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case of service by registered or certified mail, the signed return post office receipt, will be proof of service.

(c) Witnesses will be entitled to the same fees and mileage as witnesses in the district courts of the United States (28 U.S.C. 1821 and 1825). Such fees need not be paid at the time the subpoena is served.

§ 1006.4 Procedures for investigational inquiries.

(a) Testimony at investigational inquiries will be taken under oath or affirmation.

(b) Investigational inquiries are non-public investigatory proceedings. Attendance of non-witnesses is within the discretion of the OIG, except that—

(1) A witness is entitled to be accompanied, represented and advised by an attorney; and

(2) Representatives of the OIG are entitled to attend and ask questions.

(c) A witness will have an opportunity to clarify his or her answers on the record following the questions by the OIG.

(d) Any claim of privilege must be asserted by the witness on the record.

(e) Objections must be asserted on the record. Errors of any kind that might be corrected if promptly presented will be deemed to be waived unless reasonable objection is made at the investigational inquiry. Except where the objection is on the grounds of privilege, the question will be answered on the record, subject to the objection.

(f) If a witness refuses to answer any question not privileged or to produce requested documents or items, or engages in conduct likely to delay or obstruct the investigational inquiry, the OIG may seek enforcement of the subpoena under § 1006.5.

(g)(1) The proceedings will be recorded and transcribed.

(2) The witness is entitled to a copy of the transcript, upon payment of prescribed costs, except that, for good cause, the witness may be limited to inspection of the official transcript of his or her testimony.

(3)(i) The transcript will be submitted to the witness for signature.

(ii) Where the witness will be provided a copy of the transcript, the

transcript will be submitted to the witness for signature. The witness may submit to the OIG written proposed corrections to the transcript, with such corrections attached to the transcript. If the witness does not return a signed copy of the transcript or proposed corrections within 30 days of its being submitted to him or her for signature, the witness will be deemed to have agreed that the transcript is true and accurate.

(iii) Where, as provided in paragraph (g)(2) of this section, the witness is limited to inspecting the transcript, the witness will have the opportunity at the time of inspection to propose corrections to the transcript, with corrections attached to the transcript. The witness will also have the opportunity to sign the transcript. If the witness does not sign the transcript or offer corrections within 30 days of receipt of notice of the opportunity to inspect the transcript, the witness will be deemed to have agreed that the transcript is true and accurate.

(iv) The OIG's proposed corrections the record of transcript will be attached to the transcript.

(h) Testimony and other evidence obtained in an investigational inquiry may be used by the OIG or DHHS in any of its activities, and may be used or offered into evidence in any administrative or judicial proceeding.

[57 FR 3354, Jan. 29, 1992, as amended at 65 FR 24419, Apr. 26, 2000]

§ 1006.5 Enforcement of a subpoena.

A subpoena to appear at an investigational inquiry is enforceable through the District Court of the United States and the district where the subpoenaed person is found, resides or transacts business.

PART 1007—STATE MEDICAID FRAUD CONTROL UNITS

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AUTHORITY: 42 U.S.C. 1396b(a)(6), 1396b(b)(3) and 1396b(q).

SOURCE: 57 FR 3355, Jan. 29, 1992, unless otherwise noted.

§ 1007.1 Definitions.

As used in this part, unless otherwise indicated by the context:

Employ or *employee*, as the context requires, means full-time duty intended to last at least a year. It includes an arrangement whereby an individual is on full-time detail or assignment to the unit from another government agency, if the detail or assignment is for a period of at least 1 year and involves supervision by the unit.

Provider means an individual or entity that furnishes items or services for which payment is claimed under Medicaid.

Unit means the State Medicaid fraud control unit.

§ 1007.3 Scope and purpose.

This part implements sections 1903(a)(6), 1903(b)(3), and 1903(q) of the Social Security Act, as amended by the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Pub. L. 95-142). The statute authorizes the Secretary to pay a State 90 percent of the costs of establishing and operating a State Medicaid fraud control unit, as defined by the statute, for the purpose of eliminating fraud in the State Medicaid program.

§ 1007.5 Basic requirement.

