1-1 By: Delisi, et al. (Senate Sponsor - Nelson) H.B. No. 1743
1-2 (In the Senate - Received from the House April 14, 2003;
1-3 April 22, 2003, read first time and referred to Committee on Health
1-4 and Human Services; May 21, 2003, reported adversely, with
1-5 favorable Committee Substitute by the following vote: Yeas 8,
1-6 Nays 0; May 21, 2003, sent to printer.)

1-7 COMMITTEE SUBSTITUTE FOR H.B. No. 1743 By: Nelson

1-8 A BILL TO BE ENTITLED
1-9 AN ACT

1-10 relating to prevention of fraud and abuse under the medical
1-11 assistance program; creating an offense.
1-12 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-13 SECTION 1. Subchapter B, Chapter 32, Human Resources Code,
1-14 is amended by adding Section 32.0291 to read as follows:
1-15 Sec. 32.0291. PREPAYMENT REVIEWS AND POSTPAYMENT HOLDS.
1-16 (a) Notwithstanding any other law, the department may:
1-17 (1) perform a prepayment review of a claim for
1-18 reimbursement under the medical assistance program to determine
1-19 whether the claim involves fraud or abuse; and
1-20 (2) as necessary to perform that review, withhold
1-21 payment of the claim for not more than five working days without
1-22 notice to the person submitting the claim.
1-23 (b) Notwithstanding any other law, the department may
1-24 impose a postpayment hold on payment of future claims submitted by a
1-25 provider if the department has reliable evidence that the provider
1-26 has committed fraud or wilful misrepresentation regarding a claim
1-27 for reimbursement under the medical assistance program. The
1-28 department must notify the provider of the postpayment hold not
1-29 later than the fifth working day after the date the hold is imposed.
1-30 (c) On timely written request by a provider subject to a
1-31 postpayment hold under Subsection (b), the department shall file a
1-32 request with the State Office of Administrative Hearings for an
1-33 expedited administrative hearing regarding the hold. The provider
1-34 must request an expedited hearing under this subsection not later
1-35 than the 10th day after the date the provider receives notice from
1-36 the department under Subsection (b). The administrative law judge
1-37 shall order the department to discontinue imposing the hold unless
1-38 the department makes a prima facie showing at the hearing that the
1-39 evidence relied on by the department in imposing the hold is
1-40 relevant, reliable, credible, and material to the issue of fraud or
1-41 wilful misrepresentation.
1-42 (d) The department shall adopt rules that allow a provider
1-43 subject to a postpayment hold under Subsection (b) to seek an
1-44 informal resolution of the issues identified by the department in
1-45 the notice provided under that subsection. A provider must seek an
1-46 informal resolution under this subsection not later than the
1-47 deadline prescribed by Subsection (c). A provider's decision to
1-48 seek an informal resolution under this subsection does not extend
1-49 the time by which the provider must request an expedited
1-50 administrative hearing under Subsection (c). However, the
1-51 department may request that any hearing initiated under Subsection
1-52 (c) be stayed until the informal resolution process is completed.
1-53 SECTION 2. Section 32.032, Human Resources Code, is amended
1-54 to read as follows:
1-55 Sec. 32.032. PREVENTION AND DETECTION OF FRAUD AND ABUSE.
1-56 The department shall adopt reasonable rules for minimizing the
1-57 opportunity for fraud and abuse, for establishing and maintaining
1-58 methods for detecting and identifying situations in which a
1-59 question of fraud or abuse in the program may exist, and for
1-60 referring cases where fraud or abuse appears to exist to the
1-61 appropriate law enforcement agencies for prosecution.
1-62 SECTION 3. Section 32.0321(a), Human Resources Code, is
1-63 amended to read as follows:

2-1 (a) The department by rule may require each provider of
2-2 medical assistance in a provider type that has demonstrated
2-3 significant potential for fraud or abuse to file with the
2-4 department a surety bond in a reasonable amount. The department by
2-5 rule shall require a provider of medical assistance to file with the
2-6 department a surety bond in a reasonable amount if the department
2-7 identifies a pattern of suspected fraud or abuse involving criminal
2-8 conduct relating to the provider's services under the medical
2-9 assistance program that indicates the need for protection against
2-10 potential future acts of fraud or abuse.
