

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 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 re-

ceive 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 § 433.68c; 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 must demonstrate, to CMS's satisfaction, that its tax program meets all of the following requirements:

(1) The net impact of the tax and any payments made to the provider by the State under the Medicaid program is generally redistributive, as described in § 433.68(e);

(2) The amount of the tax is not directly correlated to Medicaid payments; and

(3) The tax program does not fall within the hold harmless provisions specified in § 433.68(f).

(c) *Effective date.* A waiver will be effective:

(1) The date of enactment of the tax for programs in existence prior to August 13, 1993 or;

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(2) For tax programs commencing on or after August 13, 1993, on the first day in the quarter in which the waiver is received by CMS.

[57 FR 55138, Nov. 24, 1992, as amended at 58 FR 43182, Aug. 13, 1993]

§ 433.74 Reporting requirements.

(a) Beginning with the first quarter of Federal fiscal year 1993, each State must submit to CMS quarterly summary information on the source and use of all provider-related donations (including all bona fide and presumed-to-be bona fide donations) received by the State or unit of local government, and health care-related taxes collected. Each State must also provide any additional information requested by the Secretary related to any other donations made by, or any taxes imposed on, health care providers. States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures.

(b) Each State must provide the summary information specified in paragraph (a) of this section on a quarterly basis in accordance with procedures established by CMS.

(c) Each State must maintain, in readily reviewable form, supporting documentation that provides a detailed description and legal basis for each donation and tax program being reported, as well as the source and use of all donations received and taxes collected. This information must be made available to Federal reviewers upon request.

(d) If a State fails to comply with the reporting requirements contained in this section, future grant awards will be reduced by the amount of FFP CMS estimates is attributable to the sums raised by tax and donation programs as to which the State has not reported properly, until such time as the State complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the State has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the State complies with all reporting requirements.

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Subpart C—Mechanized Claims Processing and Information Retrieval Systems

§ 433.110 Basis, purpose, and applicability.

(a) This subpart implements the following sections of the Act:

(1) Section 1903(a)(3) of the Act, which provides for FFP in State expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems and for the operation of certain systems. Additional HHS regulations and CMS procedures for implementing these regulations are in 45 CFR part 74, 45 CFR part 95, subpart F, and part 11, State Medicaid Manual; and

(2) Section 1903(r) of the Act, which—
(i) Requires reductions in FFP otherwise due a State under section 1903(a) if a State fails to meet certain deadlines for operating a mechanized claims processing and information retrieval system or if the system fails to meet certain conditions of approval or conditions of reapproval;

(ii) Requires a Federal performance review at least every three years of the mechanized claims processing and information retrieval systems; and

(iii) Allows waivers of conditions of approval, conditions of reapproval, and FFP reductions under certain circumstances.

(b) The requirements under section 1903(r) of the Act do not apply to Puerto Rico, Guam, the Virgin Islands, American Samoa and the Northern Mariana Islands.

[50 FR 30846, July 30, 1985, as amended at 54 FR 41973, Oct. 13, 1989]

§ 433.111 Definitions.

For purposes of this section:

(a) The following terms are defined at 45 CFR part 95, subpart F § 95.605:

“Advance Planning Document”; “Design” or “System Design”; “Development”; “Enhancement”; “Hardware”; “Installation”; “Operation”; and, “Software”.

(b) “Mechanized claims processing and information retrieval system” or “system” means the system of software and hardware used to process