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NY May Sidestep Line-Item Veto

By Ronald Powers

Associated Press Writer

Thursday, October 9, 1997; 10:06 p.m. EDT

WASHINGTON (AP) -- Federal officials proposed a series of Medicaid waivers Thursday that would allow New York state to boost its payments from the federal government through state taxes on health care providers.

The proposal would effectively sidestep President Clinton's line-item veto of a provision in the August budget deal to let New York continue passing on to the federal government a portion of the "provider tax" it levies on hospitals, nursing homes and other health care providers.

However, the proposal by the Department of Health and Human Services would require Congress to pass a law specifying the state "health care provider" taxes that Medicaid will cover.

New York Gov. George Pataki immediately labeled it "unacceptable," expressing doubts Congress would pass such a measure.

"It is too little and the administration has an obligation to go back and do better," Pataki said.

The HHS proposal would also assist seven other states and the District of Columbia with similar health care provider taxes. But the bulk of the benefits would go to New York; HHS estimated the benefit to that state at \$1 billion.

The other states that would get the proposed waivers are Alabama, Louisiana, Ohio, Mississippi, Montana, South Carolina, Utah and Wisconsin.

Congress in 1991 decided to disallow Medicaid coverage of state provider taxes but New York had continued to reap the extra money under an HHS waiver.

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NY - Del.
 Conn Jurisd
 GOVERNORS

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

October 9, 1997

TO: DISTRIBUTION

FROM: Chris Jennings and Jeanne Lambrew

RE: MEDICAID PROVIDER TAX MATERIAL: EMBARGOED UNTIL 4PM

Attached are the Department of Health and Human Services' materials for release this afternoon. This includes:

- DHHS Press Release
- Summary (for internal use)
- Fact sheet
- Questions and answers
- Letter being sent to State Medicaid Directors

The public documents will be presented at briefings of the Congressional committees of jurisdiction, the National Governors' Association, a meeting with the New York gubernatorial staff, and the New York delegation beginning at 4pm.

Given the sensitive nature of the material, these are close hold until 4pm.

Please call with questions.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Press Office
Washington, DC 20201

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

Thursday, October 9, 1997

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

We have a responsibility to make sure that state taxes collected from health care providers and then used to generate federal matching funds for Medicaid are levied in a way that is fair and equitable among all states. Permitting some states to use improper provider taxes to obtain federal funds threatens Medicaid's fiscal integrity and is unfair to states that play by the rules.

We are today clarifying policy on taxes collected from health care providers based on patient days or occupied beds. This action makes clear that certain taxes are acceptable in 10 states that have asked us for waivers. Because of the complexity of the law there are states that have other taxes that still require review.

Given the outstanding questions, we are today announcing our intention to work with Congress and the states to enact legislation that codifies the tests for whether a state provider tax is permissible. This legislation will also enhance the Secretary's authority to resolve current liabilities for states that come into full compliance with the law. We sincerely hope such legislation will expeditiously end the use of impermissible taxes. However, if such legislation is not passed by next August, HCFA will apply with full force the current policies.

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

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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.10 *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, Louisiana, Ohio, Mississippi, Montana, New York, South Carolina, Utah, Wisconsin).

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 is 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 10, 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 this 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.

HEALTH CARE RELATED TAX QUESTIONS & ANSWERS

GENERAL QUESTIONS ABOUT PROCESS

- 1.Q. What is HCFA's rationale for a change in some of its policies regarding these taxes?**
- A. Since the original publication of 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.
- 2.Q. HCFA could tomorrow begin enforcing the provider tax laws. Aren't you avoiding the hard decisions that you could make under current law by introducing legislation?**
- A. Quite the opposite: we think that legislation could make enforcing the provider tax laws more efficient and timely. Given the complexity of the provider taxes and questions that states have about HCFA's interpretation, it could take years of costly audits, appeals and possible law suits to resolve each state's case. Legislation offers the opportunity to clarify the ways that a tax may be identified as permissible and concentrates the Department's authority to work with states to resolve their current liabilities if the states comes into full compliance as soon as possible.
- 3.Q. Isn't HCFA just issuing these policy clarifications to provide cover for President Clinton's retreating on his use of the line-item veto of a special fix for New York's improper provider taxes in the Balanced Budget Act?**
- A. No. HCFA has been reviewing provider tax policies for some time. The policy review described today was in the pipeline prior to the President's action but has received increased attention as a result of the line item veto. The item canceled by President Clinton would have given preferential treatment to New York by allowing that state to continue relying on potentially impermissible taxes to fund its share of the Medicaid program.

FOR INTERNAL USE

4.Q. Does HCFA's policy change resolve most of state provider taxes problems or are some still open to dispute?

- A. The policy changes affect some but not all of state provider tax concerns. After review of our interpretation of the law, we have clarified our interpretations of three types of taxes. First, we have determined that one of the types of taxes we questioned — those imposed on providers based on patient days or the occupied beds — are indeed uniform. In addition, we have determined that States do not need to submit a new waiver request for a tax under its existing waiver if there is a uniform change in the rate. Thirdly, HCFA has published in the *Federal Register* a correcting amendment to the uniformity test in the regulation lowering the threshold for allowable tax programs based on regional variations, enacted and in effect prior to November 24, 1992.

These policy clarifications and corrections will apply to all States, and we think that certain taxes in at least 10 States will immediately be considered permissible and require no further review (Alabama, District of Columbia, Louisiana, Ohio, Mississippi, Montana, New York, South Carolina, Utah, Wisconsin).

However, many issues remain unresolved. HCFA will attempt to resolve these issues through discussions with States and will support legislation to assist in these efforts. The Administration will support 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, it 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.

5.Q. Many states have had waiver applications at HCFA for several years. Why has this action take so long?

- A. Reviewing the state waiver requests has taken longer than we would have liked. The evaluation of each waiver request is a lengthy and complicated process that often requires HCFA to seek additional information from states and for states to resubmit calculations that may have been done in error. Resolving some of these tax issues could involve lengthy litigation. That is why the Administration will support a legislative codification of what qualifies as a permissible tax.