2-11 SECTION 4. Section 32.039(a), Human Resources Code, is
2-12 amended by adding Subdivision (1-a) to read as follows:
2-13 (1-a) "Inducement" includes a service, cash in any
2-14 amount, entertainment, or any item of value.
2-15 SECTION 5. Section 32.039, Human Resources Code, is amended
2-16 by amending Subsections (b), (u), and (v) and adding Subsections
2-17 (w) and (x) to read as follows:
2-18 (b) A person commits a violation if the person:
2-19 (1) presents or causes to be presented to the
2-20 department a claim that contains a statement or representation the
2-21 person knows or should know to be false;
2-22 (1-a) engages in conduct that violates Section
2-23 102.001, Occupations Code;
2-24 (1-b) solicits or receives, directly or indirectly,
2-25 overtly or covertly any remuneration, including any kickback,
2-26 bribe, or rebate, in cash or in kind for referring an individual to
2-27 a person for the furnishing of, or for arranging the furnishing of,
2-28 any item or service for which payment may be made, in whole or in
2-29 part, under the medical assistance program, provided that this
2-30 subdivision does not prohibit the referral of a patient to another
2-31 practitioner within a multispecialty group or university medical
2-32 services research and development plan (practice plan) for
2-33 medically necessary services;
2-34 (1-c) solicits or receives, directly or indirectly,
2-35 overtly or covertly any remuneration, including any kickback,
2-36 bribe, or rebate, in cash or in kind for purchasing, leasing, or
2-37 ordering, or arranging for or recommending the purchasing, leasing,
2-38 or ordering of, any good, facility, service, or item for which
2-39 payment may be made, in whole or in part, under the medical
2-40 assistance program;
2-41 (1-d) offers or pays, directly or indirectly, overtly
2-42 or covertly any remuneration, including any kickback, bribe, or
2-43 rebate, in cash or in kind to induce a person to refer an individual
2-44 to another person for the furnishing of, or for arranging the
2-45 furnishing of, any item or service for which payment may be made, in
2-46 whole or in part, under the medical assistance program, provided
2-47 that this subdivision does not prohibit the referral of a patient to
2-48 another practitioner within a multispecialty group or university
2-49 medical services research and development plan (practice plan) for
2-50 medically necessary services;
2-51 (1-e) offers or pays, directly or indirectly, overtly
2-52 or covertly any remuneration, including any kickback, bribe, or
2-53 rebate, in cash or in kind to induce a person to purchase, lease, or
2-54 order, or arrange for or recommend the purchase, lease, or order of,
2-55 any good, facility, service, or item for which payment may be made,
2-56 in whole or in part, under the medical assistance program;
2-57 (1-f) provides or offers an inducement in a manner or
2-58 for a purpose not otherwise prohibited by this section or Section
2-59 102.001, Occupations Code, to an individual, including a recipient,
2-60 provider, or employee of a provider, for the purpose of influencing
2-61 a decision regarding selection of a provider or receipt of a good or
2-62 service under the medical assistance program or for the purpose of
2-63 otherwise influencing a decision regarding the use of goods or
2-64 services provided under the medical assistance program; or
2-65 (2) is a managed care organization that contracts with
2-66 the department to provide or arrange to provide health care
2-67 benefits or services to individuals eligible for medical assistance
2-68 and:
2-69 (A) fails to provide to an individual a health

3-1 care benefit or service that the organization is required to
3-2 provide under the contract with the department;
3-3 (B) fails to provide to the department
3-4 information required to be provided by law, department rule, or
3-5 contractual provision;
3-6 (C) engages in a fraudulent activity in
3-7 connection with the enrollment in the organization's managed care
3-8 plan of an individual eligible for medical assistance or in
3-9 connection with marketing the organization's services to an
3-10 individual eligible for medical assistance; or
3-11 (D) engages in actions that indicate a pattern
3-12 of:
3-13 (i) wrongful denial of payment for a health
3-14 care benefit or service that the organization is required to
3-15 provide under the contract with the department; or
3-16 (ii) wrongful delay of at least 45 days or a
3-17 longer period specified in the contract with the department, not to
3-18 exceed 60 days, in making payment for a health care benefit or
3-19 service that the organization is required to provide under the
3-20 contract with the department.
