§ 411.25 Primary payer's notice of primary payment responsibility.

(a) If it is demonstrated to a primary payer that CMS has made a Medicare primary payment for services for which the primary payer has made or should have made primary payment, it must provide notice about primary payment responsibility and information about the underlying MSP situation to the entity or entities designated by CMS to receive and process that information.

* * * * *

(c) The primary payer must provide additional information to the designated entity or entities as the designated entity or entities may require this information to update CMS' system of records.

§ 411.45 [Amended]

■ 4. Section 411.45(a)(2) is amended by removing the word ''capacity'' and adding the word ''incapacity'' in its place.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: September 4, 2007.

Herb B. Kuhn,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 19, 2007.

Michael O. Leavitt,

Secretary.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 433

[CMS 2275–F]

RIN 0938–AO80

Medicaid Program; Health Care-Related Taxes

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule revises the collection threshold under the regulatory indirect guarantee hold harmless arrangement test to reflect the provisions of the Tax Relief and Health Care Act of 2006. When determining whether there is an indirect guarantee under the 2-prong test for portions of fiscal years beginning on or after January 1, 2008 and before October 1, 2011, the allowable amount that can be collected from a health care-related tax is reduced from 6 to 5.5 percent of net patient revenues received by the taxpayers. This final rule also clarifies the standard for determining the existence of a hold harmless arrangement under the positive correlation test, Medicaid payment test, and the guarantee test (with conforming changes to parallel provisions concerning hold harmless arrangements with respect to provider-related donations); codifies changes to permissible class of health care items or services related to managed care organizations as enacted by the Deficit Reduction Act of 2005; and, removes obsolete transition period regulatory language.

DATES: *Effective date:* This rule is effective April 22, 2008.

Compliance date: CMS will not consider a State to be out of compliance with the revision to the definition of permissible classes until October 1, 2009.

FOR FURTHER INFORMATION CONTACT: Charles Hines, (410) 786–0252 or Stuart Goldstein, (410) 786–0694.

SUPPLEMENTARY INFORMATION:

I. Background

A. General

Title XIX of the Social Security Act (the Act) authorizes Federal grants to the States for Medicaid programs to provide medical assistance to persons with limited income and resources. While Medicaid programs are administered by the States, they are jointly financed by the Federal and State governments. The Federal government pays its share of medical assistance expenditures to the State on a quarterly basis according to a formula described in sections 1903 and 1905(b) of the Act. The amount of the Federal share of medical assistance expenditures is called Federal financial participation (FFP). The State pays its share of medical expenditures in accordance with section 1902(a)(2) of the Act.

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102–234), enacted December 12, 1991, amended section 1903 of the Act to specify limitations on the amount of FFP available for medical assistance expenditures in a fiscal year when States receive certain funds donated from providers and revenues generated by certain health care-related taxes. We issued regulations to implement the statutory provisions concerning provider donations and health care-related taxes in an interim final rule (with comment period) published on November 24, 1992 (57 FR 55118). A final rule was issued on August 13, 1993 (58 FR 43156). The Federal statute and implementing regulations were designed to protect Medicaid providers from being unduly burdened by health care related tax programs. Health care related tax programs that are compliant with the requirements set forth by the Congress create a significant tax burden for health care providers that do not participate in the Medicaid program or that provide limited services to Medicaid individuals.

B. Health Care-Related Taxes

Section 1903(w) of the Act requires that State health care-related taxes must be imposed on a permissible class of health care services; be broad based or apply to all providers within a class; be uniform, such that all providers within a class must be taxed at the same rate; and avoid hold harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers. Section 1903(w)(3)(E) of the Act specifies that the Secretary shall approve broad based (and uniformity) waiver applications if the net impact of the health care-related tax is generally redistributive and the amount of the tax is not directly correlated to Medicaid payments. The broad based and uniformity requirements are waivable through a statistical test that measures the degree to which the Medicaid program incurs a greater tax burden than if these requirements were met. The permissible class of health care services and hold harmless requirements cannot be waived. The statute and Federal regulation identify 19 permissible classes of health care items or services that States can tax without triggering a penalty against Medicaid expenditures.

The regulatory language at 42 CFR 433.68(f) sets forth tests for determining the presence of a hold harmless arrangement that were directly based on the language contained in section 1903(w)(4) of the Act. The preamble to the 1993 regulation provided guidance and some illustrative examples of the types of health care-related tax programs that we believed would violate the hold harmless prohibitions. In a June 29, 2005 decision, however, the HHS Departmental Appeals Board (DAB), DAB No. 1981, found that these regulations did not clearly preclude certain types of arrangements that we believe to be within the scope of the

statutory hold harmless prohibition and implementing regulations. The DAB consequently reversed disallowances issued by CMS to five States. In each of these reversed disallowances, the States had created programs that imposed a tax on nursing homes and simultaneously created programs that awarded grants or tax credits to private pay residents of those nursing homes. These grants and/or tax credits were designed by the States to compensate private pay residents of nursing homes for the costs of the tax passed on to them by their nursing homes through increased charges. The DAB, however found that CMS regulations did not clearly identify that such grants and tax payments amounted to hold harmless arrangements that would preclude FFP.

One of the hold harmless tests, set forth in current rules at § 433.68(f)(3)(i), defines arrangements that are considered to be prohibited indirect guarantees. Taxes imposed on health care-related providers may not exceed 6 percent of the revenue received by the taxpayer unless the State makes a showing that, in the aggregate, 75 percent of taxpayers do not receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments. Prior to the enactment of the Tax Relief and Health Care Act of 2006, States could tax individual classes of health care services and providers, including inpatient hospital services, outpatient hospital services, and nursing facility services up to 6 percent of the net patient revenue attributable to the assessed permissible class of health care items or services without violating prohibitions on the indirect hold harmless arrangements. The 6 percent limit was established to maintain consistency with the average level of taxes applied to other goods and services in the State, as discussed in the November 24, 1992 preamble to the interim final rule implementing the statute.

On December 20, 2006 the Tax Relief and Health Care Act of 2006 was signed into law as Public Law 109–432. Section 403 of that law incorporated the existing regulatory test for an indirect guarantee into the Medicaid statute but provided for a temporary reduction in the allowable tax rate under the first prong of the test. Specifically, the indirect hold harmless threshold has been reduced from 6 percent to 5.5 percent effective January 1, 2008 and before October 1, 2011. We want to remind States that the collection threshold test is an annual test and while the effective date of this change does not coincide with the beginning of any State's fiscal year the test must still be performed on an annual basis. Therefore, if a State chooses to impose a health care related tax at a rate in excess of 5.5 percent prior to January 1, 2008, it will have to appropriately adjust the tax rate after January 1, 2008 so that health care related tax collections will not exceed 5.5 percent on a per class basis going forward. Compliance in State fiscal year 2008 will be evaluated from January 1, 2008 through the last day of State fiscal year 2008. Beginning with State fiscal year 2009 the 5.5 percent tax collection will be measured on an annual State fiscal year basis.

II. Provisions of the Proposed Rule

In the March 23, 2007 proposed regulation we proposed to:

- Codify section 6051 of the Deficit Reduction Act of 2005 (Pub. L. 109–171) which amended section 1903(w)(7)(viii) of the Act to expand the previous Medicaid managed care organization (MCO) class of health care items and services to include all MCOs.
- Clarify the provisions of the hold harmless tests found at § 433.68(f).
- Modify and clarify the positive correlation test set forth at § 433.68(f)(1), to specify that a State or other unit of government will violate this test if they impose a health care-related tax and also provide for a direct or indirect non-Medicaid payment and the payment amount is positively correlated to the tax amount or to the difference between the Medicaid payment and tax amount. We proposed to interpret the phrase ''direct and indirect non-Medicaid payment'' broadly. These payments may take many forms, such as grants or tax credits, although there will undoubtedly be other types of payments that we have not yet anticipated.
- Clarify the definition of tax amounts and payment amounts for purposes of hold harmless analyses. We proposed to unify these definitions so that they would have identical meanings in all three hold harmless tests under § 433.68(f).
- Clarify within § 433.68(f)(2) that a Medicaid payment would be considered to vary based on the tax amount when the payment is conditional on the tax payment.
- Clarify the guarantee test at § 433.68(f)(3) to specify that a State can provide a direct guarantee through a direct or indirect payment. A direct guarantee would be found when a State payment is made available to a taxpayer or a party related to the taxpayer (for example, as a nursing home resident is related to a nursing home), in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax. An indirect payment to the taxpayer would also constitute a direct guarantee. One such example of this indirect payment providing a direct guarantee would be found where a State imposing a tax on nursing facilities provided grants or tax credits to private pay residents of those facilities that could be used to compensate those residents for any portion of the tax amount that the State has allowed to be passed down to them by their nursing homes. This represents a direct guarantee of an indirect payment to taxpayers.
- Modify under § 433.68(f)(3)(i), the indirect hold harmless threshold percentage to be consistent with the Tax Relief and Health Care Act of 2006, which lowered the collection threshold under the indirect hold harmless provision from 6 percent of net patient service revenue to 5.5 percent effective for portions of fiscal years beginning on or after January 1, 2008 through September 30, 2011, prior to a State being required to demonstrate the second prong of the indirect hold harmless provision.
- Clarify at § 433.56(a)(4) the permissible class for purposes of health care-related taxes to only those services of ICF/MRs by removing narrow exception for similar services of community-based residences for the mentally retarded if certain criteria are met.
- Modify parallel hold harmless provisions with respect to provider-related donations at § 433.54(c).
- Remove transition periods related to provider-related Donations and health care related taxes provided under section 1903(w)(1)(C)(ii) of the Act since the last transition period expired in 1993.

