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taxes in excess of the limit calculated under paragraph (a) of this section.

[57 FR 55138, Nov. 24, 1992; 58 FR 6095, Jan. 26, 1993]

§ 433.66 Permissible provider-related donations after the transition period.

(a) *General rule.* (1) Except as specified in paragraph (a)(2) of this section, subsequent to the end of a State's transition period, as defined in § 433.58(b), 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, whether or not the State's transition period continues beyond that date.

(b) *Permissible donations.* Subject to the limitations specified in § 433.67, a State may receive, without a reduction in FFP, provider-related donations that meet at least one of the following requirements:

(1) The donations must be bona fide donations, as defined in § 433.54; or

(2) The donations are made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at the facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. Direct costs of outstationed eligibility workers refers to the costs of training, salaries and fringe benefits associated with each outstationed worker and similar allocated costs of State or local agency support staff, and a prorated cost of outreach activities applicable to the outstationed workers at these sites. The prorated costs of outreach activities will be calculated taking the percent of State outstationed eligibility workers at a facility to total outstationed eligibility workers in the State, and multiplying the percent by the total cost of outreach activities in the State. Costs for such items as State agency overhead and provider of-

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fice space are not allowable for this purpose.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43180, Aug. 13, 1993]

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

(a)(1) *Limitations on bona fide donations.* There are no limitations on the amount of bona fide provider-related donations that a State may receive without a reduction in FFP, as long as the bona fide donations meet the requirements of § 433.66(b)(1).

(2) *Limitations on donations for outstationed eligibility workers.* Effective October 1, 1992, regardless of when a State's transition period ends, 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.

(b) *Calculation of FFP.* CMS will deduct from a State's quarterly medical assistance expenditures, before calculating FFP, any provider-related donations received in that quarter that do not meet the requirements of § 433.66(b)(1) and provider donations for outstationed eligibility workers in excess of the limits specified under paragraph (a)(2) of this section.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43180, Aug. 13, 1993]

§ 433.68 Permissible health care-related taxes after the transition period.

(a) *General rule.* Beginning on the day after a State's transition period, as defined in § 433.58(b), ends, a State may receive health care-related taxes, without a reduction in FFP, only in accordance with the requirements of this section.

(b) *Permissible health care-related taxes.* Subject to the limitations specified in § 433.70, a State may receive, without a reduction in FFP, health care-related taxes if all of the following are met:

(1) The taxes are broad based, as specified in paragraph (c) of this section;

(2) The taxes are uniformly imposed throughout a jurisdiction, as specified in paragraph (d) of this section; and

(3) The tax program does not violate the hold harmless provisions specified in paragraph (f) of this section.

(c) *Broad based health care-related taxes.* (1) A health care-related tax will be considered to be broad based if the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-Federal, non-public providers in the State, and is imposed uniformly, as specified in paragraph (d) of this section.

(2) If a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the area over which the unit of government has jurisdiction.

(3) A State may request a waiver from CMS of the requirement that a tax program be broad based, in accordance with the procedures specified in § 433.72. Waivers from the uniform and broad-based requirements will automatically be granted in cases of variations in licensing and certification fees for providers if the amount of such fees is not more than \$1,000 annually per provider and the total amount raised by the State from the fees is used in the administration of the licensing or certification program.

(d) *Uniformly imposed health care-related taxes.* A health care-related tax will be considered to be imposed uniformly even if it excludes Medicaid or Medicare payments (in whole or in part), or both; or, in the case of a health care-related tax based on revenues or receipts with respect to a class of items or services (or providers of items or services), if it excludes either Medicaid or Medicare revenues with respect to a class of items or services, or both. The exclusion of Medicaid reve-

nues must be applied uniformly to all providers being taxed.

(1) A health care-related tax will be considered to be imposed uniformly if it meets any one of the following criteria:

(i) If the tax is a licensing fee or similar tax imposed on a class of health care services (or providers of those health care items or services), the tax is the same amount for every provider furnishing those items or services within the class.

(ii) If the tax is a licensing fee or similar tax imposed on a class of health care items or services (or providers of those items or services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of those items or services in the class.

(iii) If the tax is imposed on provider revenue or receipts with respect to a class of items or services (or providers of those health care items or services), the tax is imposed at a uniform rate for all services (or providers of those items or services) in the class on all the gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the State, unit, or jurisdiction. Net operating revenue means gross charges of facilities less any deducted amounts for bad debts, charity care, and payer discounts.

(iv) The tax is imposed on items or services on a basis other than those specified in paragraphs (d)(1) (i) through (iii) of this section, e.g., an admission tax, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class.

