u>NEGOTIATION STRATEGY</u>

HCFA will issue disapproval letters to the States for impermissible tax programs and inform States that HCFA Regional Offices will perform audits.

The HCFA Regional Offices will perform audits.

States will be notified of audit results and of HCFA's analysis of the tax programs to give States an opportunity to [respond in writing and/or to] meet informally with an

HHS/HCFA tax team to attempt to resolve any differences in factual issues or interpretations of the law.

HCFA and States will enter into negotiation discussions in order to reach settlement.

Following these negotiation discussions, HCFA will prepare disallowance letter(s). (States that wish to settle will ultimately receive a disallowance letter of a lesser amount.)

HCFA will clear disallowance letters through the Department and the Office of Management and Budget.

HCFA will issue disallowance letters. The States which do not agree to settlement negotiations can appeal the decision to the Departmental Appeals Board.

HCFA will defer future grant awards for those States which do not agree to settlement negotiations and/or those States which continue to collect impermissible taxes..

HCFA and OGC are currently working with the Department of Justice to determine whether the Agency has the discretion to settle these administrative claims without DOJ approval as long as there is no litigation. This issue should be resolved by early next.

The following are the factors that we believe should be considered in determining the terms of settlement:

1. Whether the litigation resources required to prevail in litigation would be justified in light of the strength or weakness of the State's legal argument, the discovery that would be necessary, and the amount in dispute;

2. Whether the State is either no longer collecting the tax or agrees to discontinue collection;

3. Whether the tax will be permissible prospectively because of regulatory amendment or change in policy;

4. Whether the loss of the revenue collected from the tax would have a significant impact on the State program;

5. Whether the tax places a significant burden on the Medicaid program;

6. Whether the revenue collected from the tax was used to promote State health care programs;

7. Whether the State has previously been afforded other special financial treatment through legislation or waivers; and,

Velasquez
& ASSOCIATES

1617 INLET COURT □ RESTON, VA 20190 □ PH: 703-437-4556 FAX: 703-437-4590

FAX COVER SHEET

To:	Chris Jennings	From:	Joe Velasquez
Fax:	202-456-5557	Pages:	2
Date:	August 14, 1997		
Re:	New York Medicaid Veto Meeting		

690-7755

Mr President Task File

Velasquez
& ASSOCIATES

Memorandum

To: Chris Jennings

From: Joe Velasquez

Date: August 14, 1997

Re: New York Medicaid Veto Meeting

This is to follow up on yesterday's conversation concerning the meeting to discuss the Medicaid veto issue with representatives of the health care industry and New York government officials.

Dennis Rivera is viewed as the broker for this meeting. He has spoken with the affected parties and we suggest the following people to participate in the meeting:

Sheldon Silver, Speaker of the New York State Assembly
Barbara DeBueno, Commissioner of Health, State of New York
Randy Mastro, Deputy Mayor, City of New York
Peter Vallone, City Council President, City of New York
Kenneth Raske, President, The Greater New York Hospital Association
Jerry McEntee, President, AFSCME

Again, this list is a suggestion. Mickey and the political shop will vet this list and amend it as necessary. If you cannot arrange a meeting soon you should at least set a specific date so that people know you are serious.

You should take a parallel path with the congressional delegation, particularly with Senator Moynihan and Representative Rangel. They should receive a call today from a senior White official. Dennis spoke with Mr. Rangel yesterday afternoon and Rangel is disturbed that no one has reached out to him.

Thanks and call if we can help.

[illegible] Court • Reston, VA 20190 4429
[illegible] • FAX [illegible]

TO: JEFF SACHS
FROM: HOWARD BERLINER
DATE: OCTOBER 16, 1996
RE: INFO FROM NYSDOH

JEFF,

I JUST RECEIVED THIS FROM DEBORAH (7:00 PM EASTERN TIME). IN ESSENCE, LIST A IS WHAT THEY THINK WE CAN DO WITHOUT RUNNING INTO THE UPPER PAYMENT LIMIT, LIST B IS WHAT MAY BE MORE PROBLEMATIC FROM THEIR PERSPECTIVE IN TERMS OF THE UPL. SHE HAS NOT RECEIVED ANYTHING FROM DOL, BUT IT SEEMS UNLIKELY GIVEN THE DISCUSSION THAT WE HAD THAT THERE WAS ANYTHING SUBSTANTIAL FROM THAT SOURCE.