III. Analysis of and Responses to Public Comments

We received 21 items of timely public comments which contained approximately 190 public comments that raised 47 individual issues, in response to the March 23, 2007 proposed regulation (72 FR 13726 through 13734). The comments came from a variety of correspondents, including health care provider associations, national and State organizations and State Medicaid agencies. The majority of commenters urged us to reconsider proposed changes to the hold harmless provisions. The following is a summary of the comments received and our response to those comments.

A. General Comments

Comment: One commenter expressed support for the codification of the 6 percent maximum tax amount allowed and agreed with CMS' implementation of section 403 of the Tax Relief and Health Care Act of 2006. The commenter indicated that while health care provider taxes are not an optimal approach to sustainable appropriate and equitable Medicaid funding, but stated that cutting the maximum tax rate allowed substantially below 6 percent would have resulted in Medicaid payment reductions and thus harmed low income populations needing care. The commenter also suggested that such taxes create a significant tax burden for health care providers that provide limited services to or no services to Medicaid beneficiaries.

Response: We appreciate the support for our implementation of section 403 of the Tax Relief and Health Care Act 2006. We understand the concern about the burden of health care related taxes on providers that have little or no Medicaid revenues. Medicaid limits on health care related taxes protect those providers at the same time as ensuring that such health care related taxes do not effectively shift a disproportionate burden of the Medicaid program to the federal government. We also recognize that States use revenues received from permissible health care related taxes to support Medicaid payment rates, but States have other sources of revenue that can support Medicaid payments and ensure that low income populations receive needed care. This rule balances all these concerns in clarifying the definitions of permissible classes and hold harmless arrangements.

Comment: A couple of commenters asserted that the proposed rule violated the Administrative Procedure Act provision codified at 5 U.S.C. 553(b). The commenters took issue with the preamble clarifications regarding interpretations of regulatory provisions that were included in the proposed rule. The commenters argued that CMS should have included precise regulatory language to implement such changes and that CMS cannot implement the proposed rule until it publishes sufficient notice in the form of substantive regulatory language. Other commenters stated that CMS provided no rational support for the proposed rule.

Response: We disagree with the suggestion of any procedural deficiency. Through publication of the proposed regulation, CMS adhered to all requirements of the Administrative Procedure Act. Proper notice was given of proposed changes and a public comment period was provided. Those comments were considered, and are discussed in this final rule. The final rule includes all necessary changes to the regulatory framework and gives States clear guidance on how that regulatory framework will be applied to health care related tax programs.

Comment: Numerous commenters argued that the proposed regulatory changes directly contradict provisions of the Social Security Act and that CMS exceeded its statutory authority. These commenters cited section 5(c) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Pub.L. 102–234) which mandated that the Secretary consult with States before issuing any regulations under this public law. The commenters asserted that significant changes were made through this proposed regulation and that consultation with States was required prior to the issuance of the regulatory changes. For these reasons, the commenters indicated that CMS should not implement the new rule and begin consultations with States.

Response: We believe the conditions of section 5(c) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1191, Public Law 102–234 were fully satisfied by the process the Secretary undertook when the regulations implementing that Act were issued in 1992 and 1993. Even if these conditions were read to extend in perpetuity, however, they have been met with respect to this final rule. The notice and public comment procedures used to issue this final rule have provided a full and fair opportunity for consultation with States. This opportunity is in addition to the ongoing dialogue between CMS and the States over proposed State financing in the review process for Medicaid State plan amendments.

Comment: Several commenters believe that CMS' approach will harm State Medicaid programs by decreasing the resources necessary to support the growing and changing nature of Medicaid services. Another commenter raised concern about the financial and administrative burden for States of the proposed rule. One commenter argued that the changes proposed in the regulation will compel States to dismantle already approved financing. One commenter asserted that the negative effect of the proposed rule could exceed approaches rejected by Congress. One commenter was concerned that CMS did not fully consider the significant financial issues confronting States and the continual pressure to contain Medicaid spending in the face of State budgets. Another commenter stated that the proposed regulation will cause a shift in burden of health care financing from the federal government to the States.

Response: This final regulation implements section 403 of the Tax Relief and Health Care Act of 2006 and clarifies existing Federal law related to permissible classes of health care services and the hold harmless provisions. We do not agree that the statutorily-mandated reduction in the indirect guarantee threshold will result in excessive financial and administrative burdens or reductions in program benefits. In any case, CMS is bound by the law to make this change. Moreover, the clarifications provided in this regulation were not designed to target particular existing health care related tax programs for which States have received waiver approval from CMS of the broad based and/or uniformity requirements. These clarifications were instead to ensure a consistent and uniform understanding of the application of the hold harmless provisions. We refer to them as clarifications because they reflect CMS's understanding of how the hold harmless provisions should be applied. These clarifications are based on the need to ensure that the regulations effectively identify hold harmless arrangements in which health care related taxes operate to effectively shift a disproportionate burden of the Medicaid program to the federal government. Although the clarifications are not targeted toward any particular financing arrangements, CMS reserves the right to perform financial management reviews of any tax structures to ensure compliance with Federal statute, expressly approved by CMS or otherwise.

Comment: Several commenters requested that CMS affirm that the proposed rule would not jeopardize already approved State plan amendments (SPAs) and provider tax programs. The commenters also requested that CMS confirm that it will continue to approve SPAs and provider tax submissions with similar features as those already approved. In the absence of such confirmations, the commenters requested that CMS identify with written explanations which specific approved SPAs and provider tax submissions would be problematic under the proposed regulation. Another commenter suggested that if these provisions are adopted in final, they should only apply to payments contained in SPAs adopted after the effective date of the final rule.

Response: With respect to the change in the indirect guarantee test, Congress

did not make any provision to exempt or grandfather existing approved tax provider programs. Under the direction of the Congress, the final regulation is effective January 1, 2008. With respect to the other changes contained in this final rule, we considered and rejected a possible exception for already approved provider tax programs. Such an exception would not be uniform and would not achieve the objective of ensuring that provider taxes did not shift the effectively shift a disproportionate burden to the federal government. As part of the routine CMS review of Medicaid State plan amendments (SPA) that affect Medicaid payment to providers, CMS examines the sources of the non-Federal share of Medicaid payments, including the revenues received by States from health care-related taxes. Such SPAs are reviewed and decided upon on a case-by-case basis under the consistent application of Federal statute and regulations. Because these clarifications reflect current CMS practices regarding ongoing reviews, CMS is not aware of any approved tax programs that are not in compliance with the final rule. However, CMS always reserves the right to ensure any State Medicaid financing source and associated reimbursement methodologies comply with Federal requirements.

Comment: A few commenters were concerned that the proposed rule would ultimately decrease funding for the Medicaid program and threaten access to important long-term care services. Another commenter was concerned that the proposed rule will adversely affect safety net providers by lowering Medicaid payments and as a result patients' access to essential health care services would be disrupted.

Response: This final regulation along with the Federal Medicaid statute governing health care related taxes was designed in part to protect health care providers. Specifically, the reduction to the allowable collection threshold serves to minimize the burden imposed on health care providers by States through taxation in order to support the State's Medicaid program. The effect of this reduction is that health care providers can realize a greater net revenue base when they are no longer obligated to fund a portion of their Medicaid payments through a State imposed tax. Further, those health care providers that do not participate in the Medicaid program would experience an overall reduction in their tax rate. In addition, States have the option to replace any tax revenue lost as a result of the reduction to the allowable collection threshold with other sources of non-Federal share payment, including additional State and local general fund dollars. If such general fund dollars are used health care providers may experience no reduction in the level of their Medicaid funding. States still have many available resources to ensure that necessary services are available to the most vulnerable populations. The purpose of this regulation was not to reduce access to any health care services but to strengthen the fiscal integrity of the Medicaid program.

Comment: One commenter stated that addressing perceived problems with Medicaid financing would be better addressed through legislation. Another commenter specified that CMS should work with the Congress to clarify existing statutory language.

Response: The final regulation implements section 403 of the Tax Relief and Health Care Act of 2006 and clarifies existing Federal law related to permissible classes of health care services and the hold harmless provisions. The clarifications are to ensure that the regulatory framework effectively implements existing statutory provisions setting permissible classes and prohibiting hold harmless arrangements that shift a disproportionate share of the cost of the Medicaid program to the federal government.

