Federal Highway Administration

National Motor Carrier Advisory Committee Meeting

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of public meeting.

SUMMARY: The FHWA announces a public meeting of the National Motor Carrier Advisory Committee. The focus of the meeting is on: (1) the North American Free Trade Agreement; (2) the National Highway System; (3) major regulations; (4) the results of Roadcheck 1993; and (5) findings and next steps for the zero base approach to regulations.

DATES: The meeting will be from 8:30 a.m. to 5 p.m. on September 9, 1993, and from 8 a.m. to 12:00 noon on September 10, 1993.

ADDRESSES: Federal Highway Administration, 400 Seventh Street, SW., room 2201, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Mr. Douglas J. McKelvey, HIA–20, room 3104, 400 Seventh Street, SW., Washington, DC 20590, (202) 366–1861. Office hours are from 7:45 a.m. to 4:15 p.m., e.t., Monday through Friday, except for legal Federal holidays.

(23 U.S.C. 315; 49 CFR 1.48)

Issued on: August 6, 1993.

Rodney E. Slater,

Federal Highway Administrator.

[FR Doc. 93–19453 Filed 8–12–93; 8:45 am]

BILLING CODE 4910–22–P

U.S. INFORMATION AGENCY

Culturally Significant Objects Imported for Exhibition; Determination

Notice is hereby given of the following determination: Pursuant to the authority vested in me by the Act of October 19, 1965 (79 Stat. 985, 22 U.S.C. 2549), Executive Order 12047 of March 27, 1978 (43 F.R. 13359, March 29, 1978), and Delegation Order No. 85–5 of June 27, 1985 (50 F.R. 27393, July 2, 1985), I hereby determine that the objects to be included in the exhibit, "The Age of Rubens" (see list),[1] imported from abroad for the temporary exhibition without profit within the United States are of cultural significance. These objects are imported pursuant to a loan agreement with the foreign lender. I also determine that the temporary exhibition or display of the listed exhibit objects at the Museum of Fine Arts, Boston, Massachusetts, from on or about September 22, 1993, to on or about January 2, 1994, and the Toledo Museum of Art from on or about February 2, 1994 to on or about April 24, 1994, is in the national interest.

Public notice of this determination is ordered to be published in the **Federal Register.**

Dated: August 10, 1993.

Peter Ritenburg,

Acting General Counsel.

[FR Doc. 93–19532 Filed 8–12–93; 8:45 am]

BILLING CODE 8230–01–M

[1] A copy of this list may be obtained by contacting Mr. Paul Manning of the Office of the General Counsel of USIA. The telephone number is 202/619–6827, and the address is Room 700, U.S. Information Agency, 301 Fourth Street, SW., Washington, DC 20547.

DEPARTMENT OF VETERANS AFFAIRS

Information Collection Under OMB Review

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

The Department of Veterans Affairs has submitted to OMB the following proposals for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35). This document lists the following information:

(1) The title of the information collection, and the Department form number(s), if applicable;

(2) A description of the need and its use;

(3) Who will be required or asked to respond;

(4) An estimate of the total annual reporting hours, and recordkeeping burden, if applicable

(5) The estimated average burden hours per respondent;

(6) The frequency of response; and

(7) An estimated number of respondents.

ADDRESSES: Copies of the proposed information collection and supporting documents may be obtained from Patti Viers, Office of Information Resources Management (723), Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 233–3172.

Comments and questions about the items on the list should be directed to VA's OMB Desk Officer, Joseph Lackey, NEOB, room 3002, Washington, DC 20503, (202) 395–7316. Do not send requests for benefits to this address.

DATES: Comments on the information collection should be directed to the OMB Desk Officer within 30 days of this notice.

Dated: August 6, 1993.

By direction of the Secretary.

Patti Viers,

Chief, Forms, Correspondence and Mail Management Division.

Reinstatement

1. VA Acquisition Regulation Part 809 (48 CFR chapter 8, part 809)
2. The information is used to qualify contractors and/or their products under applicable Federal or interim Federal specifications. The information is necessary to ensure that VA receives quality products and services.
3. Businesses or other for-profit—Small businesses or organizations
4. 75 hours
5. 30 minutes
6. On occasion
7. 150 respondents

Reinstatement

1. VA Acquisition Regulation part 836 (48 CFR chapter 8, part 836)
2. The information is necessary in order to obtain the proposal and supporting cost or pricing data from the contractor and subcontractor in the negotiation of all architect-engineer contracts for the design services when the contract price is estimated to be $50,000 or over.
3. Businesses or other for-profit—Small businesses or organizations
4. 5,735 hours
5. 26.8 hours
6. On occasion
7. 214 respondents.

[FR Doc. 93–19468 Filed 8–12–93; 8:45 am]

BILLING CODE 8320–01–M

Information Collection Under OMB Review

AGENCY: Department of Veterans Affairs.

ACTION: Notice.

The Department of Veterans Affairs has submitted to OMB the following proposals for the collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35). This document lists the following information:

(1) The title of the information collection, and the Department form number(s), if applicable;

(2) A description of the need and its use;

(3) Who will be required or asked to respond;

(4) An estimate of the total annual reporting hours, and recordkeeping burden, if applicable;

(5) The estimated average burden hours per respondent;

(6) The frequency of response; and

(7) An estimated number of respondents.

ADDRESSES: Copies of the proposed information collection and supporting documents may be obtained from Janet G. Byers, Veterans Benefits Administration (20A5), Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420 (202) 233–3021.

Comments and questions about the items on the list should be directed to VA's OMB Desk Officer, Joseph Lackey, NEOB, room 3002, Washington, DC 20503, (202) 395–7316. Do not send requests for benefits to this address.

DATES: Comments on the information collection should be directed to the OMB Desk Officer within 30 days of this notice.

Dated: August 6, 1993.

By direction of the Secretary.

Patti Viers,

Chief, Forms, Correspondence and Mail Management Division.

Extension

1. Counseling Record—Personal Information, VA Form 28–1902
2. The form is used to collect information to assist a counseling psychologist in VA to determine the claimant's eligibility for counseling services. The information then becomes the basis for development of approaches to explore the claimant's rehabilitation, training, employment or adjustment needs.
3. Individuals or households
4. 30,000 hours
5. 30 minutes
6. On occasion
7. 60,000 respondents

Revision

1. Monthly Certification of Flight Training, VA Form 22–6553c
2. The form is used by students (veterans, servicemembers and reservists) and flight schools to report the hours and cost of flight training received and the termination of training. The information is used by VA to determine the amount of benefits payable to the student who is pursing flight training.
3. Individuals or households—Businesses or other for-profit—Non-profit institutions—Small businesses or organizations
4. 3,000 hours
5. 30 minutes
6. On occasion—Monthly
7. 1,000 respondents.

[FR Doc. 93–19469 Filed 8–12–93; 8:45 am]

BILLING CODE 8320–01–M

Sunshine Act Meetings

Federal Register
Vol. 58, No. 155
Friday, August 13, 1993

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

FEDERAL DEPOSIT INSURANCE CORPORATION

Notice of Change in Subject Matter of Agency Meeting

Pursuant to the provisions of subsection (e)(2) of the "Government in the Sunshine Act" (5 U.S.C. 552b(e)(2)), notice is hereby given that at its open meeting held at 10:07 a.m. on Tuesday, August 10, 1993, the Corporation's Board of Directors determined, on motion of Director Jonathan L. Fiechter (Acting Director, Office of Thrift Supervision), seconded by Director Eugene A. Ludwig (Comptroller of the Currency), concurred in by Acting Chairman Andrew C. Hove, Jr., that Corporation business required the withdrawal from the agenda for consideration at the meeting, on less than seven days' notice to the public, of a memorandum and resolution regarding payment of claims arising from severance pay or "golden parachute" agreements of failed banks where employment has been terminated after bank failure.

By the same majority vote, the Board further determined that no notice earlier than August 5, 1993, of the change in the subject matter of the meeting was practicable.

The meeting was held in the Board Room of the FDIC Building located at 550 17th Street, NW., Washington, DC.

Dated: August 10, 1993.

Federal Deposit Insurance Corporation.

Robert E. Feldman,

Deputy Executive Secretary.

[FR Doc. 93–19638 Filed 8–10–93; 4:39 pm]

BILLING CODE 6714–01–M

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

TIME AND DATE: 10:00 a.m., Wednesday, August 18, 1993.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW., Washington, DC 20551.

STATUS: Open.

MATTERS TO BE CONSIDERED:

Summary Agenda

Because of its routine nature, no substantive discussion of the following item is anticipated. This matter will be voted on without discussion unless a member of the Board requests that the item be moved to the discussion agenda.

1. Publication for comment of proposed amendments to Regulation S (Reimbursement for Providing Financial Records; Recordkeeping Requirements for Certain Financial Records) regarding enhanced recordkeeping requirements for certain wire transfers by financial institutions.

Discussion Agenda

2. Publication for comment of proposed amendments to Regulation O (Loans to Executive Officers, Directors, and Principal Shareholders of Member Banks) regarding: (1) Exceptions to the aggregate insider lending limit; (2) the definition of "extension of credit"; and (3) modifications to the recordkeeping requirements.

3. Any items carried forward from a previously announced meeting.

Note: This meeting will be recorded for the benefit of those unable to attend. Cassettes will be available for listening in the Board's Freedom of Information Office, and copies may be ordered for $5 per cassette by calling (202) 452–3684 or by writing to:

Freedom of Information Office, Board of Governors of the Federal Reserve System, Washington, DC 20551

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452–3204.

Dated: August 11, 1993.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 93–19639 Filed 8–11–93; 11:26 am]

BILLING CODE 6210–01–P–M

BOARD OF GOVERNORS OF THE FEDERAL RESERVE SYSTEM

TIME AND DATE: Approximately 11:00 a.m., Wednesday, August 18, 1993, following a recess at the conclusion of the open meeting.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW., Washington, DC. 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

2. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452–3204. You may call (202) 452–3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Dated: August 11, 1993.

Jennifer J. Johnson,

Associate Secretary of the Board.

[FR Doc. 93–19640 Filed 8–11–93; 11:26 am]

BILLING CODE 6210–01–P

federal register

Friday
August 13, 1993

Part II

Department of Health and Human Services

Health Care Financing Administration

16 CFR Parts 433 and 447

Medicaid Program; Limitations on Payments to Disproportionate Share Hospitals; Rule and Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 433 and 447

[MB-062-F]

RIN 0938-AF99

Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule clarifies HCFA's policies concerning provider related donations and health care related taxes. In addition, this final rule revises regulations with regard to disproportionate share hospital spending limitations. This final rule amends an interim final rule that was published in the **Federal Register** on November 24, 1992. The interim final rule established in Medicaid regulations limitations on Federal financial participation (FFP) in State medical assistance expenditures when States receive funds from provider-related donations and revenues generated by certain health care-related taxes. The interim final rule also added provisions that establish limits on the aggregate amount of payments a State may make to disproportionate share hospitals for which FFP is available.

The provisions of the interim final rule were required by the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991.

EFFECTIVE DATE: This rule is effective September 13, 1993.

FOR FURTHER INFORMATION CONTACT: Bernard Truffer (410) 966-1357.

SUPPLEMENTARY INFORMATION:

I. Provider-Related Donations and Health Care-Related Taxes

A. Summary of Interim Final Regulations

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Public Law 102-234), enacted December 12, 1991, amended section 1903 of the Social Security Act (the Act) by adding a new subsection (w) regarding the receipt of provider-related donations and health care-related taxes by a State as the State's share of financial participation under Medicaid. In general, under section 1903(w) of the Act, a reduction in Federal financial participation (FFP) will occur if a State receives donations made by, or on behalf of, health care providers unless the donations are bona fide donations or meet outstationed eligibility worker donation requirements, as specified in the law.

The law specifies the types of health care-related taxes a State is permitted to receive without a reduction in FFP. In general, such taxes are broad-based taxes that apply in a uniform manner to all health care providers in a class, and that do not hold providers harmless for their tax costs. However, the law permits States that have received, by specific dates prior to the enactment of Public Law 102-234, provider-related donations and health care-related taxes that are not permitted by this law, to continue to receive them during the State's transition period without a reduction in FFP.

On November 24, 1992, we published in the **Federal Register** (57 FR 55261) an interim final regulation implementing the limitations on FFP in State medical assistance expenditures when States receive funds from provider-related donations and revenues generated by certain health care-related taxes. In this interim final rule, we provided the following changes to our regulations to implement the new statutory provisions:

- We incorporated the statutory definitions of an entity related to a health care provider, provider-related donations, and health-care related taxes.
- We defined bona fide donations.
- We incorporated the classes of health care items and services and providers, as defined by the Act, for purposes of determining permissible health care-related taxes, and expanded the class that included intermediate care facilities for the mentally retarded (ICF/MR) specified in the statute to include ICF/MR services provided in certain group homes for the mentally retarded. We also incorporated an additional class that includes certain licensing or certification fees on providers of medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- We specified the general rules regarding the reduction in State expenditures by revenues generated from provider-related donations and health care-related taxes received by a State or unit of local government before calculating FFP.
- We established the rules regarding the use of revenues from provider donations and health care-related tax programs during a State's transition period.
- We established rules regarding the calculation of the State base percentage (25-percent cap on taxes and donations) for purposes of determining the maximum amount of total provider-related donations and health care-related taxes that a State may receive without a reduction in FFP during a State fiscal year.
- We established rules regarding the types of donations and health care-related taxes that are permissible after the State's transition period. In particular, revenues from broad-based, health care-related taxes that are applied uniformly to providers, and do not exceed the 25-percent cap or hold providers harmless for the cost of the tax, may be received by States without a reduction in FFP.
- We established the waiver criteria under which we will determine whether a tax that does not meet the statutorily defined broad-based or uniform requirements is generally redistributive.
- We provided circumstances in which a provider is considered to be held harmless from a health care-related tax.
- We established reporting requirements for the State's submission of information to HCFA related to provider-related donations received and health care-related taxes collected by the State or units of local government during the Federal fiscal year.

B. Discussion of Public Comments

In response to the November 24, 1992, interim final rule with comment, we received 98 timely items of correspondence. The comments were submitted by hospitals, hospital associations, various levels of State and local governments, and a number of national health care organizations. Only a few of the commenters supported the taxes and donations provisions of the interim final rule in its entirety. The majority of the commenters urged us to reconsider our positions regarding the hold harmless provisions and the classes of health care items and services that are eligible for inclusion as a permissible health care-related tax.

The specific comments made by the commenters relating to the taxes and donations provisions of the interim final rule and our responses follow.

1. General Comments

Comment: One commenter stated that the interim final rule will significantly erode financial support for Medicaid programs in many States.

Response: Prior to the enactment of Public Law 102-234, some States directly linked donations and other voluntary payment programs to

increases in Medicaid payment rates. Other States levied taxes or other mandatory payments on providers and modified Medicaid payment rates in such a way as to reimburse the provider for the cost of the tax. We agree that the statutory provisions and the implementing regulations will affect a State's use of provider-related donations and health care-related taxes, but only to the extent that a State is unable to either comply with the provisions of the law or find alternative sources of State funds to finance the Medicaid program.

Comment: Several commenters indicated that expanding the scope of this rule to tax and donation programs not used to fund the Medicaid program affects intergovernmental transfers and creates an inconsistency between the statute and rule and is not a true reflection of Congressional intent regarding the treatment of intergovernmental transfers. Commenters recommended that we review the statute and revise the regulation to clarify the treatment of intergovernmental transfers. Specifically, commenters requested that we clarify § 433.56 (which defines the separate classes of health care services and providers for purposes of imposing health care-related taxes) to make a State responsible only for taxes and donations received by political subdivisions that, through intergovernmental transfers, contribute to the State's general fund.

Response: These regulations do not interfere with the State's use of intergovernmental transfers unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share of Medicaid.

Comment: One commenter indicated that we should not attempt to dictate how each State should use their hospital tax levies.

Response: We do not agree that we are attempting to dictate States' use of hospital tax levies. The regulatory requirements address only the consequences on FFP, as delineated in the statute, when States receive provider-related donations and/or health care-related taxes. We believe the statute is consistent with our longstanding policy encouraging State flexibility in administering the Medicaid program. We do not want to dictate to States the permissible uses of particular dollars. The only statutory provision indirectly related to the use of health care-related tax revenue is in section 1903(w)(4) of the Act, which 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. This section of the statute also provides that States are not precluded from using a tax to reimburse health care providers for medical assistance expenditures, or precluded from relying on this reimbursement to justify or explain the tax. In our view, we believe States may use revenue from otherwise permissible taxes to increase payment rates to the providers subject to the tax. However, States may not make Medicaid or other payments to providers that result in taxpayers being repaid dollar (or part of a dollar)-for-dollar for their tax costs.

Comment: Numerous commenters indicated that we incorrectly explained in the preamble of the interim final rule that the statutory provisions apply to all provider donations and taxes regardless of the use of the funds. Several other commenters indicated a range of general opinions about the regulation, ranging from those who thought it too expansive to those who found it too restrictive. Many of these comments recommended that we revise the rule to remove its regulatory authority over provider donations and taxes unrelated to Medicaid and give consideration to unique circumstances in each State, particularly when revenue from provider donation and tax programs is used to expand, not supplant, Medicaid. Others indicated that we do not have the authority through this regulatory policy to constrain States' non-Medicaid funding programs solely on the basis that health care providers participate in a program.

Response: We acknowledge that the interim final rule contains several technical provisions. However, we believe that the statute is clear regarding the applicability of its provisions and that the interim final rule does not create an inconsistent regulatory policy. Under section 1903(w) of the Act, effective January 1, 1992, a reduction in FFP will occur if a State either receives provider-related donations made by or on behalf of health care providers that are not bona fide or meet outstationed eligibility worker donation requirements (as specified in the law), or receives health care-related taxes that are not broad based or uniformly imposed, or that hold taxpayers harmless for their tax costs. Nowhere does the statute restrict its applicability to the Medicaid program nor is the designated use of this type of revenue addressed. Further, the use of provider-related donations and health care-related taxes to fund State-operated programs is protected to the extent that the technical requirements of the law are met.

Comment: One commenter indicated that the financial obligation to provide for those who cannot afford their own medical care should be spread as widely and as equitably as possible and not placed solely on one small segment of the community—that is, health care providers.

Response: Nothing in the law or the interim final rule was intended to encourage or sanction taxes on health care providers. Rather, the provisions of the law and implementing regulations merely stipulate the rules governing the availability of FFP when States impose such taxes.

