

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

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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

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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.

### **Subpart D [Reserved]**

### **Subpart E—Beneficiary Counseling and Assistance Grants**

SOURCE: 59 FR 51128, Oct. 7, 1994, unless otherwise noted.

#### **§ 403.500 Basis, scope, and definition.**

(a) *Basis.* This subpart implements, in part, the provisions of section 4360 of Public Law 101–508 by establishing a minimum level of funding for grants made to States for the purpose of providing information, counseling, and assistance relating to obtaining adequate and appropriate health insurance coverage to individuals eligible to receive benefits under the Medicare program.

(b) *Scope of subpart.* This subpart sets forth the following:

(1) Conditions of eligibility for the grant.

(2) Minimum levels of funding for those States qualifying for the grants.

(3) Reporting requirements.

(c) *Definition.* For purposes of this subpart, the term “State” includes (except where otherwise indicated by the context) the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

#### **§ 403.501 Eligibility for grants.**

To be eligible for a grant under this subpart, the State must have an approved Medicare supplemental regulatory program under section 1882 of the Act and submit a timely application to CMS that meets the requirements of—

(a) Section 4360 of Public Law 101–508 (42 USC 1395b-4);

(b) This subpart; and

(c) The applicable solicitation for grant applications issued by CMS.