

§ 433.56

42 CFR Ch. IV (10-1-06 Edition)

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 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.

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

§ 433.57 General rules regarding revenues from provider-related donations and health care-related taxes.

Effective January 1, 1992, CMS will deduct from a State's expenditures for medical assistance, before calculating FFP, funds from provider-related donations and revenues generated by health care-related taxes received by a State or unit of local government, in accordance with the requirements, conditions, and limitations of this subpart, if the donations and taxes are not—

(a) Donations and taxes that meet the requirements specified in § 433.58, except for certain revenue received during a specified transition period;

(b) Permissible provider-related donations, as specified in § 433.66(b); or

(c) Health care-related taxes, as specified in § 433.68(b).

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

(a) *General rule.* During the State's transition period specified in paragraph