

(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