Comment: One commenter indicated that § 433.58(g)(2)(ii) (which specifies that a State may not modify health care-related taxes in existence as of November 22, 1991, without a reduction of FFP, unless the modification only makes technical changes that do not alter the rate of the tax or the base of the tax and do not otherwise increase the proceeds of the tax) prohibits States from modifying its tax base during the transition period and precludes a State from coming into compliance by expanding a tax to all hospitals.

Response: Section 433.58(g)(2)(ii) is intended to provide guidance to States on the allowable changes to impermissible tax programs that would not result in a reduction of FFP. We agree that, as written, the regulatory section could be misconstrued. Therefore, we have modified this section by adding subsection (iv) which now explicitly specifies that modifications necessary to bring an impermissible tax program into compliance with the provisions of the statute will be permissible without a reduction of FFP.

Comment: One commenter asked that the cap on health care-related taxes be based on the best available data, including taxes and donations, as of State fiscal year 1992.

Response: Section 1903(w)(5)(C) (i) and (ii) of the Act (codified at § 433.60) specifies the requirements for the computation of the State base percentage during the State's transition period. Specifically, this provision of the law requires that when computing the State base percentage, the total amount of health care-related taxes must be determined based only on those taxes that were in effect, or for which legislation or regulations imposing such taxes were enacted, as of November 22, 1991. Further, in the case of a tax that is not in effect for the entire State fiscal year 1992, the law requires that the amount of the tax must be projected as

if the tax were in effect for the entire year. With regard to donations, the law explicitly provides that the amount of provider-related donations must be determined based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date. Further, section 1903(w)(5) of the Act stipulates that the amount of provider-related donations and health care-related taxes applicable to State fiscal year 1992 will be determined based on the best available data as of the enactment of the law. Therefore, any change in the computation requirements must be accomplished through legislation, not regulation.

Comment: One commenter strongly supports the continuation of the limitation on provider taxes after October 1, 1995.

Response: Section 1903(w)(1)(A)(iv) of the Act (codified at § 433.70(a)(2)) specifies the time periods governing the limitations applicable to the receipt of health care-related taxes. Consequently, any extension of the applicable limits must be accomplished through legislation, not regulation.

Comment: One commenter recommended that we implement the regulation prospectively.

Response: Section 2(c)(1) of Public Law 102–234 requires that the provisions of this law be effective January 1, 1992, without regard to whether or not regulations are promulgated. To delay implementation of this rule by applying it prospectively would be in direct violation of the law. However, when the regulations impose new requirements, such as the hold harmless provisions, we have extended the deadline for compliance.

Comment: Several commenters requested that States that enacted new tax programs be given adequate time to revise such programs, without penalty, to comply with the law. Further, the commenters recommended that the length of the "grace period" be contingent on factors such as whether the State legislatures would need to revise these programs and when these legislatures will be in session.

Response: To accommodate States, we have extended the deadline for compliance of the hold harmless requirements to [30 days after publication date of this final rule]. We do not believe an additional grace period is necessary, since we have made minimal changes to the hold harmless provisions and States have been on notice of these requirements since the publication of the interim final rule on November 24, 1992.

Comment: One commenter suggested that compliance reviews be done on a State-by-State basis, and that three criteria be used to determine cases where a State law may not comply with the new requirements: (1) The reasonableness of the difference in interpretation of the law occurring between two parties; (2) the impact on a State's health care system if a retroactive denial occurs; and (3) the overall impact on the State's fiscal solvency and provision of general services to their citizens. The commenter further recommended that FFP not be withheld until the first quarter beginning after the end of the State legislative session following the publication of the final rule.

Response: The statute precludes implementation of the recommended review criteria or disallowance date. Moreover, we do not agree that compliance reviews should be done on the merits of individual State circumstances. Such reviews would be labor-intensive and administratively burdensome. The results of such reviews would be subjective and weaken the consistency and continuity in the national administration of the law.

Comment: One commenter requested that we make clear that no attempt will be made to disallow claims for FFP or adjust claimed expenditures because they were offset by withheld taxes where the withholding was not applicable in any quarter in which the State was not officially on notice at the outset of the quarter of HCFA's policies.

Response: We do not agree that the scope of these regulations applies to the operational aspects of withheld taxes. To the extent that the voluntary withholding of the tax is reported as the provider's income to the Internal Revenue Service (IRS) on Form 1099–MISC, and the IRS recognizes the full amount of the reported payment as income to the provider, the voluntary withholding of the tax amount would be permissible.

Comment: One commenter believes that States should be given the flexibility to raise funds from providers to administer a reasonable indigent care and Medicaid disproportionate share hospital (DSH) program without having to financially penalize non-Medicaid hospitals or hospitals whose indigent care/Medicaid levels do not reach the highest thresholds.

Response: In accordance with section 1903(w) of the Act, we intentionally described in the interim final rule how a State's expenditure for medical assistance is calculated when a State receives provider-related donations and/or health care-related taxes. We believe that neither the statute nor the interim final rule impairs a State's flexibility to raise funds from providers to administer either State or Federal health care programs.

Comment: One commenter indicated that the rules limit a State's ability to generate revenue, and that the effect of these rules limits a State's taxing authority. Another commenter indicated that the evaluation of State tax programs by HCFA sets a dangerous precedent by allowing a Federal agency a significant degree of control over State government funding.

Response: Neither the statute nor interim final rule limits a State's flexibility to impose health care-related taxes or other mandatory payments. Rather, the regulations address only the consequences on FFP when a State receives revenues from donations and health care-related taxes.

Comment: Numerous commenters expressed concern over our authority to reduce FFP for all impermissible donations and taxes. These commenters believed that we are assuming oversight of individual State's rights and that this policy interferes with each State's rights of taxation.

Response: As mentioned previously in this preamble, nothing in the statute limits a State's flexibility to impose health care-related taxes. Further, section 1903(w)(1)(A) of the Act is clear that the total amount expended by a State during a fiscal year as medical assistance will be reduced by the sum of any revenues received by the State or unit of local government in the State from either impermissible provider-related donations or impermissible health care-related taxes.

2. General Definitions (§ 433.52)

Comment: One commenter recommended that the definition of *entity related to a health care provider* exclude a supplier of health care items or services or a supplier to providers of health care items or services since a supplier cannot reasonably be considered "similar" in nature or kind to the close relationship that exists among corporate affiliates, common owners, or employees/spouses/siblings.

Response: We are concerned that if this category is not added, suppliers will have the power to donate money to the State and charge providers for this donation via the sale of supplies. Such a maneuver would be contrary to the intent of Public Law 102–234. Therefore, we have not revised the definition.

3. Bona Fide Donations (§ 433.54)

Comment: Two commenters suggested that the thresholds for presuming that a donation is bona fide—$5,000 for individuals and $50,000 for organizations—be indexed or periodically reviewed to ensure that they remain reasonable in light of current realities.

Response: We do not agree that the thresholds should be adjusted annually for inflation. The presumption of a bona fide donation threshold was established to minimize the administrative burden on the States and HCFA and to detect and effectively control any potential abusive situations. We believe the established thresholds are at a sufficient level to meet these objectives. If subsequent experience indicates a need for revisions of these thresholds, we will consider subsequent rulemaking to make appropriate revisions.

Comment: One commenter expressed concern that the operational definition of a bona fide donation is overly restrictive and prohibits legitimate donations that pose no significant financial risk to the Federal Government.

Response: Nothing in the interim final rule would in any way limit philanthropic provider donations. Moreover, the interim final rule does not preclude health care providers from making donations to Medicaid or other State programs as long as the requirements of the law are met. In the interim final rule, we exercised our authority to specify the types of provider-related donations that will be considered to be bona fide provider-related donations. In making this determination, we attempted to strike a meaningful balance between the explicit statutory provisions applicable to bona fide donations and those donations that can be presumed to be bona fide assuming a hold harmless practice does not exist.

Comment: One commenter suggested that a reasonable limitation on bona fide donations would be to establish a limit on any and all donations up to a maximum aggregate amount equal to 10-percent of the State's total Medicaid administrative expenditures.

Response: The statute neither imposes nor supports limits on the amount of bona fide provider-related donations a State may receive. To impose such limitations would be restrictive to States and would violate the provisions of the law.

Comment: Two commenters suggested that we broaden the definition of a bona fide donation to include donations from charitable organizations made to the State through health care providers, as long as the provider certifies that the source of the donation is bona fide as defined in the regulations.

Response: The statutory provisions of Public Law 102–234 do not apply to the treatment of donations from non-provider entities (that is, charitable organizations not related to providers). Further, both the statute and the interim final rule already sanction donations from health care providers regardless of the source of the funds when such donations satisfy the requirements of a bona fide donation. There is, however, no statutory authority that would permit health care providers to designate the source of the donated funds for purposes of satisfying the bona fide donation criteria.

4. Outstationed Eligibility Workers (§§ 433.58(d)(2) and 433.66(b)(2))

Comment: One commenter suggested that the regulations be amended to provide States flexibility in designing Medicaid eligibility outreach projects financed, in part, with provider donations to cover State administrative costs.

Response: The statutory provisions applicable to the permissible donations for the administrative costs of outstationed eligibility workers are explicit. Section 1903(w)(2)(C) of the Act is applicable to the direct costs of outstationed eligibility workers and does not include donations for outreach projects. However, nothing in this rule precludes States from receiving bona fide provider-related donations.

Comment: Two commenters requested that the rule be amended to make clear that the prorated costs of outreach activities (such as advertising campaigns) are allowable in the 10-percent cap on direct costs. Another commenter indicated that the rule needs clarification to allow for additional direct costs of outstationed eligibility workers not currently listed in the regulation.

One commenter indicated that outreach activities covers more than just activities applicable to the outstationed (State or local) workers at these sites. Therefore, the regulation should be revised to acknowledge more permissible outreach activities that are not directly tied to eligibility activities of the State or local staff. Specifically, section 1902(a)(55) of the Act directs States to provide receipt and initial processing of applications for medical assistance eligibility at locations other than those (welfare offices) used for receipt and processing of applications for Aid for Families with Dependent Children.

Response: We agree that the prorated costs of outreach activities should be allowable in the 10-percent cap. Therefore, we have modified §§ 433.58(d)(2) and 433.66(b)(2) of the regulations to reflect that prorated costs of all outreach activities applicable to the outstationed workers at these sites—not just pamphlets and materials distributed by the outstationed workers—are part of the costs of outstationed eligibility workers and are, therefore, applicable to the 10-percent cap. In addition, we have removed advertising campaigns as a disallowed cost because it is considered an outreach activity.

We also agree that outreach activities include more than just activities applicable to the outstationed (State or local) workers. However, because the law specifically addresses permissible provider donations only for the direct costs of State or local outstationed eligibility workers, we are not making further modifications, other than those described in the previous paragraph, to these regulations.

5. Health Care-Related Taxes Defined (§ 433.55)

Comment: Several commenters indicated that a health care-related tax subject to the provisions of Public Law 102–234 should include only those taxes that were specifically designed to raise revenue for the State's Medicaid program. Two commenters further indicated that a tax specifically used to improve State-funded health care delivery systems should not be subject to the provisions of Public Law 102–234.

Response: We believe the statute is explicit as to the kinds of taxes that are subject to the requirements of Public Law 102–234. Section 1903(w)(3)(A) of the Act defines a health care-related tax as a tax that is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals. The statute does not give the Secretary the authority to provide exceptions to the statutory definition of a health care-related tax.

Comment: Two commenters indicated that licensing fees should not be deemed health care related. Several commenters believed that the regulations should be clarified to specify that discretionary assessments (such as certificates of need or State-supported mortgage loan applications),

Clinical Laboratories Improvement Amendments (CLIA) fees, and Federally mandated rebates that States collect from pharmaceutical manufacturers (including parallel State rebating programs) are not health care-related taxes and, therefore, do not count toward the State's cap.

Response: Section 1903(w)(7)(F) of the Act specifies that the term "tax" includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment). This includes certificates of need and State-supported mortgage loan applications. If these fees are imposed across the board, they will probably not meet the 85-percent health care-related test.

We recognize that CLIA and Federally mandated drug rebate programs are Federally controlled programs. Therefore, we want to make clear that all Federally mandated assessments, taxes, or fees are not subject to the provisions of Public Law 102–234. However, fees associated with State-only programs, enacted in lieu of CLIA or other Federal programs, are subject to the provisions of Public Law 102–234.

Comment: One commenter indicated that the definition of health care related should be clarified so that only licensing and certification fees for health care providers who participate in the Medicaid program be subject to the statute.

Response: Section 1903(w)(1)(A)(ii) of the Act makes it clear that all health care-related taxes that are not broad based will be subject to the provisions of this law, regardless of whether the provider participates in the Medicaid program.

Comment: One commenter indicated that § 433.55(c) (which specifies that a tax is considered to be health care related if it is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to other individuals or entities) should be revised to specify that when determining if the treatment of a tax applicable to health care providers is different from the treatment of other taxpayers, HCFA will only take into account any State credits or rebates that are explicitly stated in the law related to any of the payers of the tax.

Response: Providing credits and/or rebates that are explicitly stated in the law is not the only method a State can use when targeting the tax to health care providers. For example, a State could provide a tax on a unit that is more prevalent in a health care provider setting (such as a tax on bedpans). A tax on a health care-related unit would automatically provide for unequal treatment of health care individuals or entities subject to the tax.

Comment: One commenter believed that our interpretation that a tax that is applied at a different rate on health care providers and non-health care providers may be health care related is not consistent with statutory intent.

Response: This portion of our regulatory definition of health care-related taxes is directly supported by section 1903(w)(3)(A)(ii) of the Act, which specifies that a health care-related tax includes a tax not limited to health care items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities. An example of this type of unequal treatment is a tax on non-health care providers at a different rate than a tax on health care providers.

Comment: One commenter indicated that the 85-percent test, whereby a tax is considered to be related to health care items or services if at least 85 percent of the burden of the tax falls on health care providers, will allow States to dilute a health care tax by renaming existing taxes.

Response: Section 1903(w)(3)(A) of the Act defines a health care-related tax as a tax that is (i) related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or (ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals. The statutory language further points out that in applying clause (i), a tax is considered to be related to health care items or services if at least 85 percent of the burden of such tax falls on health care providers. The remaining portion of section 1903(w)(3)(A) of the Act further distinguishes a health care-related tax as one that is not limited to health care providers but treat health care providers differently. This portion of the statute is not subject to the 85-percent test. We believe section 1903(w)(3)(A)(ii) prevents the State from implementing a tax that may be masked by an existing non-health care-related tax. However, a State can add health care providers to an already existing non-health care-related tax without penalty as long as it meets the 85-percent test.

Comment: One commenter indicated that the regulation goes beyond the statute by limiting the 85-percent test only to health care-related taxes related to health care items or services (§ 433.55(a)(1)). The commenter believed the 85-percent test should also apply to health care-related taxes related to the provision of, or the authority to provide, the health care items or services (§ 433.55(a)(2)) and the payment for the health care items or services (§ 433.55(a)(3)).

Response: Section 1903(w)(3)(A) of the Act specifies that in applying clause (i) (which defines a health care-related tax as a tax that is related to health care items or services, or to the provision of, the authority to provide, or payment for, the health care items or services), a tax is considered to be related to health care items or services if at least 85 percent of the burden of such tax falls on health care providers. The statute does not address how the tax should be considered when it is related to the provision of, or the authority to provide the health care items or services (§ 433.55(a)(2)) or the payment for the health care items or services (§ 433.55(a)(3)).

Comment: One commenter suggested that the term "revenue" be deleted from § 433.55(b), which states that a tax will be considered to be related to health care items or services if at least 85 percent of the burden of the tax revenue falls on health care providers.

Response: The significance of the term revenue in this paragraph is that revenue is the only equitable measure when applying the 85-percent health care related rule in the statute. Therefore, we have not modified the regulation.

Comment: One commenter indicated that the scope of the regulation, as written, is not limited only to the review of public programs involving health care providers but applies to public programs affecting the payers of health care—patients and insurers. The commenter did not believe HCFA has the authority to do this.

Response: Section 1903(w)(3)(A) of the Act specifies that a health care-related tax is a tax that is related to health care items or services or to the provision of, the authority to provide, or payment for, such items or services. Therefore, the statute provides that a tax on health care payments made by payers (that is, insurance payers or patients) is subject to Public Law 102–234 and the implementing Federal regulations.

6. Classes of Health Care Services and Providers Defined (§ 433.56)

Comment: Several commenters wanted us to expand the classes already listed in the statute and our regulations to include additional classes or State defined classes. Commenters had various suggestions for permissible health care classes, including allowing States to recognize their own health care classes, recognizing all licensed providers of Medicaid services, and recognizing all licensed providers in a State. Further suggestions included incorporating permissible classes as identified in the State plan or Federal law as long as the aggregate Medicaid utilization or revenue within the class is no greater than 90 percent, or extending a permissible tax that is also applicable to one or more of the classes listed in the statute. In the latter case, the terms of the tax on the additional categories of providers would have to be the same as those applicable to a statutorily named class, and the tax would have to cover the entire new category in the same manner as its coverage of the statutorily named class.

Response: We have revised § 433.56 to include 10 additional health care classes based on recommendations received by the commenters. These additional classes provide States further flexibility when imposing health care-related taxes.

Comment: One commenter recommended that additional classes may permit States to adopt narrowly focused, rather than broad-based, health care-related taxes in direct contravention of Congressional intent. This commenter found that those health care classes not represented by lobbyists were at the highest risk of being subject to the tax. Small classes that would be affected are nurses, optometrists, social workers, physical therapists, etc. Accordingly, the commenter requested that § 433.56(a)(9) (which provides for other health care items or services not specified in the regulation on which the State has enacted a licensing or certification fee, subject to certain requirements) be revised to apply when at least three of the other classes specified in the regulation are also subject to the tax.

Response: Neither the statute nor the regulations preclude a State from taxing more than one class of health care items or services of providers. The statute allows the States a certain degree of flexibility in determining which providers will be taxed.

Comment: One commenter requested that we clarify in the regulations whether a tax imposed on inpatient hospital services would need to cover revenues or activities of hospitals not related to inpatient hospital services (such as a separate wing certified as a nursing facility) to be broad based. The commenter believed that such a policy would conflict with both the statute and the regulations, both of which list hospitals and nursing facilities as separate classes.

Response: The commenter is correct that both section 1903(w)(7)(A) of the Act and § 433.56 list inpatient hospital services and nursing facility services as separate classes. In addition, we note that the statute and the regulations clearly state that a tax is imposed on the services of providers—not on the providers themselves. Since the class definition is determined by the type of service provided, only the revenues or activities of the provider pertaining to that class of service need be covered by the tax. Therefore, if a hospital has a separate wing that provides nursing facility services, these services would not be subject to an inpatient hospital services tax because nursing facility services is a separate class. Moreover, if there is a tax on all hospital services, including nursing facility services provided in the hospital, we would consider the tax on inpatient hospital services separate from the tax on nursing facility services.