Comment: One commenter noted that, given the most recently issued proposed regulations restricting IGTs and CPEs, CMS should not further limit States' ability to fund the non-federal share of Medicaid payments.

Response: This final regulation implements and clarifies statutory provisions that permit States to fund the non-federal share of Medicaid payments with permissible health care related taxes. The statutory provisions, and these regulations, are a response to States that imposed health care related taxes that had the effect of shifting financial burdens from the States to the federal government. This shift resulted from hold harmless arrangements under which providers were effectively repaid some or all of the tax burden, and the federal government was left with a disproportionate share of the tax burden. The changes made in this final regulation should assist States in determining the permissibility of tax programs. While the temporary reduction in the indirect guarantee threshold test may reduce the amount of permissible tax revenues, States have the option to replace any tax revenue lost as a result of the reduction to the allowable collection threshold with other sources of non-Federal share payment, including additional State and local general fund dollars.

Comment: One commenter expressed concern that the proposed rule unnecessarily grants CMS authority to delve into relationships between States and local governments and does not provide sufficient clarity on the criteria for evaluation of these relationships. The commenter believes that open ended interpretations of tax and reimbursement programs could result in case by case inconsistencies and confusion while States attempt to structure a permissible provider tax program.

Response: This final regulation implements section 403 of the Tax Relief and Health Care Act of 2006 and clarifies existing Federal law related to permissible classes of health care services and the hold harmless provisions. This rule does not specifically require review of relationships between States and local governments. Under existing statutory law, however, CMS must ensure that State claims for federal funding are supported by non-federal expenditures and comply with all provisions of the law. This includes review of health care related taxes and associated payment or grant arrangements, whether on a State or local level. In other words, our review is limited to tracing the flow of funds to verify the non-federal share of Medicaid expenditures. This final rule makes changes to the regulatory framework to ensure that this review is consistent, uniform, and effectively implements the statutory requirements.

Comment: A couple of commenters specified that CMS did not have the statutory authority to go beyond the explicit direction provided in the Tax Relief and Health Care Act of 2006 to only temporarily reduce the maximum allowable tax rate.

Response: CMS' responsibility is to ensure that the Federal statutory requirements governing health care related taxes are met. In addition to codifying in regulation section 403 of the Tax Relief and Health Care Act of 2006, the new regulation clarifies some issues that have arisen since the issuance of the 1993 rule. Therefore, we believe it is necessary and appropriate for the Secretary to issue new regulatory provisions to address these issues so that States will have clear guidance on which health care related tax programs will be entitled to FFP. Furthermore, this final rule fully complies with the requirements of the Administrative Procedure Act.

Comment: One commenter noted that changes to tax programs will further exacerbate health care challenges in

areas impacted by major natural disasters.

Response: We do not agree that either the statutorily mandated reduction in the indirect guarantee test, or the clarification of permissible classes or hold harmless tests, will exacerbate health care challenges in areas impacted by major natural disaster. The reduction to the allowable collection limit serves in part to minimize the burden imposed on health care providers through health care related taxation. This result should help to minimize the cost structure of providers in areas impacted by major natural disasters.

Comment: One commenter stated that the proposed regulations reflect a fundamental suspicion of States' Medicaid financing practices. The commenter encouraged CMS to address any inappropriate financing arrangements through enforcement of current regulatory standards on a case by case basis rather than regulatory changes.

Response: Our responsibility is to ensure that the Federal statutory requirements governing health care related taxes are met in a consistent and uniform manner. Revision to the regulatory framework ensures consistent and effective implementation of the statute.

B. Implementation

Comment: Several commenters recommended that CMS delay the implementation of the new rule until State legislatures can adequately assess its implications and take the necessary action to ensure proper funding of their Medicaid programs. A few commenters recommended that the proposed rule be delayed until CMS works closely with States to establish some optional funding solutions for Medicaid services. Another commenter suggested that, at a minimum, States should be provided an adequate transition period to implement the new rule. Another commenter recommended that the effective date of the rule be delayed by at least 6 to 12 months.

Response: As required by section 403 of the Tax Relief and Health Care Act of 2006, the final regulation with respect to the reduction in the indirect guarantee threshold percentage is effective January 1, 2008. We have provided for a transition period until October 1, 2009 for States to come into compliance with the statutory revision to the permissible class of health care services identified as ''services of a managed care organizations.'' Since the other provisions of the regulation are clarifications that reflect CMS's existing understanding of the law, further transition is not warranted.

C. Permissible Classes of Health Care Items and Services—ICF/MR (§ 433.56(a)(4))

Comment: Several commenters, including a commenter from a State that the commenter believes was the intended beneficiary of the provision, expressed concern that CMS did not explain why community based residences included in the ICF/MR class in 1993 would be excluded from the class. One commenter stated that CMS violated the APA by not providing a reasoned analysis for the proposed change. Another commenter stated that this proposed change would adversely affect the provision of home and community based services.

Response: We proposed to delete this exception because we believed it was no longer applicable to any State. In response to these comments, we have determined that there is one State to which the exception applies. Therefore, we are no longer deleting the exception.

In the 1993 interim final rule implementing Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991, the statutory class of health care items and services at section 1903(w)(7)(iv) of the Act for services of intermediate care facilities for the mentally retarded (ICF/MR) was defined to include similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver. This exception was very narrow and was only intended to capture those States that were granted section 1915(c) waivers that converted most of their ICF/MRs to community-based residences prior to the effective date of the interim final rule.

Over the past several years, a few States have requested CMS approval to expand their ICF/MR services tax programs to include certain home and community-based services. None of those States were able to demonstrate compliance with the parameters of this permissible class of health care items or services. Therefore, when CMS proposed deleting the exception, CMS did not believe there were any States that did or could meet these specific requirements.

In response to public comments, CMS was able to identify one State that meets the requirements for this class of health care services. Rhode Island has a long-standing tax program that meets these requirements and as a result, the final regulation retains the original regulatory language.

Comment: Several commenters asked for CMS to expand the inclusion of home and community-based service providers in the ICF/MR class for all States, arguing that it is not equitable to accord different treatment to States that converted ICF/MRs into waiver facilities before 1992 than to other States. These commenters noted that this policy would generally benefit home and community-based service providers. These commenters argued that, in order for the class to be truly broad-based, all types of home and community-based residences for persons with mental retardation and developmental disabilities should be included. One commenter specifically asserted that this policy would allow States to impose health care-related taxes to help fund home and community-based services, and would increase access and availability of such services. Many commenters cited the benefits of home and community-based waiver services, and mentioned Federal policies supporting the expansion of such services.

Response: The statutory provision at section 1903(w)(7)(iv) of the Act refers only to ICF/MR facilities as the permissible class. As discussed above, in 1993, we provided for a limited exception to address the unique situation of States with existing waivers that converted most of their ICF/MRs to community-based residences prior to the effective date of the interim final rule. We do not believe a broader exception would be consistent with the statutory language. Moreover, we were not persuaded by the arguments that higher taxes on home and community-based services would actually encourage and stimulate the provision of such services. It appears counterintuitive that taxes that make such services more costly would stimulate broader use and availability.

Comment: One commenter requested that CMS more precisely define intermediate care facilities for the mentally retarded (ICF/MR) to include all facilities licensed as ICFs/MR, no matter the size of the facility.

Response: The regulation was not intended to redefine ICF/MRs or any other provider type. Instead, in part, the rule proposed to clarify a permissible class of health care services for purposes of health care-related tax requirements. For purposes of health care-related taxes, if a State were to impose a tax on ICF/MR services, in order to be considered broad-based, all licensed

ICF/MR providers within the State would need to be subject to the tax.

Comment: One commenter suggested that CMS exercise its statutory authority to update the historical listing of permissible classes by adopting additional provider classes through regulation. The commenter noted that CMS has reminded States of this opportunity. The commenter specified that inviting proposals to add classes helps update the Medicaid program by recognizing change in providers, acknowledging State environments are different, supporting Congressional intent and recognizing that individual States and providers should be free to collaborate and choose the best means suited to address financing relationships to meet their State's needs.

Response: The preamble to the 1993 final rule stated that the Secretary would consider adding additional classes if States can demonstrate the need for additional designation and that any proposed class meet 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. At this time, we do not see a reason to alter this policy or to add new permissible classes of health care items or services.

D. Permissible Classes of Health Care Items and Services—Managed Care (§ 433.56(a)(8))

Comment: One commenter recommended that CMS consider a definition for the term ''preferred provider organizations'' so that States will know what entities must be included in a tax program on this class of providers for it to comply with the broad-based requirement of the statute and associated regulations.