(2) A tax imposed with respect to a class of health care items or services will not be considered to be imposed uniformly if it meets either one of the following two criteria:

(i) The tax provides for credits, exclusions, or deductions which have as its purpose, or results in, the return to providers of all, or a portion, of the tax paid, and it results, directly or indirectly, in a tax program in which—

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(A) The net impact of the tax and payments is not generally redistributive, as specified in paragraph (e) of this section; and

(B) The amount of the tax is directly correlated to payments under the Medicaid program.

(ii) The tax holds taxpayers harmless for the cost of the tax, as described in paragraph (f) of this section.

(3) If a tax does not meet the criteria specified in paragraphs (d)(1)(i) through (iv) of this section, but the State establishes that the tax is imposed uniformly in accordance with the procedures for a waiver specified in § 433.72, the tax will be treated as a uniform tax.

(e) *Generally redistributive.* A tax will be considered to be generally redistributive if it meets the requirements of this paragraph. If the State desires waiver of only the broad-based tax requirement, it must demonstrate compliance with paragraph (e)(1) of this section. If the State desires waiver of the uniform tax requirement, whether or not the tax is broad-based, it must demonstrate compliance with paragraph (e)(2) of this section.

(1) *Waiver of broad-based requirement only.* This test is applied on a per class basis to a tax that is imposed on all revenues but excludes certain providers. For example, a tax that is imposed on all revenues (including Medicare and Medicaid) but excludes teaching hospitals would have to meet this test. This test cannot be used when a State excludes any or all Medicaid revenue from its tax in addition to the exclusion of providers, since the test compares the proportion of Medicaid revenue being taxed under the proposed tax with the proportion of Medicaid revenue being taxed under a broad-based tax.

(i) A State seeking waiver of the broad-based tax requirement only must demonstrate that its proposed tax plan meets the requirement that its plan is generally redistributive by:

(A) Calculating the proportion of the tax revenue applicable to Medicaid if the tax were broad based and applied to all providers or activities within the class (called P1);

(B) Calculating the proportion of the tax revenue applicable to Medicaid

under the tax program for which the State seeks a waiver (called P2); and

(C) Calculating the value of P1/P2.

(ii) If the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 1, CMS will automatically approve the waiver request.

(iii) If a tax is enacted and in effect prior to August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.90, CMS will review the waiver request. Such a waiver will be approved only if the following two criteria are met:

(A) The value of P1/P2 is at least 0.90; and

(B) The tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxed:

(1) Providers that furnish no services within the class in the State;

(2) Providers that do not charge for services within the class;

(3) Rural hospitals (defined as any hospital located outside of an urban area as defined in § 412.62(f)(1)(ii) of this chapter);

(4) Sole community hospitals as defined in § 412.92(a) of this chapter;

(5) Physicians practicing primarily in medically underserved areas as defined in section 1302(7) of the Public Health Service Act;

(6) Financially distressed hospitals if:

(i) A financially distressed hospital is defined by the State law;

(ii) The State law specifies reasonable standards for determining financially distressed hospitals, and these standards are applied uniformly to all hospitals in the State; and

(iii) No more than 10 percent of non-public hospitals in the State are exempt from the tax;

(7) Psychiatric hospitals; or

(8) Hospitals owned and operated by HMOs.

(iv) If a tax is enacted and in effect after August 13, 1993, and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.95, CMS will review the waiver request. Such a waiver request will be approved only if the following two criteria are met:

(A) The value of P1/P2 is at least 0.95; and

(B) The tax complies with the provisions of § 433.68(e)(1)(iii)(B).

(2) *Waiver of uniform tax requirement.* This test is applied on a per class basis to all taxes that are not uniform. This includes those taxes that are neither broad based (as specified in § 433.68(c)) nor uniform (as specified in § 433.68(d)).

(i) A State seeking waiver of the uniform tax requirement (whether or not the tax is broad based) must demonstrate that its proposed tax plan meets the requirement that its plan is generally redistributive by:

(A) Calculating, using ordinary least squares, the slope (designated as *B*) (that is, the value of the *x* coefficient) of two linear regressions, in which the dependent variable is each provider's percentage share of the total tax paid by all taxpayers during a 12-month period, and the independent variable is the taxpayer's "Medicaid Statistic". The term "Medicaid Statistic" means the number of the provider's taxable units applicable to the Medicaid program during a 12-month period. If, for example, the State imposed a tax based on provider charges, the amount of a provider's Medicaid charges paid during a 12-month period would be its "Medicaid Statistic". If the tax were based on provider inpatient days, the number of the provider's Medicaid days during a 12-month period would be its "Medicaid Statistic". For the purpose of this test, it is not relevant that a tax program exempts Medicaid from the tax.

