

§ 431.52

after it has submitted the certification and CMS has made the findings required under the Act, and so notified the State.

(ii) For exceptions under § 431.54 (e) or (f), the State must submit the certificate by the end of the quarter in which it implements the project.

[56 FR 8847, Mar. 1, 1991, as amended at 67 FR 41094, June 14, 2002]

§ 431.52 Payments for services furnished out of State.

(a) *Statutory basis.* Section 1902(a)(16) of the Act authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State.

(b) *Payment for services.* A State plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State, and any of the following conditions is met:

(1) Medical services are needed because of a medical emergency;

(2) Medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence;

(3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;

(4) It is general practice for recipients in a particular locality to use medical resources in another State.

(c) *Cooperation among States.* The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

§ 431.53 Assurance of transportation.

A State plan must—

(a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and

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(b) Describe the methods that the agency will use to meet this requirement.

(Sec. 1902(a)(4) of the Act)

§ 431.54 Exceptions to certain State plan requirements.

(a) *Statutory basis.* Section 1915(a) of the Act provides that a State shall not be deemed to be out of compliance with the requirements of sections 1902(a) (1), (10), or (23) of the Act solely because it has elected any of the exceptions set forth in paragraphs (b) and (d) through (f) of this section.

(b) *Additional services under a prepayment system.* If the Medicaid agency contracts on a prepayment basis with an organization that provides services additional to those offered under the State plan, the agency may restrict the provision of the additional services to recipients who live in the area served by the organization and wish to obtain services from it.

(c) [Reserved]

(d) *Special procedures for purchase of medical devices and laboratory and X-ray tests.* The Medicaid agency may establish special procedures for the purchase of medical devices or laboratory and X-ray tests (as defined in § 440.30 of this chapter) through a competitive bidding process or otherwise, if the State assures, in the certification required under § 431.51(d), and CMS finds, as follows:

(1) Adequate services or devices are available to recipients under the special procedures.

(2) Laboratory services are furnished through laboratories that meet the following requirements:

(i) They are independent laboratories, or inpatient or outpatient hospital laboratories that provide services for individuals who are not hospital patients, or physician laboratories that process at least 100 specimens for other physicians during any calendar year.

(ii) They meet the requirements of subpart M of part 405 or part 482 of this chapter.

(iii) Laboratories that require an interstate license under 42 CFR part 74

are licensed by CMS or receive an exemption from the licensing requirement by the College of American Pathologists. (Hospital and physician laboratories may participate in competitive bidding only with regard to services to non-hospital patients and other physicians' patients, respectively.)

(3) Any laboratory from which a State purchases services under this section has no more than 75 percent of its charges based on services to Medicare beneficiaries and Medicaid recipients.

(e) *Lock-in of recipients who over-utilize Medicaid services.* If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following conditions are met:

(1) The agency gives the recipient notice and opportunity for a hearing (in accordance with procedures established by the agency) before imposing the restrictions.

(2) The agency ensures that the recipient has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality.

(3) The restrictions do not apply to emergency services furnished to the recipient.

(f) *Lock-out of providers.* If a Medicaid agency finds that a Medicaid provider has abused the Medicaid program, the agency may restrict the provider, through suspension or otherwise, from participating in the program for a reasonable period of time.

Before imposing any restriction, the agency must meet the following conditions:

(1) Give the provider notice and opportunity for a hearing, in accordance with procedures established by the agency.

(2) Find that in a significant number or proportion of cases, the provider has:

(i) Furnished Medicaid services at a frequency or amount not medically necessary, as determined in accordance with utilization guidelines established by the agency; or

(ii) Furnished Medicaid services of a quality that does not meet professionally recognized standards of health care.

(3) Notify CMS and the general public of the restriction and its duration.

(4) Ensure that the restrictions do not result in denying recipients reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality, including emergency services.

§ 431.55 Waiver of other Medicaid requirements.

(a) *Statutory basis.* Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act to the extent he or she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost effective, efficient, and consistent with the objectives of the Medicaid program. Sections 1915 (f) and (h) prescribe how such waivers are to be approved, continued, monitored, and terminated. Section 1902(p)(2) of the Act conditions FFP in payments to an entity under a section 1915(b)(1) waiver on the State's provision for exclusion of certain entities from participation.

(b) *General requirements.* (1) General requirements for submittal of waiver requests, and the procedures that CMS follows for review and action on those requests are set forth in § 430.25 of this chapter.

(2) In applying for a waiver to implement an approvable project under paragraph (c), (d), (e), or (f) of this section, a Medicaid agency must document in the waiver request and maintain data regarding:

(i) The cost-effectiveness of the project;

(ii) The effect of the project on the accessibility and quality of services;

(iii) The anticipated impact of the project on the State's Medicaid program and;

(iv) Assurances that the restrictions on free choice of providers do not apply to family planning services.