Comment: One commenter indicated that the regulations are not clear in the instance where a provider falls into more than one class of services. This commenter believes a more explicit exemption from the hospital services class should be added to address the situation where services are provided by a facility that is owned and operated by a health maintenance organization (HMO). Several commenters were concerned that a State could unfairly tax a health care provider twice by imposing a separate tax on two provider classes. For example, a State could tax HMO services and inpatient hospital services, resulting in an unfair tax on hospitals that provide HMO services. One commenter suggested that the State have the discretion to choose which class a tax would fall under (HMO or inpatient hospital service). Another commenter suggested that we specify in the regulation that the HMO services class apply to "services of HMOs not otherwise taxed" to ensure an equitable interpretation of the law.

Response: While the regulations specify classes that can be taxed, the regulations cannot interfere with the State's authority to impose taxes on one or more of the providers or prohibit a State from taxing a provider that would fall under two classes. However, we will consider a tax to be broad based when the tax is imposed on all inpatient hospital services, with the exclusion for HMO owned and operated hospitals if the HMO services are also being taxed. However, if HMO services are not being taxed, the tax on inpatient hospital services would not be broad based unless it is imposed on all hospital services, including HMO inpatient hospital services.

Comment: Three commenters suggested that we grandfather in provider classes that had been subject to such tax programs prior to the implementation of Public Law 102–234. More specifically, the commenters suggested that all services that had been operating under an approved program as of January 1, 1992 (or November 22, 1991) should be grandfathered into an approved provider list. Two commenters suggested that we amend the regulations to grandfather in all existing licensing fees regardless of whether the fee exceeds the cost of operating the licensing or certification program.

Response: Section 1903(w)(1)(C)(ii) of the Act provided for a transition period during which, under certain circumstances, States may receive, without a reduction in FFP, revenues from impermissible health care-related tax programs in effect prior to the enactment of Public Law 102–234. We believe that the transition period provision in section 1903(w)(1)(C)(ii) afforded States ample opportunity to correct any licensing fees or provider classes that did not comport with the requirements of Public Law 102–234. Since licensing and certification was a new class, not listed in the statute, we felt a fiscal responsibility to limit these fees to the cost of operating the program.

Comment: Several commenters indicated that they did not believe the new licensing fee class should be added because it exceeds Federal intent. These commenters also believed that the Secretary does not have the authority to create such qualifying conditions. One commenter indicated that the provision in § 433.56(a)(9)(iii) (which specifies that for all health items or services in which the State has enacted a licensing or certification fee, the aggregate amount of the fee cannot exceed the State's estimated cost of operating these programs) would introduce considerable administrative burden for States.

Response: Section 1903(w)(7)(F) of the Act specifies that the term "tax" includes any licensing fee, assessment, or other mandatory payment. Several States asserted that a licensing fee is most likely broad based, and that the revenue generated from the fee is paying

for the administration of the licensing program for the provider on whom the fee is imposed, not for Medicaid services. Therefore, we added to the list of permissible health care classes in the interim final regulations licensing fees that apply to items and services not otherwise listed. This change clarifies that the application of a broad-based and uniform licensing fee on providers of items and services not otherwise listed in the statute is a permissible health care-related tax as long as the revenue generated from the licensing fee does not exceed the estimated costs of operating the licensing program. We believe these conditions are an appropriate exercise of our statutory authority to add additional classes.

Comment: Several commenters indicated that the definition of inpatient hospital services that we presented in the preamble of the interim final rule is not correct. (In that definition, we noted that inpatient hospital services includes all services defined as inpatient hospital services, such as inpatient psychiatric services.) The commenters noted that in both section 1905(a) of the Act and in the Federal Medicaid regulations at § 440.10, inpatient hospital services specifically excludes services furnished in free-standing psychiatric hospitals (referred to under Medicaid as institutions for the mental diseases (IMDs)).

Two commenters requested that the regulations be clarified to state that psychiatric hospital services are included in the inpatient hospital services class. One commenter recommended that the classes be expanded to include psychiatric hospitals, hospitals owned by HMOs, and hospitals that do not charge for care.

Response: We believe inpatient hospital services encompass all services provided in an inpatient hospital setting, including psychiatric services. Consequently, we believe psychiatric hospital services need not be listed as a specific inpatient hospital service. However, we have revised the regulations to add psychiatric hospitals as a favorable exception under the waiver standards for the broad-based and uniform requirements in §§ 433.68(e)(1) and (e)(2).

Comment: A few commenters suggested limits that could be applied to the licensure fee class. The suggestions included limiting the applicability of the regulation to only licensing and certification fees imposed by the State, not local governments, or limiting the applicability to only those fees imposed as a general purpose, revenue-generating mechanism. One commenter recommended that we add a threshold standard (for example $1,000) for licensing fees, below which fees would be deemed to satisfy the statutory requirements.

Response: We have revised the broad-based requirements in § 433.68(c)(3) to allow automatic approval of a waiver when a licensing fee that is not uniformly applied to all providers in a class is under $1,000 annually and the total amount raised by the State from the fee is used in the administration of the licensing or certification program.

Comment: One commenter requested guidance concerning what is considered a licensing fee and questioned if it included initial application fees, examination fees, and reciprocal licensing fees, or only annual, biannual or triennial renewal fees. The commenter also questioned whether licensing fees of athletic trainers, or funeral directors are health care related.

Response: Any mandatory payment by a health care provider associated with the cost of operating the licensing program is considered a licensing fee. Social workers who provide medical or remedial care services in a health care setting would be considered a provider of health care services for the licensing fee class. Since most athletic trainers and funeral directors provide services outside the clinical setting, these groups would not be considered health care related.

Comment: One commenter suggested that the test covering the cost of the licensing program be applied in the aggregate—that is, the test would be met as long as the fees in the aggregate do not exceed aggregate costs of licensing for all licensed groups. Two commenters recommended deleting the test altogether.

Response: We believe that a test in the aggregate does not follow the intent of the statute because such a test would permit States to target Medicaid providers through the licensing fee process.

Comment: One commenter believed that the exclusive list of classes contained in the regulations is too restrictive. This commenter believed that the restrictive definition of classes is inconsistent with the DSH statute's considerable leeway afforded to States in their designation of hospitals to receive DSH payments.

Response: Based on numerous comments concerning the statute's limited list of classes, we have expanded the list of classes in the final regulations. However, we are unclear as to the correlation made by the commenter between the limited list of classes contained in the statute and regulations and the State's limited ability to define hospitals eligible for DSH payments. The State will still have the flexibility to define hospitals as DSH facilities under the eligibility criteria at section 1923 of the Social Security Act.

Comment: Two commenters recommended that we establish an approval process for those States that wish to tax providers in classes not specified in the statute.

Response: We have revised § 433.56 to include 10 additional health care classes based on recommendations received by the commenters. Also, the Secretary will consider adding additional classes if States can demonstrate the need for additional designations and that any class of classes proposed for addition meets the following criteria:

- 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);
- The class must be clearly identifiable, such as through designation for State licensing purposes, recognition for Federal statutory purposes, or being included as a provider in State plans; and
- The class must be nationally recognized and not be unique to a State.

7. Permissible Health Care-Related Taxes (§ 433.68)

a. General Rule (§ 433.68(a))

Comment: One commenter believes the restrictions on the receipt of tax revenue after a State's transition period ends places severe hardship on States.

Response: In accordance with section 1903(w)(1)(D)(ii) of the Act (codified at § 433.68(a)), the amount of impermissible tax revenue a State may collect during its transition period in State fiscal year 1993 is limited to the amount received, not the amount levied, for that period. Consequently, a reduction in FFP will occur if impermissible tax revenue levied for the transition period is received by the State after that date. Contingent upon the design of a State's tax program and the State's ability to comply with the provisions of Public Law 102–234, a State could experience some degree of difficulty. However, this law was enacted in December 1991 and the statute permitted all States using provider taxes enacted prior to November 22, 1991, to continue such a program through at least September 30, 1992. The purpose of the transition period was to afford States sufficient time to replace health care-related tax and provider-related donation programs

that do not meet the requirements of the law with permissible programs. Therefore, we believe the statute was designed to minimize financial hardship that States could incur.

b. Broad Based and Uniformity Requirements (§§ 433.68(c) and (d))

Comment: Several commenters believed it was not necessary that a uniform tax be applied as a single rate (as specified in § 433.68(d)(1)(i)) provided that a multiple tax rate structure (progressive/regressive) is applied in a consistent and uniform manner or a consistent formula is applied to all providers in the class. These commenters believed that a measure of "generally redistributive" may be better met with a tax using some sliding rate scale. Furthermore, one commenter indicated that we should provide additional guidance as to which types of taxes would fall within the catchall category under § 433.68(d)(1)(iv) (which provides for additional taxes on items or services to be considered as uniformly imposed if the State establishes to the Secretary's satisfaction that the amount of the tax is the same for each provider of such items or services in a class).

Response: Public Law 102–234 requires that a tax be applied as a single rate or amount per provider in order for it to be considered uniform. Section 433.68(d)(1)(iv) provides States with the opportunity to demonstrate through the waiver process that a tax using a consistent formula or a regressive/progressive tax can be more redistributive than one that meets the uniformity requirements under § 433.68(d)(1)(i) through (d)(1)(iii).

Comment: One commenter indicated that a tax that is broad based in one State may not be broad based in another State since some States will have more Medicaid providers to be taxed.

Response: The law does not address a provider who provides services solely to Medicaid recipients. We believe the majority of "Medicaid" providers are "Medicaid" providers for only a portion of their practices. Furthermore, we strongly question whether there are existing providers that furnish services only to Medicaid recipients. The law, however, does allow for the exclusion of Medicaid revenues from a tax. Therefore, services furnished by providers under the Medicaid program may be excluded from a tax and the tax would still be considered uniform if those services were the only excluded services.

Comment: One commenter stated that States should be allowed to exempt non-Federal, public organizations when determining if a tax is broad based. The commenter believed that this would be consistent with the existing provision in § 433.68(c)(1), which specifies that 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. This commenter believed that it is administratively pointless for the State to tax revenues from its own programs. Several commenters indicated that in addition to excluding Medicaid and Medicare revenue from the tax, States should be allowed to exclude providers who do not charge for services and providers that lack sufficient revenues to pay the tax.

Response: Section 433.68(c)(1) of our regulations is based on section 1903(w)(3)(B) of the Act, which specifies that a tax is broad based when it is imposed with respect to all items or services in the class furnished by all non-Federal, non-public providers in the State or is imposed with respect to all non-Federal, non-public providers in the class. Therefore, we are bound by the statute to retain this requirement in our regulations. In addition, the statute does not give the Secretary the authority to exclude providers from a broad-based tax except under a waiver in accordance with section 1903(w)(3)(E) of the Act.

Comment: One commenter requested clarification of whether a tax on gross revenues that exempts revenues paid to providers by a State program fails to meet the uniformity requirements.

Response: The regulations allow States to provide specific exclusions as long as the tax is found to be generally redistributive in accordance with the waiver requirements in § 433.68(e). Until the State can make this demonstration, the statute provides that expenditures are reduced by the amount of bad taxes collected.

Comment: One commenter believed we should establish a presumption that gross revenue taxes that exempt revenues from Medicaid and Medicare are permissible, even if they do not meet all of the remaining technical requirements of the law.

Response: Section 1903(w)(1)(A)(iii) of the Act specifies that a tax is not permissible, regardless of its exclusions of Medicare or Medicaid revenue, when a hold harmless practice exists. This section further indicates that a tax is not eligible for Federal matching when there is in effect a hold harmless provision with respect to a broad-based health care-related tax. However, a tax that excluded only Medicaid or Medicare would still meet the uniformity standards.

Comment: One commenter stated that we should clarify in the regulations that States may impose health care-related taxes that contain exemptions, credits, deductions, or exclusions without first going through the waiver process. The commenter acknowledged that if a State does not proceed without first seeking a waiver, it takes the risk that the Secretary will challenge its exemption, credit, deduction, or exclusion.

Response: While it is permissible for the State to implement the tax prior to the approval of its waiver, it is to the State's advantage to submit its waiver request prior to the implementation of its tax.

Comment: One commenter indicated that the definition of uniform tax in § 433.68(d) should be illustrative and not restrictive. Furthermore, the commenter did not believe that an admissions tax requires the Secretary's approval.

Response: Section 1903(w)(3)(C) of the Act provides a precise definition of a uniform tax. Under this section, there are three specific types of taxes defined as uniform. The statute also allows for a fourth category of other types of uniform taxes if approved by the Secretary. Moreover, the items specified in the statute are exclusive, not merely illustrative.

Comment: One commenter believed that it is more appropriate to interpret "net operating revenue" (as defined in the uniformity requirements in § 433.68(d)(1)(iii)) to mean "operating margin" because it is a commonly used interpretation of the term, and the alternative definition in the rule makes the term "net operating revenue" redundant with "receipt." The commenter further believed that even if "net operating revenue" is not interpreted to specifically mean "operating margin," operating margin is sufficiently related as an accounting concept to gross revenues and gross receipts that to interpret this more inclusively to include operating margin as an acceptable tax base for a uniform tax would be consistent with the statute. Therefore, we should clarify in the rule that a tax on operating margins of providers may be a broad-based tax.

Response: Operating margin is not synonymous with net operating revenue. In accordance with Medicare cost finding principles, operating margin reflects a provider's revenues after such revenues are reduced by expenses. On the other hand, net operating revenue is defined in § 433.68(d)(1)(iii) as gross charges of

facilities, less any amounts for bad debts, charity care, and payer discounts. Gross charges and gross receipts are not reduced by expenses to determine net operating revenue. The statute recognizes a tax on net operating revenue as a uniform tax. However, it does not do so with respect to net operating margins, which is an entirely different accounting concept.

c. Generally Redistributive (§ 433.68(e))

Comment: One commenter suggested we define the term "generally redistributive".

Response: As stated in the preamble in the November 24 interim final rule, our definition of "generally redistributive" is the tendency of a State's tax and payment program to derive revenues from taxes imposed on non-Medicaid services in a class and to use these revenues as the State's share of Medicaid payments.

Comment: Several commenters indicated that the 95 percent generally redistributive test is too restrictive. These commenters proposed a variety of numerical thresholds that were lower than 95 percent.

Response: Section 1903(w)(1)(A)(ii) of the Act specifies that for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan shall be reduced by the sum of any revenues received by the State during the fiscal year from health care-related taxes other than broad-based health care-related taxes. The purpose of this provision was to preclude the use of revenues derived from taxes imposed primarily on Medicaid providers and activities. However, to relieve the restrictive nature of this provision, we believed it was necessary to adopt an alternative for States enacting taxes that were not broad based. Based on Federal review and analysis, we believe the 95-percent test allows States a reasonable degree of flexibility to receive FFP for a tax that is otherwise not broad based or uniform, while continuing to maintain the intent of the statute. However, we have revised the P1/P2 value at § 433.68(e)(1)(iii) to 0.90 for taxes enacted and in effect prior to July 1, 1993.

Comment: Several commenters indicated that we should allow States greater flexibility for waiver requests of the broad-based and uniform requirements. One commenter indicated that we should revise the regulations to remove regulatory authority over provider-related donations and health care-related taxes unrelated to Medicaid to allow this greater flexibility. Some commenters suggested policy-based arguments as an alternative to "statistical" thresholds.

Response: We believe that, as a part of the broad-based and uniform waiver test, health care-related taxes as a whole are an integral part in determining the amount of burden the tax has on Medicaid. We also believe that policy-based arguments do not allow for a reasonable test of the broad-based and uniform requirements. If we allowed a policy-based argument, we would have no specific standards by which a waiver of these requirements could be measured. This subjective analysis would be administratively burdensome and virtually impossible to apply fairly throughout the nation.

Comment: Several commenters requested expansion of the list of providers of items and services excluded in the uniformity waiver if the value of B1/B2 is at least equal to .95 but not greater than 1.

Response: The regulations have been revised to include additional classes of providers of items and services that can be excluded under the uniformity waiver test.

Comment: One commenter indicated that the waiver requirements in § 433.68 (e)(1) and (e)(2) are too restrictive in relation to exemptions for sole community and rural hospitals. This commenter believed that waivers of the broad-based and uniformity provisions should automatically be approved without an additional mathematical test.

Response: The purpose of these requirements is to ensure that the tax burden does not shift to Medicaid by the waiver. We believe that the mathematical tests allow specific standards by which the appropriateness of a waiver of these requirements can be measured.

Comment: A few commenters indicated that the waiver process should be timely and States should be given appropriate guidance in providing adequate information for evaluating the waiver request. Other commenters indicated that a time period should be specified for HCFA to approve a waiver request of the broad-based and uniform requirements.

Response: The statute does not mandate a specified time period for us to approve a waiver of the broad-based and uniformity requirements. Due to the complexity of the tests and the amount of data involved, we did not establish a specified time period. We will, however, review waivers in an expeditious manner and welcome any State questions concerning waivers of the broad-based and uniformity requirements for health care-related tax programs.

Comment: A few commenters indicated that by establishing the threshold of the P1/P2 test at 1, the waiver provisions in § 433.68(e)(1) will allow most taxes that are not broad based to be considered generally redistributive only if such tax is more redistributive than a tax that is applied to all such providers in a class.

Response: We have revised the generally redistributive test to indicate that if the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 1, HCFA will automatically approve the waiver.

Comment: A few commenters indicated that the five specified categories of exceptions under the generally redistributive test in § 433.68(e) should be deleted. These commenters also stated that a waiver should be approved if a State can show a particular exception is consistent with public policy.

Response: If we allowed a policy-based argument, we would have no specific standards by which a waiver of these requirements could be measured. This subjective analysis would be administratively burdensome and virtually impossible to apply fairly throughout the nation.

Comment: A few commenters indicated that we should informally review and provide guidance concerning waivers of the broad-based and uniformity requirements on health care-related taxes that are proposed but not yet enacted.

Response: We welcome any State questions concerning waivers of the broad-based and uniformity requirements for health care-related tax programs not yet enacted.

Comment: A few commenters suggested we define waiver standards to cover pooling arrangements.

Response: We have revised the waiver standards in § 433.68(e)(2)(iii)(B)(*8*) to cover pooling arrangements.

Comment: A few commenters suggested that the broad-based requirement should be separate and apart from the uniformity requirement.