FOR INTERNAL USE

6.Q. Are some states getting a better deal than others? Can you say unequivocally that this policy is being applied fairly among all the states?

A. Yes, we can say that no state is getting “a better deal” than another state. The HCFA policy has a national application and effect. For instance, all state hospital taxes that are based on the number of days that patients are in the hospital (occupied bed/or patient days) or only make a uniform change in the rate of a tax that is otherwise broad-based are now considered to be permissible taxes, to the extent these tax programs do not contain a hold harmless provision.

7.Q. What is the White House’s involvement in this issue?

A. Medicaid enforcement actions are handled directly by the Department of Health and Human Services, and the Health Care Financing Administration (HCFA) in particular. As we do for all similar types of policy issues, the White House and the Office of Management and Budget have reviewed HCFA’s policy interpretations. However, the White House has no direct involvement with compliance actions affecting specific states.

NEW YORK QUESTIONS

8.Q. The “correcting amendment” would change the generally redistributive waiver test threshold from 0.85 to 0.7. Is it true that this new number benefits only the State of New York? Is this another attempt by New York to get some sort of special fix? Why is HCFA so determined to give NY special treatment in the first place?

A. While it is HCFA’s understanding that the State of New York is the only State that has a tax program of this nature, the correcting amendment is not an attempt to give the State of New York preferential treatment. HCFA is simply bringing its regulation into compliance with the Congressional intent.

FOR INTERNAL USE

9.Q. New York's Governor and Congressional Delegation have made it clear that no less than a "hold harmless" outcome (meaning the state owes no money to the Federal government) to the Administration's review of provider taxes would be acceptable. They may feel that HCFA's failure to give them a hold harmless will harm the State's Medicaid program. Don't you care about the hospitals and the poor people that the Medicaid program serves?

A. First, the President's record of support for the Medicaid program is longstanding and clear. He fought long and hard to ensure that the program would not be block granted and that guarantee of health coverage for millions of Americans would be preserved.

Second, the announcement today makes clear that New York cannot be held liable for over \$1 billion in regional provider taxes that were previously in question. This is -- without question -- the largest provider tax that New York relied on, and today's action relieves the state of major budgetary concerns.

Third, the outstanding provider taxes still in question are just that -- still in question. HCFA will be contacting the State asking for more information if needed on some of its taxes. New York will have the opportunity to provide information to illustrate that their provider taxes are consistent with the law.

But let's be clear: to maintain the integrity of the Medicaid program and the confidence of the taxpayers who support it, we must be certain that the Federal Treasury is not impermissibly being tapped to underwrite costs that are the responsibility of the states. To not do so would damage the integrity of the Medicaid system and would be unfair to those other states (and the taxpayers who support them) which are in compliance

10.Q. The Mayor's Office, the Governor's Office, the New York Hospital Association, and even Al Sharpton are threatening to sue the Federal Government over this provider tax issue. Do you have any response to these threats?

A. They certainly have the right to sue, but we would hope that these parties would allow the Governor's office and the Health Care Financing Administration to work through either an administrative or legislative process that meets the Administration's criteria before they pursue a lengthy and potentially expensive legal response.

FOR INTERNAL USE

11.Q. What about the issue of the constitutionality of the line item veto and Senator Moynihan's indication that he supports a challenge of the President's veto?

A. We believe that the President's line item veto power authority, which was authorized in statute by the Congress, would be upheld in any court challenge.

12.Q. Doesn't your action leave New York \$500 million in hole? The state is claiming that you are still leaving them with a huge liability that will jeopardies their ability to run their Medicaid program.

A. The amount of the provider tax dollars that may be out of compliance is unclear. It is true that HCFA does have questions about some of New York's provider taxes. The agency will request more information from the state about these taxes, and the state will have the opportunity to provide information to illustrate that their taxes are consistent with the law.

POLICY QUESTIONS

13.Q. How will you make sure vulnerable people are not hurt, or kicked off Medicaid rolls if the federal government recoups its overpayments from states?

A. The Administration's record of protecting Medicaid and the people it serves is well documented. One of the major reasons why the President vetoed the 1995 Republican budget bill was its intent to dramatically reduce its Medicaid funding and eliminate the guarantee of health care to low income and disabled Americans. It would not support policies that disadvantage Medicaid beneficiaries. It is, however, HCFA's responsibility to run this program in a way that is fair and consistent across all states. Such management will increase the public's confidence in the Federal oversight of the Medicaid program.

FOR INTERNAL USE

14.Q. What is impermissible about provider taxes? What does “broad based and uniform” mean?

A. Impermissible health care related taxes fall into three general categories: taxes imposed on groups not listed in the statute or regulation (“bad classes”); taxes returned to the taxpayers (“hold harmless”); and taxes that fail the broad based and/or uniformity waiver test. In general a broad based health care related tax is one that applies to all members of a recognized class or category. Uniform health care related taxes mean a tax which is levied at the same rate for all those in a particular group or class. A “hold harmless” means that the taxes are returned to the taxpayer at the expense of the Federal government.

15.Q. How much in total does the Federal government expect to recover?

A. Recovery is not HCFA’s primary goal; it is to end the use of impermissible taxes. There is no precise estimate of how much money is at stake since audits must be performed to determine the exact amount of revenue collected from impermissible health care related taxes. However, based on initial estimates through March 1997, HCFA estimates the total amount of impermissible taxes to be between \$2 and \$4 billion.

ALL STATES - GENERAL POLICY LETTER

Dear State Medicaid Director:

We are writing to inform you of several policy interpretations which the Health Care Financing Administration (HCFA) has recently adopted. These interpretations relate to the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234 § 2(a) (codified at section 1903(w) of the Social Security Act (the Act)), and related regulations, and were adopted as part of a review of HCFA's policies in the area of provider taxes.

