

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—

- (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 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