3-21 (u) Except as provided by Subsection (w), a [~~A~~] person found
3-22 liable for a violation under Subsection (c) that resulted in injury
3-23 to an elderly person, as defined by Section 48.002(a)(1)
3-24 [~~48.002(1)~~], a disabled person, as defined by Section
3-25 48.002(a)(8)(A) [~~48.002(8)(A)~~], or a person younger than 18 years
3-26 of age may not provide or arrange to provide health care services
3-27 under the medical assistance program for a period of 10 years. The
3-28 department by rule may provide for a period of ineligibility longer
3-29 than 10 years. The period of ineligibility begins on the date on
3-30 which the determination that the person is liable becomes final.
3-31 [~~This subsection does not apply to a person who operates a nursing~~
3-32 ~~facility or an ICF-MR facility.~~]
3-33 (v) Except as provided by Subsection (w), a [~~A~~] person found
3-34 liable for a violation under Subsection (c) that did not result in
3-35 injury to an elderly person, as defined by Section 48.002(a)(1)
3-36 [~~48.002(1)~~], a disabled person, as defined by Section
3-37 48.002(a)(8)(A) [~~48.002(8)(A)~~], or a person younger than 18 years
3-38 of age may not provide or arrange to provide health care services
3-39 under the medical assistance program for a period of three years.
3-40 The department by rule may provide for a period of ineligibility
3-41 longer than three years. The period of ineligibility begins on the
3-42 date on which the determination that the person is liable becomes
3-43 final[~~. This subsection does not apply to a person who operates a~~
3-44 ~~nursing facility or an ICF-MR facility~~].
3-45 (w) The department by rule may prescribe criteria under
3-46 which a person described by Subsection (u) or (v) is not prohibited
3-47 from providing or arranging to provide health care services under
3-48 the medical assistance program. The criteria may include
3-49 consideration of:
3-50 (1) the person's knowledge of the violation;
3-51 (2) the likelihood that education provided to the
3-52 person would be sufficient to prevent future violations;
3-53 (3) the potential impact on availability of services
3-54 in the community served by the person; and
3-55 (4) any other reasonable factor identified by the
3-56 department.
3-57 (x) Subsections (b)(1-b) through (1-f) do not prohibit a
3-58 person from engaging in:
3-59 (1) generally accepted business practices, as
3-60 determined by department rule, including:
3-61 (A) conducting a marketing campaign;
3-62 (B) providing token items of minimal value that
3-63 advertise the person's trade name; and
3-64 (C) providing complimentary refreshments at an
3-65 informational meeting promoting the person's goods or services;
3-66 (2) the provision of a value-added service if the
3-67 person is a managed care organization; or
3-68 (3) other conduct specifically authorized by law,
3-69 including conduct authorized by federal safe harbor regulations (42

4-1 C.F.R. Section 1001.952).
4-2 SECTION 6. Subchapter B, Chapter 32, Human Resources Code,
4-3 is amended by adding Section 32.0391 to read as follows:
4-4 Sec. 32.0391. CRIMINAL OFFENSE. (a) A person commits an
4-5 offense if the person intentionally or knowingly commits a
4-6 violation under Section 32.039(b)(1-b), (1-c), (1-d), or (1-e).
4-7 (b) An offense under this section is a state jail felony.
4-8 (c) If conduct constituting an offense under this section
4-9 also constitutes an offense under another provision of law,
4-10 including a provision in the Penal Code, the person may be
4-11 prosecuted under either this section or the other provision.
4-12 (d) With the consent of the appropriate local county or
4-13 district attorney, the attorney general has concurrent
4-14 jurisdiction with that consenting local prosecutor to prosecute an
4-15 offense under this section.
4-16 SECTION 7. Subchapter B, Chapter 32, Human Resources Code,
4-17 is amended by adding Section 32.060 to read as follows:
4-18 Sec. 32.060. THIRD-PARTY BILLING VENDORS. (a) A
4-19 third-party billing vendor may not submit a claim with the
4-20 department for reimbursement on behalf of a provider of medical
4-21 services under the medical assistance program unless the vendor has
4-22 entered into a contract with the department authorizing that
4-23 activity.