I WILL BE BUSY UNTIL ABOUT 10:00 EASTERN TIME TONIGHT AND I WILL GIVE YOU A CALL AS SOON AS I AM AVAILABLE TO DISCUSS THIS WITH YOU. THE ISSUE IS HOW TO REVISE THE DRAFT OR JUST TO GO IN WITH THESE NUMBERS AND START THE DISCUSSION WITHOUT THE DRAFT. WE STILL HAVE NO CONCEPT OF HOW WE WILL SPECIFICALLY SPEND THE MONEY.

OTHER ISSUES:

1) SHE DOESN'T WANT ME TO SHOW THIS TO STEVE WARNKE (SHE SAYS SHE TOLD YOU HER OBJECTIONS TO THIS)-- BUT STEVE BELIEVES THAT WE CAN GET A LOT MORE MONEY THAN THEY ARE PUTTING IN THE DOCUMENT (FOR EXAMPLE THERE IS MORE MONEY IN CHIP THAT CAN BE MATCHED AND IT WON'T TURN THE PROGRAM INTO AN ENTITLEMENT).

2) SHE WILL BE IN NYC WITH DENNIS TOMMOROW GETTING A TOUR OF THE HOSPITALS.

HOPE YOU'RE HAVING A GOOD TIME

HOWARD

PS. MY HOME NUMBER IS 718-596-1085 IF YOU WANT TO LEAVE A MESSAGE ON MY MACHINE

LIST A

	GROSS	New Federal
Secure Federal Financial Participation (FFP) of Indigent Care Surcharges currently supported solely through State and Local Funding.	$308.0M	$154.0M
The Child Health Insurance Program will provide coverage for inpatient care. This and other insurance programs' coverage could be deemed eligible for FFP under disproportionate share.	$26.6M	$13.3M
Grants to hospitals to assist in the transition to a market driven system could be distributed as Medicaid rate adjustments.	$7.5M	$3.75M
Grants to hospitals for expansion of primary care capacity could be distributed as Medicaid rate adjustments.	$10.0M	$5.0M
Grants to rural hospitals to strengthen linkages and reconfigure services could be distributed as Medicaid rate adjustments.	$8.5M	$4.25M
Grants to hospitals which operate regional poison control programs could be distributed as Medicaid rate adjustments.	$5.0M	$2.5M
Grants to hospitals for nutrition, AIDS, and other public health activities could be distributed as Medicaid rate adjustments.	$22.0M	$11.0M
Total	**$387.6M**	**$193.8**

LIST B

	GROSS	New Federal
FFP on the programs described in List A could be secured for non-hospital distributions to clinics and other providers.	$38.0M	$15.2M
Indigent Care pool distributions to clinics, laboratories and ambulatory surgery centers could be made as Medicaid rate adjustments.	$51.0M	$20.4M
Grants for workforce retraining could be distributed through providers as Medicaid rate adjustments.	$64.0M	$25.6M
Capital restructuring grants for providers could be deemed Medicaid eligible.	$20.0M	$10.0M
Total	$173.0M	$71.2M

PROPOSAL FOR COMMUNITY HOSPITAL CONVERSION TRANSITION FUND DEMONSTRATION PROJECT

The objectives of the Community Hospital Conversion Transition Fund Demonstration Project are as follows:

1. Expand primary care infrastructure in New York City's health crisis zones and underserved areas (and thus further the access and quality objectives of New York State's waiver application) by rapidly deploying available capital dollars.

2. Enable vulnerable, high-Medicaid institutions to preserve market share, reconfigure their physical plant and operations, and cost-effectively service Medicaid managed care enrollees by developing needed, state-of-the-art ambulatory care capacity and management information systems.

3. Provide training and education to hospital employees so that they can improve their skills and adapt to a managed care environment without job displacement.

To achieve these objectives, the Demonstration Project would provide Federal Financial Participation ("FFP") for the following State expenditures, consistent with New York State's Federal Medicaid Assistance Percentage and the overall budget-neutrality limits of the Section 1115 waiver authority. The State's share of these expenditures would derive from revenues to be deposited in the health care initiatives pool under the New York State Health Care Reform Act of 1996 (the "Reform Act"); these revenues, in turn, are generated by a surcharge on payments to general hospitals and other "designated providers of service" (i.e., Diagnostic & Treatment Centers ("D&TCs") and clinical labs). While these dollars are already committed by the Reform Act to certain program expenditures, a number of such expenditures would be deemed eligible for FFP by agreement with HCFA, thus freeing up State dollars to the extent of this federal match.

