Amend **HB 1743** as follows:

(1) On page 9, between lines 3 and 4, insert the following new SECTION, appropriately numbered, and renumber the sections of the bill accordingly:

SECTION ____. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1005 to read as follows:

Sec. 531.1005. DEFINITIONS. In this subchapter:

(1) "Abuse" means:

(A) a provider practice that is inconsistent with sound fiscal, business, or medical practices and results in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; and

(B) recipient practices that result in unnecessary cost to the Medicaid program.

(2) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or another person. The term includes an act that constitutes fraud under applicable federal or state law.

(3) "Furnished" means the provision of items or services directly by or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in the person's own capacity), a provider, or another supplier of items or services. The term does not include the provision of items or services ordered by one party but billed for and provided by or under the supervision of another party.

(4) "Hold on payment" means the temporary denial of reimbursement under the Medicaid program for items or services furnished by a specified provider.

(5) "Practitioner" means a physician or other individual licensed under state law to practice the person's profession.

(6) "Program exclusion" means the suspension of a provider from being authorized under the Medicaid program to request reimbursement for items or services furnished by that specific provider.

(7) "Provider" means a person that was or is approved by the department to:

(A) provide medical assistance under a contract or provider agreement with the department; or

(B) provide third-party billing vendor services to other providers under a contract or provider agreement with the department.

(2) On page 9, line 5, strike "(f) and (g)" and substitute "(f), (g), (h), (i), and (j)".

(3) On page 9, strike lines 17-27, and on page 10, strike lines 1-4, and substitute the following:

(f) If the department receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, the department must conduct an integrity review to determine whether there is sufficient basis to warrant a full investigation. The department shall begin the integrity review not later than the 30th day after the department receives a complaint or identifies a questionable practice. The department shall complete the integrity review not later than the 60th day after the department begins the review.

(g) If the results of the integrity review give the department reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the department, not later than the 30th day after the review is completed, shall:

(1) refer the case to the attorney general's Medicaid fraud control unit if a provider is suspected of fraud or abuse; or

(2) conduct a full investigation if the department has reason to believe that a recipient has committed fraud or abuse.

(h) In connection with the investigation of fraud or abuse in the provision of health and human services, the department shall impose a hold on payment of claims for reimbursement submitted by a provider or impose a program exclusion with respect to a provider, as applicable, to compel the production of records or when requested by the attorney general's Medicaid fraud control unit. The department shall notify the provider of the hold on payment or the program exclusion not later than the fifth working day after the date the hold or exclusion is imposed.

(i) The department, by documented policy or administrative procedure, shall establish protocols under which, after consultation with the attorney general's Medicaid fraud control unit, the department:

(1) may decide to impose a hold on payment or a program exclusion; or

(2) is required to automatically impose a hold on payment or a program exclusion.

(j) If the department learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or falsified in any way, the department shall presume that fraud has occurred and shall immediately refer the case to the attorney general's Medicaid fraud control unit.

(4) Strike SECTION 10 of the bill (page 10, line 27, through page 12, line 12) and substitute the following appropriately numbered section:

SECTION ___. Section 531.104, Government Code, is amended by adding Subsection (c) to read as follows:

(c) The memorandum of understanding must provide that the department is required to permit:

(1) Medicaid agencies to make direct fraud referrals to the attorney general's Medicaid fraud control unit; and

(2) unimpeded communication between Medicaid agency employees and the unit.

(5) On page 13, strike lines 25 and 26 and substitute "531.104, Government Code, as necessary to comply with Section 531.104(c), Government Code, as added by this Act."

(6) On page 14, between lines 15 and 16, insert the following appropriately numbered section:

SECTION ___. Section 531.103(e), Government Code, is repealed.