As you know, the Medicaid Voluntary Contribution and Provider Specific Tax Amendments were enacted to limit Federal financial participation (FFP) in States' medical assistance expenditures when the States receive funds from, among other sources, impermissible health care related taxes. Under the Act, States may continue to receive FFP with respect to ~~the~~ broad based and ~~the~~ uniform health care related taxes. According to section 1903(w) (3) (B), a broad based health care related tax means a health care related tax which is imposed with respect to a permissible class of items or services on all providers in that class. In addition, under section 1903(w) (3) (C) of the Act, a uniform health care related tax means a tax which is imposed with respect to a permissible class of items or services at the same rate for all providers. For those taxes which are not broad based or uniform, the Secretary may grant waivers if she finds that the taxes in question are "generally redistributive," pursuant to section 1903(w) (3) (E) of the Act.

In this letter, we first clarify HCFA's interpretation of the requirement that health care related taxes be applied uniformly. Second, we clarify that, when the Secretary has granted a waiver with regard to a health care related tax because she has concluded that the tax is generally redistributive, a later uniform change in the rate of tax will not require the State to submit a new waiver request. Third, we are reminding States of their opportunity to propose additional classes of providers, items, or services which the Secretary may consider including as permissible classes. Fourth, we are reminding States that all provider related donation revenue and health care related tax revenue, which includes licensing fee revenue, must be reported to HCFA on the HCFA-form 64.11A. Lastly, we commit to working with States to consider ways, including legislation, to expedite the identification of impermissible taxes and end their use.

First, with regard to the requirement that health care related taxes be uniformly imposed, the implementing Federal regulation at 42 C.F.R. § 433.68(d)(iv) specifies that a health care related tax will be considered uniformly imposed if the tax is imposed on items or services on a basis other than those provided by statute, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class. We are clarifying that HCFA interprets 42 C.F.R. § 433.68(d)(iv) to include health care related taxes on the occupied beds of a facility or the patient days of a facility. HCFA has concluded that, to the extent the rate of a health care related tax is the same for each occupied bed or patient day and the tax is applied to all providers in the permissible class of services, a health care related tax program based on occupied beds or patient days will be considered uniformly applied. Previously, HCFA had interpreted the Act to require that the tax be applied to all beds or all days to be considered uniform.

Second, where States have sought and obtained waivers for existing health care related tax programs, HCFA is clarifying that a uniform change in the rate of tax will not require a new waiver. To the extent a State makes no other revisions to an existing health care-related tax program (e.g., modifications to provider or revenue exclusions), HCFA would not view a uniform change in the tax rate as a new health care related tax program.

Third, section 1903(w)(7)(A)(ix) of the Act states that the Secretary may establish, by regulation, classes of health care items and services, other than those listed by statute. The implementing regulation, at 42 C.F.R. § 433.56 specifies 10 additional permissible classes of items and services. In addition, the preamble to the implementing regulation indicates that the Secretary will consider adding additional classes if States can demonstrate the need for additional designations and that any proposed class meets the following criteria: 1) the revenue of the class is not predominantly from Medicaid and Medicare (not more than 50 percent from Medicaid and not more than 80 percent from Medicaid, Medicare, and other Federal programs combined); 2) the class is clearly identifiable, for example, by designation through State licensing programs, recognition for Federal statutory purposes, or inclusion as a provider in State plans; and 3) the class is nationally recognized rather than unique to a State. This is a reminder and an invitation to States that they may identify additional classes.

Fourth, section 1903(w)(7)(F) of the Act defines the term ~~tax~~ to include any licensing fee, assessment, or other mandatory payment. Therefore, any licensing fee applied to the items or services listed by statute and/or regulation must comply with the

law. Furthermore, section 42 C.F.R. 433.56(a)(19) requires that for health care items or services not listed by regulation on which the State has enacted a licensing fee or certification fee, the fee must be broad based, uniform, not contain a hold harmless provision, and the aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program. Section 42 C.F.R. 433.68(c)(3) states that waivers from the uniform and broad based requirements will automatically be granted in cases of variations in licensing and certification fees for providers if the amount of such fee is not more than \$1,000 annually per provider and the total amount raised by the State from the fees is used in the administration of the licensing or certification program. This is a reminder to States that any licensing or certification fee imposed on providers of health care items or services is considered a health care related tax.

Furthermore, section 1903(d)(6)(A) of the Act requires that States include in their quarterly expenditure reports, information related to provider-related donations and health care-related taxes. This is a reminder to report all provider-related donation revenue and health care-related tax revenue on the HCFA-form 64.11A

The Administration remains committed to ending the use of impermissible taxes. Failure to end their use undermines the integrity of the Medicaid program and would be unfair to those States that are in compliance as well as to the taxpayers who pay for the program.

HCFA will continue to apply the current provider tax laws. As a part of this process, HCFA will have discussions with States individually to understand their existing provider taxes and, where necessary, to develop better compliance plans that recognize the challenges that States may face.

The Administration's goal is to end the use of impermissible taxes as soon as possible. To achieve rapid and full State 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 current 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.

If you have any questions concerning these policy clarifications, please contact your regional office.

Sincerely,

Sally K. Richardson
Director
Center for Medicaid and State
Operations

cc: All Regional Administrators

All HCFA Associate Regional Administrators
Division of Medicaid and State Operations

Lee Partridge
American Public Welfare Association

Joy Wilson
National Conference of State Legislatures

Jennifer Baxendell
National Governors' Association

Draft Roll-Out Schedule: Provider Taxes

Monday, October 6/Tuesday, October 7:

- Briefing for Secretary Shalala
- White House Briefing (Nancy-Ann Min DeParle)
- Arrange "Brief the Briefers" Session (Chris Peacock/Lloyd Bishop)
- Draft talking points for Secretary Shalala's New York and Missouri calls
- Arrange publication of Correcting Amendment (David Cade)

Wednesday, October 8:

- "Brief the Briefers" Session for Dept. and WH staff
- "Murder Board" for those authorized to speak to the press, even on background.
(Chris Peacock)
- HCFA/IGA to arrange briefing of HCFA Regional/Consortia Administrators and ARAs.
- Arrange IG Briefing (David Cade/Lloyd Bishop)
- 3:00 Brief IG (HCFA/CMSO)
- 3:00 ASL calls to invite New York Congressional Delegation to briefing the following morning.
- 3:00 ASL calls to invite committee staff to briefings the following morning; HCFA Congressional Affairs to call personal offices for separate briefings.
- 3:00 OS and HCFA IGA to invite NGA, APWA, NCSL, and state health reps to IGA State briefing.
- 6:00 HCFA/CMSO to brief HCFA Regional Offices.
- Evening Heads Up Calls: Commissioner DeBono. Offer briefing. (Sally Richardson), Sens. Moynihan and D'Amato, Rep. Rangel (Richard Tarplin)
- Evening New York Regional Director Alison Greene to call N.Y.S. Speaker's Office and Judith Hope, Co-Executive Director/N.Y.S. Democratic Party.

