

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Part 433**

**[CMS 2275-P]**

**RIN 0938-A080**

**Medicaid Program; Health Care-Related Taxes**

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

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule would revise the threshold under the indirect guarantee hold harmless arrangement test to reflect the provisions of the Tax Relief and Health Care Act of 2006, Pub. L. 109-432, by providing that, when determining whether there is an indirect guarantee under the 2-prong test for any part of a fiscal year on or after January 1, 2008 through September 30, 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 proposed rule would also clarify 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); codify descriptions for two classes of health care services permissible under Federal statute for purposes of taxes on health care providers; and, remove obsolete transition period regulatory language.

**DATES:** To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [OFR--insert date 60 days after date of publication in the **Federal Register**].

**ADDRESSES:** In commenting, please refer to file code CMS-2275-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of three ways (no duplicates, please):

1. Electronically. You may submit electronic comments to <http://www.cms.hhs.gov/regulations/ecomments>.

(attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

2. By mail. You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2275-P,

P.O. Box 8017,

Baltimore, MD 21244-8017.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201; or

7500 Security Boulevard,

Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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

**SUPPLEMENTARY INFORMATION:**

*Submitting Comments:* We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code **CMS-2275-P** and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. After the close of the comment period, we post all electronic comments received before the close of the comment period on its public website. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

**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 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 that the amount of the tax is not directly correlated to Medicaid payments. The broad based and uniformity provisions are waivable through a statistical test that measures the degree to which the Medicaid program

incurs a greater tax burden when a State tax program is otherwise not compliant with the broad based and/or uniformity requirement. 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 that 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. We concluded that the grants and tax credits amounted to hold harmless arrangements prohibited from FFP under the Medicaid statute and regulations.

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 total revenues received by the taxpayers 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. States can 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 revenues received by the taxpayers within the class of health care 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 Pub. L. 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 in any portion of fiscal years beginning on or after January 1, 2008 and through September 30, 2011.

## **II. Provisions of the Proposed Rule**

**[If you choose to comment on issues in this section, please include the caption "PROVISIONS OF THE PROPOSED RULE" at the beginning of your comments.]**

### A. Permissible Class of Services - Managed Care

#### Organizations -- §433.56(a)(8)

Section 6051 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171), enacted on February 8, 2006, amends section 1903(w)(7)(viii) of the Act to expand the previous Medicaid managed care organization (MCO) provider class to include all MCOs. The effective date of section 6051 of the

DRA is the date of enactment, that is, February 8, 2006.

Therefore to qualify for Federal reimbursement, a State's health care-related tax would need to apply to both Medicaid participating and non-Medicaid participating MCOs.

Previously, the statute recognized services of a Medicaid MCO with a contract under section 1903(m) of the Act as a permissible class of health care services. This particular class of health care services was unlike any other permissible class of health care services identified in statute and regulation, as it was the only listed class of health care services that permitted taxation of solely Medicaid providers of the service. In addition, MCOs that participated in Medicaid were beginning to use the statutory language to reorganize their corporate structure to protect their commercial lines of business from tax liability. The result of this corporate restructuring was that the tax was imposed on only the Medicaid subsidiary of the MCO. With this reorganization, States were able to impose a tax on only the Medicaid revenues of the MCO, effectively shifting the entire burden of the tax to the Medicaid program.

We are proposing to implement the statutory amendment made in the section 6051 of the DRA with conforming changes to the regulatory provision in §433.56(a)(8). We are proposing to revise the regulatory language to specify that

all services of MCOs (including health maintenance organizations and preferred provider organizations) regardless of payer source will be considered a permissible class of health care items or services for purposes of health care-related taxes.

We note that the DRA provides a transition period for those States with existing Medicaid MCO taxes. For those States with a Medicaid MCO only tax enacted as of December 8, 2005, this provision becomes effective October 1, 2009.