Capital Financing

- A dedicated primary care capital access fund would be established, with the following two purposes. The first purpose would be to provide an extra layer of credit enhancement (in which HCFA and the State jointly participate) for tax-exempt bonds issued by the New York State Dormitory Authority under the PCDC financing program; i.e., to the extent project sponsors defaulted in their sublease payments, the Dormitory Authority would have recourse to this collateral prior to any claim against New York City's lease obligation or the reserve accounts created under the bond resolutions. The second purpose would be to fund initial working capital during a facility's start-up period and other emergency cash needs thereafter as appropriate.

- Funding for the Primary Care Initiatives ("PCI") grant program would be significantly expanded, with the funds targeted to small and mid-sized construction projects (in the range of $3MM to $5MM per facility) and to investment in MIS and other equipment. The grants would be creatively structured (i) to maximize leverage (e.g., by requiring that the sponsor provide 25% of the funding through an equity contribution or bank debt), (ii) to ensure that the requisite amount of care is delivered to Medicaid and indigent patients, and (iii) to give the sponsor an ongoing financial stake in the viability of the project. The timetable for grant awards would be expedited, with the PCDC serving as the conduit and monitoring agency for the grant funds.

Capital Reimbursement

- The NYS Department of Social Services would make supplementary payments to new primary care clinics (whether organized as hospital extension clinics or free-standing D&TCs) to cover the capital costs of serving the uninsured. By securing funding throughout the five-year waiver period, the State would accelerate new project approvals, improve the marketability of bonds, and reduce borrower interest expense.

- Likewise, Medicaid capital reimbursement would be paid on a discrete, pass-through basis for both Medicaid fee-for-service recipients and Medicaid managed care enrollees. By reimbursing capital outside the plan capitation in the case of facility sponsors covered by the Demonstration Project, the State would serve the following two objectives: (i) it would guarantee the availability of debt service payments during the critical start-up period; and (ii) it would remove disincentives for new construction by allowing facilities to compete solely on the basis of quality and operating cost. The State could also agree to fund the rapid amortization of new debt, thus maximizing payments during the waiver period and further reducing the credit risk associated with new projects.

Operating Reimbursement

- Bad Debt & Charity Care funding would be significantly expanded for new voluntary D&TCs that provide comprehensive primary care services. The $16 million that the Reform Act allocates annually for such clinics is inadequate, particularly as no funds are available during the first two years of facility operation. By reimbursing medically indigent visits and removing the base-year requirement, the State would overcome a substantial impediment to financial feasibility.

Training and Education Grants

- The State would make training and education grants to the City University of New York ("CUNY") and to other qualified institutions of higher learning to support continuing education for hospital administrators and unionized employees who are at risk of job displacement. The purpose of the curriculum would be to teach the existing members of the health care workforce the skills they need to adapt to a managed care/ambulatory care environment (e.g., encounter reporting, case management, and capitation contracting). A secondary purpose, especially with rank-and-file union employees, would be enhancing their professional skills and credentials so that they can qualify for promotions and higher pay. The grants could be structured as capitation, with incentive bonuses to ensure results: i.e., CUNY and the other awardees would accept per enrollee/per month payments for a defined population and over a defined period of time in return for committing to attain certain mileposts.

States with Impermissible Taxes to be Negotiated
(Estimated FFP Calculated Through 9/30/96)

still in existence

I. Hold Harmless	FFP Disallowance	Disallowance as % of Medicaid Expenditures (Federal share)
HI--Nursing Facility Tax	$ 11,248,875	1.28%
IL--Nursing Facility Tax (expired 6/30/93)	88,544,909	.87
IN--Hospital Tax (expired 6/30/94)	30,674,059	.86
LA--Nursing Facility Tax	188,377,175	.57
ME--Nursing Facility Tax (expired 12/31/93)	7,687,661	.69
MO--Hospital Tax	892,322,473	13.84
TN--Nursing Facility Tax	251,269,954	2.98
Total =	$1,470,125,106	

II. Bad Classes		
NY--Impermissible classes	Awaiting Audit	Awaiting Audit

4 still going

ISSUES RELATED TO LEGISLATION

- **Failed administratively.** In proposing legislation, the Administration is admitting that it cannot enforce the law (there is nothing precluding HCFA from accomplishing the same end administratively).