4-24 (b) To the extent practical, the contract shall contain
4-25 provisions comparable to the provisions contained in contracts
4-26 between the department and providers of medical services, with an
4-27 emphasis on provisions designed to prevent fraud or abuse under the
4-28 medical assistance program. At a minimum, the contract must
4-29 require the third-party billing vendor to:
4-30 (1) provide documentation of the vendor's authority to
4-31 bill on behalf of each provider for whom the vendor submits claims;
4-32 (2) submit a claim in a manner that permits the
4-33 department to identify and verify the vendor, any computer or
4-34 telephone line used in submitting the claim, any relevant user
4-35 password used in submitting the claim, and any provider number
4-36 referenced in the claim; and
4-37 (3) subject to any confidentiality requirements
4-38 imposed by federal law, provide the department, the office of the
4-39 attorney general, or authorized representatives with:
4-40 (A) access to any records maintained by the
4-41 vendor, including original records and records maintained by the
4-42 vendor on behalf of a provider, relevant to an audit or
4-43 investigation of the vendor's services or another function of the
4-44 department or office of attorney general relating to the vendor;
4-45 and
4-46 (B) if requested, copies of any records described
4-47 by Paragraph (A) at no charge to the department, the office of the
4-48 attorney general, or authorized representatives.
4-49 (c) On receipt of a claim submitted by a third-party billing
4-50 vendor, the department shall send a remittance notice directly to
4-51 the provider referenced in the claim. The notice must:
4-52 (1) include detailed information regarding the claim
4-53 submitted on behalf of the provider; and
4-54 (2) require the provider to review the claim for
4-55 accuracy and notify the department promptly regarding any errors.
4-56 (d) The department shall take all action necessary,
4-57 including any modifications of the department's claims processing
4-58 system, to enable the department to identify and verify a
4-59 third-party billing vendor submitting a claim for reimbursement
4-60 under the medical assistance program, including identification and
4-61 verification of any computer or telephone line used in submitting
4-62 the claim, any relevant user password used in submitting the claim,
4-63 and any provider number referenced in the claim.
4-64 SECTION 8. Subchapter C, Chapter 531, Government Code, is
4-65 amended by adding Section 531.1011 to read as follows:
4-66 Sec. 531.1011. DEFINITIONS. For purposes of this
4-67 subchapter:
4-68 (1) "Fraud" means an intentional deception or
4-69 misrepresentation made by a person with the knowledge that the

5-1 deception could result in some unauthorized benefit to that person
5-2 or some other person, including any act that constitutes fraud
5-3 under applicable federal or state law.
5-4 (2) "Furnished" refers to items or services provided
5-5 directly by, or under the direct supervision of, or ordered by a
5-6 practitioner or other individual (either as an employee or in the
5-7 individual's own capacity), a provider, or other supplier of
5-8 services, excluding services ordered by one party but billed for
5-9 and provided by or under the supervision of another.
5-10 (3) "Hold on payment" means the temporary denial of
5-11 reimbursement under the Medicaid program for items or services
5-12 furnished by a specified provider.
5-13 (4) "Practitioner" means a physician or other
5-14 individual licensed under state law to practice the individual's
5-15 profession.
5-16 (5) "Program exclusion" means the suspension of a
5-17 provider from being authorized under the Medicaid program to
5-18 request reimbursement of items or services furnished by that
5-19 specific provider.
5-20 (6) "Provider" means a person, firm, partnership,
5-21 corporation, agency, association, institution, or other entity
5-22 that was or is approved by the commission to:
5-23 (A) provide medical assistance under contract or
5-24 provider agreement with the commission; or
5-25 (B) provide third-party billing vendor services
5-26 under a contract or provider agreement with the commission.
5-27 SECTION 9. Section 531.102, Government Code, is amended by
5-28 amending Subsections (a) and (d) and adding Subsections (f) and (g)
5-29 to read as follows:
5-30 (a) The commission, through the commission's office of
5-31 investigations and enforcement, is responsible for the
5-32 investigation of fraud and abuse in the provision of health and
5-33 human services and the enforcement of state law relating to the
5-34 provision of those services.
5-35 (d) The commission may require employees of health and human
5-36 services agencies to provide assistance to the commission in
5-37 connection with the commission's duties relating to the
5-38 investigation of fraud and abuse in the provision of health and
5-39 human services.