A State Medicaid fraud control unit must be a single identifiable entity of the State government certified by the Secretary as meeting the requirements of §§ 1007.7 through 1007.13 of this part.

§ 1007.7 Organization and location requirements.

Any of the following three alternatives is acceptable:

(a) The unit is located in the office of the State Attorney General or another department of State government which

has Statewide authority to prosecute individuals for violations of criminal laws with respect to fraud in the provision or administration of medical assistance under a State plan implementing title XIX of the Act;

(b) If there is no State agency with Statewide authority and capability for criminal fraud prosecutions, the unit has established formal procedures that assure that the unit refers suspected cases of criminal fraud in the State Medicaid program to the appropriate State prosecuting authority or authorities, and provides assistance and coordination to such authority or authorities in the prosecution of such cases; or

(c) The unit has a formal working relationship with the office of the State Attorney General and has formal procedures for referring to the Attorney General suspected criminal violations occurring in the State Medicaid program and for effective coordination of the activities of both entities relating to the detection, investigation and prosecution of those violations. Under this requirement, the office of the State Attorney General must agree to assume responsibility for prosecuting alleged criminal violations referred to it by the unit. However, if the Attorney General finds that another prosecuting authority has the demonstrated capacity, experience and willingness to prosecute an alleged violation, he or she may refer a case to that prosecuting authority, as long as the Attorney General's Office maintains oversight responsibility for the prosecution and for coordination between the unit and the prosecuting authority.

§ 1007.9 Relationship to, and agreement with, the Medicaid agency.

(a) The unit must be separate and distinct from the Medicaid agency.

(b) No official of the Medicaid agency will have authority to review the activities of the unit or to review or overrule the referral of a suspected criminal violation to an appropriate prosecuting authority.

(c) The unit will not receive funds paid under this part either from or through the Medicaid agency.

(d) The unit will enter into an agreement with the Medicaid agency under

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which the Medicaid agency will agree to comply with all requirements of § 455.21(a)(2) of this title.

(e)(1) The unit may refer any provider with respect to which there is pending an investigation of a credible allegation of fraud under the Medicaid program to the State Medicaid agency for payment suspension in whole or part under § 455.23 of this title.

(2) Referrals may be brief, but must be in writing and include sufficient information to allow the State Medicaid agency to identify the provider and to explain the credible allegations forming the grounds for the payment suspension.

(f) Any request by the unit to the State Medicaid agency to delay notification to the provider of a payment suspension under § 455.23 of this title must be in writing.

(g) When the unit accepts or declines a case referred by the State Medicaid agency, the unit notifies the State Medicaid agency in writing of the acceptance or declination of the case.

[57 FR 3355, Jan. 29, 1992, as amended at 76 FR 5970, Feb. 2, 2011]

§ 1007.11 Duties and responsibilities of the unit.

(a) The unit will conduct a Statewide program for investigating and prosecuting (or referring for prosecution) violations of all applicable State laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan.

(b) (1) The unit will also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient's private funds in such facilities.

(2) If the initial review indicates substantial potential for criminal prosecution, the unit will investigate the complaint or refer it to an appropriate criminal investigative or prosecutive authority.

(3) If the initial review does not indicate a substantial potential for criminal prosecution, the unit will refer the complaint to an appropriate State agency.

(c) If the unit, in carrying out its duties and responsibilities under paragraphs (a) and (b) of this section, discovers that overpayments have been made to a health care facility or other provider of medical assistance under the State Medicaid plan, the unit will either attempt to collect such overpayment or refer the matter to an appropriate State agency for collection.

(d) Where a prosecuting authority other than the unit is to assume responsibility for the prosecution of a case investigated by the unit, the unit will insure that those responsible for the prosecutive decision and the preparation of the case for trial have the fullest possible opportunity to participate in the investigation from its inception and will provide all necessary assistance to the prosecuting authority throughout all resulting prosecutions.

(e) The unit will make available to Federal investigators or prosecutors all information in its possession concerning fraud in the provision or administration of medical assistance under the State plan and will cooperate with such officials in coordinating any Federal and State investigations or prosecutions involving the same suspects or allegations.

(f) The unit will safeguard the privacy rights of all individuals and will provide safeguards to prevent the misuse of information under the unit's control.

