

BEFORE THE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES

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In the Matter of )  
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MEDICAID PROGRAM; )  
HEALTH CARE-RELATED TAXES )  
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CMS-2275-P2 )  

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**JOINT COMMENTS OF SIXTEEN STATE MEDICAID AGENCIES  
IN SUPPORT OF DELAYED ENFORCEMENT OF REGULATION**

These comments are submitted on behalf of the agencies and officials responsible for administering the Medicaid program in the States of Alaska, California, Connecticut, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Maine, New York, Ohio, Oklahoma, South Dakota, Tennessee, Vermont and Washington (the “Commenting States”), in support of the proposal to delay for one year the enforcement of certain portions of the final rule on Health Care-Related Taxes adopted on February 22, 2008, but suspended by Congressional action until June 30, 2009.

The portions of the final rule that are proposed to be delayed were not mandated by Congress. To the contrary, they are at odds with the underlying terms and purpose of the provider tax legislation (adopted in Public Law 102-234 and codified in section 1903(w) of the Social Security Act). The provisions import uncertainty and confusion into a regulatory regime that has been straightforward and has functioned as intended by Congress since its adoption in 1991. The Commenting States not only support delayed implementation but urge that the provisions be rescinded in their entirety.

The statutory provisions relating to health care-related taxes, and the corresponding CMS regulations (until the changes adopted on February 22, 2008) possessed two vital characteristics: they were comprehensive, and they were clear. Recognizing the delicacy of intruding on the power of states to impose taxes, Congress strove to adopt a regime that would protect legitimate Medicaid program interests without impairing the crucial revenue-generating function of the states.

That regime required that health care-related taxes, in order to be considered an appropriate source of funding for Medicaid program purposes, meet specified standards (broad based; uniform; imposed on defined classes), including the absence of “hold harmless” provisions. Three hold harmless categories were specifically defined in the statute, and elaborated on to some degree in the implementing regulations.

These statutory and regulatory provisions have worked remarkably well. Very few disputes have arisen over their meaning and application; most questions that have arisen have been resolved administratively. One case went to decision by the Departmental Appeals Board after almost a decade of consideration (or inaction) by the agency as to whether the taxes involved (all long since abandoned) satisfied the statutory and regulatory criteria. But otherwise, the standards have become well known and accepted by states, whose use of health care-related taxes has been governed and guided by them.

The rule changes adopted on February 22, 2008, threaten this stable situation. They purport to revise the hold harmless provisions of the regulations explicitly to import more subjectivity into their implementation--in effect, to allow the agency a discretion to find a hold harmless whether or not the specific terms of the hold harmless provisions have been violated. No justification was advanced for this change (other than expressed dissatisfaction with the

decision of the Board in the one case that went to decision). To the contrary, in adopting the rule changes CMS acknowledged that it knew of no outstanding state health care-related taxes that would be impacted by its new, more subjective, interpretation.

Perhaps the changes in the rules (which are minor on their face but embody the intention to adopt a more subjective approach to the hold harmless analysis) will not in the end change the way the rules are applied. But the threat of a more subjective and less predictable interpretation is there, and it makes it much more difficult for States to develop compliant tax policies. This is of particular concern at this time, when the decline in traditional state revenues has forced States to look more to new sources of revenue, including the possibility of raising revenue from health care providers.

For these reasons, the Commenting States support the CMS proposal to delay implementation of the changes in the hold harmless provisions (other than the statutorily-mandated change in the hold harmless percentage) for a year, and urge CMS to go further and rescind the changes altogether, thereby removing the cloud that those changes place on what up to now has been a reasonably clear set of standards that States have come to know and follow. The adage “if it ain’t broke, don’t fix it” is particularly apropos in this case.

Respectfully submitted,

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On behalf of the Medicaid agencies of the  
States of Alaska, California, Connecticut,  
Hawaii, Illinois, Kansas, Kentucky,  
Louisiana, Maine, New York, Ohio,  
Oklahoma, South Dakota, Tennessee,  
Vermont and Washington

June 1, 2009