- **Possibly lose support of validators**: If we send the letters and propose legislation, we may be criticized for compromising too soon -- we haven't even tried to enforce the law and we are looking for a way out.

- **Risk of Congress changing parameters**: Certain Congressmen (Gephardt) may want to allow partial permissibility of future use of taxes. May be hard to get ideal legislative solution.

- **Could suffer from the same problem -- delay:** The same states that we are worried about suing or dragging out the administrative process will likely find ways to do the same in the legislative solution since, today, we do not have solid claims against any of them.

- **Which states**: Since the letters we are sending have no legal standing, we do not yet have states that we can name in legislation. Audits at least and probably letters of disallowance may be needed.

- **Timing**: Immediate legislation poses two problems: (1) is there time in this session to pass it; (2) we do not yet know which states are affected (no audits).

  However, saying that we would support legislation and then delaying may cause states to not be cooperative in the next few months with HCFA in hope that the legislative solution will help them. It also gives them more time to mobilize their support for total forgiveness.

MEDICAID PROVIDER TAXES: RETROSPECTIVE LIABILITY
(Federal Share 1993 through March 1997)

	Permissible	Potentially Impermissible		Additional Information	TOTAL POTENTIAL LIABILITY	Liability as % of 1995 Fed. Spending
Alabama	7,500,000	-		12,582,794	12,582,794	1%
Connecticut	-	-		463,878,653	463,878,653	37%
DC	6,139,000	-		-	-	
Florida	-	-		431,734,302	431,734,302	13%
Hawaii	-	11,285,542		10,072,653	21,358,195	7%
Illinois	-	88,544,909		-	88,544,909	3%
Indiana	-	30,674,059		-	30,674,059	2%
Louisiana	85,343,568	186,860,145	*	-	186,860,145	6%
Massachusetts	-	658,129,757	*	-	658,129,757	27%
Maine	-	7,687,661		-	7,687,661	1%
Minnesota	-	Unknown	*	-	Unknown	
Mississippi	32,291,175	-		-	-	
Missouri	-	1,008,734,099	*	-	1,008,734,099	61%
Montana	29,885,317	-		-	-	
Nevada	-	27,605,684		-	27,605,684	12%
New Hampshire	-	-		11,609,880	11,609,880	3%
New York	1,027,507,994	545,335,326	*	2,014,769	547,350,095	5%
Ohio	-	-		-	-	
South Carolina	17,835,270	-		-	-	
Tennessee	-	269,593,730	*	380,950,000	650,543,730	30%
Utah	6,012,829	-		10,054,156	10,054,156	2%
Wisconsin	48,384,465	-		-	-	
TOTAL	**1,260,899,618**	**2,834,450,912**		**1,322,897,207**	**4,157,348,119**	

"*" Indicates that the tax is still active

-draft-

DRAFT

STATEMENT BY SALLY RICHARDSON
DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS
HEALTH CARE FINANCING ADMINISTRATION

October 8, 1997

Sally Richardson, Director of HCFA's Center for Medicaid and State Operations, issued the following statement regarding today's policy clarification on state provider taxes used to obtain Medicaid matching funds.

Our goal is to put a stop to the use of special taxes which are levied solely to increase states' share of federal Medicaid funds, and to bring states into compliance with the law as soon as possible.

We have a responsibility to make sure that provider taxes used to generate federal matching funds are levied in a manner consistent with the law passed by Congress in 1991. Allowing some states to continue to use improper taxes to obtain federal funds for their Medicaid programs is unfair to the states that play by the rules, and unfair to the federal taxpayer.

We have clarified the policy on taxes collected from health care providers which are used to obtain federal matching funds for Medicaid. Today's action makes clear that some state taxes in question are acceptable. Others require additional review, and some are impermissible. States with improper taxes can correct their errors, come into compliance with the law, collect proper taxes.

We realize this is a big undertaking, and stand ready and willing to work with states in this effort.

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-draft-

MESSAGE POINTS

- We are notifying states today that we have clarified the policy on taxes collected from health care providers which are used to obtain federal matching funds for Medicaid.