Response: Section 1903(w)(3)(B)(ii) of the Act defines a broad-based health care-related tax as a health care-related tax that is imposed uniformly. Consequently, in applying for a waiver of the broad-based requirement, a State must also meet the uniformity requirements.

Comment: A few commenters suggested that we combine the waiver tests for the broad-based and uniformity requirements and conduct a single test of a tax's redistributive nature utilizing a State's total Medicaid expenditures. These commenters suggested that the

test should be whether the waivered tax itself is generally redistributive.

Response: We have designed an efficient test to determine redistributiveness using a comparison of a broad-based, uniform tax against a waivered tax. We do not believe that testing a tax's redistributive nature utilizing total Medicaid expenditures measures anything about the tax itself.

Comment: One commenter indicated we should increase the 90-day limit for States to inventory and analyze taxes and fees that may require a waiver of the broad-based and/or uniformity requirements.

Response: On February 19, 1993, we rescinded the deadline of 90 days in which States were to submit requests for waivers of broad-based and uniform tax requirements for any tax programs in effect before October 22, 1992.

Comment: One commenter requested us to clarify the phrase "applicable to Medicaid," as used in § 433.68(e).

Response: The proportion of the tax revenue applicable to Medicaid means how much of the tax burden shifts to Medicaid.

Comment: One commenter suggested that we not require a provider-by-provider calculation for any class that includes more than 100 providers for a waiver of the uniformity requirement because of the administrative burden. Instead, the commenter suggested that we should use random sampling.

Response: When performing the uniform test, a State must compare the redistributiveness of a broad-based and uniform tax, which is a tax on all providers in the class at the same rate, to the State's proposed tax. Therefore, data from a random sample of providers could not satisfy the requirements of this waiver test.

Comment: One commenter requested that we add "providers of IMD services where the Medicaid State plan prohibits such entities from participating in the Medicaid program" to the defined groups of providers that can be excluded or given a credit/deduction. Two commenters suggested that we eliminate the additional criteria altogether.

Response: We have revised the regulations to include psychiatric hospitals in the list of excluded providers at § 433.68(c)(1)(ii)(B).

Comment: One commenter requested that we revise the regulation to explicitly state that facility costs are an acceptable tax base.

Response: States are given the flexibility to decide what is an acceptable tax base. Using facility costs as a tax base may or may not be uniform.

Comment: One commenter indicated that the statistical test that we have established for waivers will simply serve to deny any waivers. The commenter suggested that there be some burden on HCFA to prove that reasonable waiver requests can and will be approved.

Response: We strongly believe the numerical test is reasonable and that States whose programs meet the waiver tests will have their waiver requests approved.

Comment: One commenter indicated that if a tax program has a tendency to redistribute the funds of a provider tax to those providers with relatively more charity care, and if the program distributes all the provider tax funds that are collected to providers in the affected provider class without using any of the tax funds to claim FFP, the tax would be considered redistributive.

Response: We have defined redistributive as the tendency of a State's tax program to derive revenues from taxes imposed on non-Medicaid services in a class and to use these revenues as the State's share of Medicaid payments. Assuming a State imposes a non-Medicaid tax and uses the funds solely for Medicaid payments, we believe a perfect redistribution would exist. On the other hand, a tax that is broad based and uniform is not a perfect redistribution. The redistribution test is an attempt to demonstrate how a tax compares to a broad-based and uniform tax.

Comment: One commenter indicated that there is nothing in the test for a broad-based requirement that would address a situation in which only the revenues from private payers, VA payers, Medicare payers, and other insurance payers were taxed with no taxes applicable to the Medicaid payers' revenues. The commenter suggested that this appears to provide an unacceptable cost shift to non-Medicaid patients.

Response: The statute does not restrict a State's taxing authority. The statute and regulation were designed to protect Medicaid providers from being disproportionately taxed. Those excluded providers are providing care for low-income patients. It is up to each State, however, to decide who will be assessed.

Comment: One commenter suggested that States be required to include the effect of taxing Medicaid and Medicare when performing tests for waiver calculation purposes, even if Medicaid and Medicare, among other things, are excluded from the tax.

Response: A broad-based tax applies to all items and services within a class. The waiver of this requirement compares a tax containing exclusions against a tax that is broad based. Consequently, Medicare and Medicaid need to be included to satisfy the broad-based portion of the test. Under the broad-based test, the proportion of the tax applicable to Medicaid under a broad-based tax (P1) would include the effect of taxing Medicaid and Medicare. Under the uniformity test, the slope of the linear regression applicable to the hypothetical broad-based uniform tax (B1) would include the effect of taxing Medicaid and Medicare.

Comment: One commenter indicated that States having taxes on more than one class of providers or multiple taxes and fees on the same class should be able to treat taxes separately and seek waivers only for those taxes that are not broad based and uniform.

Response: We have revised § 433.68(e) to specify that the waiver tests will be applied on a per class basis.

Comment: A few commenters suggested that we change the B1/B2 test to "total tax revenues." Since the current dependent variable in the test is a proportion and the independent variable is an absolute magnitude (the Medicaid statistic), the ratio of the regression coefficients can lead to results that are incorrect.

Response: The Medicaid statistic is not an absolute magnitude. The test breaks down the tax per facility. Therefore, in each case, a value for the tax for each facility will be applied to a value for the Medicaid statistic for each facility. This test is looking at a comparison. It is looking at the proportion of the change.

Comment: One commenter suggested that we delete the waiver approval condition that stipulates the waiver will be approved if the tax program does not fall within the hold harmless provisions.

Response: Section 1903(w)(1)(A)(iii) of the Act specifies that for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan shall be reduced by the sum of any revenues received by the State during the fiscal year from a broad-based health care-related tax, if there is a hold harmless provision with respect to the tax. Consequently, by law, this provision may not be removed from the approval condition of a waiver.

Comment: One commenter indicated that using regression to measure redistributiveness is not logical or statistically valid. The commenter indicated that the problem with using slope alone is that it is not unusual to get a high value for the slope of the regression when two variables in the

analysis have no real relationship as indicated by a very low correlation. A regression will always generate a value for "slope", and the degree of slope can be determined as often by random errors or outliers as by a real relationship.

Response: The intent of this test is to look at a comparison. We believe a measurable relationship exists when the two variables used are the tax imposed on each provider and the Medicaid activity related to each provider. The test does not look at an absolute value of the slope but, instead, looks at the proportion of the change between a tax that is broad based and a tax that is not broad based.

Comment: One commenter suggested that we revise the regulations to specify that any gross revenues tax that exempts Medicaid and Medicare is automatically redistributive, and States do not need to follow the broad-based and uniform requirements nor go through the waiver process.

Response: The statute permits States to exclude Medicaid and Medicare from an assessment. If the tax excludes Medicaid and Medicare only and is applied at the same rate, the tax is considered broad based and uniform. However, if the tax provides for other exclusions, the State should apply for a waiver.

Comment: One commenter indicated that the regulations apply a very strict test of uniformity to licensing fees based on beds, and that the test is unclear as to how it would apply to this type of fee. The commenter questioned what the Medicaid statistic would be for licensing fees on beds and proposed that we require a reasonable relationship of the licensing fee to the cost of licensing the individual facility.

Response: We have revised § 443.68(c)(3) to waive the broad-based and uniformity requirements in the case of variations in licensing and certification fees for providers where the amount of the fee is not more than $1,000 annually per provider and the total amount raised by the State from the fee is used in the administration of the licensing or certification program.

d. Hold Harmless (§ 433.68(f))

Comment: Several commenters indicated that the numerical values of 75/75 in the second prong of the hold harmless test in § 433.68(f)(3)(i) are too restrictive. These commenters proposed several alternative numerical thresholds and provider exclusions from the test.

Response: We believe that the 75/75 numerical threshold under the second prong of the hold harmless test is a reasonable parameter to ensure that States do not use Medicaid rates to repay providers for tax costs in a way not permitted under the statute, and at the same time, permit States flexibility in the design of their tax and payment programs.

Comment: Several commenters indicated that in § 433.68(f)(3)(i), which states that if the health care-related tax is applied at a rate that is less than or equal to 6 percent of the revenues received by the taxpayer, the tax is presumed to be permissible under the guarantee test, the term "presumed" should be clarified. The commenters proposed alternative language and deletions to revise the regulations.

Response: We have revised the regulations at § 433.68(f)(3)(i) to remove the word "presumed." This should clarify that a tax that is broad-based and uniform, and applied at a rate of 6 percent or less, is considered a permissible health care-related tax under the first prong of the two-prong hold harmless test.

Comment: Several commenters indicated that the 6-percent test is too restrictive and proposed clarifications and deletions to revise the regulations.

Response: As stated in the regulations, the 6-percent threshold is based on the average level of taxes applied to other goods and services in the States. A tax equal to or below the 6-percent level is considered permissible under the first prong of the two-prong hold harmless test.

Comment: Several commenters indicated that in the case of a tax that violates the two-prong hold harmless test, only the portion of the tax over 6 percent should be disallowed.

Response: The intent of the statute was to prevent States from guaranteeing to hold taxpayers harmless for any portion of the costs of the tax. The purpose of the two-prong test is to prevent States from guaranteeing payment of the tax back to the taxpayer, which is prohibited by law. A tax failing this two-prong test is impermissible. We do not believe it reasonable to allow a bad tax to be considered partially good. States do have the option to reduce the rate of the tax and, thus, avoid this situation.

Comment: Several commenters indicated that we should extend the April 1, 1993, compliance deadline to comply with the 6-percent test and proposed alternative dates and contingency factors.

Response: We have extended the deadline for compliance with the 6-percent hold harmless test to September 13, 1993.

Comment: One commenter requested clarification that the 6-percent rate is applied by comparing the amount of the tax imposed to the total revenues applicable to the class of service being taxed. The commenter stated that if the tax is on more than one class, the revenues are applicable to all classes.

Response: The 6-percent rate is applied by comparing the amount of the tax imposed to the total revenues received by the class of service being taxed. In addition, if the tax is on more than one class, the amount of the tax should be compared to the revenues received by each class subject to the tax to determine the 6-percent rate.

Comment: Several commenters indicated that the hold harmless provisions are vague and that the application of the tests must permit States flexibility to improve provider reimbursement without triggering a hold harmless situation and denial of FFP.

Response: We believe the regulations provide clear and specific rules in determining a hold harmless situation. Furthermore, we believe the numerical tests do not prevent States from improving provider reimbursement. Instead, these tests are intended to prevent States from guaranteeing payment of the tax to the taxpayer.

Comment: Several commenters indicated that it is difficult and restrictive to apply the hold harmless test in determining that some portion of the Medicaid payment varies directly with the amount of the tax paid. In any case where a provider receives Medicaid payment that is greater than or equal to the amount of tax paid, it would be shown that there is one-to-one correspondence between some portion of Medicaid payment and the tax.

Response: We have developed a test in the regulation which allows States some degree of "one-to-one" correspondence within certain limitations at § 433.68(f).

Comment: A few commenters indicated that we should revise the regulations to clarify that all grant programs do not violate the hold harmless provisions.

Response: Based on the grant programs we have seen, we believe that certain States are using non-Medicaid funds to indirectly compensate providers for the cost of the tax imposed on private charges. This violates section 1903(w)(4)(A) of the Act. However, it is possible that grant programs could be structured to avoid hold harmless problems.

Comment: One commenter expressed disagreement with the example in the preamble that states that the use of grant payments to third party payers is an example of a hold harmless situation.

Response: We believe that if the tax is considered to be levied on a third party,

the State is directly providing for a non-Medicaid payment to a private pay patient that is positively correlated to the amount of the tax.

Comment: A few commenters indicated that pass-through cost associated with health care-related taxes should be excluded from the hold harmless test since they are allowable costs under the Medicaid program.

Response: A tax can be claimed as an allowable cost and included in the establishment of reimbursement rates. This would not necessarily constitute a hold harmless situation. Section 1903(w)(4) of the Act clearly indicates that the hold harmless provisions must not prevent the use of the tax to reimburse health care providers in a class for expenditures under title XIX nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process. However, pass-through costs associated with health care-related taxes are not excluded from the hold harmless provisions.

Comment: One commenter indicated that we should make clear that provider taxpayers are not held harmless by a provision in a State law that allows the provider to pass the tax incidence through to private sectors.

Response: Pass-through costs associated with health care-related taxes are not excluded from the hold harmless provisions. However, a tax can be claimed as an allowable cost and included in the establishment of reimbursement rates. This, in itself, would not necessarily constitute a hold harmless situation.

Comment: A few commenters requested clarification that a health care-related tax is an allowable cost on a provider's cost report and repayment of the tax as an allowable cost does not create a hold harmless effect in violation of the regulation.

Response: A tax can be claimed as an allowable cost and included in the establishment of reimbursement rates. This would not necessarily constitute a hold harmless situation. Section 1903(w)(4) of the Act clearly indicates that the hold harmless provisions must not prevent the use of the tax to reimburse health care providers in a class for expenditures under title XIX nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

Comment: One commenter stated that the intent of the statute was to prohibit States from excluding non-Medicaid services from taxes, assessments and fees—not to exclude Medicaid from recognizing mandatory taxes as an allowable cost in establishing reimbursement rates.

Response: It is true that it was not the intent of the statute to exclude Medicaid from recognizing mandatory taxes as an allowable cost in establishing reimbursement rates. However, this does not exclude the taxes from the hold harmless provisions.

Comment: A few commenters indicated that the regulation is vague in describing positive correlation.

Response: A positive correlation is the statistical term for a positive relationship between two variables. For example, there could be a positive correlation between the amount of education a person has received and his or her income. The two variables being education and income. The term positive correlation used in § 433.68(f)(1) has the same meaning as the statistical term. Therefore, a hold harmless exists if there is a positive correlation between the tax paid and the non-Medicaid payment, or between the tax paid and the difference between the Medicaid payment and the total tax paid. If a provider is receiving a non-Medicaid payment for its tax cost, there would be positive correlation between these two variables, or a hold harmless would exist.

Comment: One commenter indicated that the term "direct correlation" is not achievable since a direct correlation exists any time the correlation is not random.

Response: The hold harmless test applies to all providers subject to the tax. It does not allow for random statistical data. However, the regulations do allow for a correlation to exist by a certain degree according to the statistical thresholds provided for in the hold harmless tests.

Comment: One commenter stated that we should clarify that the phrase "directly correlated" is understood to embody the hold harmless principle.

Response: The hold harmless provisions mean that while States may use revenue from otherwise permissible taxes to increase payment rates to the providers subject to the tax, States may not make Medicaid or other payments to providers that result in taxpayers automatically being repaid dollar (or part of a dollar)-for-dollar for their tax costs. This is a direct correlation and is the embodiment of the hold harmless principle.

Comment: One commenter suggested that we raise hold harmless as an issue only when the facts demonstrate a compelling case of intention to and effect of relieving nursing homes from any significant impact of the tax.

Response: We believe that subjective analysis does not allow for a reasonable test of the hold harmless provisions. The use of a subjective analysis would result in a lack of specific standards by which hold harmless could be measured. In addition, a subjective analysis would be administratively burdensome and virtually impossible to apply fairly throughout the nation.

Comment: One commenter noted that we do not define when an "explicit guarantee" exists and provided a proposed definition.

Response: We have revised the regulations at § 433.68(f)(3)(i) to remove the term "explicit guarantee" and clarify that an indirect guarantee is determined to exist by applying the two prong hold harmless test.

Comment: One commenter indicated that the hold harmless guarantee test should be eliminated, since the statute does not define the term "guarantee" or contain any test to be used to determine whether or not a guarantee exists.

Response: Since not all hold harmless situations are explicit, we believe that it was necessary to adopt a test to ensure that a State does not violate the hold harmless provision of the statute.

Comment: One commenter requested that we clarify the language "revenues received by the provider" to make clear how this would be done in the case of a bed tax or a revenue tax that excludes Medicare and Medicaid.

Response: The total amount paid by the provider based on the bed tax would be compared to total revenues received by the provider to generate the rate of the tax to total revenue. For example, a $1 per bed per day tax may be equal to 4 percent of the provider's total revenue received.

Comment: One commenter indicated that the hold harmless provisions that apply to State-funded programs need clarification. The commenter believed these provisions should not include programs that provide reimbursement to individuals without public or private health insurance coverage for direct medical expenses, but do not recognize or reimburse any provider-specific taxes, assessments, or fees.

Response: Section 1903(w)(4)(A) of the Act specifies that a hold harmless situation exists if the State provides (directly or indirectly) for a payment to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

8. Reporting Requirements (§ 433.74)

Comment: Several commenters indicated that a more systematic and comparable reporting process should be developed to provide explicit guidance to States with respect to donations and health care-related tax programs. Other commenters requested that we provide States with detailed information on the reporting requirements, such as supporting documentation, format, timing, and content. Another commenter asked for more specific guidance in the areas of appeals, waiver approval, and process of the reporting requirements.

Response: We agree with these comments. We will, as part of the State Medicaid Manual (SMM), provide guidance to States with respect to the reporting requirements process for donations and health care-related taxes to ensure accuracy of the data.

Comment: Several commenters indicated that the reporting requirements are extensive and administratively burdensome to States. A few commenters requested that we clarify how non-Medicaid funding programs are to be identified and evaluated.

Response: Section 1903(d)(6)(A) of the Act requires that each State submit all provider-related information related to donations made to the State or units of local government, and all health care-related taxes collected by the State or such units, regardless of its association with funding of the Medicaid program, and information related to the total amount of payment adjustments made and the amount of payment adjustments made to individual providers under section 1923(c) of the Act. We will collect this information on a quarterly basis to monitor the program, and to relieve the State from implementing additional reporting requirements on an annual basis.

Comment: A few commenters indicated that it is unclear what process we will use to reduce FFP when a tax program is found to be impermissible. Another commenter indicated that we should establish timeframes for State receipt of notices of FFP disallowances based on impermissible health care-related taxes.

Response: The process of reducing FFP is the same as the current deferral/disallowance procedure specified in §§ 430.40 and 430.42. Notice of FFP disallowance is also based on current Federal policy at § 430.42.

Comment: A few commenters indicated that there is no specified time period for HCFA to approve programs that either the State believes are permissible or that are submitted for a waiver.

Response: The statute does not mandate a specified time period for us to approve States' waiver requests. However, we will review these waivers in a timely manner.

Comment: One commenter requested that we clarify the appeals processes and guidelines needed to properly administer the law. Another commenter indicated that we should establish a separate appeals process for waiver disallowances under the regulations.