B. Tests to Determine Hold Harmless Arrangements --

§433.68(f)

Currently, the regulations at §433.68(f) set forth three broad tests to determine if there is a hold harmless arrangement with respect to a health care-related tax. If States enact a tax program that violates any of these tests, FFP will be reduced by the amount collected through that tax program. As mentioned above, the recent DAB decision has drawn into question how the current hold harmless provisions will be interpreted and applied. Therefore, it is necessary to clarify these provisions and ensure proper implementation of section 1903(w)(4) of the Act. We propose to continue using the same regulatory structure of §433.68(f), while

clarifying certain terms in each of these hold harmless tests.

*Positive Correlation Test - §433.68(f)(1)*

We propose to modify and clarify the test set forth at §433.68(f)(1), also known as the positive correlation test. 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.

This proposed rule explains that both direct and indirect payments to providers, or others paying a health care-related tax, will be analyzed in determining compliance with this test. We propose 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. The provision of non-Medicaid payments may violate both the positive correlation test and the guarantee test, discussed further below. Our discussion of direct and indirect non-Medicaid payments is applicable to both tests.

Determining if a direct payment exists should be readily apparent. When a non-Medicaid payment is made directly to a provider, and it is positively correlated to the tax amount, then FFP will be denied for the health care related tax.

Unlike a direct payment, an indirect payment to a provider may be more difficult to detect. Yet, even though an indirect payment may not be as obvious, indirect payments that are positively correlated to a tax will also violate this test. An indirect payment can take many forms. For example, if the State imposes a health care-related tax, such as a tax on nursing home beds, and a provider is allowed under State statutes or regulations (either expressly or implicitly) to pass the costs of its tax onto patients through rate increases, payments by the State to those non-Medicaid patients that demonstrate a linkage to the rate increase would be an indirect payment to that provider. Under this example, the revenue source for the payment is not relevant in determining that the payment is an indirect payment. 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 as compensation for the tax. In reviewing this issue, we would look at whether the payment

would be made by the entity for documented charitable or business reasons even if the State were not involved. We endeavored to prohibit these indirect payments in the 1993 rules, but the recent DAB decision evidences that the original rule may have been unclear. This proposed rule is intended to further clarify the Secretary's policy. However, the purpose of this example is only to provide illustration of the broad scope of indirect payments. Due to the difficulty in predicting all possible types of indirect payments, this example does not limit our ability to detect other indirect payments in the future.

We recognize that this test interjects some degree of subjectivity into this analysis. However, the Congress intended to prohibit hold harmless arrangements that directly or indirectly paid a taxpayer for the costs of a tax. Some degree of subjective analysis is inevitable in determining whether an indirect payment exists. We will look at all relevant circumstances surrounding a tax and payment program to determine whether a linkage exists to establish an indirect payment.

The phrase "positively correlated" was defined in the 1993 final rule as having the "same meaning as the statistical term." As is evidenced in the DAB decision, this definition has led to much confusion as to how

"positively correlated" should be defined. Therefore, we would clarify that tax and payment amounts are positively correlated when they have a positive relationship with each other even when that relationship is not evidenced through a strict correlation in a mathematical sense. Two variables can be positively correlated even though the correlation may vary over time. For example, the rate of a tax and payment may be closely related, but, the next year, the tax rate might be increased while the payment might stay the same. Although the correlation between the two variables may have changed, it would still be positive since providers incurring the tax receive increased payments to offset the tax. For example, a State might impose a \$4 a day occupied bed tax on nursing homes, which the homes are permitted to pass onto their residents in the form of rate increases. At or about the same time they impose the tax, the State issues a \$3.75 grant (or tax credit) for non-Medicaid nursing home residents. A year later, the tax might be increased to \$4.10, but the grant or tax credit might remain level. In such a case, a positive correlation would be found to exist between the grant and the tax because, in each year, there would be a positive correlation between the tax and grant amounts paid in relation to each individual service unit (bed-days) to non-Medicaid residents. The correlation would

not be destroyed through the variation of one of the two variables (in tax or grant amounts). Moreover, as discussed above with respect to identifying indirect payments, we may look to extrinsic evidence, such as legislative history and circumstances surrounding the tax and grant programs, to establish the positive correlation.