§ 1007.13 Staffing requirements.

(a) The unit will employ sufficient professional, administrative, and support staff to carry out its duties and responsibilities in an effective and efficient manner. The staff must include:

(1) One or more attorneys experienced in the investigation or prosecution of civil fraud or criminal cases, who are capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors;

(2) One or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud; and

(3) A senior investigator with substantial experience in commercial or financial investigations who is capable

of supervising and directing the investigative activities of the unit.

(b) The unit will employ, or have available to it, professional staff who are knowledgeable about the provision of medical assistance under title XIX and about the operation of health care providers.

§ 1007.15 Applications, certification and recertification.

(a) *Initial application.* In order to receive FFP under this part, the unit must submit to the Secretary, an application approved by the Governor, containing the following information and documentation—

(1) A description of the applicant's organization, structure, and location within State government, and an indication of whether it seeks certification under § 1007.7 (a), (b), or (c);

(2) A statement from the State Attorney General that the applicant has authority to carry out the functions and responsibilities set forth in this part. If the applicant seeks certification under § 1007.7(b), the statement must also specify either that—

(i) There is no State agency with the authority to exercise Statewide prosecuting authority for the violations with which the unit is concerned, or

(ii) Although the State Attorney General may have common law authority for Statewide criminal prosecutions, he or she has not exercised that authority;

(3) A copy of whatever memorandum of agreement, regulation, or other document sets forth the formal procedures required under § 1007.7(b), or the formal working relationship and procedures required under § 1007.7(c);

(4) A copy of the agreement with the Medicaid agency required under § 1007.9;

(5) A statement of the procedures to be followed in carrying out the functions and responsibilities of this part;

(6) A projection of the caseload and a proposed budget for the 12-month period for which certification is sought; and

(7) Current and projected staffing, including the names, education, and experience of all senior professional staff already employed and job descriptions, with minimum qualifications, for all professional positions.

(b) *Conditions for, and notification of certification.* (1) The Secretary will approve an application only if he or she has specifically approved the applicant's formal procedures under § 1007.7 (b) or (c), if either of those provisions is applicable, and has specifically certified that the applicant meets the requirements of § 1007.7;

(2) The Secretary will promptly notify the applicant whether the application meets the requirements of this part and is approved. If the application is not approved, the applicant may submit an amended application at any time. Approval and certification will be for a period of 1 year.

(c) *Conditions for recertification.* In order to continue receiving payments under this part, a unit must submit a reapplication to the Secretary at least 60 days prior to the expiration of the 12-month certification period. A reapplication must—

(1) Advise the Secretary of any changes in the information or documentation required under paragraphs (a) (1) through (5) of this section;

(2) Provide projected caseload and proposed budget for the recertification period; and

(3) Include or reference the annual report required under § 1007.17.

(d) *Basis for recertification.* (1) The Secretary will consider the unit's reapplication, the reports required under § 1007.17, and any other reviews or information he or she deems necessary or warranted, and will promptly notify the unit whether he or she has approved the reapplication and recertified the unit.

(2) In reviewing the reapplication, the Secretary will give special attention to whether the unit has used its resources effectively in investigating cases of possible fraud, in preparing cases for prosecution, and in prosecuting cases or cooperating with the prosecuting authorities.

(Approved by the Office of Management and Budget under control number 0990-0162)

§ 1007.17 Annual report.

At least 60 days prior to the expiration of the certification period, the unit will submit to the Secretary a report covering the last 12 months (the

first 9 months of the certification period for the first annual report), and containing the following information—

(a) The number of investigations initiated and the number completed or closed, categorized by type of provider;

(b) The number of cases prosecuted or referred for prosecution; the number of cases finally resolved and their outcomes; and the number of cases investigated but not prosecuted or referred for prosecution because of insufficient evidence;

(c) The number of complaints received regarding abuse and neglect of patients in health care facilities; the number of such complaints investigated by the unit; and the number referred to other identified State agencies;

(d) The number of recovery actions initiated by the unit; the number of recovery actions referred to another agency; the total amount of overpayments identified by the unit; and the total amount of overpayments actually collected by the unit;

(e) The number of recovery actions initiated by the Medicaid agency under its agreement with the unit, and the total amount of overpayments actually collected by the Medicaid agency under this agreement;

(f) Projections for the succeeding 12 months for items listed in paragraphs (a) through (e) of this section;

(g) The costs incurred by the unit; and

(h) A narrative that evaluates the unit's performance; describes any specific problems it has had in connection with the procedures and agreements required under this part; and discusses any other matters that have impaired its effectiveness.