Response: Disputes that pertain to disallowances of FFP in Medicaid expenditures are heard by the Departmental Appeals Board as specified at § 430.3(b). The statute does not require us to establish a separate appeals process for waiver disapprovals. We believe that the appeals process specified in § 430.3(b) is adequate for all disallowances, including those the State believes are related to waiver disapprovals.

Comment: One commenter indicated that there is no appeals process if a non-waivered program is not approved.

Response: If a non-waivered program is not approved, and the total amount expended during a fiscal year is reduced by the sum of the impermissible tax, the State may appeal the resulting disallowance to the Departmental Appeals Board.

C. Summary of Revised Regulations

As a result of our review of the comments we received during the public comment period, as discussed in section I.B. of this preamble, and negotiations with States and the National Governors Association (NGA), we are making, in addition to editorial and typographical changes, the following revisions to the regulations published in the November 24, 1992, interim final rule.

1. Classes of Health Care Items or Services

We are adding to § 433.56(a) the following classes of health care items or services:

- Dental services.
- Podiatric services.
- Chiropractic services.
- Optometric/Optician services.
- Psychological services.
- Therapist services—Defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services.
- Nursing services—Defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses.
- Laboratory and x-ray services—Defined as services provided in a licensed, freestanding laboratory or x-ray facility. These services would not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department.
- Emergency ambulance services.
- Ambulatory surgical services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Act. These services are defined to include facility services only and do not include surgical procedures.

2. Outstationed Eligibility Worker Donations

We have expanded the definition of donations for outstationed eligibility workers by revising §§ 433.58(d)(2) and 433.66(b)(2) to indicate that the direct costs of outstationed eligibility workers now includes the prorated costs of outreach activities applicable to the outstationed workers at these sites.

3. Waiver Standards

To decrease the burden a State may have when imposing a licensing fee that is not uniform or broad based, we have revised § 433.68(c)(3) to specify that a waiver will automatically be granted in the case of variations in licensing and certification fees for providers where the amount of the fee is not more than $1,000 annually per provider and the total amount raised by the State from the fee is used in the administration of the licensing or certification program.

We have revised § 433.68(e)(1) to indicate that the test for waiver of the broad-based requirements is applied to a tax that is imposed on all revenues but excludes certain providers. We have provided an example of a situation in which this test would apply. We have revised § 433.68(e)(2) to indicate that the test of the broad-based and uniformity requirements is applied to all other taxes not provided in § 433.68(e)(1) and not automatically approved.

We have revised §§ 433.68(e)(1)(ii) and 433.68(e)(2)(ii) in the following manner. Under the current regulations, § 433.68(e)(1)(ii) specifies that if the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is greater than 1, HCFA will automatically approve the waiver request. Similarly, § 433.68(e)(2)(ii) indicates that if the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is greater than 1, HCFA will automatically approve the waiver request. Under this scenario, a tax would be generally redistributive only if such tax is more redistributive than a tax that is applied

to all providers in a class. Consequently, we have revised § 433.68(e)(1)(ii) to indicate that if the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 1, HCFA will automatically approve the waiver request. Likewise, we have revised § 433.68(e)(2)(ii) to indicate that if the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least 1, HCFA will automatically approve the waiver request.

Also, we have added § 433.68(e)(1)(iii) to indicate that if a tax is enacted and in effect prior to [publication date of this final rule], and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.90, HCFA will review the waiver request. We have added § 433.68(e)(1)(iv) to indicate that if a tax is enacted and in effect after [publication date of this final rule], and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.95, HCFA will review the waiver request.

In addition, we have revised §§ 433.68(e)(1)(iii)(B) and 433.68(e)(2)(iii)(B) by adding the following criteria for favorable treatment under the waiver standards. A tax that excludes or provides credits or deductions to the following providers is permissible:

(1) Financially distressed hospitals:
(a) Defined by State statute;
(b) The State's statute has reasonable standards for determining financially distressed hospitals and these standards are applied uniformly to all hospitals in the State; and
(c) No more than 10 percent of non-public hospitals in the State are exempt from the tax;
(2) Psychiatric hospitals; or
(3) Hospitals owned and operated by HMOs.

We have further added to § 433.68(e)(2)(iii)(B)(8) that providers with tax rates that vary based exclusively upon regions, but only if the regional variations are coterminous with preexisting political (and not special purpose) boundaries and enacted and in effect prior to November 24, 1992, will be grandfathered in for special treatment under the uniformity test by applying a B1/B2 value of 0.85 for waivers to permit such variations.

4. Hold Harmless

We have revised § 433.58(g)(2) to specify that the State may modify taxes in existence as of November 22, 1991 in order to comply with the hold harmless rules established at § 433.68(f).

Section 433.68(f)(3)(ii) had indicated that a State must come into compliance with the hold harmless provisions by April 1, 1993. To accommodate the States, we have extended the deadline to September 13

D. Additional Clarifications

As a result of comments and ongoing discussions and negotiations regarding the interim final rule, we are making the following clarifications to HCFA's policies concerning provider-related donations and health care-related taxes:

1. Additional Health Care Classes

The Secretary will consider adding additional classes by further expedited rulemaking if States can demonstrate the need for additional designations and that any class of classes proposed for addition meets the following criteria:

- 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);
- The class must be clearly identifiable, such as through designation for State licensing purposes, recognition for Federal statutory purposes, or being included as a provider in State plans; and
- The class must be nationally recognized and not be unique to a State.

2. Withholding Rules

We are restating our existing policy on withholding rules. We recognize a matchable expenditure if the State meets the following criteria:

- The provider voluntarily elects to have the State withhold the funds, or a State or Federal court requires the State to withhold the funds (such as alimony, child support, or debts owed to the State);
- With respect to payees for whom an Internal Revenue Service (IRS) Form 1099–MISC must be submitted, the State must report the total amount claimed as an expenditure (including the withheld amount) as the provider's income to the IRS on Form 1099–MISC; and
- The IRS recognizes the full amount of the reported payment as income to the provider.

3. Formula for Determining State Base Percentage

We are clarifying that, due to an inadvertent editorial error, the formula contained in the preamble of the interim final rule for determining the maximum amount of provider-related donations and health care-related taxes a State may receive without a reduction in FFP is incorrect. The State base percentage is calculated by dividing the amount of the provider-related donations and health care-related taxes to be received in State fiscal year 1992 by the total non-Federal share of medical assistance expenditures (including administrative costs) in that fiscal year based on the best available HCFA data. This percentage is then multiplied by the State's total medical assistance expenditures for the fiscal year to determine the actual dollar limit. This formula is consistent with the statute and § 433.60 of the regulations. The preamble, however, included administrative costs in the multiplication factor and not in the State base percentage determination.

4. Application of the Uniform and Broad-based Test and Hold Harmless Guarantee Test

- We are clarifying that the waiver tests will be applied on a per class basis.
- We are also clarifying that the hold harmless guarantee test will be performed on a per class basis. For the first prong of the guarantee test, the State will compare the amount of all health care taxes applied to one health care class to 6 percent of the revenues received by all providers in the health care class. For example, if the total amount of three separate taxes on the inpatient hospital services class produces revenue greater than 6 percent of the revenues received by the hospitals, the State would proceed to the 75/75 portion of the guarantee test. If 75 percent of the providers in a class receive 75 percent of their total tax costs back, the providers are considered to be held harmless from the cost of their tax.

II. Disproportionate Share Hospitals

A. Summary of Interim Final Regulations

1. Background

Public Law 102–234 established limits on the amount of FFP for medical assistance expenditures made to disproportionate share hospitals (DSHs) that, because of their geographic location or various other reasons, serve a larger number of Medicaid recipients and other low-income individuals than other hospitals. The law deleted the prohibition of an upper payment limit for DSHs from section 1902(h) of the Act and prohibited HCFA from restricting a State's authority to designate hospitals as DSHs. The law also imposed two restrictions on DSH payments.

The first DSH restriction, effective from January 1, 1992, through September 30, 1992, placed a moratorium on DSH State plan amendments. States may receive FFP for DSH payments made during the

moratorium period only if the payments were made in accordance with specified criteria.

The second DSH restriction, effective October 1, 1992, establishes both national and State limits on DSH payments. The national limit is established at 12 percent of the total amount of medical assistance expenditures (excluding State administrative costs) under Medicaid State plans during the Federal fiscal year (FFY).

In general, each State's DSH limit is similarly set at 12 percent of the State's medical assistance expenditures (excluding administrative costs) during the FFY. States with DSH payments applicable to FFY 1992 above the 12-percent limit are defined as "high-DSH States." States that are designated as "high-DSH States" will have DSH payment adjustments limited to the State base allotment.

States with DSH payments applicable to FFY 1992 below the 12-percent limit are referred to as "low-DSH States." These States are permitted to increase DSH payments to the extent that their Medicaid programs grow and to the extent that these States are entitled to receive a supplemental amount that does not result in the States' aggregate DSH payments exceeding the national limit.

The preliminary national DSH limit and the preliminary State-specific DSH limits are calculated prospectively, before the beginning of the FFY (that is, October 1).The law requires the Secretary, before the beginning of each fiscal year (beginning with fiscal year 1993), to estimate and publish in the Federal Register the national DSH payment limit and each State's DSH allotment within that DSH limit.

2. DSH Provisions Published in the Interim Final Rule.

In the November 24, 1992, interim final rule cited earlier under section II of this preamble, we also implemented the DSH provisions of the Public Law 102–234. We provided the following changes to our regulations to implement the statutory provisions:

- We specified the limitation on aggregate DSH payments for the moratorium period January 1, 1992, through September 30, 1992.
- We specified preliminary national and State DSH limitations on aggregate DSH payments beginning October 1, 1992. We specified that the national payment limit on aggregate DSH payments for any FFY beginning on or after October 1, 1992, is equal to 12 percent of total medical assistance expenditures (excluding administrative costs) that are projected to be made during the FFY under State plans. We specified that HCFA will make and publish a preliminary allotment in the Federal Register prior to October 1 of each FFY year, update the projections by April 1 of the FFY, and reconcile actual expenditures to final allotments by April 1 of the following year.
- We specified the method and formula for the calculation of individual State DSH payment limits—referred to as the "State DSH allotment." For FFY 1993, each State's base DSH allotment will be calculated using the greater of:

(1) The State's allowable DSH payments applicable to FFY 1992 (beginning on October 1, 1991); or

(2) $1,000,000.

For FFY 1992, HCFA will derive these DSH amounts from payment plans that meet the requirements for FFP during the period from January 1, 1992, through September 30, 1992.

- We specified a process that HCFA would use to update the preliminary national DSH expenditure limit and State DSH allotments.
- We specified a reconciliation process that HCFA would use to reconcile final allotments to actual expenditures.
- We specified the publication requirements that HCFA will follow when publishing both the preliminary and final national DSH expenditure limit and State DSH allotments.
- We specified how HCFA would calculate each State's percentage of total medical assistance payments (excluding administrative costs) during FFY 1992.
- We specified the requirements for State DSH allotments in FFY 1993, FFY 1994, and subsequent years for both high-DSH and low-DSH States. For a high-DSH State, the dollar amount of DSH payments may not exceed the dollar amount of DSH payments applicable to FFY 1992 until the State's DSH payments equal 12 percent or less of its medical assistance payments. For a low-DSH State, the allotment in FFY 1993 would be calculated by HCFA by increasing the State base allotment by a growth factor based on the State's growth in total medical assistance expenditures, including all administrative expenditures, and (2) a supplemental amount if available under the national limit. The FFY 1994 allotment for low-DSH States would be calculated by increasing each State's prior year DSH allotment by: (1) Its State growth amount, and (2) a supplemental amount from a redistribution pool if such a pool is available under the national limit.

The State growth amount for a State in a fiscal year would be equal to the product of (1) The State growth factor, which is the projected percentage increase in the State's total medical assistance expenditures (including total administrative expenditures) relative to the corresponding State medical assistance expenditures (including total administrative expenditures) in the previous FFY, as adjusted by HCFA, and (2) the State's prior year DSH allotment. If there is no growth, the growth factor would be zero. If the State's growth factor is negative, the amount would be deducted from the State's prior year's DSH allotment. We specifically invited public comments on this approach.

- We specified our method of calculating and distributing a redistribution pool to low-DSH States.
- We specified that States that amend their State plans to meet the minimum DSH payment requirements may not have a State DSH allotment that is less than the minimum DSH payment adjustment.
- We specified that if the aggregate amount of the State DSH allotments for any FFY, beginning October 1, 1992, exceeds 12 percent of the total amount of aggregate national medical assistance expenditures (excluding administrative costs) projected to be made during that fiscal year, each State's DSH allotment will be reduced proportionally to ensure that the 12-percent statutory cap is not exceeded.
- We specified reporting requirements for State DSH payments.

B. Preliminary Notice of Individual State Allotments

On November 24, 1992, we also published a notice in the Federal Register (57 FR 55261–55265) announcing the preliminary national aggregate DSH limit and individual State allotments for FFY 1993. This notice was published in accordance with the requirement in § 447.298(c) that we publish preliminary DSH allotments at the beginning of the FFY.

C. Discussion of Comments

A summary of the public comments on the DSH portion of the interim final rule included among the 98 timely items of correspondence received and our responses to these comments follow:

1. Reconciliation Process

Comment: Several commenters objected to HCFA's retroactive adjustment of the DSH allotment. These commenters stated that the reconciliation procedures described in § 447.297(d) are unworkable. In accordance with the interim final rule, a State would not be notified of any allotment reductions until the final

allotments are published April 1 of the fiscal year following the fiscal year in which payments are made. The commenters indicated that an allotment reduction at that point in the DSH payment process would confront a State with only two choices: (1) Recoup from hospitals payments in excess of the reduced allotment; or (2) reduce future DSH payments to offset earlier payments in excess of the final allotment. The commenters believed further that the significant lag between payment to a hospital and determination of final State DSH allotments, as envisioned in the interim final rule, makes it almost impossible to recoup payments, given the changing hospital participation in the DSH program from year to year.

Response: As a result of the comments received on this issue and negotiations and consultations with the National Governors' Association and States, we have totally revised the reconciliation process described in § 447.297(d). We will continue to publish preliminary State DSH allotments prior to October 1 of each FFY. However, the final national and State DSH limits for each FFY will be published by April 1 of each FFY. The final limit numbers will be based on our updated estimates of Medicaid expenditures for the FFY. For purposes of determining the final estimated Medicaid expenditures for the FFY, we will use the February Medicaid budget submissions—as reviewed and adjusted, if necessary, by us. However, for purposes of calculating the final FFY 1993 national limits and State DSH allotments, we used FFY 1992 DSH payment adjustment expenditures data reported by the States through March 31, 1993. The data were confirmed and updated, as necessary, by the States in response to an April 1993 letter that was sent to each State Medicaid director.

If we determine that a State has exceeded its final DSH allotment for a FFY, the excess DSH expenditures will be disallowed. If, on the other hand, a State's actual DSH expenditures in a FFY are less than its final State DSH allotment for the year, to the extent permitted by its approved State plan, we will permit the State to make additional DSH expenditures that do not exceed its final DSH allotment for the year.

Comment: Several commenters noted that section 1923(f)(i)(C) of the Act provides for the publishing of the national and State DSH allotments before the beginning of each FFY. The statute requires only one estimate and does not provide for preliminary numbers subject to mid-year updating and final reconciliation. However, the regulation at § 447 297 provides for three different estimates. The commenters believed that three estimates are bound to create chaos by requiring a State to wait 6 months after the close of the fiscal year to learn if it meets the final limit. The commenters are concerned that this requirement will wreck havoc with a State's ability to plan expenses. The commenters interpreted the statute as explicitly providing only one estimate, given prospectively at the beginning of the FFY, that is binding on both the State and the Federal Government.

Response: Because of the normal time lag between a State actually incurring an expense and its submission of a FFP claim, we did not have adequate accurate data available to calculate the FFY 1992 DSH expenditure levels. To be equitable to all States and to satisfy the statutory requirement that we publish a national and State limit at the beginning of each year, we decided to use the latest available data to publish preliminary limit numbers. We believe the issuance of preliminary limit numbers satisfies the statutory publication requirement. We also believe that, while not required by the statute, the publication of mid-year updates is not prohibited by the statute. As we noted above, we have revised the reconciliation process. Final national and State DSH limit numbers will be published by April 1 of each FFY. If a State exceeds its final DSH limit for a FFY, excess expenditures will be disallowed. If, on the other hand, a State's actual DSH expenditures in a FFY are less than its final State DSH allotment, the State is permitted to make additional DSH expenditures that do not exceed its final DSH allotment for the year, if its approved State plan permits these additional payments.

Comment: One commenter noted that the statute requires that estimated DSH limits be published before the beginning of each FFY beginning with FFY 1993. The commenter acknowledged that because of HCFA's lack of existing DSH expenditure data and the need to conduct a special information collection process, these FFY 1993 limits were not published until November 1992. However, the commenter asked if the statutory publication deadlines will be met in the future.

Response: We realize we were late publishing the preliminary FFY 1993 DSH limits. However, as the commenter noted, we needed time to gather and evaluate DSH expenditure data from States via a State survey process before implementing the statutory requirements of section 1923(f) of the Act. We also needed time to consult with the States. This process delayed the publication of the preliminary FFY 1993 DSH limits. (For the same reasons, the publication of the final FFY 1993 limits was delayed beyond the April 1 publication date noted above. These figures are being published as a separate notice in this issue of the **Federal Register**.)

We have subsequently revised the financial reporting requirements contained in the Forms HCFA–37 and HCFA–64 to capture State DSH expenditure data and added specific reporting requirements described in § 447.299. Now that we have these reporting requirements in place, we hope to meet all future publication requirement dates.

Comment: One commenter from a State Medicaid agency stated that HCFA's mid-year revisions could force States to make recoupments after many financially marginal hospitals have been paid their maximum payments and after the public entities have completed their intergovernmental transfers for the year. If HCFA's mid-year revisions indicate that higher DSH payments could be made, State law and the complexity of the administrative process could preclude upward mid-year adjustments to DSH payments.

Response: As we noted above, we eliminated the mid-year revision. The preliminary numbers will be finalized by April 1 of each FFY. We believe the 6-month time lag between publication of the preliminary and final numbers will not be detrimental to States. We recommend that States adopt language within their State plans that would permit them to automatically adjust DSH payments to the published preliminary and final DSH limits. We believe the inclusion of such language within the State plan should help avoid conflicts with State law or other additional administrative complexities.

Comment: One commenter suggested that HCFA indicate how it will advise State Medicaid Directors of the mid-year revisions.

Response: As previously explained, we have eliminated mid-year revisions. We will publish in the **Federal Register** prior to October 1 of each year the preliminary national and State DSH limits for the FFY. Final national and State DSH numbers will be published by April 1 of each FFY.