We want to make clear that a positive correlation can be discovered in various ways. First, a positive correlation can be found through a statistical, numerical test where a series of tax and payment amounts are analyzed to determine if there is a statistical relationship between both amounts. Second, a positive correlation could be found where the rate of a tax and the rate of a non-Medicaid payment are based on the same numeric factors (such as the amount of revenues, or bed days). Third, a positive correlation could be found based on a finding that the non-Medicaid payment is conditional on payment (direct or indirect) of the tax. In addition to these numerical tests, evidence of the intended effect of linked tax and payment programs may demonstrate that a positive correlation exists, especially when a State enacts the tax and/or payment programs in the same legislative session. Tax and payment amounts, as articulated in either statute or regulation, can be compared and if there is a positive relationship between

those amounts, then the arrangement will be considered a hold harmless arrangement. Further, if the calculation of the payment amount is determined in whole or in part by the tax amount, we would also find that those amounts are positively correlated. The same would hold true if the tax amount was calculated based in whole or in part on the payment amount. There may be other ways that this positive relationship could be found, and we only provide these examples as a demonstration of the broad interpretation of the positive correlation test. It is simply impossible to anticipate all hold harmless plans that could be created.

*Defining Tax and Payment Amounts for Hold Harmless Analyses*

We propose to clarify the definition of tax amounts and payment amounts for purposes of hold harmless analyses. We propose to unify these definitions so that they will have identical meanings in all three hold harmless tests. In the current rule, we use terms such as "amount of the payment," "amount of such tax," "total tax cost," and "amount of total tax payment." These slightly differing phrases have apparently lead to confusion as to what amounts should be examined in determining whether a hold harmless exists. We propose that in the positive correlation test, as well as the other two tests, to use the terms "tax amount" and "payment amount."

Although we are using standardized terminology, we intend for these terms to encompass all of the meanings that could previously have been attributed to each of the prior terms, to permit maximum flexibility in analyzing the relationships between tax and payment programs, depending on the particular circumstances presented by State tax programs. A relationship between a tax program and Medicaid or non-Medicaid payments, or a direct or indirect guarantee, could be found based either on the aggregate tax amount that the provider pays over a period of time, or on the unit tax rate that is applied for a particular service. Therefore, if a State statute articulates a tax rate applicable to each nursing home bed within a nursing home, then that tax rate could be used in this analysis as the tax amount. Likewise, an analysis could be based on aggregate payments to providers, on payments made on a per-service basis, or on payments to individual patients. As with other terms that we have clarified, it is impossible to anticipate all permutations of what would constitute a tax or payment amount. Our intention is to define these terms broadly to capture new hold harmless arrangements as they arise.

We also believe that standardization of the term "tax amount" and "payment amount" in all three tests will demonstrate that money does not have to be expended before a

hold harmless situation can be discovered. Therefore, we will look at the State legislation creating a tax and hold harmless payment program (for example, grant or tax credit program). If a hold harmless situation exists on the face of the legislation, FFP will be denied for the tax amount. It is not necessary for us to determine, for example, the amount of grant funds actually expended by a State in an effort to hold taxpayers harmless for the tax. It would be extremely costly and administratively burdensome for us to track individual monies actually paid by States in these payment programs. If the tax and pay back programs exist to allow for a hold harmless situation, such a hold harmless violation will be found.

*Medicaid Payment Test - §433.68(f)(2)*

Under the current second hold harmless test, a hold harmless arrangement exists if all or any portion of the Medicaid payment varies based only on the amount of the total tax payment. For the reasons discussed above, we are proposing to revise this rule to use the standardized terminology "tax amount." We are also adding a clarification that a Medicaid payment will be considered to vary based on the tax amount when the payment is conditional on the tax payment. In that circumstance, the variation

between a payment of zero and a positive payment would be based only on the payment of the tax amount.