- Because HCFA is obligated to ensure that provider taxes are consistent with the law passed by Congress in 1991. Our goal is to end the use of provider taxes, and help states come into compliance with the law by eliminating the use of impermissible taxes to finance state Medicaid programs.

- This is a big undertaking, and we stand ready and willing to work with the states on their individual situations.

SUMMARY: MEDICAID PROVIDER TAXES

- **What is being released.** Today, the Department of Health and Human Services (DHHS) has sent a letter to State Medicaid Directors. This letter clarifies how DHHS will implement the law and regulations on states' use of health care-related taxes for their share of Medicaid. There will also be a notice in the Federal Register containing a correcting amendment to the regulation to make it consistent with Congressional intent.

  The State Medicaid Director letter also includes an announcement of our support for legislation that (a) codifies current regulations that contain the tests to determine that a tax is permissible; and (b) would concentrate authority in the Department to resolve impermissible tax liabilities if a state comes into full compliance by ending the use of impermissible taxes. This legislative approach may more expeditiously end the use of impermissible taxes. If, however, by August 1998 no legislation is passed, the Secretary will move forward to complete the process already begun to apply with full force the current law.

- **Why action is needed**? States' use of impermissible provider taxes poses a major threat to Medicaid's fiscal integrity. During the late 1980s, health care provider tax programs were used to increase Federal Medicaid funding without using additional state resources. These schemes contributed to the doubling of Federal Medicaid spending between 1988 and 1992.

  Today, a number of states continue to use potentially impermissible provider taxes. To maintain the integrity of the Medicaid program, we must be certain that the Federal Treasury is not impermissibly being tapped to underwrite costs that are the responsibilities of the states. To not do so would be unfair to those states (and their taxpayers) which are in compliance.

- **Why now?** This review, which has been on-going at DHHS for many months, has drawn increased attention recently due to the line-item veto of a Medicaid provider tax provision in the Balanced Budget Act. Under this provision, all of New York's over 30 provider taxes would be deemed approved. The President vetoed this provision because it was too broad and singled out a single state for special treatment. However, he promised that DHHS would intensify its review of its interpretation of the law for New York and all states. Today's action is a result of this review.

- **Impact on New York**. One of New York's major concerns have been that Medicaid regulations have not grandfathered the State's "regional" tax. Given evidence of Congressional intent for this tax treatment, the Administration will publish a correcting amendment to the regulation in the Oct. 15 *Federal Register*. This action relieves New York of over $1 billion of provider tax liability.

  No final resolution on New York's other provider taxes has been reached. However, HCFA will be contacting New York and other states to gather further information on taxes.

- **Impact on other states**. 10 States will benefit from the clarification that the Department is providing today. States will be contacted with requests for additional information. It is our hope that all states and their representatives will work toward legislation that protects the Federal Treasury as well as treats States fairly as we move to ensure that all states are in compliance with the law (D.C., Alabama, Lousiana, Ohio, Mississippi, Montana, New York, South Carolina, Utah, Wisconsin).

Associated Press

on, center, the District of Columbia's nonvoting delegate in Congress,
l. The House later approved a bill that would establish the program.

r Plan for Nation's Capital

e nation's capital, at $10,000 a child, e being cheated," Mr. Gingrich id. "They are being cheated by the liticians, they are being cheated by e teachers, they are being cheated the unions."

And turning toward the Democrat- side of the aisle, he said: "You ow why you are afraid? Because if is succeeds, the failure and the ireaucracy of the unions will be roved. What this vote is about is hether 2,000 children have a chance go to college and not go to jail."

This year's spending bill for the istrict revived old political battles, ke over abortion (it continues to rohibit the use of any Federal or cal money to provide abortions xcept in the case of rape, incest or anger to the woman's life). It also uched off new confrontations, like ne over the language that would rder the stretch of Pennsylvania venue in front of the White House to be reopened as a through street. The Secret Service closed off that stretch to vehicles three years ago for security reasons.

The school voucher proposal, though, has commanded the most attention in this year's debate.

The voucher provision would provide $7 million to establish "choice scholarships" for 2,000 public school students in Washington who come from low-income families. Those students would be eligible to receive $2,400 to $3,200 apiece for tuition at private schools in the city or in suburban schools. And low-income families would also be eligible for up to $500 for tutoring and transportation costs.

