

§ 433.53

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cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider, an entity related to such a health care provider, or an entity providing goods or services to the State for administration of the State's Medicaid plan.

(1) Donations made by a health care provider to an organization, which in turn donates money to the State, may be considered to be a donation made indirectly to the State by a health care provider.

(2) When an organization receives less than 25 percent of its revenues from providers and/or provider-related entities, its donations will not generally be presumed to be provider-related donations. Under these circumstances, a provider-related donation to an organization will not be considered a donation made indirectly to the State. However, if the donations from providers to an organization are subsequently determined to be indirect donations to the State or unit of local government for administration of the State's Medicaid program, then such donations will be considered to be health care related.

(3) When the organization receives more than 25 percent of its revenue from donations from providers or provider-related entities, the organization always will be considered as acting on behalf of health care providers if it makes a donation to the State. The amount of the organization's donation to the State, in a State fiscal year, that will be considered health care related, will be based on the percentage of donations the organization received from the providers during that period.

§ 433.53 State plan requirements.

A State plan must provide that—

(a) State (as distinguished from local) funds will be used both for medical assistance and administration;

(b) State funds will be used to pay at least 40 percent of the non-Federal share of total expenditures under the plan; and

(c) State and Federal funds will be apportioned among the political subdivisions of the State on a basis that assures that—

(1) Individuals in similar circumstances will be treated similarly throughout the State; and

(2) If there is local financial participation, lack of funds from local sources will not result in lowering the amount, duration, scope, or quality of services or level of administration under the plan in any part of the State.

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

§ 433.54 Bona fide donations.

(a) A bona fide donation means a provider-related donation, as defined in § 433.52, made to the State or unit of local government, that has no direct or indirect relationship, as described in paragraph (b) of this section, to Medicaid payments made to—

(1) The health care provider;

(2) Any related entity providing health care items and services; or

(3) Other providers furnishing the same class of items or services as the provider or entity.

(b) Provider-related donations will be determined to have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice, as described in paragraph (c) of this section.

(c) A hold harmless practice exists if any of the following applies:

(1) The amount of the payment received (other than under title XIX of the Act) is positively correlated either to the amount of the donation or to the difference between the amount of the donation and the amount of the payment received under the State plan;

(2) All or any portion of the payment made under Medicaid to the donor, the provider class, or any related entity, varies based only on the amount of the total donation received; or

(3) The State or other unit of local government receiving the donation provides for any payment, offset, or waiver that guarantees to return any portion of the donation to the provider.

(d) CMS will presume provider-related donations to be bona fide if the voluntary payments, including, but not limited to, gifts, contributions, presentations or awards, made by or on behalf of individual health care providers to

the State, county, or any other unit of local government does not exceed—

(1) \$5,000 per year in the case of an individual provider donation; or

(2) \$50,000 per year in the case of a donation from any health care organizational entity.

(e) To the extent that a donation presumed to be bona fide contains a hold harmless provision, as described in paragraph (c) of this section, it will not be considered a bona fide donation. When provider-related donations are not bona fide, CMS will deduct this 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 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