(Approved by the Office of Management and Budget under control number 0990–0162)

§ 1007.19 Federal financial participation (FFP).

(a) *Rate of FFP.* Subject to the limitation of this section, the Secretary will reimburse each State by an amount equal to 90 percent of the costs incurred by a certified unit which are attributable to carrying out its functions and responsibilities under this part.

(b) *Retroactive certification.* The Secretary may grant certification retroactive to the date on which the unit first met all the requirements of the statute and of this part. For any quarter with respect to which the unit is certified, the Secretary will provide reimbursement for the entire quarter.

(c) *Amount of FFP.* FFP for any quarter will not exceed the higher of \$125,000 or one-quarter of 1 percent of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State Medicaid program.

(d) *Costs subject to FFP.* (1) FFP is available under this part for the expenditures attributable to the establishment and operation of the unit, including the cost of training personnel employed by the unit. Reimbursement will be limited to costs attributable to the specific responsibilities and functions set forth in this part in connection with the investigation and prosecution of suspected fraudulent activities and the review of complaints of alleged abuse or neglect of patients in health care facilities.

(2) (i) Establishment costs are limited to clearly identifiable costs of personnel that—

(A) Devote full time to the establishment of the unit which does achieve certification; and

(B) Continue as full-time employees after the unit is certified.

(ii) All establishment costs will be deemed made in the first quarter of certification.

(e) *Costs not subject to FFP.* FFP is not available under this part for expenditures attributable to—

(1) The investigation of cases involving program abuse or other failures to comply with applicable laws and regulations, if these cases do not involve substantial allegations or other indications of fraud;

(2) Efforts to identify situations in which a question of fraud may exist, including the screening of claims, analysis of patterns of practice, or routine verification with recipients of whether services billed by providers were actually received;

(3) The routine notification of providers that fraudulent claims may be punished under Federal or State law;

(4) The performance by a person other than a full-time employee of the unit of any management function for the unit, any audit or investigation, any professional legal function, or any criminal, civil or administrative prosecution of suspected providers;

(5) The investigation or prosecution of cases of suspected recipient fraud not involving suspected conspiracy with a provider; or

(6) Any payment, direct or indirect, from the unit to the Medicaid agency, other than payments for the salaries of employees on detail to the unit.

§ 1007.21 Other applicable HHS regulations.

Except as otherwise provided in this part, the following regulations from 45 CFR subtitle A apply to grants under this part:

Part 16, subpart C—Department Grant Appeals Process—Special Provisions Applicable to Reconsideration of Disallowances [Note that this applies only to disallowance determinations and not to any other determinations, e.g., over certification or recertification];

Part 74—Administration of Grants;

Part 75—Informal Grant Appeals Procedures;

Part 80—Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services, Effectuation of title VI of the Civil Rights Act of 1964;

Part 81—Practice and Procedure for Hearings Under 45 CFR part 80;

Part 84—Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting From Federal Financial Assistance;

Part 91—Nondiscrimination on the Basis of Age in HHS Programs or Activities Receiving Federal Financial Assistance.

PART 1008—ADVISORY OPINIONS BY THE OIG

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AUTHORITY: 42 U.S.C. 1320a-7d(b).

SOURCE: 62 FR 7357, Feb. 19, 1997, unless otherwise noted.

Subpart A—General Provisions

§ 1008.1 Basis and purpose.

(a) This part contains the specific procedures for the submission of requests by an individual or entity for advisory opinions to, and the issuance of advisory opinions by, the OIG, in consultation with the Department of Justice (DoJ), in accordance with section 1128D(b) of the Social Security Act (Act), 42 U.S.C. 1320a-7d(b). The OIG will issue such advisory opinions based on actual or proposed factual circumstances submitted by the requesting individual or entity, or by counsel