5-40 (f)(1) If the commission receives a complaint of Medicaid
5-41 fraud or abuse from any source, it must conduct an integrity review
5-42 to determine whether there is sufficient basis to warrant a full
5-43 investigation. An integrity review must commence not later than 60
5-44 days after the commission receives a complaint or has reason to
5-45 believe that fraud or abuse has occurred. An integrity review shall
5-46 be completed not later than 90 days after it has commenced.
5-47 (2) If the findings of an integrity review give the
5-48 commission reason to believe that an incident of fraud or abuse
5-49 involving possible criminal conduct has occurred in the Medicaid
5-50 program, the commission must take the following action, as
5-51 appropriate, not later than 30 days after the completion of the
5-52 integrity review:
5-53 (A) if a provider is suspected of fraud or abuse
5-54 involving criminal conduct, the commission must refer the case to
5-55 the state's Medicaid fraud control unit, provided that such
5-56 criminal referral does not preclude the commission from continuing
5-57 its investigation of the provider, which investigation may lead to
5-58 the imposition of appropriate administrative or civil sanctions; or
5-59 (B) if there is reason to believe that a
5-60 recipient has defrauded the Medicaid program, the commission may
5-61 conduct a full investigation of the suspected fraud.
5-62 (g)(1) Whenever the commission learns or has reason to
5-63 suspect that a provider's records are being withheld, concealed,
5-64 destroyed, fabricated, or in any way falsified, the commission
5-65 shall immediately refer the case to the state's Medicaid fraud
5-66 control unit. However, such criminal referral does not preclude
5-67 the commission from continuing its investigation of the provider,
5-68 which investigation may lead to the imposition of appropriate
5-69 administrative or civil sanctions.

6-1 (2) In addition to other instances authorized under
6-2 state or federal law, the commission shall impose without prior
6-3 notice a hold on payment of claims for reimbursement submitted by a
6-4 provider to compel production of records or when requested by the
6-5 state's Medicaid fraud control unit, as applicable. The commission
6-6 must notify the provider of the hold on payment not later than the
6-7 fifth working day after the date the payment hold is imposed.
6-8 (3) On timely written request by a provider subject to
6-9 a hold on payment under Subdivision (2), other than a hold requested
6-10 by the state's Medicaid fraud control unit, the commission shall
6-11 file a request with the State Office of Administrative Hearings for
6-12 an expedited administrative hearing regarding the hold. The
6-13 provider must request an expedited hearing under this subdivision
6-14 not later than the 10th day after the date the provider receives
6-15 notice from the commission under Subdivision (2).
6-16 (4) The commission shall adopt rules that allow a
6-17 provider subject to a hold on payment under Subdivision (2), other
6-18 than a hold requested by the state's Medicaid fraud control unit, to
6-19 seek an informal resolution of the issues identified by the
6-20 commission in the notice provided under that subdivision. A
6-21 provider must seek an informal resolution under this subdivision
6-22 not later than the deadline prescribed by Subdivision (3). A
6-23 provider's decision to seek an informal resolution under this
6-24 subdivision does not extend the time by which the provider must
6-25 request an expedited administrative hearing under Subdivision (3).
6-26 However, the commission may request that any hearing initiated
6-27 under Subdivision (3) be stayed until the informal resolution
6-28 process is completed.
6-29 (5) The commission shall, in consultation with the
6-30 state's Medicaid fraud control unit, establish guidelines under
6-31 which holds on payment or program exclusions:
6-32 (A) may permissively be imposed on a provider; or
6-33 (B) shall automatically be imposed on a provider.
6-34 SECTION 10. Section 531.103(f), Government Code, is amended
6-35 to read as follows:
6-36 (f) A [The] district attorney, county attorney, city
6-37 attorney, or private collection agency may collect and retain costs
6-38 associated with a [the] case referred to the attorney or agency and
6-39 20 percent of the amount of the penalty, restitution, or other
6-40 reimbursement payment collected.
6-41 SECTION 11. Section 531.104, Government Code, is amended by
6-42 adding Subsection (c) to read as follows:
6-43 (c) The memorandum of understanding must ensure that no
6-44 barriers to direct fraud referrals to the state's Medicaid fraud
6-45 control unit by Medicaid agencies or unreasonable impediments to
6-46 communication between Medicaid agency employees and the state's
6-47 Medicaid fraud control unit will be imposed.
