Amend **HB 1720** (house committee printing) by striking all below the enacting clause and substituting the following:

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.024161 to read as follows:

Sec. 531.024161. REIMBURSEMENT CLAIMS FOR CERTAIN MEDICAID OR CHIP SERVICES INVOLVING SUPERVISED PROVIDERS. (a) If a provider, including a nurse practitioner or physician assistant, under the Medicaid or child health plan program provides a referral for or orders health care services for a recipient or enrollee, as applicable, at the direction or under the supervision of another provider, and the referral or order is based on the supervised provider's evaluation of the recipient or enrollee, the names and associated national provider identifier numbers of the supervised provider and the supervising provider must be included on any claim for reimbursement submitted by a provider based on the referral or order. For purposes of this section, "national provider identifier" means the national provider identifier required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) The executive commissioner shall adopt rules necessary to implement this section.

SECTION 2. Subchapter C, Chapter 531, Government Code, is amended by adding Sections 531.1131 and 531.117 to read as follows:

Sec. 531.1131. FRAUD AND ABUSE RECOVERY BY CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS. (a) If a managed care organization's special investigative unit under Section 531.113(a)(1) or the entity with which the managed care organization contracts under Section 531.113(a)(2) discovers fraud or abuse in the Medicaid program or the child health plan program, the unit or entity shall:

(1) immediately notify the commission's office of inspector general;

(2) subject to Subsection (b), begin payment recovery efforts; and

(3) ensure that any payment recovery efforts in which the organization engages are in accordance with applicable rules adopted by the executive commissioner.

(b) If the amount sought to be recovered under Subsection (a)(2) exceeds $100,000, the managed care organization's special investigative unit or contracted entity described by Subsection (a) may not engage in payment recovery efforts if, not later than the 10th business day after the date the unit or entity notified the commission's office of inspector general under Subsection (a)(1), the unit or entity receives a notice from the office indicating that the unit or entity is not authorized to proceed with recovery efforts.

(c) A managed care organization may retain any money recovered under Subsection (a)(2) by the organization's special investigative unit or contracted entity described by Subsection (a).

(d) A managed care organization shall submit a quarterly report to the commission's office of inspector general detailing the amount of money recovered under Subsection (a)(2).

(e) The executive commissioner shall adopt rules necessary to implement this section, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by this section.

Sec. 531.117. RECOVERY AUDIT CONTRACTORS. To the extent required under Section 1902(a)(42), Social Security Act (42 U.S.C. Section 1396a(a)(42)), the commission shall establish a program under which the commission contracts with one or more recovery audit contractors for purposes of identifying underpayments and overpayments under the Medicaid program and recovering the overpayments.

SECTION 3. Subchapter D, Chapter 62, Health and Safety Code, is amended by adding Section 62.1561 to read as follows:

Sec. 62.1561. PROHIBITION OF CERTAIN HEALTH CARE PROVIDERS. The executive commissioner of the commission shall adopt rules for prohibiting a person from participating in the child health plan program as a health care provider for a reasonable period, as determined by the executive commissioner, if the person:

(1) fails to repay overpayments under the program; or

(2) owns, controls, manages, or is otherwise affiliated with and has financial, managerial, or administrative

influence over a provider who has been suspended or prohibited from participating in the program.

SECTION 4. Section 32.047, Human Resources Code, is amended to read as follows:

Sec. 32.047. PROHIBITION OF CERTAIN HEALTH CARE SERVICE PROVIDERS. (a) A person is permanently prohibited from providing or arranging to provide health care services under the medical assistance program if:

(1) the person is convicted of an offense arising from a fraudulent act under the program; and

(2) the person's fraudulent act results in injury to an elderly person, as defined by Section 48.002(a)(1) [~~48.002(1)~~], a disabled person, as defined by Section 48.002(a)(8)(A) [~~48.002(8)(A)~~], or a person younger than 18 years of age.

(b) The executive commissioner of the Health and Human Services Commission shall adopt rules for prohibiting a person from participating in the medical assistance program as a health care provider for a reasonable period, as determined by the executive commissioner, if the person:

(1) fails to repay overpayments under the program; or

(2) owns, controls, manages, or is otherwise affiliated with and has financial, managerial, or administrative influence over a provider who has been suspended or prohibited from participating in the program.

SECTION 5. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.068 to read as follows:

Sec. 32.068. IN-PERSON EVALUATION REQUIRED FOR CERTAIN SERVICES. (a) A medical assistance provider may order or otherwise authorize the provision of home health services for a recipient only if the provider has conducted an in-person evaluation of the recipient within the six-month period preceding the date the order or other authorization was issued.

(b) A physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse-midwife that orders or otherwise authorizes the provision of durable medical equipment for a recipient in accordance with Chapter 157, Occupations Code, and other applicable law, including rules, must certify on the

order or other authorization that the person conducted an in-person evaluation of the recipient within the six-month period preceding the date the order or other authorization was issued.

(c) The executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement this section.

SECTION 6. Section 531.1131, Government Code, as added by this Act, applies to the investigation of a fraudulent Medicaid or child health plan program claim or other program abuse that commences on or after the effective date of this Act. An investigation that commences before the effective date of this Act is governed by the law in effect when the investigation commenced, and the former law is continued in effect for that purpose.

SECTION 7. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 8. This Act takes effect September 1, 2011.