(B) Calculating the slope (designated as *B1*) of the linear regression, as described in paragraph (e)(2)(i) of this section, for the State's tax program, if it were broad based and uniform.

(C) Calculating the slope (designated as *B2*) of the linear regression, as described in paragraph (e)(2)(i) of this section, for the State's tax program, as proposed.

(ii) If the State demonstrates to the Secretary's satisfaction that the value of *B1/B2* is at least 1, CMS will automatically approve the waiver request.

(iii) If the State demonstrates to the Secretary's satisfaction that the value of *B1/B2* is at least 0.95, CMS will review the waiver request. Such a waiver will be approved only if the following two criteria are met:

(A) The value of *B1/B2* is at least 0.95; and

(B) The tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxes:

(1) Providers that furnish no services within the class in the State;

(2) Providers that do not charge for services within the class;

(3) Rural hospitals (defined as any hospital located outside of an urban area as defined in § 412.62(f)(1)(ii) of this chapter;

(4) Sole community hospitals as defined in § 412.92(a) of this chapter;

(5) Physicians practicing primarily in medically underserved areas as defined in section 1302(7) of the Public Health Service Act;

(6) Financially distressed hospitals if:

(i) A financially distressed hospital is defined by the State law;

(ii) The State law specifies reasonable standards for determining financially distressed hospitals, and these standards are applied uniformly to all hospitals in the State; and

(iii) No more than 10 percent of non-public hospitals in the State are exempt from the tax;

(7) Psychiatric hospitals; or

(8) Providers or payers with tax rates that vary based exclusively on regions, but only if the regional variations are coterminous with preexisting political (and not special purpose) boundaries. Taxes within each regional boundary must meet the broad-based and uniformity requirements as specified in paragraphs (c) and (d) of this section.

(iv) A *B1/B2* value of 0.70 will be applied to taxes that vary based exclusively on regional variations, and enacted and in effect prior to November 24, 1992, to permit such variations.

(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 directly or indirectly for a non-Medicaid payment to those providers or others paying the tax and the amount of the payment is positively correlated to either the amount of the tax or to the difference between the Medicaid payment and the total tax cost.

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(2) All or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payment.

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

(i) An indirect guarantee will be determined to exist under a two prong "guarantee" test. This specific hold harmless test is effective September 13, 1993. In this instance, 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. When the tax or taxes are applied at a rate that produces revenues in excess of 6 percent of the revenue received by the taxpayer, CMS will consider a 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 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) If, as of August 13, 1993, a State has enacted a tax in excess of 6 percent that does not meet the requirements in paragraph (f)(3)(i) of this section, CMS will not disallow funds received by the State resulting from the tax if the State modifies the tax to comply with this requirement by September 13, 1993. If, by September 13, 1993, the tax is not modified, funds received by States on or after September 13, 1993 will be disallowed.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43181, Aug. 13, 1993; 62 FR 53572, Oct. 15, 1997]

§ 433.70 Limitations on level of FFP for revenues from health care-related taxes after the transition period.

(a) *Limitations.* (1) Subsequent to the end of a State's transition period (as

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defined in § 433.58(b)), and extending through September 30, 1995, the maximum amount of health care-related taxes specified in § 433.68 that a State may receive during a State fiscal year (or portion thereof), without a reduction in FFP, is limited to—

(i) The greater of 25 percent or the State base percentage as described in § 433.60(b); multiplied by

(ii) The State's share of total medical assistance expenditures for the State fiscal year, less all health care-related taxes other than those described in § 433.68 that are deducted separately pursuant to paragraph (b) of this section.

(2) Beginning October 1, 1995, there is no limitation on the amount of health care-related taxes that a State may receive without a reduction in FFP, as long as the health care-related taxes meet the requirements specified in § 433.68.

(b) *Calculation of FFP.* CMS will deduct from a State's medical assistance expenditures, before calculating FFP, revenues from health care-related taxes that do not meet the requirements of § 433.68 and any health care-related taxes in excess of the limits specified in paragraph (a)(1) of this section.

§ 433.72 Waiver provisions applicable to health care-related taxes.

(a) *Bases for requesting waiver.* (1) A State may submit to CMS a request for a waiver if a health care-related tax does not meet any or all of the following:

(i) The tax does not meet the broad based criteria specified in § 433.68(c); and/or

(ii) The tax is not imposed uniformly but meets the criteria specified in § 433.68(d)(2) or (d)(3).

(2) When a tax that meets the criteria specified in paragraph (a)(1) of this section is imposed on more than one class of health care items or services, a separate waiver must be obtained for each class of health care items and services subject to the tax.

(b) *Waiver conditions.* In order for CMS to approve a waiver request that would permit a State to receive tax revenue (within specified limitations) without a reduction in FFP, the State