6-48 SECTION 12. Section 531.107(b), Government Code, is amended
6-49 to read as follows:
6-50 (b) The task force is composed of a representative of the:
6-51 (1) attorney general's office, appointed by the
6-52 attorney general;
6-53 (2) comptroller's office, appointed by the
6-54 comptroller;
6-55 (3) Department of Public Safety, appointed by the
6-56 public safety director;
6-57 (4) state auditor's office, appointed by the state
6-58 auditor;
6-59 (5) commission, appointed by the commissioner of
6-60 health and human services;
6-61 (6) Texas Department of Human Services, appointed by
6-62 the commissioner of human services; [and]
6-63 (7) Texas Department of Insurance, appointed by the
6-64 commissioner of insurance; and
6-65 (8) Texas Department of Health, appointed by the
6-66 commissioner of public health.
6-67 SECTION 13. Section 31.03, Penal Code, is amended by adding
6-68 Subsection (j) to read as follows:
6-69 (j) With the consent of the appropriate local county or

7-1 district attorney, the attorney general has concurrent
7-2 jurisdiction with that consenting local prosecutor to prosecute an
7-3 offense under this section that involves the state Medicaid
7-4 program.
7-5 SECTION 14. Section 32.45, Penal Code, is amended by adding
7-6 Subsection (d) to read as follows:
7-7 (d) With the consent of the appropriate local county or
7-8 district attorney, the attorney general has concurrent
7-9 jurisdiction with that consenting local prosecutor to prosecute an
7-10 offense under this section that involves the state Medicaid
7-11 program.
7-12 SECTION 15. Section 32.46, Penal Code, is amended by adding
7-13 Subsection (e) to read as follows:
7-14 (e) With the consent of the appropriate local county or
7-15 district attorney, the attorney general has concurrent
7-16 jurisdiction with that consenting local prosecutor to prosecute an
7-17 offense under this section that involves the state Medicaid
7-18 program.
7-19 SECTION 16. Section 37.10, Penal Code, is amended by adding
7-20 Subsection (i) to read as follows:
7-21 (i) With the consent of the appropriate local county or
7-22 district attorney, the attorney general has concurrent
7-23 jurisdiction with that consenting local prosecutor to prosecute an
7-24 offense under this section that involves the state Medicaid
7-25 program.
7-26 SECTION 17. Articles 59.01(1) and (2), Code of Criminal
7-27 Procedure, are amended to read as follows:
7-28 (1) "Attorney representing the state" means the
7-29 prosecutor with felony jurisdiction in the county in which a
7-30 forfeiture proceeding is held under this chapter or, in a
7-31 proceeding for forfeiture of contraband as defined under
7-32 Subdivision (2)(B)(iv) of this article, the city attorney of a
7-33 municipality if the property is seized in that municipality by a
7-34 peace officer employed by that municipality and the governing body
7-35 of the municipality has approved procedures for the city attorney
7-36 acting in a forfeiture proceeding. In a proceeding for forfeiture
7-37 of contraband as defined under Subdivision (2)(B)(vii) of this
7-38 article, the term includes the attorney general.
7-39 (2) "Contraband" means property of any nature,
7-40 including real, personal, tangible, or intangible, that is:
7-41 (A) used in the commission of:
7-42 (i) any first or second degree felony under
7-43 the Penal Code;
7-44 (ii) any felony under Section 15.031(b),
7-45 21.11, 38.04, 43.25, or 43.26 or Chapter 29, 30, 31, 32, 33, 33A, or
7-46 35, Penal Code; or
7-47 (iii) any felony under The Securities Act
7-48 (Article 581-1 et seq., Vernon's Texas Civil Statutes);
7-49 (B) used or intended to be used in the commission
7-50 of:
7-51 (i) any felony under Chapter 481, Health
7-52 and Safety Code (Texas Controlled Substances Act);
7-53 (ii) any felony under Chapter 483, Health
7-54 and Safety Code;
7-55 (iii) a felony under Chapter 153, Finance
7-56 Code;
7-57 (iv) any felony under Chapter 34, Penal
7-58 Code;
7-59 (v) a Class A misdemeanor under Subchapter
7-60 B, Chapter 365, Health and Safety Code, if the defendant has been
7-61 previously convicted twice of an offense under that subchapter;
7-62 [or]
7-63 (vi) any felony under Chapter 152, Finance
7-64 Code; or
7-65 (vii) any felony under Chapter 31, 32, or
7-66 37, Penal Code, that involves the state Medicaid program, or any
7-67 felony under Chapter 36, Human Resources Code;
7-68 (C) the proceeds gained from the commission of a
7-69 felony listed in Paragraph (A) or (B) of this subdivision or a crime

8-1 of violence; or
8-2 (D) acquired with proceeds gained from the
8-3 commission of a felony listed in Paragraph (A) or (B) of this
8-4 subdivision or a crime of violence.