Comment: One commenter expressed concern that the limits are set based on total DSH spending for only 15 months of actual paid claims activity. The commenter noted that this is too short a period to capture all actual date of service utilization since providers have one year from the service date to actually submit their claim for payment.

Response: As discussed above, due to the elimination of the mid-year update adjustment, there is now only a 6-month time lag between setting of the preliminary national and State DSH limits and the final national and State DSH limit numbers. Both the preliminary and final DSH numbers are determined based on projections of Medicaid expenditures. Based on these revisions, we believe we have addressed the commenter's concerns.

Comment: One commenter recommended that HCFA delete the word "projections" from all references in § 447.297 (d)(2) and (e). The commenter indicated that this will be final allotments and will not be projections.

Response: We have revised §§ 447.297(d) and (e) to provide that final DSH expenditure "allotments" will be published by April 1 of the FFY.

Comment: One commenter noted a typographical error in the fourth sentence of § 447.297(c) in our description of DSHs. Specifically the reference to "low-number patients" should be changed to "low-income patients."

Response: We agree that this was a typographical error. However, we have completely revised § 447.297(c), and the revised language no longer includes the referenced term.

2. DSH Cap

Comment: Numerous commenters believed that the DSH cap should be the 1992 base DSH percentage plus a growth factor. These commenters noted that the statute specifically provides that low-DSH States are entitled to receive increased DSH payments equivalent to State growth.

Response: We have reevaluated our policy enumerated in the interim final rule and determined that the 12-percent national limit is a target rather than an absolute cap. Since we have now decided that the 12-percent national limit is a target, we have included State growth for low-DSH States in the final FFY 1993 State DSH allotments.

Comment: One commenter objected to the requirement that a State submit an assurance that it has not exceeded its DSH cap. The commenter stated that this is needless paperwork since HCFA knows each State's cap and States already regularly report on DSH payments as a distinct category when submitting financial reports on the Forms HCFA–37 and HCFA–64. The commenter suggested that HCFA monitor a State's compliance with its DSH caps through the financial reports.

Response: Although States do provide specific DSH payment information on both the Forms HCFA–37 and HCFA–64, we still believe it appropriate to require States to submit a separate DSH payment limit assurance with the submission of each State plan amendment. We note that the review of the State plans and the review of the financial reports are two separate and distinct functions carried out by different HCFA components. State plan reviews of a State's methods and standards used to set payment rates are performed by the Division of Payment Policy. The financial reports submitted on the Forms HCFA–37 and HCFA–64 are reviewed by the Office of Medicaid Management to determine the amount of FFP monies that are disbursed. Consequently, we believe the DSH payment limit assurances should be submitted with State plan amendments separately from the financial reports. The requirement of specific assurances with each State plan amendment has been an established HCFA policy to ensure a State's compliance with certain statutory requirements. We believe the addition of this new DSH requirement as part of the State plan review process is the proper means to ensure a State's compliance with the statutory DSH payment limit which this rule implements.

Comment: Numerous commenters disputed HCFA's authority in § 447.298(g) to reduce DSH caps to all States on a pro rata basis if the aggregate of Medicaid DSH allotments, as projected by HCFA, exceeds 12 percent. These commenters believed that the statute does not give HCFA the authority to reduce payments. They concluded that the statute only provides authority for HCFA to increase DSH allotments for supplemental growth amounts to low-DSH States. These commenters explained that the statute guarantees high-DSH States a State DSH allotment that exceeds the 12-percent cap and HCFA cannot just arbitrarily reduce or adjust this guaranteed allotment. Further, these commenters noted that HCFA's method of reducing DSH caps to all States on a pro rata basis is extremely onerous for States because they would be required to change their program payments to come into compliance within the 6 months between April and October when many legislatures are not in session.

Response: We initially chose to reduce DSH caps to all States on a pro rata basis if aggregate medical assistance expenditures exceeded the 12-percent national limit because we determined this was the most equitable means to bring DSH expenditures to the required 12-percent level. However, as explained above, we have subsequently determined that the 12-percent national limit was not intended to be an absolute cap but rather a target towards which all States must strive. In light of our revised interpretation, we have revised § 447.298 by deleting paragraph (g), the national limit adjustment. The FFY 1993 State DSH allotment for high-DSH States will be set based on the dollar amount of DSH expenditures applicable to FFY 1992, while low-DSH States will have their final FFY 1993 State DSH allotment set using FFY 1992 DSH expenditures increased by a growth amount.

Comment: One commenter from a low-DSH State stated that its preliminary DSH allotment (an allotment that may be reduced retroactively) is too small. The commenter noted that the allotment does not include any adjustment for growth in the Medicaid program, nor does it reflect any shift of unused growth not provided to high-DSH States via the redistribution pool. Without a factor for State growth and the supplementary amount from the redistribution pool, the State acknowledged that projected DSH payments under its approved State plan will exceed its State DSH allotment. This commenter pointed out that States have three unattractive options available under this scenario. A State can either choose to: (1) Be out of compliance with the State plan requirements, (2) revise its State plan to reduce DSH payments, or (3) make excess DSH payments with 100 percent State funds.

Response: As explained above, we have included State growth in the final FFY 1993 State DSH allotments for low-DSH States. However, because FFY 1992 DSH expenditure levels exceed the 12-percent targeted levels, we have not provided for a redistribution pool. The statute provides for a redistribution pool only to the extent that total DSH expenditures do not exceed the prescribed national limit.

Comment: One commenter noted that although the DSH statutory language (upon which the regulations are based) was negotiated among the National Governors' Association, HCFA, the Office of Management and Budget, and the States, the negotiated language was intended to provide a mechanism for low-DSH States to move toward the national limit of 12 percent. The commenter pointed out that the negotiated language was based on projections of Medicaid expenditures that were incorrect. In this context, low-DSH States did not object to the negotiated language because it appeared to provide for a reasonable rate of growth in their DSH programs.

However, because of the inaccurate 12-percent estimate, low-DSH States are severely disadvantaged by the new regulations and are being treated unfairly. The commenter asked HCFA to take immediate steps to minimize unfair treatment to low-DSH States.

Response: We realize the 12-percent estimates upon which Congress relied when setting the national limits have subsequently proven to be inaccurate. We believe that if estimates of 1992 DSH spending had been accurately projected, Congress would have set the national limit at a higher level to reflect the true current level of DSH expenditures. With this in mind, we have changed our interpretation of the national DSH limit. We are no longer interpreting the national DSH limit as an absolute cap but rather as a target percentage. Under this revised interpretation, we have eliminated the national limit adjustment from § 447.298(g). We are no longer reducing 1992 State DSH expenditures on a proportional basis to reach the 12-percent specified national limit. We are including a growth factor in the calculation of the State DSH allotments for low-DSH States and are calculating high-DSH States DSH allotments using State aggregate 1992 DSH expenditures. We believe that our revised interpretation provides fair treatment to both high-DSH and low-DSH States.

Comment: One commenter stated that the portion of the interim final rule that sets forth the national DSH payment limit of 12 percent and the State DSH allotment of a low-DSH State for 1992 is based on very questionable assumptions. The commenter questioned how the national DSH limit provision can be used to preempt the provisions concerning calculating the DSH allotment for a low-DSH State. The commenter stated that there is no basis in the law for assuming that, if there is a conflict between the national 12-percent limit and the 1992 State DSH allotment for low-DSH States, the national limit would overrule the provisions relating to setting the DSH allotment for low-DSH States.

Response: As we explained above, based on our revised interpretation that the national limit is not an absolute cap but a target percentage, we have included State growth (§ 447.298(d)) for low-DSH States in the final FFY 1993 State DSH allotments.

Comment: One commenter from a State Medicaid agency recommended that instead of proportionally reducing all State DSH allotments based on the States' share of aggregate national DSH payments, the DSH allotment reduction should be calculated based on the extent to which changes in each State's Medicaid program from year to year contribute to the national overage.

Response: As we previously explained, we have eliminated the national payment limit adjustment described in § 447.298(g). Therefore, no State will have its DSH allotment reduced because 1992 aggregate DSH expenditures exceeded the specified 12-percent limit.

Comment: One commenter noted that the language in § 447.298 (c) and (d) appears to make it possible for low-DSH States to receive an amount in excess of the 12-percent limit. The prior year's allotment appears to be increased by the growth factor without regard to the percent limit. HCFA should clarify whether State growth will be allowed to increase a low-DSH State's percentage above the 12-percent limit.

Response: As we previously explained, we have provided a growth factor to all low-DSH States in the final FFY 1993 State DSH allotments. We have determined that the 12-percent national limit is not an aggregate absolute cap, but a target percentage. This change has permitted State growth to low-DSH States. However, the amount of State growth is limited to the extent that in no FFY will a low-DSH State's DSH allotment be allowed to exceed the 12-percent national DSH target percentage.

Comment: One commenter objected to the rule's national DSH payment limit being applied to individual State allotments. The commenter believes a national funding mechanism standard should not be adopted because States cannot predict the impact of other States' expenditures on their revenues.

Response: A national DSH payment limit is required by section 1923(f)(1)(B) of the Act. However, we are now interpreting this provision as a target percentage rather than an absolute cap. Under the target percentage concept, no State's FFY 1992 baseline DSH expenditures are affected by other States' DSH expenditures. Therefore, under this interpretation, no State has been unfairly penalized due to spending experience of other States.

Comment: One commenter expressed concern that HCFA's limitation in § 447.298(a)(2)(ii) that specifically excludes from the base those DSH payments made in FFY 1992 but applicable to another fiscal year, is inappropriate.

Response: As explained above, we believe it was not the Congress' intent to limit DSH payments based on actual cash payments made in FFY 1992. We believe that the Congress chose FFY 1992 as a baseline measuring period. To avoid skewing the measurement of DSH payments for FFY 1992, we purified the base to remove DSH payment adjustments made in FFY 1992 for prior periods. A complete, detailed description of how we determined FFY 1992 DSH payment adjustments is included in the final FFY 1993 DSH notice that is published as a separate document in this issue of the **Federal Register**.

Comment: One commenter asked for clarification of the method used to make the DSH allotment determinations. Specifically, the commenter questioned if HCFA proceeded as required by section 1923(f)(3) of the Act when determining that there were no dollars available for redistribution to low-DSH States for FFY 1993. The commenter asked that we explain this calculation. The commenter questioned whether preliminary high-DSH State base allotments included only 1992 amounts. The commenter believed that holding high-DSH States to 1992 allotment levels should yield redistribution amounts for low-DSH States due simply to the effects of inflation, not to mention Medicaid program growth for many States.

Response: We explained the method used to make the DSH allotment determinations in the notice published in the **Federal Register** (57 FR 55261) on November 24, 1992. Our calculations were made in accordance with our interpretation of the requirements of section 1923(f) of the Act. However, as we previously explained, we have reevaluated our initial interpretation of the national 12-percent limit specified in the statute and now consider this specified 12-percent national limit a target percentage rather than an absolute cap. Consequently, we have revised our calculation of the DSH State allotments in determining FFY 1993 final limits and are publishing a notice in this issue of the **Federal Register** to provide these revised State DSH allotments. That notice contains an explanation of our method of calculating the final FFY 1993 national target percentage and State DSH allotments.

Comment: Numerous commenters questioned the provision that specifies that a negative supplemental amount can be used to reduce or eliminate the growth factor and to reduce the 1992 base DSH allotment. These commenters stated that the law plainly states that the base allotment may be increased by the growth factor and the supplemental amount. They believed that HCFA was wrong to suggest that the law included the possibility of a negative increase to the base allotment, or that the growth factor could be reduced if the redistribution pool is calculated to have

a negative amount. The commenters believed that the law guarantees low-DSH States the 1992 base allotment plus the growth factor. One commenter further noted that although the supplemental amount may be zero, it may not be used to reduce other factors. The implementation of the national DSH limit may cause the supplemental amount to be zero for some time but cannot set aside other provisions of the law. Several commenters noted that HCFA's interpretation concerning negative growth not only conflicts with the statute but also creates enormous uncertainty among hospitals and States as to what payment levels will be allowed from year to year.

Response: After further consideration of the negative growth issue, we have revised § 447.298(d) by deleting paragraph (d)(1)(ii)(3), which provided for a reduction of the prior year's DSH allotment for those States that had negative growth. States that have a negative growth factor will be treated the same as States whose growth factor is zero. States with zero or negative growth will have their DSH allotments maintained at the prior period's level. However, we added a new paragraph (d)(2) to § 447.298 that provides that if a low-DSH State experiences a level of negative growth such that its previous FFY State DSH allotment would be more than 12 percent of its current FFY's total unadjusted medical assistance expenditures (excluding administrative costs), then the low-DSH State's previous year's DSH allotment will be reduced to the extent necessary to maintain the individual low-DSH States' 12-percent limit. That amount will become the low-DSH State's DSH allotment for the current FFY. In no FFY will a low-DSH State's DSH allotment be allowed to exceed its individual State 12-percent limit.

Comment: Several commenters expressed concern that the process used to develop the FFY 1993 allotments resulted in the reporting of data that required a $1.5 billion adjustment. One commenter noted that it was expected that some adjustments would be required because States had minimal administrative guidance and no regulatory guidance for reporting DSH expenditures. However, the size and scope of adjustments indicate that the reported information used to set the DSH allotments was inaccurate or unreliable. The commenters raised questions regarding the adjustment process and expressed concern that the process was not made public.

Response: The November 24, 1992, DSH notice explained that we purified the FFY 1992 DSH expenditure data submitted by States in June 1992 as the result of our May 6, 1992, State survey request, updated by States in August 1992. As we explained in that notice, the States had submitted unadjusted FFY 1992 DSH expenditures totalling over $18 billion. We reviewed these DSH expenditures and adjusted the State data to remove DSH expenditures that did not qualify under the provisions of section 1923 of the Act as base allotment expenditures. Specific adjustments totalling over $1.5 billion were made for the following categories: (1) Amounts representing retroactive DSH expenditures that were not applicable to FFY 1992; (2) Non-DSH expenditures incorrectly included as DSH expenditures; (3) One-time DSH expenditures, which are not allowable in the calculation of the base allotments, made under plan amendments effective October 1, 1991, through December 31, 1991; and (4) DSH expenditures for non-approvable DSH plans. The total adjustments resulted in adjusted FFY 1992 DSH expenditures of over $16.5 billion. The adjustments were based on the best data available at the time. However, we have revised the reconciliation process at § 447.297(d) to ensure that the latest available data are used in updating and finalizing the FFY 1992 DSH expenditures that are used in setting the final FFY 1993 limits. In the DSH notice published elsewhere in this issue of the **Federal Register**, we again explain how we determined FFY 1992 DSH payment adjustments.

Comment: One commenter observed that the interim final regulations at § 447.298 provide that each State's base DSH allotment is calculated using the greate of: (1) Allowable DSH payments in FFY 1992 (beginning October 1, 1991), or (2) $1 million. The interim final regulations appear to allow States to count payments earned from October 1 through September 30. For States operating on a July 1 through June 30 fiscal year, this language could be construed to allow payments made for two State DSH periods.

Response: All States, regardless of their fiscal year periods, are having their DSH payments limited based on DSH expenditure levels for FFY 1992 (that is, for the period October 1, 1991, through September 30, 1992.) Only DSH expenditures applicable to FFY 1992 are included in the base used for determining the DSH national and State limits. The State fiscal period does not come into play for the DSH limit calculations.

Comment: One commenter recommended that HCFA rewrite § 447.298(a)(3) to clarify that DSH payments are included in the denominator as part of total medical assistance expenditures.

Response: Section 447.298(a)(3) provides that HCFA will calculate a percentage for each State by dividing the disproportionate share hospital base allotment by the "total" medical assistance expenditures, excluding administrative costs. The phrase "total medical assistance expenditures, excluding administrative costs" does include DSH payments. We believe that, by including the word "total," we have clearly included DSH payments in this calculation. Therefore, we believe it unnecessary to make this clarifying change.

Comment: One commenter pointed out that § 447.298(e)(2)(iv) appears to be worded incorrectly. The commenter noted that this paragraph should say the "* * * total amount of additional disproportionate share * * *" and suggested that the word "additional" be inserted to reflect the language in the statute.

Response: We agree that the word "additional" should be inserted in this section and have revised § 447.298(e)(2)(iv) accordingly.

Comment: One commenter objected to § 447.298(a), which provides that State DSH allotments be calculated on an accrual basis, rather than a cash basis. The commenter believed that this regulation is in direct conflict with Public Law 102–234, which states that State base allotments will be the total amount of payment adjustments made during fiscal year 1992. The commenter added that the regulation bases the State allotment on payments attributable to the fiscal year.

Response: Because of the normal time lag between a State actually incurring an expense and its submission of an expenditure claim for FFP, we determined that to be fair to all States in setting the DSH allotments it was reasonable to use total DSH payments attributable to FFY 1992 instead of payments actually paid in FFY 1992. We believe it was not the Congress' intent to limit DSH payments based on actual cash payments made in FFY 1992. Therefore, we did not narrow our interpretation of the statute by using the literal reading of the statute but adopted the expanded interpretation contained in § 447.298(a) that all DSH payments attributable to FFY 1992 be included in the calculation of the State DSH allotments.

3. Other Comments

Comment: One commenter noted that the statute makes no reference to the exclusion of administrative costs in the determination of Medicaid expenditures

for purposes of the calculation of the national 12-percent DSH limit. The commenter believed, therefore, that HCFA exceeded its authority in excluding these costs.

Response: Section 1923(f)(1)(B) of the Act imposes a national DSH payment limit equivalent to 12 percent of the total amount of expenditures under title XIX State plans for medical assistance expenditures incurred during a FFY. Medical assistance expenditures, as described in section 1905(a) of the Act, include payment for part or all of the cost of specific care and services provided. Administrative costs are not included within the section 1905(a) definition of medical assistance expenditures. Sections 1903(a)(2) through (a)(7) of the Act set forth separate FFP matching percentages for State administrative costs, which differ from the FFP matching percentages for medical assistance expenditures. Therefore, in keeping with the statutory distinction between medical assistance expenditures and State administrative costs, we believe we have properly excluded State administrative costs from the calculation of the 12-percent national DSH limit which is tied to medical assistance expenditures.

Comment: One commenter noted that an attempt to limit present DSH payments through new regulations would be devastating and would result in the closure of one particular small rural hospital. The commenter requested that HCFA rethink any planned reductions in DSH payments. The commenter explained that small rural hospitals provide the first and, in many cases, the only medical care to millions of rural citizens living in rural areas.