Thursday, October 9/Roll Out Day:

- HCFA/Press Office to coordinate all press calls. Spokespeople: (Sally Richardson, David Cade, Chris Peacock)
- Public Paper: -SMD Letter
-state-specific letters
-Fact Sheet
For the Press Office:
-Sally Richardson Press Statement (Chris Peacock to draft)
-Chart categorizing states by group: uniformity of occupied beds/patient days, those failing redistributive waiver test, etc. (C. Peacock/L.Bishop/D. Cade)
- Correcting Amendment on display at the Federal Register (HCFA/Exec. Sec.)

Briefings

- 9:00-10:00 Secretarial calls to

New York: Gov. Pataki, Sens. Moynihan and D'Amato, Reps. Rangel and Solomon.
Missouri: Gov. Carnahan, Sens. Ashcroft and Bond, Rep. Gephardt

(Sally Richardson to staff)
- 10:00-11:00 Special briefing for NY Delegation (Sally Richardson, Charlene Brown)
- 10:00-11:00 Hill Briefing: Joint House Commerce and Appropriations; and Senate Finance and Appropriations (Kathy King, David Cade)
- 11:30-1:00 Briefing for state groups and DC Governors' reps at Hall of States (Sally Richardson, Kathy King, David Cade, Charlene Brown)
- 2:00 - Press Availability for Background (Chris Peacock/David Cade)
- 2:00-3:00 House Personal Staff briefing (Sally Richardson, Charlene Brown)
- 3:00-4:00 Senate Personal Staff briefing (Kathy King, Jim Frizzera)

Core HCFA Briefing Team

Sally Richardson
David Cade
Charlene Brown
Jim Frizzera
Kathy King

Dept. Reps

Katie Steele
Rich Tarplin

ASL, IGA, and HCFA Legislative Staff

Thursday, October 9/Friday, October 10

• **Editorial Boards:**

- NY Times
- Newsday
- NY Post
- NY Daily News
- Albany Times Union
- Gannett News
- Kansas City Papers
- Washington Post
- Others TBD

Friday, October 10

- **Regions begin contacting states.**

HEALTH CARE RELATED TAX SUMMARY

Policy Revisions

HCFA will publish a correcting amendment necessary to correct an error in the published regulation. This amendment would only affect the State of New York.

HCFA will also issue a State Medicaid Director (SMD) letter advising States of revised policy interpretation that permits taxes on occupied beds or patient days to be considered uniform. In addition, this letter will notify States that a uniform change in the rate will not require a waiver. This will affect ten (10) States.

(AL, DC, LA, OH, MS, MT, NY, SC, UT, WI)

Impermissible Taxes

For taxes that fail the generally redistributive waiver test, contain a hold harmless provision or are imposed on an impermissible class, HCFA will notify States of the applicable tax policies affecting health care related tax programs in their State. Eleven (11) States will be notified of potentially impermissible taxes.

(HI, IL, IN, LA, ME, MA, MN, NV, NY, MO, TN)

Additional Information

Nine (9) States have submitted requests for a waiver of the broad based or uniformity requirements. HCFA will ask for additional information in order to determine the approvability of these waivers.

(AL, CT, FL, HI, IL, NH, NY, TN, UT)

III Failed Waiver Test	FFP Disallowance	Disallowance as % of Medicaid Expenditures (Federal share)
CT--Hospital Tax*	\$ 555,801,151	11%
FL--Hospital Tax*	342,385,568	3.47
NH--Hospital Tax*	21,052,981	5
MA--Acute Care Hospital Tax Fails test .68	559,017,947	6.05
MIN--Nursing Facility Tax Fails test .9926	67,618,019	1.18
NV--Hospital Tax** Fails test .51	27,605,684	1.65
NY--Bad Debt & Charity Care & Capital Statewide Pool Assessment--Fails test .908	158,268,269	.63
NY--Health Facility Cash Receipt Assessment Program (6%) Inpatient--Fails test .915	98,274,328	.39
NY--Health Facility Cash Receipt Assessment Program (6%) Outpatient--Fails test .81	34,210,657	.14
NY--Health Care Services Allowance Fails test .8	92,302,461	.36
NY--Bad Debt & Charity Care Regional Allowance for Financially Distressed Hospital Fails test .8	31,630,324	.12
Total =	\$1,988,167,389	

*State submitted incomplete waiver documentation, but would ultimately fail waiver test.

**Stopped reporting 3/31/96. Therefore, tax collection unknown for remaining Federal fiscal year 1996.

3458 = 6870

IV. Effective Date	FFP Disallowance	Disallowance as % of Medicaid Expenditures (Federal share)
NY—Nursing Facility Cash Receipt Assessment	\$21,373,732	.08%
OH—Inpatient Hospital Gross Revenue Tax	did not report	
OH—Outpatient Hospital Gross Revenue Tax	did not report	

To: Terry

From: Chris J

LINE-ITEM VETO PROVISIONS FOR SPENDERS

Higher Medicaid Matching Rate for Alaska

- The final balanced budget presented to the President raised Alaska's Federal Medicaid matching rate (FMAP) from 50 percent to 59.8 percent for fiscal years 1998, 1999 and 2000. According to CBO, this costs about \$200 million over 5 years.
- This provision was designed to address a perceived inequity. Alaska has a higher cost of living which the matching formula does not address.
- We are sympathetic to the need to fix the Medicaid matching rate. The formula, based only on per capita income, penalizes higher cost states like Alaska, Hawaii, and New York. It also does not take into account factors like a state's number of poor people or ability to afford Medicaid, which matters to states like Georgia and Texas. In fact, since 1994, the President has supported reexamining this formula and included a commission to do so in his last two budgets.
- However, fixing the matching rate on a state-by-state basis is unfair to other states that also perceive themselves disadvantaged by the current formula. It would also set a precedent for these states to ask for similarly favorable treatment, which would lead to significantly higher Federal costs.