Response: Inclusion of the term preferred provider organization (PPO) as a type of managed care organization that would be in the permissible class of services for health care-related taxation purposes mirrored the statutory language enacted under section 6051 of the Deficit Reduction Act which amended section 1903(w)(7)(A)(viii) of the Social Security Act. The statutory language was designed to more broadly encompass services provide by all managed care organizations without regard to their status as Medicaid or commercial health plan or the form of such plans. The statutory language included examples to clearly establish that all types of managed care businesses must be included in order for a health care-related tax to be truly broad based. For Medicare accreditation purposes it is established that MCOs are licensed as both HMOs or PPOs. The intent is to fully encompass the types of managed care products available to individuals in commercial markets for coordinated care plans. This is a generally accepted term and type of entity in the managed health care market and we do not feel that a definition is necessary for Medicaid regulation purposes.

E. Hold Harmless § 433.68(f)—General

Comment: Some commenters expressed concern that the new rule appears to replace a purely objective test for hold harmless arrangements with one that is subjective. They argued that the Secretary had rejected the introduction of a subjective analysis when he published the original hold harmless prohibitions in 1993 and that the new rule should continue along this same course.

Response: We believe that the new regulation continues to apply a largely objective analysis in determining whether state tax programs contain hold harmless arrangements. This regulation is intended to carry out the purposes originally outlined in the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102–234) and the implementing regulations, by prohibiting FFP for health care-related taxes where the state has implemented a hold harmless provision. One lesson we have learned in the years since we first endeavored to implement Congress's prohibitions on taxes with hold harmless arrangements is that it is simply impossible to anticipate every hold harmless arrangement that may be implemented by States. As a result, it would not be true to Congressional intent to implement a mathematical model to be applied in detecting hold harmless arrangements that violate the statutory prohibitions. We do not believe the Medicaid statute contemplates such a formula, but anticipates that the Secretary will carefully analyze all circumstances relevant to the creation and operation of a state health care-related tax and attendant tax relief programs in carrying out his mandate to prohibit FFP where hold harmless arrangements exist. The analysis of state provider taxes remains an overwhelmingly objective process, but the unique and individual nature of State tax programs means that the analysis is always on a case-by-case basis. The individualized analysis outlined in this rule is not the type of subjective analysis that the Secretary expressly rejected in the 1993 final rule. In that rule, the Secretary rejected a suggestion that CMS should assess the egregiousness of a hold harmless violation in determining whether to take a disallowance.

Comment: One commenter opined that Congress did not authorize the Secretary to expand the tests for determining when an impermissible hold harmless arrangement exists, arguing that the regulations should mimic the statutory language. Other commenters suggested that the existing rules were appropriate and the new rules could place existing tax programs at risk.

Response: It is not our intent to expand the test for determining when an impermissible hold harmless arrangement exists beyond the original purposes authorized by Congress and underlying the 1993 rules. As noted above, we are not aware of any state tax programs that would have been permissible under the Secretary's prior interpretation of the rules, but are no longer permissible under the new rules. The new rule endeavors to address issues that have arisen since the issuance of the 1993 rule, which effectively repeated the statutory language but did little to elucidate that language. That rule proved largely successful in stopping impermissible hold harmless arrangements, with the overwhelming majority of States ending such programs. A recent decision issued by the HHS Departmental Appeals Board, however, has indicated confusion concerning the degree of flexibility in the application of the Secretary's longstanding interpretation of that rule in addressing new issues that have arisen. (DAB No. 1981, June 29, 2005.) Therefore, we believe it is necessary and appropriate for the Secretary to issue new regulations so that States will have clear guidance on which health care-related tax programs will be entitled to FFP.

Comment: Several commenters requested that they be able to retain the ability to use rates that are based on receipt of provider taxes rather than overall provider costs.

Response: The Social Security Act clearly allows States to collect permissible health care-related taxes to be used as a source of non-federal share funding for Medicaid payments to health care providers. Further, States can consider Medicaid's portion of a permissible health care-related tax as an

allowable cost for purposes of developing Medicaid reimbursement rates. However, basing Medicaid payment rates solely on the receipt of health care-related taxes is a clear hold harmless violation.

Comment: Several commenters noted that broadening the definition of hold harmless will penalize States that have other non-Medicaid funding initiatives for health care organizations. Under the proposed rule, payments made to health care providers as part of regular business could become entangled in the enforcement of the new rule.

Response: The hold harmless clarifications in this regulation are necessary to ensure compliance with the statutory limitations on hold harmless arrangements. In reviewing a health care related tax program, CMS needs to review the tax and associated financial arrangements as a whole, including any non-Medicaid payments. Taxes or fees that are imposed in the ordinary course of business and are not health care related would not trigger such a review, nor would non-Medicaid governmental payments that occur in the regular course of business, for example through procurements.

Comment: One commenter stated that the changes to the hold harmless provisions could make their current provider tax program non-approvable because the fees for the most part are used to pay back the cost to the fee payer.

Response: We are not aware of any State tax programs that would have been permissible under the Secretary's prior interpretation of the rules, but are no longer permissible under the new rules. If, however a State increases Medicaid reimbursement rates based solely on the receipt of a health care related tax, rather than on the costs incurred for providing Medicaid services, such an arrangement would be considered a hold harmless violation. We believe this result is consistent with the requirements of the statute and existing regulation and is unchanged by this final rule.

Comment: One commenter requested that CMS include in the rule itself the language in the preamble to the proposed rule indicating that States using cost-based payment systems may include provider tax costs as one of many provider costs that are considered in setting individualized provider rates. The commenter argued that including this language in the rule would prevent any changes in CMS interpretation.

Response: We are not including this language in the rule itself because the rule is limited to the basic framework and cannot address every specific circumstance and nuance. And this is an example of a very complex issue. The clarification to the Medicaid payment hold harmless test states that a Medicaid payment will be considered to vary based on the tax amount when the payment is conditional on the tax payment. This provision does not prevent States that use cost-based reimbursement methodologies from including Medicaid's share of health care related tax costs as one of many health care provider costs that are considered in setting individualized Medicaid reimbursement rates. However, where a Medicaid payment is conditional on receipt of health care related taxes, we would view the Medicaid payment to be, in part or in full, the repayment of the health care related tax to repay the taxes in a hold harmless arrangement rather than as a protected reimbursement for cost of Medicaid services.

Comment: A few commenters addressed the DAB decision that CMS acknowledged it was attempting to respond to with this regulation, suggesting that a more appropriate response to that decision would have been to simply clarify that the hold harmless standard applies to situations where the benefits accrue to private pay patients rather than to the taxpaying facilities directly.

Response: We do not believe that the commenter's suggestion would address all of the confusion created by the Board's decision. We agree that clarifying the rules to explain that the hold harmless standard applies to situations where the state payments are made to third parties would help to clarify the questions raised by the Board's decision and we have attempted to do that in this rule. However, we do not believe such a clarification alone would be sufficient.

F. Hold Harmless—§ 433.68(f)(1)—Positive Correlation

Comment: Several commenters stated that by including any positive correlation over any amount of time, the proposed rule destroys any standard by which a State may assess whether or not a tax based Medicaid funding arrangement will be determined by CMS to be a hold harmless violation. Other commenters disagreed with CMS' statement that the current regulations related to positive correlation led to confusion. The commenters believe that the subjective analysis proposed will only lead to additional confusion.

Response: Our experience is that States and providers are typically very aware of the overall character of a tax based Medicaid funding arrangement. Moreover, it is clear that to achieve the statutory purpose of ending hold harmless arrangements that result in shifting a disproportionate burden to the federal government, the test must be applied flexibly. Otherwise, financing arrangements will be structured to meet the letter but not the underlying purpose of the statutory limitations. This regulation is intended to further clarify the existing hold harmless provisions and not to lead to additional confusion.

Comment: Several commenters asserted that the test for a ''positive correlation'' under § 433.68(f)(1) is too subjective, and should instead remain a statistical test. They expressed concern that under the proposed test, CMS could find a positive correlation in almost any situation.

Response: The 1993 rule does confine the statutory term ''positive correlation'' to a test requiring mathematical certainty. The insertion of the statistical concept suggests that a positive correlation contemplates a positive relationship between two variables. Such a correlation would exist, for example, where a state passes a tax on nursing home beds that a facility is permitted to pass on to its residents in the form of rate increases. If at or about the same time, the state passes a grant program that pays private pay residents of the nursing home an amount similar to the bed tax, the grant money would be available for use to compensate the nursing facility for the tax and a positive correlation would be found to exist between the tax and the grant. The correlation would not be destroyed by altering one variable over time and would not necessarily need to be measured in a statistical sense. This has always been CMS's position with respect to the 1993 regulations, but unfortunately the description of positive correlation as a statistical concept in the 1993 rule created some confusion. In retrospect, we now believe that characterizing positive correlation as having ''the same meaning as the statistical term'' in the 1993 rule was imprecise. The use of this language caused some readers to view the test as requiring a mathematical certainty with specifically measurable statistical significance over the life of the grant and tax programs, or measured with respect to specific amounts collected and paid out under the specific programs. Where we did impose a mathematical test in evaluating a tax program it was clearly spelled out in the 1993 rule, as it was with respect to the ''indirect guarantee test'' described at page 43182 of the 1993 rule. The rule was, however, never meant to bring

mathematical certainty into the positive correlation examination. We do not consider the current rule to signal a significant change in our analysis; rather, it clarifies our interpretation of the statutory term ''positive correlation.'' We will continue to evaluate health care related tax programs to determine whether there is a positive correlation with a state payment program.

