§ 433.55 Amount from the State's medical assistance expenditures before calculating FFP. This offset will apply to all years the State received such donations and any subsequent fiscal year in which a similar donation is received.

§ 433.55 Health care-related taxes defined.

(a) A health care-related tax is a licensing fee, assessment, or other mandatory payment that is related to—
   (1) Health care items or services;
   (2) The provision of, or the authority to provide, the health care items or services; or
   (3) The payment for the health care items or services.

(b) A tax will be considered to be related to health care items or services under paragraph (a)(1) of this section if at least 85 percent of the burden of the tax revenue falls on health care providers.

(c) A tax is considered to be health care related if the tax 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.

(d) A health care-related tax does not include payment of a criminal or civil fine or penalty, unless the fine or penalty was imposed instead of a tax.

(e) Health care insurance premiums and health maintenance organization premiums paid by an individual or group to ensure coverage or enrollment are not considered to be payments for health care items and services for purposes of determining whether a health care-related tax exists.

§ 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:
   (1) Inpatient hospital services;
   (2) Outpatient hospital services;
   (3) Nursing facility services (other than services of intermediate care facilities for the mentally retarded);
   (4) Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver;
   (5) Physician services;
   (6) Home health care services;
   (7) Outpatient prescription drugs;
   (8) Services of managed care organizations (including health maintenance organizations, preferred provider 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.

(b) Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

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

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

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

(b) Calculation of FFP. CMS will deduct from a State's quarterly medical