Response: These regulations do not specifically target rural hospitals. However, section 1923(f) of the Act does not exclude rural hospitals from these new DSH limits. These DSH limits are applied to State aggregate DSH payments to all hospitals. States still have the flexibility to determine which hospitals are designated as DSHs and the amount of DSH payments to be made to qualifying DSHs within the State limits. Under these regulations, States have the flexibility to provide increased DSH payments to rural hospitals by redistributing DSH payments among other hospitals.

Comment: One commenter recommended that the regulations be revised to conform more closely to the law. The commenter explained that there is a significant difference in the definition of State base allotment as contained in section 1923(f)(4)(C) of the Act and the regulation at § 447.298(a)(i). The statute makes it clear that the State base allotment is the greater of $1,000,000 or the total amount of payment adjustments made during fiscal year 1992. The regulation at § 447.298 creates a "State projected disproportionate share hospital payment for FFY 1992." The commenter noted that in the November 24, 1992, **Federal Register** (57 FR 55130–55131), HCFA acknowledges that for a high-DSH State, the State base allotment is the total amount of DSH payment adjustments in 1992. This 1992 limit is guaranteed to the high-DSH States by statute as its share until these payments equal 12 percent of the State's Medicaid budget. The commenter recommended that HCFA change the regulations to reflect the language of the statute.

Response: We used the phrase, "State projected disproportionate share hospital payment for FFY 1992" in § 447.298(a) because the calculation of both the preliminary and final national and State DSH limits are based on estimated Medicaid expenditures. Since these calculations are based on estimated expenditures, we believe the use of the phrase is appropriate.

Comment: One commenter stated that the Secretary should consider publishing regulations on the method that States may employ to determine which hospitals may be "deemed" to be DSHs under 42 U.S.C. 1396r–4(b)(1) (section 1923(b) of the Act) and the method States may use to determine the additional minimum payment under 42 U.S.C. 1396r–4(c). The commenter noted that HCFA omitted addressing these issues out of concern for the proscriptions contained in 42 U.S.C. 1396r–4(b)(4). The commenter expressed his legal opinion that 42 U.S.C. 1396r–4(b)(4) should not be construed to limit the Secretary's authority to publish regulations which assure that States appropriately implement the "deemed" DSH provision of 42 U.S.C. 1396r–4(b)(1). Also the commenter did not construe 42 U.S.C. 1396r–4(b)(4) to prohibit the Secretary from promulgating regulations that interpret the payment provisions of 42 U.S.C. 1396r–4(c), nor did the commenter construe either the now amended or predecessor provision of 42 U.S.C. 1396(h) as imposing such limitations.

Response: We understand the commenter's interest in desiring implementing regulations for the subject areas. However, these issues are outside of the purview of the national and State DSH limits that were the subject of the interim final rule. Although, the commenter advised us that, in his legal opinion, the provisions of 42 U.S.C. 1396r–4 (b) and (c) do not prohibit the issuance of regulations dealing with these issues, we believe that 42 U.S.C. 1396r–4 does limit the Secretary's authority to restrict a State's authority to designate hospitals as disproportionate share hospitals. Therefore, we are not addressing these issues in this final rule. However, should we decide to address these issues at a later date, we will publish a proposed rule.

Comment: One commenter noted that the interim final rule does not provide States any grace period for making changes in their State plans to reflect the necessity to recoup DSH payments that grow directly out of the rule.

Response: We did not provide a grace period for recoupment purposes because States have the flexibility to develop methods and standards for recoupment of overpayments tailored to their particular needs. Many State plans already contain recoupment procedures. If a State plan does not currently contain provisions describing recoupment procedures and the State wishes to develop methods and standards for recoupment purposes, the State may file a State plan amendment to add any necessary recoupment procedures. However, this amendment must comply with all applicable Federal State plan amendment requirements and the State must provide the assurances and related information required in accordance with Federal regulations at §§ 447.253 and 447.255.

Comment: One commenter noted that the prospective reduction of DSH payments raises issues of equity. The commenter observed that the hospital base of a given DSH program may change from year to year as new hospitals qualify and participating hospitals fail to qualify. The rule, as written, could result in payments to hospitals in one fiscal year being reduced to compensate for payments to other hospitals in the preceding fiscal year which necessitated the reduction.

Response: We issued the interim final rules to implement the statutory requirement imposed by Public Law 102–234 that a State's aggregate DSH payments not exceed a specified limit. We did not intend to alter a State's ability to define which hospitals qualify as DSHs or prescribe a State's method for making DSH payments. Under these regulations, States continue to have the flexibility to develop their own methods and standards for complying with the DSH requirements of section 1923 of the Act. As to the commenter's concerns regarding equity, each State has the flexibility to resolve this issue. We hope that each State will be equitable in designing and determining recoupment

procedures that it desires. As previously explained, the State plan must contain a description of the methods and standards that will be used to recoup overpayments.

Comment: A few commenters were concerned with HCFA's assertion in the regulatory impact statement that the interim final regulations will not have a direct or indirect affect on recipients since the rule will not preclude providers from receiving Medicaid payments for services that are furnished. The commenters noted that recipients will likely be affected. The commenters explained that individual State Medicaid programs will be uncertain of the allowable FFP for DSH payments since retroactive adjustments can be made. States will deal with the uncertainties brought about by this rule by reducing DSH payment programs and recouping DSH payments already made to hospitals. These commenters noted that the interim final rule provides no certainty in the amount of DSH funds that will be available to States and hospitals to support DSH facilities. The resulting confusion and uncertainty will work to the detriment of the health care system.

Response: The reference in the impact statement in the interim final rule to recipients was intended to mean individual Medicaid recipients. Since DSH payments are supplemental additional payments to hospitals not specifically tied to a specific Medicaid service provided to a specific Medicaid recipient, we concluded that the interim final DSH regulations would not directly or indirectly affect Medicaid services provided to individual Medicaid recipients.

Comment: Several commenters questioned whether States could appeal the determination of their base allotments as they appeared in the November 1992 notice. These commenters recommended that HCFA add appeals procedures to the regulations.

Response: In the November 1992 notice, we provided only preliminary numbers that we stated would be updated and finalized based on the most recent available data. We, therefore, believe it unnecessary to provide an appeals mechanism for the preliminary numbers. However, if a State has FFP disallowed based on these preliminary numbers, that State is entitled to appeal the disallowance using the appeal procedures for Medicaid FFP disallowances in 45 CFR part 16.

Comment: Several commenters requested that HCFA provide more detailed instructions to States on the reporting documentation and potential adjustments that could be made to their DSH expenditures.

Response: HCFA will issue instructions through a State Medicaid Manual transmittal that will provide guidance to States regarding the reporting of DSH payment adjustment expenditures.

Comment: One commenter suggested that it would be more efficient and cost-effective for the Federal Government to limit DSH payments to States' annualized value of approved State plans for DSH payments relative to total State Medicaid expenditures for medical assistance for the same fiscal period. The commenter explained that this method would reduce State/Federal disputes by eliminating the national cap and holding States to the State 12-percent cap and their annual program growth for the same fiscal period. Another commenter suggested that HCFA adopt a more equitable mechanism for limiting DSH payments. This commenter suggested that the caps of all States be equal percentages of their Medicaid budgets.

Response: We believe that the methods specified by the commenter do not comply with the requirements specified in section 1923(f) of the Act for setting the DSH limits. Section 1923(f) of the Act details specific calculations that must be made in determining the new statutory DSH limits. We have followed these requirements in our calculations of the limits and have incorporated these statutory requirements in our DSH regulations.

Comment: One commenter emphasized that the new DSH assurance required by § 447.272 relative to the applicable DSH payment limits will be subject to variables that comprise the preliminary adjusted and final DSH payment limits. Therefore, the commenter observed, States will be unable to absolutely know or control these variables. Consequently, HCFA should consider these variables in its review of the assurances provided by States.

Response: Section 447.272 requires States to assure HCFA only that DSH payments will not exceed the published limit amounts. Since these amounts are published amounts, they are known factors. To avoid problems with this DSH assurance, we strongly recommend that States add language to their State plans that allow them to make DSH payments up to, but not exceeding, the finally determined published limit amount.

Comment: One commenter expressed concern that the DSH policy will have an extremely adverse impact on access to care that is funded through DSH programs and provider institutions. The commenter noted that implementation of the DSH policy will flow inexorably down hill to the most financially strapped institutions and will consequently disadvantage patients in States that were innocent of the abuses leading to the DSH problem. This commenter noted that this DSH policy will undermine the credibility and disrupt the operation of the fledgling State-County partnership program that relies upon DSH and other Medicaid programs. Further, this commenter noted that the DSH policy is extremely disruptive to the overall health care reform strategies upon which some States embark to facilitate universal access and efficient use of all health care dollars, with a minimum of government regulation.

Response: The interim final DSH regulations implement the statutory provisions of section 1923(f) of the Act. The regulations do not eliminate DSH payments but, instead, constrain States' DSH spending to FFY 1992 levels. The regulations permit DSH payments by low-DSH States to increase in proportion to the State's growth of other Medicaid program expenditures. They do not alter the flexibility afforded to States to determine which hospitals qualify as DSHs and to choose the payment method to determine DSH payments. DSH programs that were in existence in FFY 1992 can continue at the FFY 1992 spending level. The intent of the regulations is to prohibit States from increasing DSH spending beyond the allowable FFY 1992 levels. The Congress believed it necessary to pass section 1923(f) of the Act to constrain and control Medicaid health care costs.

Comment: One commenter noted that HCFA recently separated FFP allowances for DSH out of the aggregate FFP allowances. The commenter pointed out that it is unclear at this time how these quarterly allowances will be affected by the multiple estimates, or if they will take into account date of service and date of payment variations (slow start-up lapse period spending).

Response: For purposes of monitoring DSH payment adjustment expenditures, States will be required to report this information on a quarterly basis. Guidance concerning the specific DSH expenditure reporting requirements described in § 447.299 will be provided through instructions in the State Medicaid Manual.

Comment: Many commenters recommended that HCFA provide public access to the data used for the adjustment of State DSH allotments and the State and national DSH caps.

Response: Under the Freedom of Information Act, these data are currently available to the public. To obtain this information, an individual must submit a Freedom of Information Request to HCFA.

Comment: One commenter requested that HCFA provide more information and guidance concerning the DSH State plan amendment requirements that would allow States retroactively to make additional DSH payments if, after the year-end reconciliation process, a State's actual DSH spending was below its allotment level. Further, this commenter requested that HCFA specify the timeframes for the State receipt of notices of FFP disallowances for DSH expenditures exceeding the DSH allotment.

Response: If a State wishes to make additional DSH payments up to the amount of its finally determined DSH allotment, the State must include language in its State plan that would permit higher payments. In other words, the State plan should contain language that authorizes that total DSH payments for a specified FFY can be made up to the allowable amounts permitted in accordance with the finally determined DSH allotment for the period. If the plan contains such language, we would not consider payments made in accordance with this provision to be retroactive payments. Therefore, we recommend that all States review their currently approved plans to determine if the existing language permits DSH payments for a FFY up to the finally determined DSH limit. If a State's plan does not currently permit these payments, we recommend that the State submit a State plan amendment to include DSH payments for a specified FFY up to the amount of the finally determined DSH allotment. If a State plan amendment is necessary to accommodate such language, the State plan amendment should be submitted in compliance with all the Federal State plan amendment requirements described in regulations. FFP disallowances based on exceeding the DSH allotments will be taken once the final DSH allotments are known. This process will follow the normal FFP disallowance procedures that exist in accordance with the current Federal policy.

Comment: One commenter noted that § 447.296 delineates conditions under which States can revise the disproportionate share portion of their State plans for the period January 1, 1992, through September 30, 1992, to meet the minimum payment requirements of the Act. For this purpose, HCFA defined "minimum payment adjustments" as the amount required by the Medicare payment requirements. The commenter pointed out that the Act does not define a minimum payment adjustment. The statute leaves this definition to a State's discretion as long as the payment is reasonably related to the cost, volume, or proportion of services provided to title XIX recipients or low-income patients. The commenter believes that HCFA would establish a dangerous precedent by designating Medicare payment levels as a minimum requirement, even for the limited purposes of this section. The commenter stated that such a suggestion may not go unnoticed by the courts and could eventually be costly to both the States and to the Federal Government. The commenter expressed an opinion that it is both unnecessary and inappropriate to define minimum payment adjustments in the absence of a definition in the Act, and in light of this section having application to a retroactive period.

Response: Section 447.296(b)(5) was added to implement section 1923(f)(1)(A)(i)(II) of the Act, which permitted States to submit a State plan by September 30, 1992, that increased aggregate DSH payments to meet the minimum payment adjustments required by section 1923(c)(1) of the Act. The regulation specifically links the minimum payment adjustment to the amount required to meet the Medicaid payment requirements of section 1923(c)(1) of the Act. Even though this provision applies only to the moratorium period, we included it in the regulations as a record of the requirements for that period.

Comment: One commenter indicated that in § 447.298(a)(1) and (a)(2), the phrases "payments for," "payments during," and "payments made for the FFY" are confusing. The commenter suggests that the regulations state that all timely DSH payments for services rendered during FFY 1992 be included in the calculation of the State base allotment.

Response: We believe that simply stating that the State's base allotment will be based upon "timely" DSH payments would be too vague.

Comment: One commenter was concerned that the regulation provides an overly restrictive interpretation of the statute as it applies to the DSH payment limits applicable to the States. The commenter warned that the regulations limit the ability of States to help finance these providers at a time when they are often the only "safety net" available to serve the low-income population. Furthermore, the restrictions unfairly penalize States that have limited DSH payments to date but now seek to expand their programs and advantage those States that developed DSH payment programs more quickly.

Response: The interim final regulations implement section 1923(f) of the Act. Section 1923(f) of the Act and these regulations do not eliminate DSH payments but instead constrain States' DSH spending to FFY 1992 levels, while permitting DSH payments by a low-DSH State to increase in proportion to the State's growth of other Medicaid program expenditures. These regulations do not alter the flexibility afforded to States to determine which hospitals qualify as DSHs and to choose the payment method that is used to determine DSH payments. DSH programs that were in existence in FFY 1992 can continue at the FFY 1992 spending level. These regulations were issued to prohibit States from increasing DSH spending beyond the allowable FFY 1992 levels to constrain and control Medicaid health care costs.

Comment: One commenter indicated a conflict in the regulations. The commenter pointed out that § 447.298(b)(2) provides that, "for high-DSH States, the dollar amount of DSH payments in FFY 1993 may not exceed the dollar amount of payments made in FFY 1992." This language is repeated in paragraph (c)(2). Similarly, in setting forth the limitation on aggregate payments for DSHs after FFY 1992, the regulations provide for the calculation of the payment limit based on "actual expenditures" and "payments made by a State." (§ 447.297(c)). In the same section, however, the regulations provide that HCFA will revise the preliminary State allotment based on "* * * the information available as of December 31 of each year, "attributable" to the prior FFY for which the limit is being calculated * * *" (§ 447.297(d)(2)). The commenter believed that the use of the term "actual expenditures" is inconsistent with the recognition of payments "attributable to" the FFY and that these inconsistencies could engender many unnecessary controversies. Accordingly, the commenter suggested revised language that HCFA could use to clarify the regulatory language regarding the calculation of the State base allotment. The commenter also suggested that each reference to the "payments" or "expenditures" that will be considered in the determination or application of the State allotment be clarified by adding "for services rendered during the FFY 1992 in the State base allotment, regardless of when payment is made."

Response: We have revised regulations at §§ 447.298(a)(1)(i), (a)(2)(i), and (b)(2) to state that the amounts used in determining the DSH payments made by the States will be based on payments "applicable to" rather than payments "in" a FFY.

We have not made the commenter's second recommended change. Since DSH payments are not necessarily directly tied to services, we believe that including the word "services" would cause considerable confusion.

D. Changes to the Interim Final Rule

As explained in our responses to comments, we have made the following revisions to the DSH regulations published in the November 1992 interim final rule.

1. Publication of Final National DSH Target and Individual State DSH Allotments

We have revised §§ 447.297(b), (c), (d)(1), and (d)(2) in response to comments concerning the time lag between the publication of the "preliminary" national DSH expenditure target and individual State DSH allotments and the publication of "final" national DSH expenditure target and individual State DSH allotments. As required by law, we will continue to publish the preliminary projected national DSH expenditure target and individual State DSH allotments by October 1 of each FFY. These preliminary amounts will be based upon the most current applicable actual and estimated expenditure information reported to HCFA, and adjusted by HCFA as may be necessary, immediately prior to the October 1 publishing date. However, we will publish the final national DSH expenditure target and individual State DSH allotments by April 1 of each FFY. These final amounts will be based upon the most current, applicable actual and estimated expenditure information reported to HCFA, and adjusted by HCFA as may be necessary, immediately prior to the April 1 publication date. Once the final State DSH allotments are published for the FFY, they will not be recalculated for that FFY based upon any subsequent actual or estimated expenditure information reported to HCFA. This notification will provide the States with the certainty of knowing their final FFY DSH allotments by April 1 of each FFY and that their DSH allotments will not change any further for that FFY.

2. HCFA Monitoring of DSH Payments

We have revised the regulations at §§ 447.298(a)(1)(i), (a)(2)(i), and (b)(2) to state that the amounts used in determining the DSH payments made by the States will be based on payments "applicable to" rather than payments "in" a FFY. Once the final State DSH allotments are published each FFY, actual State DSH expenditures applicable to that FFY will be reviewed on an ongoing basis as States submit expenditure reports to HCFA to ensure that no State spends in excess of its FFY DSH allotment for that FFY. Also, additional DSH expenditures reported in subsequent FFYs that are applicable to previous FFYs will be reconciled back to that previous year's final State DSH allotment to ensure that the final State DSH allotment in any FFY is not exceeded. Any DSH expenditures in excess of the final State DSH allotment for a FFY will be disallowed and be subject to the normal Medicaid disallowance procedures. Finally, if a State's actual DSH expenditures in a FFY are less than its final DSH allotment for that FFY, the State may, to the extent permissible under its approved State plan, make additional DSH expenditures up to the amount of its final State DSH allotment for that FFY.

Although not specifically included in the regulations text, we believe that it is important to note here that since we are making such a significant change to the procedures specified in the interim final regulations for establishing the final FFY national DSH expenditure target amount and State DSH allotments, we have added an additional procedure applicable only to FFY 1993. Specifically, we asked each State to confirm the actual and estimated expenditure information that we intended to use in establishing the final FFY State DSH allotments and national DSH expenditure target amounts. We reviewed any changes or updates submitted by the States and made adjustments as we determined necessary and appropriate.

