

(1) Methods and criteria for identifying suspected fraud and abuse cases.

(2) Methods for investigating fraud and abuse cases that—

(i) Do not infringe on legal rights of persons involved; and

(ii) Afford due process of law.

(b) *State program integrity unit.* The State may establish an administrative agency responsible for monitoring and maintaining the integrity of the separate child health program.

(c) *Program coordination.* The State must develop and implement procedures for referring suspected fraud and abuse cases to the State program integrity unit (if such a unit is established) and to appropriate law enforcement officials. Law enforcement officials include the—

(1) U.S. Department of Health and Human Services Office of Inspector General (OIG);

(2) U.S. Attorney's Office, Department of Justice (DOJ);

(3) Federal Bureau of Investigation (FBI); and

(4) State Attorney General's office.

**§ 457.925 Preliminary investigation.**

If the State agency receives a complaint of fraud or abuse from any source or identifies questionable practices, the State agency must conduct a preliminary investigation or take otherwise appropriate action within a reasonable period of time to determine whether there is sufficient basis to warrant a full investigation.

**§ 457.930 Full investigation, resolution, and reporting requirements.**

The State must establish and implement effective procedures for investigating and resolving suspected and apparent instances of fraud and abuse. Once the State determines that a full investigation is warranted, the State must implement procedures including, but not limited to the following:

(a) Cooperate with and refer potential fraud and abuse cases to the State program integrity unit, if such a unit exists.

(b) Conduct a full investigation.

(c) Refer the fraud and abuse case to appropriate law enforcement officials.

**§ 457.935 Sanctions and related penalties.**

(a) A State may not make payments for any item or service furnished, ordered, or prescribed under a separate child health program to any provider who has been excluded from participating in the Medicare and Medicaid programs.

(b) The following provisions and their corresponding regulations apply to a State under title XXI, in the same manner as these provisions and regulations apply to a State under title XIX:

(1) Part 455, subpart B of this chapter.

(2) Section 1124 of the Act pertaining to disclosure of ownership and related information.

(3) Section 1126 of the Act pertaining to disclosure by institutions, organizations, and agencies of owners and certain other individuals who have been convicted of certain offenses.

(4) Section 1128 of the Act pertaining to exclusions.

(5) Section 1128A of the Act pertaining to civil monetary penalties.

(6) Section 1128B of the Act pertaining to criminal penalties for acts involving Federal health care programs.

(7) Section 1128E of the Act pertaining to the reporting of final adverse actions on liability findings made against health care providers, suppliers, and practitioners under the health care fraud and abuse data collection program.

**§ 457.940 Procurement standards.**

(a) A State must submit to CMS a written assurance that title XXI services will be provided in an effective and efficient manner. The State must submit the assurance—

(1) With the initial State plan; or

(2) For States with approved plans, with the first request to amend the approved plan.

(b) A State must—

(1) Provide for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services in accordance with the procurement requirements of 45 CFR 74.43 or 45 CFR 92.36, as applicable; or

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(2) Use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with principles of actuarial soundness as defined at § 457.902.

(c) A State may establish higher rates than permitted under paragraph (b) of this section if such rates are necessary to ensure sufficient provider participation, provider access, or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.

(d) All contracts under this part must include provisions that define a sound and complete procurement contract, as required by 45 CFR part 74 or 45 CFR part 92, as applicable.

(e) The State must provide to CMS, if requested, a description of the manner in which rates were developed in accordance with the requirements of paragraphs (b) or (c) of this section.

[66 FR 2685, Jan. 11, 2001, as amended at 66 FR 33824, June 25, 2001]

**§ 457.945 Certification for contracts and proposals.**

Entities that contract with the State under a separate child health program must certify the accuracy, completeness, and truthfulness of information in contracts and proposals, including information on subcontractors, and other related documents, as specified by the State.

**§ 457.950 Contract and payment requirements including certification of payment-related information.**

(a) *Managed care entity (MCE)*. A State that makes payments to an MCE under a separate child health program, based on data submitted by the MCE, must ensure that its contract requires the MCE to provide—

(1) Enrollment information and other information required by the State;

(2) An attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury;

(3) Access for the State, CMS, and the HHS Office of the Inspector General to enrollee health claims data and payment data, in conformance with the appropriate privacy protections in the State; and

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(4) A guarantee that the MCE will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources.

(b) *Fee-for-service entities*. A State that makes payments to fee-for-service entities under a separate child health program must—

(1) Establish procedures to ensure that the entity certifies and attests that information on claim forms is truthful, accurate, and complete;

(2) Ensure that fee-for-service entities understand that payment and satisfaction of the claims will be from Federal and State funds, and that any false claims may be prosecuted under applicable Federal or State laws; and

(3) Require, as a condition of participation, that fee-for-service entities provide the State, CMS and/or the HHS Office of the Inspector General with access to enrollee health claims data, claims payment data and related records.

**§ 457.955 Conditions necessary to contract as a managed care entity (MCE).**

(a) The State must assure that any entity seeking to contract as an MCE under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse.

(b) The State must ensure that the arrangements or procedures required in paragraph (a) of this section—

(1) Enforce MCE compliance with all applicable Federal and State standards;

(2) Prohibit MCEs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to enroll with the entity; and

(3) Include a mechanism for the MCE to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors or enrollees of an MCE and other individuals.

(c) With respect to enrollees, the reporting requirement in paragraph (b)(3) of this section applies only to information on violations of law that pertain