New York Medicaid Provider Tax Exemption

- The final balanced budget presented to the President allowed several types of health care provider taxes in New York that had previously been considered impermissible. According to CBO, this costs about \$200 million over the 5 year budget window.
- The Administration supports the permissibility of the one of these taxes. The "regional tax" was intended to be allowed under the 1991 law.
- However, the other types of taxes are clearly impermissible. Taxes that fail to meet the broad-based and uniformity requirements were banned in 1991. States used them to "borrow" money from providers, use that money as their state contribution to Medicaid, and return it to the providers through higher Medicaid payments. If allowed, New York's exemption would open the door to many other states requesting similar forgiveness. According to HHS, 15 states currently have illegal provider taxes totaling \$3.5 billion.
- This is an example of a provision drafted in an overly broad way that leaves us no recourse but to veto. We cannot alter the current provision to respond to our concerns. We can and we will follow up on the veto with an immediate change in the Federal regulation that would exempt New York from a disallowance for its regional tax. This would ensure that New York is credited for about half of the CBO-estimated \$200 million cost, and a much higher amount, according to the Office of Management and Budget.

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Marshall Bladen

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Janet - intake
Marketing

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Jennifer
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Garrett
Jays

**CANCELLATION OF ITEM OF NEW DIRECT SPENDING
Report Pursuant to the Line Item Veto Act, P.L. 104-130**

Bill Citation: "Balanced Budget Act of 1997" (H.R. 2015)

Item: Section 4725(a). Subsection (a), "Alaska", of Section 4725, "Increased FMAPS", is cancelled in its entirety. The remainder of Section 4725 is not cancelled.

Agency: Department of Health and Human Services
Bureau: Health Care Financing Administration
Governmental Function Involved: Medicaid

Reason for Cancellation, and Facts, Circumstances, and Considerations relating to or bearing upon the Cancellation: Under the Medicaid program, the Federal Medical Assistance Percentage (FMAP) is the level of the Federal contribution, which is matched by a corresponding State contribution. The canceled provision would have increased, above the level of the current law formula, the FMAP for one State (Alaska). Under current law, that State's FMAP would be 50 percent, but the canceled provision would have increased the FMAP to 59.8 percent for fiscal years 1998, 1999, and 2000. This preferential treatment would have increased Medicaid costs, would have treated one State differently from all other States, and would have established a costly precedent for other States to request comparable treatment.

Estimated Fiscal Effect of Cancellation (in billions of dollars):

Outlay Changes²

<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>Total</u>
-\$0.1	-\$0.1	-\$0.1	0	0	-\$0.2

Estimated Budgetary and Economic Effects of Cancellation: The cancellation will change Federal outlays by the amounts specified above.

Estimated Effect of Cancellation on Objects, Purposes, and Programs: See "Reasons for Cancellation," above.

Adjustments to discretionary spending limits: Not applicable.

States and Congressional Districts Affected: Alaska.

Total Number of Cancellations (inclusive) in Current Session in each State and District identified above: One.

² Numbers may not add due to rounding.

File (C) NY Line Item Veto

Q: Is the administration now trying to work out a compromise with New York on line-item veto?

A: Our position has been the same before the line item veto, during the line-item veto, and after the line-item veto. We will not allow the type of impermissible or phantom provider tax that was the basis for our line-item veto-- on that point there can be no flexibility. However, as we stated before the line-item and when we did the line-item veto, to the extent that NY has legal and permissible provider taxes, we will work with them in good faith to clarify the legality of those provisions so that all permissible means for NY Medicaid financing are available to them.

As Director Raines said in our briefing on line- item veto, we did indicate our willingness to support legislation clarifying the permissibility of New York regional taxes, which would have provided significant financial relief to the State.* However, we should be clear, our proposal would not have allowed New York to make up anywhere near all of the revenue that was denied to them as a result of the line item veto. The Congress rejected our proposal and instead passed a provision that benefited only one state and "deemed" to be legal provider taxes that we believe are clearly impermissible. This is unacceptable and is the reason the President chose to line item veto this provision.

* (FYI: The counter-proposal suggested by the Administration would have clarified as acceptable one type of provider tax used by New York that no other state uses; in other words, any state who had a regional tax would have been eligible to benefit from this clarification. As far as we know, however, no state other than New York has a regional tax that would be eligible.)

File's

~~@ [unclear]~~

New York Line Item Vets



Elizabeth R. Newman
08/13/97 02:27:49 PM

Record Type: Record

To: Joshua Silverman/WHO/EOP

cc:

Subject: 1997-08-13 press briefing by Chris Jennings

----- Forwarded by Elizabeth R. Newman/WHO/EOP on 08/13/97 02:27 PM -----



SUNTUM_M @ A1
08/13/97 01:56:00 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: 1997-08-13 press briefing by Chris Jennings

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

August 13, 1997

PRESS BRIEFING BY
PRESIDENT'S PRINCIPAL HEALTH CARE ADVISOR, CHRIS JENNINGS

The Briefing Room

12:50 P.M. EDT

MR. MCCURRY: Good afternoon, ladies and gentlemen.
Today's daily press briefing will begin with the President's
principal Health Care Policy Advisor, Chris Jennings, to tell you
more about the event soon upcoming.

Chris, come on up here, help us out.

MR. JENNINGS: Later this afternoon at I believe it's 1:45 p.m., the President is going to unveil a new FDA regulation which will require pharmaceutical manufacturers for new and current drugs to do both testing and labeling for medications that are widely used by pediatric populations, or of course, children.

