

rate of increase or inflation for such payments during the State's hospitals' three cost reporting periods beginning on or after October 1, 1983. The data submitted by the State for the period subject to the rate of increase test must include the rate of increase projection for that particular period of time. For the subsequent period of time, the State must assure that payments under its system will not exceed what Medicare payments would have been, as described in § 403.304(c)(3).

(7) If the amount of Medicare payments under the State system exceeds what would have been paid under the Medicare reimbursement principles in any given year, the State must also submit quantitative evidence that the system will result in expenditures that do not exceed what Medicare expenditures would have been over the 36 month period beginning with the first month that the State system is operating. For a State that has an existing demonstration project in effect on April 20, 1983, and that elects under § 403.304(c)(3) to have a rate of increase test apply, if the State's rate of increase or inflation exceeds the national rate of increase or inflation in a given year, the State must submit quantitative evidence that, over 36 months, its payments will not exceed the national rate of increase or inflation. Furthermore, if payments under the State's system must be compared to actual Medicare expenditures, at the end of the third cost reporting period, as described in paragraph (b)(1) of this section, and payments under the State's system exceed what Medicare would have paid in a given year, the State must submit quantitative evidence that, over 36 months, payments under its system will not exceed what Medicare would have paid.

(c) *Review of assurances regarding expenditures.* CMS will review the State's assurances and data submitted under this section, as a prerequisite to the approval of the State's system. CMS will compare the State's projections of payment amounts to CMS data in order to determine if the State's assurance is reasonable and fully supportable. If the CMS data indicate that the State's system would result in payment amounts that would be more than that which

would have been paid under the Medicare principles, the State's assurances would not be acceptable. For States applying in accordance with § 403.308, if CMS data indicate that the State's system would result in a rate of increase or inflation that would be more than the national rate of increase or inflation, the State's assurances would not be acceptable.

(d) *Medicaid upper limit.* In accordance with § 447.253 of this chapter, the State system may not result in aggregate payments for Medicaid inpatient hospital services that would exceed the amount that would have otherwise have been paid under the Medicare principles as applied through the State system.

(e) *Monitoring of Medicare expenditures.* CMS will monitor on a quarterly basis expenditures under the State's system as compared to what Medicare expenditures would have been if the system had not been in effect. If CMS determines at any time that the payments made under the State's system exceed the States' projections, as established by the satisfactory assurances required under § 403.304(c) and, if appropriate, the predetermined percentage relationship of the payments as required under § 403.304(d). CMS will—

(1) Conclude that payments under the State system over a 36-month period will exceed what Medicare would have paid:

(2) Terminate the waiver; and

(3) Recoup overpayments to the affected hospitals in accordance with the procedures described in § 403.310.

§ 403.321 State systems for hospital outpatient services.

CMS may approve a State's application for approval of an outpatient system if the following conditions are met:

(a) The State's inpatient system is approved.

(b) The State's outpatient application meets the requirements and assurances for an inpatient system described in §§ 403.304 (b) and (c), and 403.306 (b)(1) and (b)(2)(ii).

(c) The State submits a separate application that provides separate assurances and estimates and data in further support of its assurance submitted under paragraph (b)(1) of § 403.320, as follows:

(1) Upon application for approval, the State must submit estimates and data that include, but are not limited to, projections for the first 12-month period covered by the assurance for each hospital, in both the aggregate and on an average cost per service and payment basis, of Medicare outpatient expenditures under Medicare principles of reimbursement; parallel projections of Medicare outpatient expenditures under the State system; and the resulting cost or savings to Medicare independent of the State system for hospital inpatient services.

(2) The State must submit separate statewide projections for each year of the 36-month period of the aggregate outpatient expenditures for each system. The projections submitted under this paragraph must—

(i) Comply with the requirements of paragraphs (b) (3) and (5) of § 403.320 regarding a detailed description of the methodology used to derive the expenditure amounts;

(ii) Include the data and assumptions set forth in paragraphs (b)(3) (i), (ii), (iii), (iv), and (v) of § 403.320; and

(iii) Include any assumption the State has adopted for establishing the number of Medicare and total base year outpatient services for each hospital.

(3) The State must provide a detailed explanation of the reasons for any difference between the data or assumptions used for the separate projections.

§ 403.322 Termination of agreements for Medicare recognition of State systems.

(a) *Termination of agreements.* (1) CMS may terminate any approved agreement if it finds, after the procedures described in this paragraph are followed that the State system does not satisfactorily meet the requirements of section 1886(c) of the Act or the regulations in this subpart. A termination must be effective on the last day of a calendar quarter.

(2) CMS will give the State reasonable notice of the proposed termination

of an agreement and of the reasons for the termination at least 90 days before the effective date of the termination.

(3) CMS will give the State the opportunity to present evidence to refute the finding.

(4) CMS will issue a final notice of termination upon a final review and determination on the State's evidence.

(b) *Termination by State.* A State may voluntarily terminate a State system by giving CMS notice of its intent to terminate. A termination must be effective on the last day of a calendar quarter. The State must notify CMS of its intent to terminate at least 90 days before the effective date of the termination.

Subparts D—F [Reserved]

Subpart G—Religious Nonmedical Health Care Institutions—Benefits, Conditions of Participation, and Payment

SOURCE: 64 FR 67047, Nov. 30, 1999, unless otherwise noted.

§ 403.700 Basis and purpose.

This subpart implements sections 1821; 1861(e), (γ), and (ss); 1869; and 1878 of the Act regarding Medicare payment for inpatient hospital or posthospital extended care services furnished to eligible beneficiaries in religious nonmedical health care institutions.

§ 403.702 Definitions and terms.

For purposes of this subpart, the following definitions and terms apply:

Election means a written statement signed by the beneficiary or the beneficiary's legal representative indicating the beneficiary's choice to receive nonmedical care or treatment for religious reasons.

Excepted medical care means medical care that is received involuntarily or required under Federal, State, or local laws.

FFY stands for Federal fiscal year.

Medical care or treatment means health care furnished by or under the direction of a licensed physician that can involve diagnosing, treating, or preventing disease and other damage to the mind and body. It may involve the