We do not believe this clarification is inconsistent with the provision in section 1903(w)(4) of the Act that indicates that the restrictions on hold harmless arrangements does not prevent States from using taxes "to reimburse health care providers in a class for expenditures under this title." Nor do we believe that this clarification would preclude States that use cost-based payment mechanisms from including provider tax costs as one of many provider costs that are considered in setting individualized provider rates. But this clarification would affect States that seek to use rates that are based solely on the receipt of provider taxes, rather than on overall provider costs (such as supplemental payments conditioned on receipt of taxes). Where Medicaid payment is conditioned on receipt of taxes, we would view the payment to be, in part or in full, to repay the taxes in a hold harmless arrangement rather than as a protected reimbursement for costs of Medicaid services.

This clarification is thus necessary to ensure that Medicaid payments are not made simply to repay providers for the tax, but also to ensure the integrity of the development of sound payment rates in compliance with the requirements

of section 1902(a)(30) of the Act. If Medicaid payments are conditional on receipt of particular tax amounts, it is an indication that the Medicaid payment rate would not otherwise be consistent with efficiency, economy, and quality of care, and is based solely on the return of funding received through the tax program. The proposed language would, however, 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.

*Guarantee Test - §433.68(f)(3)*

Under the current third hold harmless test, a hold harmless arrangement exists if there is a direct or indirect guarantee that holds taxpayers harmless for any portion of their tax cost. We propose to clarify this test to specify that a State can provide a direct or indirect guarantee through a direct or indirect payment. An indirect guarantee can be found based on the test as explained and modified below. A direct guarantee will 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. 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 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. Additionally, we interpret the phrase "all or any portion of the tax amount" to mean that a guarantee exists when a taxpayer is assured that money will be made available for repayment for any identifiable portion of the tax liability.

An indirect guarantee is distinct from a direct guarantee in that the payment to the provider is through regular or enhanced payments for pre-existing Medicaid obligations. We discuss indirect guarantees separately below.

C. Indirect Guarantee Hold Harmless Arrangements

Currently, under §433.68(f)(3)(i) an indirect hold harmless violation is determined using a two pronged test. If a health care-related tax or taxes are applied at a rate that produces revenues less than 6 percent of the revenues received by the taxpayers, the tax or taxes will not be in violation of the indirect hold harmless provision. If a health care-related tax or taxes exceed a 6 percent rate, we 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. The second prong of this test applies the test in the aggregate to all health care-related taxes applicable to each class. Moreover, in applying this test, we may consider as "enhanced Medicaid payments" any amount that any branch of the State, including legislative and executive branches, has indicated could be subject to reduction in the absence of provider tax revenues.

The Tax Relief and Health Care Act of 2006 has lowered the maximum threshold under the indirect hold harmless provision from 6 percent of net patient service revenue to 5.5 percent effective in 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.

D. Permissible Class of Services - Intermediate Care Facilities for the Mentally Retarded -- §433.56(a)(4)

In the interim final rule with comment that implemented 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 expanded 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 those facilities were classified as ICF/MRs before the grant of the waiver. These services furnished by the residences were added because, "in some States, many former ICF/MRs were converted to group homes under the waivers. These facilities could easily be converted back to ICF/MRs." This exception was very narrow and was only intended to capture those States that, before the issuance of the interim final rule December 24, 1992, were granted waivers that converted existing ICF/MRs to community-based residences.

We no longer believe that it is appropriate to include community residences in the ICF/MR class even to the extent of this narrow exception. We are no longer concerned that States will convert group homes back to ICF/MRs because of the general success of the home and community based services program. As important, it is not equitable to accord different treatment to States that converted ICF/MRs before December 24, 1992 than to other States. Therefore, we are clarifying at §433.56(a)(4) the permissible class for purposes of health care-related taxes to those services of ICF/MRs.

E. Hold Harmless Tests For Determining Bona Fide Provider Related Donations

At §433.54(c), the regulations contain tests for hold harmless arrangements with respect to provider-related donations that are similar to those with respect to provider taxes. For the reasons discussed above with respect to provider taxes, we are proposing parallel revisions to this section. We note that, similar to the provisions concerning provider taxes, we intend that a hold harmless arrangement would be found without regard to whether the transfers of funds that are the basis for the donation or the repayment are collected or distributed through third parties (such as patients, provider associations, or other entities).