And this is something -- a regulation that the Department of Health and Human Services and FDA have been working on for a good time now. It follows in an effort by HHS to do this on a voluntary level, on a voluntary basis. Unfortunately, over the last several years we've noted that we've actually seen a decline in the amount of testing and labeling done for children, despite the voluntary efforts. So we have been working with the industry, pharmacists, providers, and of course, consumer groups to develop a regulation that the President will be unveiling.

This is just the unveiling of the reg. There will be a 90-day comment period, and then we will go to final. We think it works to complement legislation that is on the Hill, or it can complement legislation on the Hill that also tries to deal with this initiative. And the President will be with the Vice President, the First Lady, and the Secretary of Health and Human Services, and the parent of a child who has had great difficulty for herself and their pediatrician to have adequate information on labeling.

So that's it. Any questions?

Q How much is this going to cost --

MR. JENNINGS: Well, it's unclear. The FDA assumes it's about one percent of the current cost of drug development. It's a very, very modest amount according to them. I think the industry may say it's more. We will certainly be getting comments during the upcoming period, but we do anticipate it being very, very modest because, one, it does not necessarily require clinical studies. They can do pharmakenetik studies, which means they don't necessarily have to have populations of children in order to get the type of information that's necessary. Also, there has been some information for current drugs that are already out there that drug companies can access to get the type of information necessary and required under this legislation.

□

Q Does it apply to all medicines?

□

MR. JENNINGS: It applies to all prescriptions that will be used widely by children or are meaningful to children. We anticipate for new drugs that's about 12 to 14 new drugs a year and current drugs, too. And the regulation itself it will mention a category of about 10 drugs that are currently on the market that have inadequate testing.

Q Did the drug companies fight this?

MR. JENNINGS: Well, the drug industry has indicated today and last night that they look forward to working with us in a collaborative effort. I think that they are not overly thrilled about the concept of it being required or mandated. We would only point out that in the last five years we've actually seen a decline in necessary testing and that we see no other way to address the problem. I anticipate that over the next 90 days we'll have even more serious discussions with them. And I hope by the end of the day they will be supportive of other regulation by the time it goes final.

Q Did you say you identified just 10 drugs that are currently on the market that need --

MR. JENNINGS: The regulation itself lists 10 categories of drugs ranging from asthma to antibiotics to pediatric AIDS and particularly these protease inhibitors that are being used in a significant way. There may well be others but we will go ahead and review. Of course, many of these drugs have been on the market for so long that some information has become available, and pediatricians feel that they have the information they need and getting the adequate clarifications will not be difficult.

Q So is this a problem -- are kids being over-medicated?

MR. JENNINGS: I think that you'll see that the major problem is that there are three categories -- what happens is really three choices for a physician. One, because they don't have the information they need, they don't prescribe medications that children may benefit from, which obviously is an unfortunate outcome. Secondly, and what I would anticipate happens most frequently, is they guess. Frequently, they guess right. They've had lots of experience. Physicians know -- have a good sense of their patients and their needs. And third, they guess wrong. They either under-medicate or over-medicate, sometimes with tragic consequences. There have been some cases of deaths that have been reported because of the lack of information. That's why the American Academy of Pediatricians and many other physicians throughout the country, the Family Physicians, the College of Physicians, strongly, strongly endorse this information being made to them -- and this regulation.

Q Chris, are there any liability concerns? Are the companies concerned that if they say that this drug might be all right to use on children under 18 or under 12 and it turns out that it isn't, then all of a sudden they've got a problem.

MR. JENNINGS: They actually raised liability concerns during the vaccine compensation debate several years ago, then they dropped that as a major concern of them. We have no indication or no evidence whatsoever that information on such testing has created any liability concerns. We've asked in the past for specific examples. They have given us none. I don't anticipate that being a very

significant concern. We will talk to them about that during the comment period, but, again, I do not think that is a serious concern.

Q How many children take these medications?

□

MR. JENNINGS: Millions. Certainly we're talking about everything from asthmatics -- children with asthma, to children who have AIDS, to every known disease that children access. So we're talking about probably anywhere between millions to even more than 10 million children.

Q Why aren't drug companies already doing something that sounds like it makes so much sense?

MR. JENNINGS: Well, I think that they would say that they have some -- I don't know exactly what they would say. I think you should ask them. My personal belief is that they think that a lot of the information they have obtained for adults is somewhat adequate, that it's not necessary to impose additional costs on the industry, and that they've raised concerns. They would also argue that they're doing better, notwithstanding some of the data to the contrary.

Q If I could switch that question just a little bit, why is it that the FDA hasn't done this before?

MR. JENNINGS: Well, the FDA, and before Dr. Kessler left, he worked very hard on this regulation. He consulted with the industry for a number of years. They asked for us to go voluntary compliance and to come up with some incentives for them to do it on a voluntary basis. We did that. We released a reg in 1994. It clearly has not had the desired effect, and so we're going beyond that today.

Q You mentioned prescription drugs, but how does this apply to over-the-counter medications?

MR. JENNINGS: Well, this is for prescription drugs that doctors prescribe frequently. A lot of over-the-counter drugs do have pediatric labeling information, but that's something that I will tell you I have not looked into or is not part of this regulation today.

Q Secretary Shalala yesterday was indicating that so many OTC medications just simply say, ask your doctor, and that she indicated that this may move to clear that up.

MR. JENNINGS: Well, this is for prescription drugs, and, certainly, if there is a major concern on OTC level, we will be consulting with the FDA about that.

Q You mentioned protease inhibitors. What is the problem there with the drug companies -- they are not adequately providing information to patients, or doctors, or who?

MR. JENNINGS: Well, as you may know the protease inhibitors are some of the most difficult to use medications and to prescribe. They are very complicated. They deal with regimens of prescriptions. They are usually and sometimes called drug cocktails. They have very, very differential impacts on children. There have been drug companies, and I'm sorry there was one Angoram or a smaller drug company that did do pediatric studies much to the praise of the AIDS community and others recently, but many other companies have not. This is very, very significant and absolutely essential information for any pediatrician for treating a child who has AIDS.