3. DSH 12-Percent Spending Target

We have made the following changes with regard to DSH spending limitations:

- We have revised the regulations at §§ 447.297(b) to state that 12 percent of total medical assistance expenditures (excluding administrative costs) is a target rather than an absolute cap in determining the amount that can be allocated for disproportionate share hospital payments. We have also revised paragraph (b) to state that HCFA will make final projections by April 1 of the current FFY rather than the April 1 following the FFY.
- We have revised paragraph § 447.297(c) to delete statements that provided that a final reconciliation would be made following the end of the FFY. We have added a new paragraph (c) that provides (1) that a preliminary national DSH expenditure target and State DSH allotments will be published prior to October 1 of each FFY, and (2) that a final national DSH expenditure target and State DSH allotments will be published by April 1 of each FFY.
- We have revised paragraph § 447.297(d) to delete statements that described the process for revising preliminary projections by April 1 of the FFY. We have added a new paragraph (d), which describes the process for determining the final national DSH expenditure target and State DSH allotments by April 1 of the FFY. In addition, we have revised paragraph (e)(2) to state that the final national DSH expenditure target and State DSH allotments will be published by April 1 of each FFY.
- We have revised § 447.298 to reflect that the 12-percent national limit is a target rather than an absolute cap. We are making these revisions based upon the comments we received on the interim final rule and our review of Congressional intent. We now believe that it was not the intent of the legislation to achieve the national 12-percent DSH expenditure limit in a FFY by requiring the State DSH allotments in any FFY to fall below the FFY 1992 State base allotments. We furthermore believe that it was not the intent of the legislation that the low-DSH States should not receive their growth amounts consistent with their individual State Medicaid program growth in those FFYs when the State's Medicaid program expenditures did not grow in excess of the national target percentage.

These revisions are further supported by the fact that the original estimates used by the drafters of the legislation appear to have significantly underestimated the FFY 1992 State DSH base allotments upon which future State DSH allotments would be based and significantly overstated projections of future FFY national Medicaid expenditures against which the national limit would be calculated.

- We have deleted paragraph § 447.298(g), which described the process to be used to reduce State DSH allotments in any FFY that the national aggregate limit exceeded 12 percent.

4. States With Negative Growth

We have added new § 447.298 (d)(2) and (d)(3) to include our method of determining State DSH allotments for low-DSH States that experience a certain level of negative growth. If a low-DSH State experiences a certain

level of negative growth that results in its previous FFY DSH allotment exceeding 12 percent of its current FFY total unadjusted medical assistance expenditures (excluding administrative costs), we will reduce the low-DSH State's previous FFY's DSH allotment to the extent necessary to maintain the low—DSH State's 12-percent limit. The reduced amount will become the low-DSH State's allotment for the current FFY. In no FFY, will a low-DSH State's DSH allotment be allowed to exceed its individual 12-percent limit.

We have revised § 447.298(d)(1)(ii)(2) to provide that, if a low-DSH State's growth factor is negative in any FFY, the State's growth amount will be zero for that FFY and the State's DSH allotment will not be reduced to account for this negative growth except as provided for in § 447.298(d)(2), as explained above.

5. Typographical Corrections

We have revised § 447.298(e)(2)(iv) by adding the word "additional" in response to a comment.

III. Regulatory Impact Statement

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any rule that meets one of the E.O. 12291 criteria for a "major rule"; that is, that is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that a rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we do not consider States or individuals to be small entities. However, we do consider all providers to be small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an 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 50 beds.

We included a voluntary regulatory flexibility analysis in the November 1992 interim final rule (57 FR 55261) because of the potential controversial nature of the regulations, the number of comments we expected to receive, and the anticipated effect on States' share of FFP. The voluntary analysis attempted to describe the effects the interim final rule would have on States, providers, and Medicaid recipients.

Although we received no comments directly concerned with the impact analysis, many commenters addressed issues that related to costs, such as outstationed eligibility worker donations, compliance with the hold harmless provisions deadline, and low-DSH States' entitlement to increased DSH payments regardless of the 12-percent limit. As a result of these and other comments, we have made changes to the interim final rule in this final rule, which are explained in detail in sections I. and II. of the preamble of this final rule. For example, we have reinterpreted the 12-percent national limit to be a target rather than an absolute cap. As a result of this interpretation, we have allowed for an increase to the FY 1993 DSH allotment of $800 million over our November 24, 1992, projected Federal DSH payments for fiscal year 1993. In light of this increase, we have recalculated our initial State and Federal projected DSH payments published in the interim final rule as follows:

REVISED PROJECTED DSH ALLOTMENTS

[In billions of dollars]

Fiscal year	Federal	State	Total
1993	10.3*	7.6	18.0
1994	10.7	7.9	18.6
1995	11.7	8.7	20.4
1996	13.1	9.7	22.8

*This is the actual 1993 DSH allotment after an increase of $800 million was added to our initial projection of $9.5 billion.

Our initial projections for State and Federal spending associated with State provider tax and donation programs published in the interim final rule were:

PROJECTED FEDERAL MEDICAID SPENDING ASSOCIATED WITH STATE PROVIDER TAX AND DONATION PROGRAMS

[in billions of dollars]

FY 1992	FY 1993	FY 1994	FY 1995	FY 1996
$8.7	$11.3	$14.4	$18.0	$22.0

While we believe that the changes we are making are beneficial to the States, we do not believe the changes have a significant impact on the voluntary analysis that was published in the interim final rule. For this reason, we have determined that the threshold criteria under E.O. 12291 are not met, and that an additional regulatory impact analysis for this final rule is not required. Further, we have determined, and the Secretary certifies, that this final rule would not have significant economic impact on a substantial number of small entities and would not have a significant impact on the operations of a substantial number of small rural hospitals. Therefore, we have not prepared a regulatory flexibility analysis or an analysis of effects on small rural hospitals.

List of Subjects

42 CFR Part 433

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

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs-health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Chapter IV, Subchapter C is amended as follows:

A. Part 433 is amended as follows:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 is revised to read as follows:

Authority: Secs. 1102, 1137, 1902(a)(4), 1902(a)(18), 1902(a)(25), 1902(a)(45), 1902(t), 1903(a)(3), 1903(d)(2), 1903(d)(5), 1903(i), 1903(o), 1903(p), 1903(r), 1903(w), 1912, 1917, and 1919(e) of the Social Security Act (42 U.S.C. 1302, 1320b-7, 1396a(a)(4), 1396a(a)(18), 1396a(a)(25), 1396a(a)(45), 1396a(t), 1396b(a)(3), 1396b(d)(2), 1396b(d)(5), 1396b(i), 1396b(o), 1396b(p), 1396b(r), 1396b(w), 1396k and 1396(p)).

2. In § 433.56, the introductory text of paragraph (a) is republished, paragraph (a)(8) is revised, paragraph (a)(9) is redesignated as paragraph (a)(19) and revised, and new paragraphs (a)(9) through (a)(18) are added to read as follows:

§ 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:

* * * * *

(8) Services of health maintenance organizations and health insuring organizations;

(9) Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;

(10) Dental services;

(11) Podiatric services;

(12) Chiropractic services;

(13) Optometric/optician services;

(14) Psychological services;

(15) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;

(16) Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses;

(17) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;

(18) Emergency ambulance services; and

(19) Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following:

(i) The fee must be broad based and uniform or the State must receive a waiver of these requirements;

(ii) The payer of the fee cannot be held harmless; and

(iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

* * * * *

3. In § 433.58, the introductory text of paragraph (d) is republished, paragraph (d)(2) is revised, and paragraph (g)(2) is revised to read as follows:

§ 433.58 Provider-related donations and health care-related taxes during a State's transition period.

* * * * *

(d) *Permissible donations.* To be permissible donations, the donations must be—

* * * * *

(2) Donations 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 that facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid and/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 office space are not allowable for this purpose; or

* * * * *

(g) *Health care-related taxes during the transition period.*

* * * * *

(2) A State may not modify health care-related taxes in existence as of November 22, 1991, without a reduction of FFP, unless the modification only—

(i) Extends a tax program that was scheduled to expire before the end of the State's transition period;

(ii) Makes technical changes that do not alter the rate of the tax or the base of the tax (for example, the providers on which the tax is imposed) and do not otherwise increase the proceeds of the tax;

(iii) Decreases the rate of the tax, without altering the base of the tax; or

(iv) Modifies the tax program to bring it into compliance with § 433.68(f).

4. In § 433.66, the introductory text of paragraph (b) is republished and paragraph (b)(2) is revised to read as follows:

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

* * * * *

(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:

* * * * *

(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 office space are not allowable for this purpose.

5. In § 433.67, paragraph (b) is revised to read as follows:

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

* * * * *

(b) *Calculation of FFP.* HCFA 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.

6. In § 433.68, paragraph (c)(3), the introductory text in paragraph (d), paragraphs (e)(1) and (e)(2), and paragraphs (f)(3)(i) and (f)(3)(ii) are revised to read as follows:

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

* * * * *

(c) *Broad based health care-related taxes.*

* * * * *

(3) A State may request a waiver from HCFA 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 revenues must be applied uniformly to all providers being taxed.

* * * * *

(e) *Generally redistributive.* * * *

(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, HCFA will automatically approve the waiver request.

(iii) If a tax is enacted and in effect prior to [publication of this final rule], and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.90, HCFA 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 nonpublic 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 [publication date of this final rule], and the State demonstrates to the Secretary's satisfaction that the value of P1/P2 is at least 0.95, HCFA 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, HCFA 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, HCFA 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 nonpublic 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 0.85 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.*

* * * * *

(3) * * *

(i) An indirect guarantee will be determined to exist under a two prong "guarantee" test. This specific hold harmless test is effective [30 days after date of publication of this final rule]. 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, HCFA 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 [publication date of this final rule], 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, HCFA will not disallow funds received by the State resulting from the tax if the State modifies the tax to comply with this requirement by [30 days after date of publication of this final rule]. If, by [30 days after date of publication of this final rule], the tax is not modified, funds received by States on or after [30 days after date of publication of this final rule] will be disallowed.

7. In § 433.72, paragraph (c) is revised to read as follows:

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

* * * * *

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

(1) The date of enactment of the tax for programs in existence prior to [publication date of this final rule] or;

(2) For tax programs commencing on or after [publication date of this final rule], on the first day in the quarter in which the waiver is received by HCFA.

B. Part 447 is amended as follows:

PART 447—PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. In § 447.297, paragraphs (b), (c), (d), and (e) are revised to read as follows:

§ 447.297 Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992.

* * * * *

(b) *National payment target.* The national payment target for disproportionate share hospital (DSH) payments for any Federal fiscal year is equal to 12 percent of the total medical assistance expenditures that will be made during the Federal fiscal year under State plans, excluding administrative costs. A preliminary national expenditure target will be published by HCFA prior to October 1 of each year. This preliminary national expenditure target will be superseded by a final national expenditure target published by April 1 of each Federal fiscal year, as specified in paragraph (d) of this section.

(c) *State disproportionate share hospital allotments.* Prior to October 1 of each Federal fiscal year, HCFA will publish in the **Federal Register** preliminary State DSH allotments for each State. These preliminary State DSH allotments will be determined using the most current applicable actual and estimated State expenditure information as reported to HCFA and adjusted by HCFA as may be necessary using the methodology described in § 447.298. HCFA will publish final State DSH allotments by April 1 of each Federal fiscal year, as described in paragraph (d) of this section.

(d) *Final national disproportionate share hospitals expenditure target and State disproportionate share hospitals allotments.*

(1) HCFA will revise the preliminary national expenditure target and the preliminary State DSH allotments by April 1 of each Federal fiscal year. The final national DSH expenditure target and State DSH allotments will be based on the most current applicable actual and estimated expenditure information reported to HCFA and adjusted by HCFA as may be necessary immediately prior to the April 1 publication date. The final national expenditure target and State DSH allotments will not be recalculated for that Federal fiscal year based upon any subsequent actual or estimated expenditure information reported to HCFA.

(2) If HCFA determines that at any time a State has exceeded its final DSH allotment for a Federal fiscal year, FFP attributable to the excess DSH expenditures will be disallowed.

(3) If a State's actual DSH expenditures applicable to a Federal fiscal year are less than its final State DSH allotment for that Federal fiscal year, the State is permitted, to the extent allowed by its approved State plan, to make additional DSH expenditures applicable to that Federal fiscal year up to the amount of its final DSH allotment for that Federal fiscal year

(e) *Publication of limits.*

(1) Before the beginning of each Federal fiscal year, HCFA will publish in the **Federal Register**—

(i) A preliminary national DSH expenditure target for the Federal fiscal year; and

(ii) A preliminary DSH allotment for each State for the Federal fiscal year.

(2) The final national DSH expenditure target and State DSH allotments will be published in the **Federal Register** by April 1 of each Federal fiscal year.

3. In § 447.298, paragraphs (a), (b), (c), (d), and (e) are revised, and paragraph (g) is removed to read as follows:

§ 447.298 State disproportionate share hospital allotments.

(a) *Calculation of State's base allotment for Federal fiscal year 1993.*

(1) For Federal fiscal year 1993, HCFA will calculate for each State a DSH allotment, using the State's "base allotment." The State's base allotment is the greater of:

(i) The total amount of the State's projected DSH payments for Federal fiscal year 1992 under the State plan applicable to Federal fiscal year 1992, calculated in accordance with paragraph (a)(2) of this section; or

(ii) $1,000,000.

(2) In calculating the State's DSH payments applicable to Federal fiscal

year 1992, HCFA will derive amounts from payments applicable to the period of October 1, 1991, through September 30, 1992, under State plans or plan amendments that meet the requirements specified in § 447.296(b). The calculation will not include—

(i) DSH payment adjustments made by the State applicable to the period October 1, 1991 through December 31, 1991 under State plans or plan amendments that do not meet the criteria described in § 447.296; and

(ii) Retroactive DSH payments made in 1992 that are not applicable to Federal fiscal year 1992.

(3) HCFA will calculate a percentage for each State by dividing the DSH base allotment by the total unadjusted medical assistance expenditures, excluding administrative costs, made during Federal fiscal year 1992. On the basis of this percentage, HCFA will classify each State as a "high-DSH" or "low-DSH" State.

(i) If the State's base allotment exceeded 12 percent of its total unadjusted medical assistance expenditures made under the State plan in Federal fiscal year 1992, HCFA will classify the State as a "high-DSH" State.

(ii) If the State's base allotment was 12 percent or less of its total unadjusted medical assistance expenditures made under the State plan in Federal fiscal year 1992, HCFA will classify the State as a "low-DSH" State.

(b) *State disproportionate share hospital allotments for Federal fiscal year 1993.* (1) For Federal fiscal year 1993, HCFA will calculate a DSH allotment for each low-DSH State that equals the State's base allotment described under paragraph (a) of this section, increased by State growth, as specified in paragraph (d) of this section.

(2) For high-DSH States, the dollar amount of DSH payments in Federal fiscal year 1993 may not exceed the dollar amount of DSH payments applicable to Federal fiscal year 1992 (that is, the State base allotment).

(c) *State disproportionate share hospital allotment for Federal fiscal years 1994 and after.* For Federal fiscal years 1994 and after—

(1) For low-DSH States, HCFA will calculate the DSH allotment for each Federal fiscal year by increasing the prior year's State DSHs allotment by—

(i) State growth, as specified in paragraph (d) of this section; and

(ii) A supplemental amount, if applicable, as described in paragraph (e) of this section.

(2) For high-DSH States, the dollar amount of DSH payments applicable to any Federal fiscal year may not exceed the dollar amount of payments applicable to Federal fiscal year 1992 (that is, the State base allotment). This payment limitation will apply until the Federal fiscal year in which the State's DSH payments applicable to that Federal fiscal year, expressed as a percentage of the State's total unadjusted medical assistance expenditures in that Federal fiscal year, equal 12 percent or less. When a high-DSH State's percentage equals 12 percent or less, the State will be reclassified as a low-DSH State.

(d) *State growth.* (1) The State growth for a State in a Federal fiscal year is equal to the product of—

(i) The growth factor that is HCFA's projected percentage increase in the State's total unadjusted medical assistance expenditures (including administrative costs) relative to the corresponding amount in the previous year; and

(ii) The State's prior year DSH allotment.

(2) If the growth factor is zero or is negative, the State growth is zero.

(3) If a low-DSH State experiences a level of negative growth to the extent that its previous Federal fiscal year's DSH allotment would be more than 12 percent of its current Federal fiscal year's total unadjusted medical assistance expenditures (excluding administrative costs), the low-DSH State's previous year's DSH allotment will be reduced to the extent necessary to maintain the individual low-DSH State's 12-percent limit and that amount will become the low-DSH State's DSH allotment for the current Federal fiscal year. In no Federal fiscal year will a low-DSH State's DSH allotment be allowed to exceed its individual State 12-percent limit.

(e) *Supplemental amount available for low-DSH States.*

(1) A supplemental amount is the State's share of a pool of money (referred to as a redistribution pool).

(2) HCFA will calculate the redistribution pool for the appropriate Federal fiscal year by subtracting from the projected national DSH expenditure target the following:

(i) The total of the State DSH base allotments for all high-DSH States;

(ii) The total of the previous year's State DSH allotments for all low-DSH States;

(iii) The State growth amount for all low-DSH States; and

(iv) The total amount of additional DSH payment adjustments made in order to meet the minimum payment adjustments required under section 1923(c)(l) of the Act, which are made in accordance with § 447.296(b)(5).

(3) HCFA will determine the percent of the redistribution pool for each low-DSH State on the basis of each State's relative share of the total unadjusted medical assistance expenditures for the Federal fiscal year compared to the total unadjusted medical assistance expenditures for the Federal fiscal year projected to be made by all low-DSH States. The percent of the redistribution pool that each State will receive is equal to the State's total unadjusted medical assistance expenditures divided by the total unadjusted medical assistance expenditures for all low-DSH States.

(4) HCFA will not provide any low-DSH State a supplemental amount that would result in the State's total DSH allotment exceeding 12 percent of its projected total unadjusted medical assistance expenditures. HCFA will reallocate any supplemental amounts not allocated to States because of this 12-percent limitation to other low-DSH States in accordance with the percentage determined in paragraph (e)(3) of this section.

(5) HCFA will not reallocate to low-DSH States the difference between any State's actual DSH expenditures applicable to a Federal fiscal year and its State DSH allotment applicable to that Federal fiscal year. Thus, any unspent DSH allotment may not be reallocated.

* * * * *

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

Dated: July 20, 1993.

Bruce C. Vladeck

Administrator, Health Care Financing Administration.

Dated: August 5, 1993.

Donna E. Shalala,

Secretary.

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