## F. Miscellaneous

Section 1903(w) of the Act, as added by the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991, became effective January 1, 1992. However, section 1903(w)(1)(C)(ii) of the Act provided for transition periods during which, under certain circumstances, States could receive, without a reduction in FFP, revenues from provider-related donations and impermissible health care-related tax programs in effect before the enactment of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991. The requirements related to these transition periods are currently located in various sections of the current regulation from §433.58 through §433.68. The last transition period expired in 1993.

We are proposing to remove from within the regulatory text all references to collection of provider-related donations and health care-related taxes during the transition periods since all transition periods have expired. We believe this would create a more streamlined regulation that is easier to read.

### **III. 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.)

#### **IV. Response to Comments**

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

#### **V. Regulatory Impact Analysis**

**[If you choose to comment on issues in this section, please include the caption "Regulatory Impact Analysis" at the beginning of your comments.]**

##### A. Overall Impact

We have examined the impact of this rule 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), and Executive Order 13132.

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 rule would 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 a secondary impact.

While the impact on health care facilities is secondary, we nevertheless discuss the potential impact on small entities. First, the reduced tax limit proposed under this rule would 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 tax limit, we cannot provide an exact and quantifiable impact on such small entities. For this reason, we would like to specifically solicit public comment on the impact this rule would have on small health care facilities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule 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 603 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 rule would 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 rule 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 rule would 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 proposed rule (and subsequent final rule) 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 threshold rate for

allowable provider taxes from 6 percent to 5.5 percent, 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 would impose substantial direct requirements or costs on State and local governments.

#### B. Anticipated Effects

Estimated Reduction in Federal Medicaid Outlays  
Resulting from the Provider Tax Reform Proposal

Being Implemented by CMS-2275-P

(Amounts in millions)

#### **Annual Expected Savings**

	Reduction in Federal Medicaid Outlays in Millions				
			Fiscal Year		
	2008	2009	2010	2011	2012
Provider Tax Reform	85	115	115	115	0
3% discount rate	83	108	105	102	0
7% discount rate	79	100	94	88	0

#### Accounting Statement

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 proposed rule. 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 proposed rule. This rule only affects transfer payments between the Federal government and State governments.

OMB-Statement of Accounts

Annualized monetized transfers (in millions)		
3%	87	per year
7%	88	per year

Provider Tax Reform

1. Effects on State Medicaid Programs

Estimates of the impact of lowering the maximum allowable provider 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 whose receipts as of the date of the reports were 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  $[(1 - 0.55/6.0) \times 100]$ . 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.

## 2. Effects on Other Providers

The reduced tax limit proposed under this rule would help alleviate 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 provider even after accounting for reduction in the 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, providers may receive higher net Medicaid reimbursement in light of the reduced tax burden.

### C. Alternatives Considered

In developing this regulation the following alternatives were considered. First, the existing regulatory threshold percentage of 6 percent could be maintained. Second, we considered reducing the regulatory 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, 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 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 provider 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 maximizing 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 recent 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.

#### D. Conclusion

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 rule would 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 proposes to amend 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;

\* \* \* \* \*

(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)(1) \* \* \*

(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.

C. Revising paragraphs (f)(1), (f)(2), (f)(3) introductory text, and (f)(3)(i).

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) 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, except that, for any portion of a fiscal year beginning on or after January 1, 2008 through September 30, 2011, the applicable percentage of net operating revenues is 5.5 percent. 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.

\* \* \* \* \*

**§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: \_\_\_\_\_

\_\_\_\_\_  
**Leslie V. Norwalk,**  
Acting Administrator,  
Centers for Medicare & Medicaid  
Services.

Approved: \_\_\_\_\_

\_\_\_\_\_  
**Michael O. Leavitt,**  
Secretary.

**BILLING CODE 4120-01-P**