G. Hold Harmless § 433.68(f)(2)—Medicaid Payment Test

Comment: Many commenters argued that, by prohibiting States from conditioning Medicaid payment on receipt of the tax, the proposed rule would prevent the State from using the tax to reimburse providers. These commenters stated that Congress clearly intended provider taxes to be used for purposes of Medicaid reimbursement purposes. The commenters noted that section 1903(w)(4) of the Social Security Act specifies that the hold harmless provisions ''shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.''

Response: We agree States can use permissible health care related tax revenues to increase Medicaid reimbursement rates. However, section 1903(w)(4) of the Act specifies three conditions under which a State or local government is determined to hold taxpayers harmless for their tax costs. If any of these conditions are met the tax program would be determined to have a hold harmless provision and the tax would be impermissible. The final rule does not change the conditions of the hold harmless provisions under Federal law. Consistent with these provisions, where a Medicaid payment is conditional on receipt of health care related taxes, we would view the Medicaid payment to be, in part or in full, the repayment of the health care related tax to repay the taxes in a hold harmless arrangement rather than as a protected reimbursement for cost of Medicaid services.

Comment: Several commenters stated that by expressly 37 conditioning Medicaid payments on the tax amount, States are explicitly explaining how the tax is being used for Medicaid reimbursement as part of the legislative process. The commenters believe that it is reasonable to condition payment on the approval and receipt of the tax and to not do so would be fiscally irresponsible. The State would be obligated to make payments without having a funding source to finance them and without conditioning States would not be able to adopt tax programs. Other commenters noted that health care providers are reluctant to support taxes unless there is an explicit assurance that the revenues from the taxes will be dedicated to increasing Medicaid payments and that State legislatures are reluctant to increase Medicaid liabilities with the ability to make them contingent on the funding source.

Response: There is a distinction between using health care related tax revenues to support Medicaid payments and specifically guaranteeing repayment of some or all of the tax amount or otherwise ensuring a direct correlation between payments to taxpayers and the amount of their taxes. States have and continue to maintain the ability to justify the imposition of a health care related tax by indicating through the State legislative process that proceeds from the health care related tax will be used to increase Medicaid reimbursement and that such funding must be approved by CMS. However, the statute is very clear that health care related taxes cannot contain hold harmless arrangements and any failure to comply with any of the three hold harmless ''tests'' would render a health care related tax impermissible. There is a distinct difference between explaining a health care related tax and its purposes through the legislative process and extending conditional guarantees to provider taxpayers. States must ensure that no payment is conditioned upon receipt of a health care related tax payment.

Comment: A few commenters requested that CMS clarify preamble language related to State use of tax proceeds and federal match to increase Medicaid rates in the form of Medicaid supplemental payments. The commenters believe that this should not prohibit States from using tax proceeds and federal match to increase Medicaid rates in the form of Medicaid per diem add-ons or rate supplements.

Response: Section 1903(w)(4) expressly provides that States may use permissible tax revenues to fund provider payments for covered services furnished to eligible individuals. This provision does not authorize States to use tax revenues for a hold harmless arrangement that effectively repays provider taxpayers. In other words, the payment methodology related to such increases to Medicaid reimbursement rates must be designed in a manner that recognizes the volume or nature of the covered services provided to Medicaid individuals, and cannot be related simply to the amount of tax proceeds.

Comment: Several commenters disagreed with any suggestion that a Medicaid payment increase funded by tax revenue is necessarily uneconomical, because the funding source of the payment is irrelevant to rate development. The commenters stated that Congress rejected the position that, because provider taxes reduced actual expenditures made by the State, the amount of the provider tax should be deducted from total State spending so that only ''real'' or ''net'' State expenditures would be matched. One commenter stated that the proposed rule would interfere with permissible taxation by presupposing that rates explicitly supported by tax revenue are too high and therefore not economical.

Response: These commenters appear to have misread the preamble of the proposed rule. We agree that States may collect permissible health care related taxes, and may use those tax revenues as a source of non-federal share funding for Medicaid payments to health care providers. Our specific concern is when the Medicaid payments are conditional on payment of the taxes. In that instance, the Medicaid payment is not linked to any rate-setting determination based on the cost or volume of services. Instead, the Medicaid payment is in the nature of a hold harmless arrangement to return all or part of the tax liability to the taxpayer. We are clarifying the Medicaid payment test to provide that a Medicaid payment will be considered to vary based on the tax amount when the payment is conditional on the tax payment. This clarification would only affect States that seek to use rates that are based on the receipt of provider taxes rather than on overall provider cost. In other words, the final regulation rule would limit the ability of States to expressly condition payment rates on tax receipts rather than on a process that determines rates that are consistent with efficiency, economy and quality of care in compliance with section 1902(a)(30)(A) of the Act.

Comment: A few commenters disagreed with the definition of enhanced Medicaid payment as a payment for which any branch of government has indicated that the payment can be reduced or eliminated if the provider tax is discontinued. The commenters were concerned that CMS is asserting that this would represent a structural repayment of the tax and violates hold harmless provisions. The commenters disagreed with this position.

Response: The phrase ''enhanced Medicaid payments'' relates to the second prong of the indirect hold harmless test (''75/75 test''). This test

stipulates that if a health care related tax exceeds the regulatory percentage threshold, CMS would consider a hold harmless to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax back in enhanced Medicaid payments or other State payments. We clarified that if a State ever had to provide a demonstration for purposes of the ''75/75 test'' we may consider any amount that any branch of the State, including legislative and executive branch, has indicated could be subject to reduction in the absence of provider tax revenues as an enhanced Medicaid payment. This comparison is between Medicaid payments and tax costs and we were not asserting in this instance that this would be a structural repayment. We were clarifying that, for purposes of the ''75/75 test'', payments which would no longer be provided if the tax funding source were eliminated, would be considered enhanced Medicaid payments, even if the State did not characterize them as such.

Comment: Several commenters stated that eliminating conditional Medicaid payments would undermine provider support for health care related taxes. The commenters asserted that assurances that provider tax revenue will be used for a specific category of Medicaid expenditures is not equivalent to holding taxpayers harmless for the cost of the tax.

Response: States have and continue to maintain the ability to justify the imposition of a health care related tax by indicating through the State legislative process that proceeds from the health care related tax will be used to increase Medicaid reimbursement and that such funding must be approved by CMS. However, the statute is very clear that health care related taxes cannot contain hold harmless arrangements and any failure to comply with any of the three hold harmless ''tests'' would render a health care related tax impermissible. There is a distinct difference between explaining a health care related tax and its purposes through the legislative process and extending conditional guarantees to repay provider taxpayers. We recognize that high volume Medicaid providers could benefit from a health care related tax that funds a Medicaid rate increase, however, States must ensure that no payment is conditioned upon receipt of a health care related tax payment.

Comment: Several commenters stated that the definitions of ''tax amount'' and ''payment amount'' in the proposed rule are too broad. One commenter argued that the shift in terminology in § 433.68(f)(2) from ''amount of the total tax payment'' to ''tax amount'' represents a significant departure from the statutory and prior regulatory language.

Response: As explained in the preamble to the proposed rule, the change in terminology is not a substantive change from what was intended in the original 1993 rule. We are using the terms ''tax amount'' and ''payment amount'' throughout the new rule in an effort to be consistent. We have found that the use of differing terms in the various sections of the 1993 rule has led to some confusion. Accordingly, we consolidated the terms ''total tax cost,'' ''total tax payment,'' ''amount of the payment,'' ''amount of such tax'' into the terms ''tax amount'' and ''payment amount'' to be used in each section of the hold harmless rule. We explained our reasoning at more length in the proposed rule and believe that reasoning remains valid (72 FR 13729, 13730). This does not represent a significant departure from prior statutory or regulatory language. It clarifies that we are not looking at the total amount of the tax payment received by the state, but we will be looking at the tax program as a whole, including whether taxpayers are being held harmless for increments of the tax. With respect to subsection (f)(2) this means that we will look at whether any portion of the Medicaid payments made by the state to providers, varies based upon the health care related tax levied upon the providers. The ''tax amount'' is the amount of the tax levied upon the provider (either directly, or indirectly).

Comment: Several commenters stated that the phrase ''including where Medicaid payment is conditional on receipt of the tax amount'' is problematic. Some commenters noted that the proposed language would appear to have the effect of prohibiting States from enforcing tax obligations on delinquent providers through intercept of Medicaid payments. Another commenter expressed concern that this would prohibit States from requiring overdue taxes as a condition for payments due to a taxpayer. Other commenters stated that it may result in situations where health provider taxes that are statutorily established in a manner that complies with the broad based and uniformity requirements of the statue cannot be enforced.