"If I had put $7 million in this bill to fix potholes, there would not have been a peep," said Representative Dick Armey of Texas, the majority leader and sponsor of the voucher plan. "Are you going to tell me that fixing children is less important then fixing potholes?"

Local taxes account for about 85

U.S. Alters Medicaid Rules, But New York Isn't Mollifiec

By ROBERT PEAR

WASHINGTON, Oct. 9 — The Clinton Administration tonight issued new nationwide standards specifying how states may finance their share of Medicaid costs, but Gov. George E. Pataki of New York immediately denounced the rules as unacceptable.

Federal officials had hoped that the standards would mollify New York and end a bitter confrontation that resulted when President Clinton used his new line-item-veto authority in August to cancel $1.5 billion in Medicaid relief for the state.

But Mr. Pataki dashed those hopes after state officials were briefed on the new Federal policy, which, by the Government's reckoning, allows New York up to $1 billion of that relief.

Mr. Pataki, a Republican, said of the Administration's new initiative: "It is unacceptable, it is too little, and the Administration has an obligation to go back and do better. All New Yorkers will be united in opposition to today's proposal."

Kenneth E. Raske, president of the Greater New York Hospital Association, whose 90 member hospitals receive tens of millions of dollars in Medicaid money each year, said, "We are very disappointed."

And Senator Alfonse M. D'Amato, Republican of New York, said, "The President has once again turned his back on the people of the state of New York."

White House officials said they were stunned by the negative reaction. They said the New Yorkers should be pleased, since, by the Government's calculation of the benefit from the new standards, the state would be freed of the obligation to repay the Treasury $1 billion, two-thirds of the amount it owes in its long Medicaid battle with Washington.

But in an interview tonight, the New York Health Commissioner, Dr.

Officials thought their change would appease Governor Pataki. Wrong.

Administration officials acknov edge now that they did not anticipa the furor that would ensue from N York.

The standards announced tonig make clear that two of the provid taxes levied by New York are p mitted, while leaving the fate of t others apparently unresolved.

One of the permitted taxes is i posed on hospital and nursing ho beds, not only in New York but also eight other states: Alabama, Loui ana, Ohio, Mississippi, Monta South Carolina, Utah and Wiscons

The other is an "add-on" to hos tal bills that finances charity care New York. The Government said had rewritten the Medicaid rules make clear that this tax was perm sible, even though contrary to F eral law requiring uniformity in t tax rate, the rate varied among t state's regions — higher in New Y City than upstate, in part becau some state legislators wanted make sure that each region paid most of the charity care provided residents.

Administration officials said th new policy established unifo standards and procedures for reso ing disputes with states over the nancing of Medicaid. They said t would begin talks with all states determine whether the states' m ods of financing Medicaid compl with Federal law.

In addition, the Administra laid out some of the criteria it use in deciding what taxes a st may impose to finance its shar Medicaid. Essentially, those crit require that any such taxes be br based and uniform.

In a letter to state officials, S K. Richardson, the Federal Medi director, said, "The Administrati goal is to end the use of impermi ble taxes as soon as possible." S taxes, she said, "undermine the tegrity of the Medicaid program.

It is unclear whether today's "p cy clarifications" will avert the l suits threatened by Mayor Rud W. Giuliani and hospitals in the N York area. Hospital executives, h pital worker unions and city offic have been considering a lawsui challenge the line item veto, on ground that it violates the cedures set forth in the Constitu for making and repealing Fed laws.

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Local taxes account for about 85 percent of the District of Columbia's budget. But the rest of the money — $825.5 million for 1998 — comes from the Federal Government and covers spending on items ranging from the repair and upkeep of corrections sites, to pay raises for police and firefighters.

It is the smallest of the Federal Government's 13 appropriations bills, but it has tended to be one of the most contentious.

Representative James P. Moran, a Virginia Democrat who led the floor effort to defeat the voucher proposal, called the bill "a magnet for controversial and extraneous riders."

"Congress has never been able to resist the opportunity to play City Council for a day and impose its will on the city," Mr. Moran said.

Since winning control of Congress three years ago, Republicans have used the District of Columbia as a testing ground for many of their urban policy ideas. But the school voucher issue has given them one of their most effective weapons yet against one of the Democrats' most solid political redoubts, inner-city communities.

Among the most outspoken supporters of vouchers was Representative Floyd H. Flake, Democrat of Queens.