Q Chris, does this mean that a lot of parents will be asking to have their children tested?

MR. JENNINGS: No, not necessarily, because a lot of this testing can be done on information currently available. Pharma-kinetic testing, which does not require that I have actual children doing testing. It's based on computer simulations of differential metabolism rates of patients. So we don't anticipate it to be a major population although there will be some of that testing. And, obviously, all of that testing is done on a voluntary basis in trials throughout the country.

Q Do you expect that the industry will try to block the regulation?

MR. JENNINGS: We would be very disappointed if they blocked this regulation. We would fight very, very hard, and I doubt that they would want to do that this year in this Congress. But I think you better ask them. But my general sense after conversations with the pharmaceutical manufacturers association last evening was that their desire was to work with the administration on this regulation in a collaborative, constructive way. We anticipate that they will live up to that commitment.

Q You mentioned categories of drugs. In what categories of drugs do you see most of the over-prescribing or the guessing by physicians that --

MR. JENNINGS: You know, I think that that's a question better answered by some of the physicians groups who will be here later this afternoon, so -- I'm not a doctor and I wouldn't want to guess some specific data in that area.

Q Chris, Mike indicated we could run a couple other health-related questions by you today.

MR. JENNINGS: It would be my pleasure. Thank you, Mike.

Q On the Medicaid situation with New York, there are some accounts saying you're trying to get together with New York legislators to fashion another solution. Is it accurate to say you're backtracking on this, or what are you trying to do exactly?

MR. JENNINGS: No, I welcome the question. I think we need to backtrack a little bit about this whole issue, just for one moment. We have worked very hard with the New York delegations, with the committees of jurisdiction, with Senator Moynihan, Senator D'Amato, with other members in trying to fashion a way to assist some of the problems New York is facing with their provider tax situation.

We explicitly raised concerns and objections -- very, very serious objections to the way the Senate Finance Committee passed a broad-based waiver approach to New York only on the provider tax issue. We made that very clear in a letter from Frank Raines and in subsequent conversations from myself and other representatives of the administration to members and staff on the Hill.

In an effort to try to work out a compromise, we worked very closely with the Secretary's office and Bruce Vladeck's at the Health Care Finance Administration to see if we could look at a compromise approach to dealing with legitimate concerns that New York had raised about provider tax issues. We gave them some specific alternative language that would have addressed about half their problem. The New York delegation -- the committees of jurisdiction were given that language. They said they needed to run it by folks. It was rejected.

We explicitly said we still had major concerns to that. No one ever reached any agreement on what was agreed to by the Senate Finance Committee by any representative of the administration. And we continue to have objections to that process.

One last point that I think I've got to make is that there are at least 14 other states who have provider taxes in this country who were not given any type of waiver protections as was outlined in the New York provision. Had we gone to doing New York it would have been a classic Washington-based rifle shot provision for one state and one state only. And it would have been impossible for us to say no on provider taxes that we believed to be impermissible under current law and statute.

As to your original question as to when we are going to meet with them or will we meet with the New York delegation, we have ongoing strong relationships with New York. I think that's best exemplified by the New York waiver negotiations that were completed about a month or two ago. It was widely praised by the Governor, by the New York delegation, by the Mayor, by representatives of Labor. We have a very good track record in working out problems with New York that are legitimate in nature. We will do the same as it relates to the provider tax issue. We will be more than happy to meet with them in the upcoming weeks. It will be done in a way that is consistent with our ongoing negotiations with every state. And it will be done by the Department of Health and Human Services.

We will be happy to help facilitate that but those are conversations that have to be done by HCFA, HHS and the state of New York in consultation with OMB and the Domestic Policy Councils.

Q So when Mr. Raines said that this question had not been raised at his level, he was mistaken?

MR. JENNINGS: No, he -- in the meetings with the members, when they were talking about children's health, Medicare, Medicaid, education, welfare, taxes and all the other multitude of issues that were raised at that level, an issue with regard to one state's labor provisions did not get raised to that level. Mr. Raines did send up a letter outlining all of our concerns with Senate provisions, including the New York problem. We, as the administration, are on record opposing the approach the Finance Committee took. But it was not raised at that level, but it was raised directly to -- by me and many other representatives of the administration to the committees of jurisdiction. And we went the extra mile in a good-faith effort to try to address concerns that would not have had a special impact on any other state, would have only dealt with a New York issue that is unique to New York, which is this regional tax issue.

Q When you said that you had discussed language that would have addressed about half of New York's problem, do you mean financially -- in other words, it would have helped them recoup about half of the \$317 million that they would have gotten out of this over five years?

MR. JENNINGS: Whatever the estimate of the number is, we think it's about half dollar-wise.

Q So you think you can come up with a solution that's legally defensible that will get them back half?

MR. JENNINGS: We made a proposal that moved in that area on the legislative front. The question now remains whether we can do it on a regulatory-administrative front ourselves without legislative action. We think that there might be possibilities. We will be deferring to conversations with HHS on that matter.

Q The Republicans say that in the final negotiations any serious issue was kicked up to the top level, and so the fact that you never kicked this up to the top level gave them every reason to believe it was not a major obstacle or in any way veto bait. Given that other issues were kicked up to the top level, didn't they have a legitimate basis for concluding that you had decided to give on this since you didn't kick it up to the top?

MR. JENNINGS: Well, I honestly do not believe that that's the case. There are hundreds and thousands of provisions in this legislation; not every single provision could be kicked up to the top. Members of this budget committee, of our working group and on the Hill, were working around the clock on major, major issues that had profound effects on the whole country. This was an issue that was related specifically to New York. Clearly, it was a major concern to us. The President, subsequent to the agreement, asked us to go through the balanced budget agreement to see if there were any provisions that met his criteria for potential line item provisions. New York, by definition, made those criteria and was the reason why

we went to the action of line item.

Q If I could just push that one more time. Given that this is the only spending issue that was vetoed, doesn't it seem logical, if it was so serious a concern that it would ultimately be vetoed, that it should have been kicked up to the top? And again, doesn't their argument that you never signaled that it was this important seem to have some basis?