Response: This regulation does not prevent State enforcement of the collection of health care related taxes. It is the State's obligation to ensure that any health care related tax program is collected in a manner consistent with legislation enacting the health care related tax program and any approved waiver of the broad-based and/or uniformity requirements. To suggest that the phrase ''including where Medicaid payment is conditional on receipt of the tax amount'' would prohibit States from enforcing tax obligations on delinquent health care providers is erroneous. If States do not enforce the proper collection of the health care related tax, the State is at risk of violating statutory broad-based and/or uniformity requirements which could render the entire tax program and its collections impermissible.

Comment: A few commenters specified that the word ''total'' is critical within the Medicaid payment test because a Medicaid payment that varies based on the Medicaid portion of the tax is permissible. The commenters stipulated that only a Medicaid payment that varies based on the total provider tax amounts constitutes a hold harmless. Other commenters stated that the portion of a provider's health care-related tax payment attributable to Medicaid services is an allowable cost, and Medicaid reimbursement may be furnished for it. The commenters recommended that the word ''total'' be restored.

Response: The regulation specifies that a hold harmless arrangement exists if all or any portion of the Medicaid payment varies based only on the amount of the tax payment. The removal of the word total does not represent a significant departure from prior statutory or regulatory language. As explained in the preamble to the proposed rule, the change in terminology is not a substantive change from what was intended in the original 1993 rule. We are using the terms ''tax amount'' and ''payment amount'' throughout the new rule in an effort to be consistent. We have found that the use of differing terms in the various sections of the 1993 rule has led to some confusion. Accordingly, we consolidated the terms ''total tax cost,'' ''total tax payment,'' ''amount of the payment,'' ''amount of such tax'' into the terms ''tax amount'' and ''payment amount'' to be used in each section of the hold harmless rule. We explained our reasoning at more length in the proposed rule and believe that reasoning remains valid (72 FR 13729, 13730). This was intended to clarify that we are not looking simply at the total amount of the tax payment received by the state, but will be looking at the tax program as a whole, including whether tax payers are being held harmless for increments of the tax.

Comment: One commenter suggested that supplemental payments should be permitted to be paid to those providers

who are providing Medicaid services based on receipt of provider taxes.

Response: Generally, States can collect permissible taxes and use such tax receipts as the non-federal share to make supplemental payments for the provision of Medicaid services. However, a hold harmless arrangement exists when States seek to use reimbursement rates that are based solely on the receipt of health care related taxes and effectively repay the taxpayer (such as supplemental Medicaid payments conditioned on receipt of a health care related tax payment), rather than on overall health care provider costs. The clarifications in this rule are necessary to ensure that Medicaid payments are not made simply to repay providers for the cost of the health care related tax beyond Medicaid's allowable share, but also to ensure the integrity of the development of sound Medicaid payment rates in compliance with the requirements of section 1902(a)(30) of the Act.

H. Hold Harmless 433.68(f)(3)—Guarantee Test

Comment: Numerous commenters asked for clarification of the proposed interpretation of the phrase ''direct and indirect'' in the guarantee test, and should confirm that use of provider tax receipts to increase Medicaid rates for or to enhance the Medicaid rate methodology applicable to the taxed provider class is not prohibited.

Response: The clarification of the guarantee test is meant to specify that a State can provide a direct or indirect guarantee through a direct or indirect payment. A direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments). A direct guarantee does not need to be an explicit promise or assurance of payment. Instead, the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy. An indirect guarantee is distinct from a direct guarantee in that such guarantee is initially measured by a percentage threshold that limits tax collections to 5.5 percent of net patient revenue attributable to the assessed service. States collecting a tax in excess of 5.5 percent of assessed patient service revenue must perform the second prong of the hold harmless test to demonstrate permissibility.

Comment: A few commenters expressed concern that CMS has taken too broad a view in stating that monies ''controlled or influenced by the state'' will be considered in applying the guarantee test in § 433.68(f)(1).

Response: The language of concern to these commenters appears in the preamble to the proposed rule. In the preamble we provided an illustration of how a health care related tax and grant program could be found to violate both the positive correlation test and the guarantee test. We believe that discussion accurately reflects existing statutory provisions governing health care related taxes. The specific language of concern to the commenters appears in a discussion of problematic indirect payments that States may make to taxpayers. The preamble notes that ''money is fungible and, as long as the payment is from a source controlled or influenced by the State, it will be considered in determining whether it has been made available for the tax.'' In evaluating whether the state has made monies available to hold providers harmless for any portion of a health care related tax, it makes little difference which part of the state treasury makes the funds available to the taxpayer, or if the state monies are funneled through some other third party, because all State monies are fungible. For example, it would be impermissible for the state to impose a nursing home bed tax to be paid to the state Medicaid agency and have the Governor's office control a separate grant payment designed to reimburse private pay residents for the amount of the tax passed on to them by the nursing homes. Even though the state may argue these are separate funding sources, CMS would consider all of the money state money and would consider the positive correlation between the two programs a violation of the hold harmless provisions. Similarly, States will not be permitted to recycle monies through third parties, by making payments to such third parties and requiring that the money be used to reimburse taxpayers for any portion of their health care related tax. This is the point the preamble was trying to address when it embraced payments ''influenced by the state.'' However, we agree with the commenters that ''influenced by the state'' is too broad a term. We believe ''controlled or directed by the state'' is a more accurate description of the types of payments that will be considered in evaluating whether an impermissible hold harmless arrangement exists.

Comment: Several commenters stated that the term ''reasonable expectation'' under the guarantee test in § 433.68(f)(3) is too broad and/or subjective.

Response: In the preamble to the proposed rule we stated that ''A direct guarantee will be found when a state payment is made available to a taxpayer or a party related to a taxpayer (for example as a nursing home resident is related to a nursing home), in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax'' (72 FR 13730). We chose to use the term reasonable expectation because we recognized that state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless. For example, state laws providing grants to nursing home residents who incur increased rates as a result of bed taxes on nursing homes, rarely required the residents receiving the grants to actually use the money to pay the increased nursing home fees. Accordingly, arguments have been made that such grants do not actually guarantee to hold the nursing homes harmless for the tax. We disagree. Because the residents must pay the increased rates passed on to them as a result of the tax and because the state has made money available to those residents to pay those increased rates, it is reasonable to expect that the payments going to the nursing home residents will promptly be sent to the nursing home as resident fee payments. This would result in a hold harmless for the nursing home. The only way to avoid this conclusion would be for the resident to leave the facility and/or not pay the rate increase. Therefore, we do not believe the use of the term reasonable expectation is overly broad or vague.

Comment: Several commenters stated that collection of unpaid provider taxes by withholding amounts of Medicaid payments due under the new rule would constitute a hold harmless because it would cause the Medicaid payment to be contingent on the payment of the tax.

Response: Withholding Medicaid payments to health care providers who have not paid their taxes would not constitute a hold harmless arrangement. This is a matter of State enforcement. States are, by themselves, obligated to ensure that any health care related tax is collected in a manner consistent with Federal law, authorizing State legislation and if applicable any CMS approved waiver of the broad-based and/or uniformity requirements. Typically, such enforcement provisions are authorized through the health care related tax's enacting legislation and are identified as enforcement collection provisions and/or penalties.

Comment: A few commenters disagreed with CMS' assertion in the

proposed rule that the direct and indirect tests differ on the kind of payment involved. The commenters stated that there is no basis for this distinction.

Response: A direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax. An indirect guarantee is distinct from a direct guarantee in that such guarantee is initially measured by a percentage threshold that limits tax collection to 5.5 percent of patient revenue attributable to the assessed service. States collecting a tax in excess of 5.5 percent of assessed patient service revenue must perform the second prong of the hold harmless test to demonstrate permissibility.

Comment: A few commenters indicated that they do not object to CMS' proposal to the direct guarantee test to clarify that payment to a taxpayer may be indirect. Nor do they disagree with CMS that, under the amended language, a grant or benefit to private pay patients or residents could be considered an indirect payment to the taxpayer for purposes of the ''direct guarantee.''

Response: We appreciate the support to ensure the fiscal integrity of the Medicaid program. Clarifying our current regulations helps us achieve this goal.

I. Hold Harmless 433.68(f)(3)(i)—Indirect Guarantee

Comment: One commenter stated that, in implementing the indirect percentage threshold changes as mandated by Congress, CMS went beyond the legislative directive by further amending the regulatory text to specify that the percentage threshold applied to net operating revenues. The commenter argued CMS' position that the safe harbor percentages are restricted to net revenue is not supported in the legislative history. The commenter believes that States should be permitted to interpret the phrase ''revenue received by providers'' as either gross or net revenue.

Response: The phrase ''revenues received by the taxpayer,'' has been interpreted by CMS to be, the net patient service revenue, received by the health care provider. This would include all revenues received from all payers for providing the particular service that is assessed by the State and would not include revenues unrelated to the service being assessed. In addition, the safe harbor percentage originally created by the 1992 interim rule was never addressed in the statutory language and therefore would not be addressed in any legislative history. However, the legislative history clearly demonstrates that Congress requires CMS to evaluate the permissibility of a health care related tax on a per service basis, as the 1991 law separately identified permissible classes of health care items or services. Finally, we believe that the phrase ''net operating revenue'' used in the regulatory text may have caused confusion. We have altered the final regulation to refer to net patient service revenue.