"I think it is time to remove the politics, Republican and Democratic, and deal with the reality that a number of our children are not being educated," Mr. Flake said from the floor today.

But in the end, Mr. Flake joined a solid block of 190 Democrats in voting against the full bill.

rsight Panel

e a goal of round-the-clock tele- ne-inquiry service by 1999. The S.'s taxpayer advocate, now ap- ted from within the agency, ld now be appointed from the ide.

he Administration plan would te 33 citizen advocacy panels nd the country. The panels could resolve disputes, but would help payers work with the advocate's e to do so.

he Administration's proposed rsight board would be called the S. Board of Trustees and would e five members who were private zens, plus the Deputy Treasury retary and the Commissioner of rnal Revenue. It would review agency's performance in such as as long-term planning and cus- ner service, and would report in- endently to the Treasury Secre- y, the President and the Congress. the Administration would leave direct authority over the I.R.S. in hands of the Treasury Secretary. he plan is intended as an alterna- to a House bill that would create independent board with more au- rity over the I.R.S. than the Ad- nistration's proposed board.

Representative Rob Portman, an io Republican who is co-sponsor the House bill, said the Adminis- tion plan would not go far enough rooting out the deep-seated man- ement problems at the I.R.S., in- ding the pattern of intimidation d harassment of taxpayers docu- nted in hearings last month be e the Senate Finance Committee

back on the people of the state of New York."

White House officials said they were stunned by the negative reaction. They said the New Yorkers should be pleased, since, by the Government's calculation of the benefit from the new standards, the state would be freed of the obligation to repay the Treasury $1 billion, two-thirds of the amount it owes in its long Medicaid battle with Washington.

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Officials thought their change would appease Governor Pataki. Wrong.

New York Health Commissioner, Dr. Barbara A. DeBuono, had a different assessment of the new rules' financial value. Dr. DeBuono said the state would be getting "much less than half a loaf" from the new policy, which, she said, "is worth considerably less than $1 billion" to New York.

At issue in the fight between New York and Washington is disagreement over whether the state may use certain types of taxes to finance its share of Medicaid, the Federal-state health care program for the poor.

Ordinarily such decisions are left to state and local officials, who resent any Federal effort to dictate their tax policies. But Congress intervened in 1991 after concluding that many states had abused Medicaid by devising elaborate schemes to minimize their own contributions while maximizing what they got from the Federal Government.

In these schemes, the states inflated their share of contributions by imposing a variety of taxes on health care providers, which then frequently got back more in Medicaid money than the amount of taxes they had paid. Federal officials say 35 states now impose various types of taxes on hospitals, nursing homes and other providers to finance Medicaid.

In the budget-balancing law passed by Congress this summer, New York specifically was given retroactive approval to use dozens of such taxes this way. But on Aug. 11, six days after signing the budget legislation into law, President Clinton exercised the line item veto to cancel the New York provision, denouncing the "preferential treatment" given the state.

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White House officials have pleade with the potential plaintiffs to hol off on any lawsuit and to try instea to negotiate a compromise wit Washington.

Melissa T. Skolfield, an Assistar Secretary of Health and Huma Services, said, "Today's action r lieves New York of over $1 billion c provider-tax liability" accumulate over the last five years.

"That's good news for New York, she said.

Ms. Richardson, the Federal Me icaid director, said the Administr tion would begin discussions wit state officials and with Congress t figure out how to end the use c improper taxes used by states t finance Medicaid. Congress, sh said, may need to revise the law t clarify the standards.

She hinted that the Federal Go ernment would reduce its financi claims against states that "com into full compliance with the Feder law" in the next 10 months.

In her letter to state officials, M Richardson said that the Secreta of Health and Human Services, Do na E. Shalala, needed "greater a thority" to negotiate such deals wi states.

Ms. Skolfield said that New Yo had about 30 other taxes on heal care providers, and that the Feder Government needed more inform tion to decide whether they we permissible. Under the provision the Balanced Budget Act vetoed b Mr. Clinton, she said, all these tax would have been "deemed to be pe missible."

Top Aides Urge Clinton to Delay Goals on Global Warming

Continued From Page A1

new, binding targets and timetables. The negotiations resume in Bonn on Oct. 20 and are supposed to be com-

there are three main options on the table: one to stabilize emissions at 1990 levels by 2010, one to do so by

Defense Fund, who favors trading emissions permits but joined oth environmentalists in denouncing t