

not result in any change in hospital admission practices that result in—

(A) A significant reduction in the proportion of patients receiving hospital services covered under the system who have no third-party coverage and who are unable to pay for hospital services;

(B) A significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is less, or is likely to be less, than the anticipated charges for or cost of the services;

(C) A refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital; or

(D) A refusal to provide emergency services to any person who is in need of emergency services, if the hospital provides the services.

(ii) *Consultation with local government officials.* The State must provide documentation that it has consulted with local government officials concerning the impact of the system on publicly owned or operated hospitals.

**§ 403.308 State systems under demonstration projects—mandatory approval.**

CMS will approve an application from a State for a State system if—

(a) The system was in effect prior to April 20, 1983 under an existing demonstration project; and

(b) The minimum requirements and assurances for approval of a State system are met under § 403.304 (b)(1)–(10) and § 403.304(c), and, if appropriate § 403.304(d).

**§ 403.310 Reduction in payments.**

(a) *General rule.* If CMS determines that the satisfactory assurances required of a State under § 403.304(c) and, if applicable, § 403.304(d) have not been met, or will not be met, with respect to any 36-month period, CMS will reduce Medicare payments to individual hospitals being reimbursed under the State's system or, if applicable, under the Medicare payment system, in an amount equal to the amount by which the Medicare payments under the system exceed the amount of Medicare

payments to such hospitals that otherwise would have been made not using the State system. The amount of the recoupment will include, when appropriate, interest charges computed in accordance with § 405.378 of this chapter.

(b) *Recoupment procedures.* The amount of the overpayment will be recouped on a proportionate basis from each of those hospitals that received payments under the State system that exceeded the payments they would have received under the Medicare payment system. Each hospital's share of the aggregate excess payment will be determined on the basis of a comparison of the hospital's proportionate share of the aggregate payment received under the State system that is in excess of what the aggregate payment would have been under the Medicare payment system. Recoupments may be accomplished by a hospital's direct payment to the Medicare program or by offsets to future payments made to the hospital.

(c) *Alternative recoupment procedures.* As an alternative to the recoupment procedures described in paragraph (b) of this section and subject to CMS's acceptance, the State may provide, by legislation or legally binding regulations, procedures for the recoupment of the amount of payments that exceed the amount of payments that otherwise would have been paid by Medicare if the State system had not been in effect.

(d) *Rule for existing Medicare demonstration projects.* In cases of existing Medicare demonstration projects where the expenditure test is to be applied by a rate of increase factor, the amount of the excess payment will be determined, for the three hospital cost reporting periods beginning before October 1, 1986, by a comparison of the State system's rate of increase to the national rate of increase. Recoupment of excessive payments will be assessed and recouped as described in this section.

[51 FR 15492, Apr. 24, 1986, as amended at 61 FR 63748, Dec. 2, 1996]

**§ 403.312 Submittal of application.**

The Chief Executive Officer of the State is responsible for—

#### § 403.314

(a) Submittal of the application to CMS for approval; and

(b) Supplying the assurances and necessary documentation as required under §§ 403.304 through 403.308.

#### § 403.314 Evaluation of State systems.

CMS will evaluate all State applications for approval of State systems and notify the State of its determination within 60 days.

#### § 403.316 Reconsideration of certain denied applications.

(a) *Request for reconsideration.* If CMS denies an application for a State system, the State may request that CMS reconsider the denial if the State believes that its system meets all of the requirements for mandatory approval under §§ 403.304 and 403.306 or, in the case of a State with a system operating under an existing demonstration project, the applicable requirements of §§ 403.304 and 403.308.

(b) *Time limit.* (1) The State must submit its request for reconsideration within 60 days after the date of CMS's notice that the application was denied.

(2) CMS will notify the State of the results of its reconsideration within 60 days after it receives the request for reconsideration.

#### § 403.318 Approval of State systems.

(a) *Approval agreement.* If CMS approves a State system, a written agreement will be executed between CMS and the Chief Executive Officer of the State. The agreement must incorporate any terms of the State's application for approval of the system as agreed to by the parties and, as a minimum, must contain provisions that require the following:

(1) The system is operated directly by the State or an entity designated by State law.

(2) For purposes of the Medicare program, the State's system applies only to Medicare payments for inpatient, and if applicable, outpatient hospital services.

(3) The system conforms to applicable Medicare law and regulations other than those relating to the amount of reimbursement for inpatient hospital services, or for inpatient and outpatient services, whichever the State

#### 42 CFR Ch. IV (10–1–23 Edition)

system covers. Applicable regulations include, for example, those describing Medicare benefits and entitlement requirements for program beneficiaries, as explained in parts 406 and 409 of this chapter; the requirements at part 405, subpart J of this chapter specifying conditions of participation for hospitals; the requirements at part 405, subparts A, G, and S of this chapter on Medicare program administration; and all applicable fraud and abuse regulations contained in titles 42 and 45 of the CFR.

(4) The State must obtain CMS's approval of the State's reporting forms and of provider cost reporting forms or other forms that have not been approved by CMS but that are necessary for the collection of required information.

(b) *Effective date.* An approved State system may not be effective earlier than the date of the approval agreement, which may not be retroactive.

#### § 403.320 CMS review and monitoring of State systems.

(a) *General rule.* The State must submit an assurance and detailed and quantitative studies of provider cost and financial data and projections to support the effectiveness of its system, as required by paragraphs (b) and (c) of this section.

(b) *Required information.* (1) Under § 403.304(c)(3) an assurance is required that the system will not result in greater payments over a 36-month period than would have otherwise been made under Medicare not using such system. If a State that has an existing demonstration project in effect on April 20, 1983 elects under § 403.304(c)(3) to have the effectiveness of its system judged on the basis of a rate of increase factor, the State must submit an assurance that its rate of increase or inflation in inpatient hospital payments does not exceed, for that portion of the 36-month period that is subject to this test, the national rate of increase or inflation in Medicare inpatient hospital payments. The election of the rate of increase test applies only to the three cost reporting periods beginning on or after October 1, 1983. At the end of these cost reporting periods, the State must assure, beginning with the