Comment: One commenter specified that under the proposed broad interpretation of the Medicaid payment hold harmless provision, CMS can find a violation in any situation where provider tax revenues are used to make Medicaid payments to taxed providers. The commenter argued that the impact of this results in the omission of the ''indirect guarantee test'', whose importance was affirmed by Congress in the Tax Relief and Health Care Act of 2006.

Response: As we have mentioned earlier, this regulation carries out the purposes originally outlined in the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102–234) and the implementing regulations, by prohibiting FFP for health care related taxes where the State has implemented a hold harmless provision. It has not been our intent to expand the test for determining when an impermissible hold harmless arrangement exists beyond the original purposes underlying the 1993 rules. We are not aware of any State health care related tax programs that would have been permissible under the Secretary's prior interpretation of the rules but are no longer permissible under this regulation. Therefore, we do not agree that we have nullified the indirect guarantee test that the commenter argues was reaffirmed by Congress.

IV. Provisions of the Final Regulations

As a result of our review of the comments we received during the public comment period, as discussed in section III of this preamble, we are making the following revisions to the proposed regulation published on January 18, 2007.

Section 433.56 Classes of Health Care Services and Providers Defined

We have modified the regulation at § 433.56(a)(4) to return to the original regulatory language. The regulation has been revised to re-incorporate that similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver can be included in the permissible class of health care items or services. CMS has modified the regulation to recognize that one State qualifies under this narrow exception.

Section 433.68 Permissible Health Care-Related Taxes

We have modified the phrase ''net operating revenues'' in § 433.68(f)(3)(i) to more accurately reflect that the base to which tax collections are applied for purposes of the indirect hold harmless threshold (i.e., net patient service revenue). Further, in response to comments we have clarified that revenues received by the taxpayer refers to the net patient revenue attributable to the assessed permissible class of health care items or services.

To increase clarity and ensure implementation of the governing statutory provision, we are also removing § 433.68(f)(3)(ii) as a technical conforming action. This section is outdated and no longer has any applicability.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35.)

VI. Regulatory Impact Analysis

A. Overall Impact

We have examined the impact of this regulation as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory

approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This regulation will surpass the economic threshold and is considered a major rule. This rule is estimated to reduce Federal Medicaid outlays by $85 million in FY 2008 and by $115 million per year in FY 2009 through FY 2011.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because the regulation will not have a direct impact on small entities. In this case the regulation directly affects payments the States receive from the Federal government and the impact on health care facilities is categorized as secondary impact.

While the impact on health care facilities is secondary, we proceed to discuss the potential impact on small entities. First, the reduced health care related tax collection threshold under this regulation will help alleviate tax burdens on small health care facilities, to the extent they were subject to a health care-related tax. If States choose to maintain reimbursement rates, small health care facilities may receive higher net Medicaid reimbursement in light of the reduced tax burden. However, States may be unwilling to maintain reimbursement rates without the full revenue from the health care-related tax to contribute to the non-Federal share. If States choose to reduce Medicaid reimbursement rates to small health care facilities, this could result in lower net Medicaid reimbursement even after accounting for a reduction in the tax burden.

Since we are uncertain how States will alter their Medicaid reimbursements in response to the reduced health care related tax collection threshold, we cannot provide an exact and quantifiable impact on such small entities. We did not receive any quantifiable information during the public comment process to determine any further detailed impact. Commenters did not raise issue with the collection threshold reduction. Nor did the commenters indicate how States will act in response to such reduction in available health care related tax revenue. It is important to note that not all health care related tax programs will be impacted. Only those health care related taxes that are currently being imposed at a rate in excess of 5.5 percent of net patient service revenue will be directly impacted.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a regulation may have a direct impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this regulation will not have a direct impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any regulation whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This regulation will not result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $120 million.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final regulation that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. While this regulation would reduce the collection threshold for permissible health care related taxes from 6 percent of the net patient service revenue attributable to the assessed permissible class of health care items or services to 5.5 percent of the net patient service revenue, this change is required by section 403 of the Tax Relief and Health Care Act of 2006. This section of the statute was self-implementing on December 20, 2006; however, this rulemaking is necessary to include the reduction in the regulatory text, therefore ensuring consistency with applicable law and thus minimizing any confusion. Furthermore, we do not believe the discretionary requirements put in place by this rulemaking will impose substantial direct requirements or costs on State and local governments.

B. Anticipated Effects

Provider Tax Reform

1. Effects on State Medicaid Programs

Estimates of the impact of lowering the maximum collection threshold for permissible health care related taxes, fees, and assessments were derived from Medicaid financial management reports on State receipts from these programs (form CMS–64.11). Since we do not believe that all States report completely their tax receipts from health care-related taxes on the form CMS–64.11, we bolstered our estimates by also analyzing information reported by some States as part of their request for waiver of the broad-based and/or uniformity requirements. These requests include estimated total tax collections and total net revenues received by taxpayers applicable to a permissible class of health care services. From this available information, we identified 15 States whose receipts as of the date of the reports are believed to equal the maximum threshold of 6 percent of net patient service revenue. In accordance with the new statutory language to reduce the maximum threshold from 6 to 5.5 percent, FFP corresponding to these receipts would be reduced by 8.33 percent $[(1 - 5.5/6.0) \times 100]$. As described below, there are a number of avenues available for States to address these reductions. Accordingly, in estimating the potential Federal savings, we applied a behavioral offset of 50 percent to the savings calculated from reported data as described above. In accordance with the statute, savings were estimated only for portions of fiscal years beginning January 1, 2008 and ending September 30, 2011.

States have a number of options open to them for addressing the reduction in FFP. In order to maintain existing reimbursement rates funded by a health care related tax in excess of the 5.5 percent threshold, they can restructure State spending and shift funds between programs. This could result in loss of State funding for other programs. States may also be able to raise funds through increases in other forms of generally applicable tax revenue increases. This could raise tax costs for other taxpaying entities within States. Finally, States, as a last resort, can reduce reimbursement to the taxpaying health care providers.

We are uncertain which options States may employ to address this change. We did not receive any further quantifiable information through the public comment process that would indicate which option States are likely

to choose in response to such reduction in available health care related tax revenue.

2. Effects on Other Providers

The reduced tax limit in this rule will help alleviate health care related tax burdens on health care providers for obligations to the Medicaid program that are otherwise the responsibility of the States. However, if States choose to reduce reimbursement rates to health care providers, this could result in lower net Medicaid reimbursement for the health care provider even after accounting for reduction in the health care related tax burden. On the other hand, if States choose to maintain reimbursement rates by finding other non-Federal share sources to support the Medicaid reimbursement rates, health care providers may receive higher net Medicaid reimbursement in light of the reduced health care related tax burden.

The new statutory language reducing the maximum threshold from 6 to 5.5 percent for the period of January 1, 2008 through September 30, 2011 is estimated to reduce Federal Medicaid outlays by $85 million in FY 2008 and by $115 million per year in FY 2009 through FY 2011. These savings will not be realized in 2012 because the threshold reverts back to 6 percent after September 30, 2011.

TABLE A.—ESTIMATED REDUCTION IN FEDERAL MEDICAID OUTLAYS RESULTING FROM THE PROVIDER TAX REFORM PROPOSAL BEING IMPLEMENTED BY CMS–2275–F

	Reduction in Federal Medicaid Outlays for fiscal years 2008–2012 (In $ million)					
	2008	2009	2010	2011	2012	Total
Provider Tax Reform	85	115	115	115	0	430
3% discount rate	83	108	105	102	0	398
7% discount rate	79	100	94	88	0	361

C. Alternatives Considered

In developing this regulation the following alternatives were considered. We considered reducing the regulatory collection threshold to 3 percent because we have noticed a recent trend in States' efforts to maximize non-Federal share funding opportunities under current Medicaid law through taxation of health care providers.

The result has been that the Federal government is providing matching funds on Medicaid rate increases that are funded without additional State dollars but instead, with revenues collected from taxes on health care providers. This shift in fiscal responsibilities is typically accompanied by creative payment mechanisms that effectively place a disproportionate burden on the Medicaid program relative to other payers. In this way, some States are avoiding their payment responsibilities to the Medicaid program by shifting their share of the increased Medicaid payment rate obligations to the same health care providers serving Medicaid beneficiaries.