MR. JENNINGS: Well, we had many issues that could have been potential veto items throughout this negotiating process that there were specific discussions, and we worked them out to a compromise -- in some ways that we would have preferred not to have been the case. There are a number of Medicare provisions, Medicare savings, MSA, the private fee for service option, et cetera, are things that we had to negotiate out, things that we didn't particularly like a great deal; but we had to go for.

There are going to be examples of provisions in any budget reconciliation legislation, I would suspect, that include hundreds, if not thousands, of provisions that may not meet the criteria of a presidential discussion that still do not meet the criteria of an acceptable provision. And this was just one of those.

Q Just to make sure I understand you correctly, are you saying now the administration is considering a regulatory compromise that will give New York roughly half of what it would have gotten under the bill?

MR. JENNINGS: What I'm saying is, we had a specific legislative authority to move into that direction and what we are trying to do is to evaluate if we have the authority to move in that direction on an executive-administrative approach.

Q You said there were about 14 other states that have this same problem with provider taxes. Did you offer them a similar -- have you been offering them similar sort of compromise?

MR. JENNINGS: That's a very good question. On the regional tax issue that we have offered, or we've tried to offer to New York, as far as I'm aware of there is no other state that has a similar concern. What New York has is a whole bunch of other issues related to other provider tax issues that are very similar to other states. But on the issue of regional tax, it is a small provision that has a significant impact on New York and New York only that does not have ramifications to a broader population of states.

Q Where do you stand in your discussions with those other states? I mean, all those states with provider taxes that are deemed unacceptable, inappropriate, or illegal --

MR. JENNINGS: Right.

Q So where are you on the status of those?

MR. JENNINGS: We've already indicated to many of them

that we do have concerns. We are going to have further discussions with them in the very near future.

Q New York was the only one that's being offered a compromise --

MR. JENNINGS: New York has one provision that is not applicable in any other part of the country, and that's something that we're willing to look at because we think it may be consistent with the original intent with the law that was passed in 1991.

MR. MCCURRY: Two last questions, here and here.

Q I've been told that New York has been applying for this waiver from HCFA since 1991. Why hasn't HCFA ruled on this previously?

MR. JENNINGS: Well, there was a question of whether we had the legal authority under the statute to be able to do that, and also to determine what kind of impact it would have on all other states. There are many other states who have waiver requests into the administration on these provider taxes. We are currently undergoing an intense review of all of those states and we will be doing -- you will be, I'm sure, hearing more of that as time goes on.

Q We understand the President has on his desk for action today a law that would create a postage stamp to support breast cancer research. If the President plans on signing this, we understand the administration had raised objections to it -- that you didn't like the way it allocated funds. Have those objections been overcome, or have you just decided as a political matter to go ahead and sign it? And are you concerned that this could result in sort of the disease of the week type legislation?

MR. JENNINGS: Well, we have raised some concerns about this. We think on balance it builds on a lot of the efforts that the administration has had. We've had a significant increase in breast cancer research dollars that the President has personally been very, very support of. The First Lady and others and Secretary Shalala has had great interest in pursuing this. We think this is just one more way to get additional resources.

The one thing that we are concerned about and will still guard against is to make sure that these dollars are not used to replace current allocation resources -- in other words, those dollars are used -- they will not supplant they will supplement what we already have in the system. And that was a question we've always had about this approach. We're going to make sure that we do everything possible working through Treasury and HHS to make sure that it happens.

Q What about other diseases? People may come and want an AIDS stamp or a leukemia stamp -- are you prepared to go along with those proposals?

MR. JENNINGS: I think that's a legitimate question that

we're going to have to evaluate and, again, we did not make the proposal ourselves. I think that there is -- you know, people can raise concerns about that approach. But, again, on balance, we think that this is more than acceptable and that we're going to do everything that we can to address our concerns.

Q And the President will approve it today?

MR. MCCURRY: I expect him to sign it today.

Q Can I just ask one question about the President's event. First of all, \$13 to 20 million is the number that has been

bandied about about what this would cost drug companies. Is that about right?

MR. JENNINGS: That is a number that is included in the current reg that is being made public today. It is an FDA estimate. I assume that the industry will raise questions about that estimate. And, again, this is a reg that is being released today. There are 90 days of comments and before it goes final, we review all that data before we make a final determination of the exact cost impact of these regulations.

Q And there are 10 drugs right now currently that will be affected?

MR. JENNINGS: There are 10 that are listed explicitly in the reg. That does not mean that that covers the whole panoply of drugs that would necessarily come under the jurisdiction.

Q Can you give an estimate for that, for that whole gamut -- 10s, 100s, 1,000s?

MR. JENNINGS: There are about, I would say, on a yearly basis we're talking about roughly 15 or so drugs a year that will have to come under this because we're estimating about -- I'd say 12 to 15, maybe more.

Q Those are new ones. I was talking about the existing ones.

MR. JENNINGS: The new drugs -- I mean, the existing drugs, there is at least 10; there may be more. And we're going to have to see how frequently -- how rapidly FDA can get that information out to pediatricians and the families who need this information.

Q Do you know those 10 off the top of your head?

MR. JENNINGS: It's in the regulation and I can tell you that asthma drugs are one of them. But if you'd like to afterwards, I can get you a list.

Q At the President's news conference last week, he

said that the administration would be addressing the issue of health care quality for nursing homes and I think possibly home care shortly. Can you expand on that at all?

MR. JENNINGS: Not in this context. No, I think he's, the President has a long -- from the days he was even an Attorney General in the state of Arkansas, he had major concerns about quality issues with the nursing homes and also has a great interest in seeing if there are ways that we can look at alternatives to institutionalized care because he thinks that there are cost-effective approaches.

In so doing, though, he also wants to make sure that we address what he considers to be unacceptable situations as it relates to allegations of and real fraud and abuse in home care. And so he wants to -- he will be, I assume, in fairly short order, looking at potential actions to address both issues coming from different angles.

Thank you.

MR. MCCURRY: Thanks, Chris.

END

1:15 P.M. EDT

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