Amend **HB 1743** as follows:

(1) On page 2, line 15, strike "an irregularity" and substitute "a pattern of suspected fraud or abuse involving criminal conduct".

(2) On page 9, between lines 3 and 4, insert a new SECTION 8 to read as follows and renumber the subsequent sections of the bill appropriately:

SECTION 8. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1011 to read as follows:

Sec. 531.1011. DEFINITIONS. For purposes of this subchapter:

(1) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person, including any act that constitutes fraud under applicable federal or state law.

(2) "Furnished" refers to items or services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in the individual's own capacity), a provider, or other supplier of services, excluding services ordered by one party but billed for and provided by or under the supervision of another.

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

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

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

(6) "Provider" means a person, firm, partnership, corporation, agency, association, institution, or other entity that was or is approved by the commission to:

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

(B) provide third-party billing vendor services under a contract or provider agreement with the commission.

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

(f) (1) If the commission receives a complaint of Medicaid fraud or abuse from any source, it must conduct an integrity review to determine whether there is sufficient basis to warrant a full investigation. An integrity review must commence not later than 60 days after the commission receives a complaint or has reason to believe that fraud or abuse has occurred. An integrity review shall be completed not later than 90 days after it has commenced.

(2) If the findings of an integrity review give the commission reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in the Medicaid program, the commission must take the following action, as appropriate, not later than 30 days after the completion of the integrity review:

(A) if a provider is suspected of fraud or abuse involving criminal conduct, the commission must refer the case to the state's Medicaid fraud control unit, provided that such criminal referral does not preclude the commission from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions; or

(B) if there is reason to believe that a recipient has defrauded the Medicaid program, the commission may conduct a full investigation of the suspected fraud.

(g) (1) In addition to other instances authorized under state or federal law, the commission shall impose a hold on payment of claims for reimbursement submitted by a provider without prior notice, as applicable, to compel production of records or when requested by the state's Medicaid fraud control unit. The commission must notify the provider of the hold on payment not later than the fifth working day after the date the payment hold is imposed.

(2) The commission shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which holds on payment or program exclusions:

(A) may permissively be imposed on a provider; or

(B) shall automatically be imposed on a provider.

(3) Whenever the commission learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the commission shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the commission from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

(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 531.103(f), Government Code, is amended to read as follows:

(f) A [~~The~~] district attorney, county attorney, city attorney, or private collection agency may collect and retain costs associated with a [~~the~~] case referred to the attorney or agency and 20 percent of the amount of the penalty, restitution, or other reimbursement payment collected.

(5) On page 12, between lines 12 and 13, insert the following appropriately numbered section and renumber subsequent sections of the bill appropriately:

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

(c) The memorandum of understanding must ensure that no barriers to direct fraud referrals to the state's Medicaid fraud control unit by Medicaid agencies or unreasonable impediments to communication between Medicaid agency employees and the state's Medicaid fraud control unit will be imposed.

(6) 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."

(7) On page 14, between lines 15 and 16, insert the following appropriately numbered section and renumber subsequent sections of the bill appropriately:

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

repealed.