The current trend in States' approach to taxing health care providers appears to start with a determination of the maximum amount of health care-related tax revenue that can be collected from health care providers. We have seen this particularly in State health care-related tax programs targeting high Medicaid utilized services solely as the basis for increasing Medicaid rates to those same providers. States appear to be exercising their ability under the law to request waivers of the broad based and/or uniformity requirements of the health care-related tax law in an effort to minimize the tax burden on facilities that furnish little to no services to Medicaid patients. Although we would only approve such a waiver request within the allowable regulatory standards, States requesting the waivers continue to propose taxes that collect the maximum 6 percent limit and vary the rate of tax to minimize the tax burden on non-Medicaid facilities within the slightest margin allowable under current regulations. Most waiver requests are initially submitted applicable to a tax structure that is inconsistent with the Federal statute and regulations. This requires CMS to provide ongoing feedback and assistance to States. States ultimately deviate from their initial tax structure until they are able to reach an optimal tax structure that enables them to gain approval while minimizing the non-Medicaid tax burden.

Through our review of these practices, we have also noticed that many States are applying the current statutory and regulatory authority that permits the exclusion of Medicare revenue from a health care-related tax, which effectively raises the rate of tax on only the Medicaid revenues and commercial/private pay revenues above the aggregate 6 percent limit (measured on all payers' revenues). We have also seen an increase in the tax revenues collected through our examination of the revenues reported by States on the CMS 64.11A. Based on a review of quarterly expenditures, States reported the collection of over $2.2 billion in tax revenues from health care providers.

However, since the Tax Relief and Health Care Act of 2006 reduced the regulatory threshold to 5.5 percent, none of the above mentioned alternatives were taken.

With respect to the other changes contained in this final rule, we considered and rejected a possible exception for already approved health care-related tax programs. Such an exception would not be uniform and would not achieve the objective of ensuring that health care-related taxes did not effectively shift a disproportionate burden to the Federal government. Because these clarifications reflect the understanding of permissible classes and how the hold harmless provisions should apply that CMS has been applying in ongoing reviews, CMS is not aware of any approved tax programs that is not in compliance with the final rule.

D. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in the table below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final regulation. This table provides our best estimate of the reduction in Federal Medicaid outlays for the years 2008 through 2012 as a result of the changes presented in this final regulation. This regulation only affects transfer payments between the Federal government and State governments.

TABLE NUMBER B.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED REDUCTION IN MEDICAID OUTLAYS FROM FY 2008 TO FY 2012

[In millions]

Category	Transfers	
Annualized monetized transfers	3% Units discount rate $87.0	7% Units discount rate $88.0
From whom to whom?	States to Federal Government	

E. Conclusion

Due to the reduction in the statutory language lowering the maximum threshold from 6 to 5.5 percent this rule is estimated to reduce Federal Medicaid outlays by $85 million in FY 2008 and by $115 million per year in FY 2009 through FY 2011.

For these reasons, we are not preparing analysis for either the RFA or section 1102(b) of the Act because we have determined that this regulation will not have a direct significant economic impact on a substantial number of small entities or a direct significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 433—STATE FISCAL ADMINISTRATION

■ 1. The authority citation for part 433 continues to read as follows:

Authority: Sections 1902(a)(2), 1903(a) and 1903(w) of the Social Security Act (42 U.S.C. 1302).

Subpart B—General Administrative Requirements State Financial Participation

■ 2. Section 433.54 is amended by revising paragraph (c) to read as follows:

§ 433.54 Bona fide donations.

* * * * *

(c) A hold harmless practice exists if any of the following applies:

(1) The State (or other unit of government) provides for a direct or indirect non-Medicaid payment to those providers or others making, or responsible for, the donation, and the payment amount is positively correlated to the donation. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

(2) All or any portion of the Medicaid payment to the donor, provider class, or related entity, varies based only on the amount of the donation, including where Medicaid payment is conditional on receipt of the donation.

(3) The State (or other unit of government) receiving the donation provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to return any portion of the donation to the provider (or other parties responsible for the donation).

* * * * *

■ 3. Section 433.56 is amended by—

A. Republishing the introductory text to paragraph (a).

■ B. Revising paragraph (a)(4).

■ C. Revising paragraph (a)(8).

The revisions read as follow:

§ 433.56 Classes of health care services and providers defined.

(a) For purposes of this subpart, each of the following will be considered as a separate class of health care items or services:

* * * * *

(4) Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver;

* * * * *

(8) Services of managed care organizations (including health maintenance organizations, preferred provider organizations);

* * * * *

§ 433.57 [Amended]

■ 4. Section § 433.57 is amended by—

■ A. Removing paragraph (a).

■ B. Redesignating existing paragraphs (b) and (c) as paragraphs (a) and (b), respectively.

§ 433.58 [Removed and reserved]

■ 5. Section 433.58 is removed and reserved.

§ 433.60 [Removed and reserved]

■ 6. Section 433.60 is removed and reserved.

■ 7. Section 433.66 is amended by—

■ A. Revising the section heading.

■ B. Revising paragraph (a).

The revisions read as follows:

§ 433.66 Permissible provider-related donations.

(a) *General rule.* (1) Except as specified in paragraph (a)(2) of this section, a State may receive revenues from provider-related donations without a reduction in FFP, only in accordance with the requirements of this section.

(2) The provisions of this section relating to provider-related donations for outstationed eligibility workers are effective on October 1, 1992.

* * * * *

■ 8. Section 433.67 is amended by revising paragraph (a)(2) to read as follows:

§ 433.67 Limitations on level of FFP for permissible provider-related donations.

(a) * * *

(2) *Limitations on donations for outstationed eligibility workers.* Effective October 1, 1992, the maximum amount of provider-related donations for outstationed eligibility workers, as described in § 433.66(b)(2), that a State may receive without a reduction in FFP may not exceed 10 percent of a State's medical assistance administrative costs (both the Federal and State share), excluding the costs of family planning activities. The 10 percent limit for provider-related donations for outstationed eligibility workers is not included in the limit in effect through September 30, 1995, for health care-related taxes as described in § 433.70.

* * * * *

■ 9. Section 433.68 is amended by—

■ A. Revising the section heading.

■ B. Revising paragraph (a).

■ C. Republishing paragraph (f) introductory text.
■ D. Revising paragraphs (f)(1), (f)(2), (f)(3) introductory text, and (f)(3)(i).
■ E. Removing and reserving paragraph (f)(3)(ii).
■ The revisions read as follows:

§ 433.68 Permissible health care-related taxes.

(a) *General rule.* A State may receive health care-related taxes, without a reduction in FFP, only in accordance with the requirements of this section.

* * * * *

(f) *Hold harmless.* A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies:

(1) The State (or other unit of government) imposing the tax provides for a direct or indirect non-Medicaid payment to those providers or others paying the tax and the payment amount is positively correlated to either the tax amount or to the difference between the Medicaid payment and the tax amount. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

(2) All or any portion of the Medicaid payment to the taxpayer varies based only on the tax amount, including where Medicaid payment is conditional on receipt of the tax amount.

(3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.

(i)(A) An indirect guarantee will be determined to exist under a two prong ''guarantee'' test. If the health care-related tax or taxes on each health care class are applied at a rate that produces revenues less than or equal to 6 percent of the revenues received by the taxpayer, the tax or taxes are permissible under this test. The phrase ''revenues received by the taxpayer'' refers to the net patient revenue attributable to the assessed permissible class of health care items or services. However, for the period of January 1, 2008 through September 30, 2011, the applicable percentage of net patient service revenue is 5.5 percent. Compliance in State fiscal year 2008 will be evaluated from January 1, 2008 through the last day of State fiscal year 2008. Beginning with State fiscal year 2009 the 5.5 percent tax collection will be measured on an annual State fiscal year basis.

(B) When the tax or taxes produce revenues in excess of the applicable percentage of the revenue received by the taxpayer, CMS will consider an indirect hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments. The second prong of the indirect hold harmless test is applied in the aggregate to all health care taxes applied to each class. If this standard is violated, the amount of tax revenue to be offset from medical assistance expenditures is the total amount of the taxpayers' revenues received by the State.

(ii) [Reserved]

§ 433.70 [Amended]

■ 10. Section 433.70 is amended by—
■ A. Revising the section heading.
■ B. Removing paragraph (a)(1).
■ C. Removing the paragraph designation for existing paragraph (a)(2).
■ The revised heading reads as follows:

§ 433.70 Limitation on level of FFP for revenues from health care-related taxes.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: October 23, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: December 3, 2007.

Michael O. Leavitt,

Secretary.

Editorial Note: This document was received at the Office of the Federal Register on February 15, 2008.

[FR Doc. E8–3207 Filed 2–21–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

Final Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: Base (1% annual chance) Flood Elevations (BFEs) and modified BFEs are made final for the communities listed below. The BFEs and modified BFEs are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The date of issuance of the Flood Insurance Rate Map (FIRM) showing BFEs and modified BFEs for each community. This date may be obtained by contacting the office where the maps are available for inspection as indicated on the table below.

ADDRESSES: The final BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: William R. Blanton, Jr., Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3151.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final determinations listed below for the modified BFEs for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Assistant Administrator of the Mitigation Directorate has resolved any appeals resulting from this notification.

This final rule is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67. FEMA has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and FIRM available at the address cited below for each community. The BFEs and modified BFEs are made final in the communities listed below. Elevations at selected locations in each community are shown.

National Environmental Policy Act. This final rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30,