8-5 SECTION 18. Article 59.06, Code of Criminal Procedure, is
8-6 amended by adding Subsection (p) to read as follows:
8-7 (p) Notwithstanding Subsection (a), and to the extent
8-8 necessary to protect the commission's ability to recover amounts
8-9 wrongfully obtained by the owner of the property and associated
8-10 damages and penalties to which the commission may otherwise be
8-11 entitled by law, the attorney representing the state shall transfer
8-12 to the Health and Human Services Commission all forfeited property
8-13 defined as contraband under Article 59.01(2)(B)(vii). If the
8-14 forfeited property consists of property other than money or
8-15 negotiable instruments, the attorney representing the state may, if
8-16 approved by the commission, sell the property and deliver to the
8-17 commission the proceeds from the sale, minus costs attributable to
8-18 the sale. The sale must be conducted in a manner that is reasonably
8-19 expected to result in receiving the fair market value for the
8-20 property.
8-21 SECTION 19. (a) The Medicaid and Public Assistance Fraud
8-22 Oversight Task Force, with the participation of the Texas
8-23 Department of Health's Bureau of Vital Statistics and other
8-24 agencies designated by the comptroller, shall study procedures and
8-25 documentation requirements used by the state in confirming a
8-26 person's identity for purposes of establishing entitlement to
8-27 Medicaid and other benefits provided through health and human
8-28 services programs.
8-29 (b) Not later than December 1, 2004, the Medicaid and Public
8-30 Assistance Fraud Oversight Task Force, with assistance from the
8-31 agencies participating in the study required by Subsection (a) of
8-32 this section, shall submit a report to the legislature containing
8-33 recommendations for improvements in the procedures and
8-34 documentation requirements described by Subsection (a) of this
8-35 section that would strengthen the state's ability to prevent fraud
8-36 and abuse in the Medicaid program and other health and human
8-37 services programs.
8-38 SECTION 20. Not later than December 1, 2003, the Office of
8-39 the Attorney General and the Health and Human Services Commission
8-40 shall amend the memorandum of understanding required by Section
8-41 531.104, Government Code, as necessary to comply with Section
8-42 531.104(c), Government Code, as added by this Act.
8-43 SECTION 21. The changes in law made by this Act through
8-44 amending Section 32.039(b), Human Resources Code, and adding
8-45 Section 32.0391, Human Resources Code, apply only to a violation
8-46 committed on or after the effective date of this Act. For purposes
8-47 of this section, a violation is committed on or after the effective
8-48 date of this Act only if each element of the violation occurs on or
8-49 after that date. A violation committed before the effective date of
8-50 this Act is covered by the law in effect when the violation was
8-51 committed, and the former law is continued in effect for that
8-52 purpose.
8-53 SECTION 22. If before implementing any provision of this
8-54 Act a state agency determines that a waiver or authorization from a
8-55 federal agency is necessary for implementation of that provision,
8-56 the agency affected by the provision shall request the waiver or
8-57 authorization and may delay implementing that provision until the
8-58 waiver or authorization is granted.
8-59 SECTION 23. Section 531.103(e), Government Code, is
8-60 repealed.
8-61 SECTION 24. (a) Except as otherwise provided by Subsection
8-62 (b) of this section, this Act takes effect September 1, 2003.
8-63 (b) Section 32.060, Human Resources Code, as added by this
8-64 Act, takes effect January 1, 2004.

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