BILL ANALYSIS

C.S.S.B. 1803
By: Huffman
Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Physicians, physicians groups, and other medical providers throughout the state have recently expressed concerns relating to certain investigations of suspected Medicaid fraud and abuse by the Health and Human Services Commission's office of inspector general, including concerns regarding due process, transparency, and conflicts of interest. In addition, interested parties contend that provisions relating to payment holds on providers because of a credible allegation of fraud must be revised to meet federal requirements in order for the state to continue receiving matching funds from the federal government. C.S.S.B. 1803 seeks to address these issues in order to enhance the state's ability to detect and prevent fraud, waste, and abuse in Medicaid and across the health and human services system.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission and to the State Office of Administrative Hearings in SECTIONS 2 and 3 of this bill.

ANALYSIS

C.S.S.B. 1803 amends the Government Code to require the Health and Human Services Commission's (HHSC) office of inspector general to conduct a preliminary investigation as provided by the bill, rather than an integrity review, to determine whether there is a sufficient basis to warrant a full investigation if HHSC receives a complaint or allegation of Medicaid fraud or abuse from any source. The bill specifies that the office's authority to conduct a full investigation of suspected fraud is subject to the bill's requirements for a preliminary investigation, including the requirement for the resulting report to document certain matters, including the office's determination of whether a full investigation is warranted. The bill requires the office to impose without prior notice a payment hold on claims for reimbursement submitted by a Medicaid provider to compel production of records on the determination that a credible allegation of fraud exists, rather than on receipt of reliable evidence that the circumstances giving rise to the hold involve fraud or wilful misrepresentation under the state Medicaid program in accordance with federal law, as well as on request of the state's Medicaid fraud control unit, and makes a determination that a credible allegation of fraud exists subject to certain expert review requirements and criteria adopted under the bill's provisions for determining when good cause exists to not impose, discontinue, partially discontinue, or convert a payment hold on a provider. The bill requires the notice of such a payment hold, in addition to meeting federal requirements, to also include the specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation and a representative sample of any documents that form the basis of the hold, and a description of administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both.

C.S.S.B. 1803 requires the office of the inspector general, on timely request by a provider subject to a payment hold other than a hold requested by the state's Medicaid fraud control unit, to file a

request with the appeals division of HHSC, as an alternative to filing a request with the State Office of Administrative Hearings (SOAH), for an expedited hearing regarding the hold. The bill extends the deadline for a provider to request an expedited administrative hearing regarding a payment hold from not later than the 10th day to not later than the 30th day after the date the provider receives notice from the office of inspector general that a hold has been imposed. The bill requires the state and the provider, unless otherwise determined by the administrative law judge for good cause at an expedited administrative hearing before SOAH, to each be responsible for one-half of the costs charged by SOAH, for one-half of the costs for transcribing the hearing, for the party's own costs related to the hearing, and for all other costs associated with the hearing that are incurred by the party. The bill requires SOAH and the executive commissioner of HHSC to jointly adopt rules that require a provider, before an expedited administrative hearing before SOAH regarding a hold, to advance security for the costs for which the provider is responsible.

C.S.S.B. 1803 authorizes a provider subject to a payment hold other than a hold requested by the state's Medicaid fraud control unit to appeal a final administrative order by filing a petition for judicial review in a district court in Travis County following an expedited administrative hearing.

C.S.S.B. 1803 requires a provider that is subject to a payment hold other than a hold requested by the state's Medicaid fraud control unit and that seeks an informal resolution to the issues identified in the notice of the hold to request an initial informal resolution meeting not later than the 30th day after the date the provider receives notice. The bill sets out provisions relating to scheduling and giving notice regarding the time and place of an initial informal resolution meeting. The bill authorizes a provider to request a second informal resolution meeting; sets out provisions relating to such a request and to scheduling and giving notice regarding the time and place of a second meeting; and requires the provider to have an opportunity to provide additional information before that second informal resolution meeting for consideration by the office of inspector general. The bill removes a specification making the requirement for an expedited administrative hearing to be stayed until the informal resolution process is complete contingent on a request from the office of inspector general.

C.S.S.B. 1803 requires the office of inspector general to employ a medical director who is a licensed physician and a dental director who is a licensed dentist who preferably each have significant knowledge of the Medicaid program. The bill requires the medical director and the dental director to ensure that investigative findings based on the necessity or the quality of certain medical or dental services or care, as applicable, have been reviewed by a qualified expert as described by the Texas Rules of Evidence who preferably has significant knowledge of the Medicaid program rules and requirements before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

C.S.S.B. 1803 requires the executive commissioner, in conjunction with the office of inspector general and in consultation with the state's Medicaid fraud control unit, to adopt rules for the office that establish criteria for initiating a full fraud or abuse investigation, conducting the investigation, and collecting evidence; training requirements for Medicaid provider fraud or abuse investigators; and criteria for determining, in accordance with state and federal law, when good cause exists to not impose a payment hold on a provider, discontinue a payment hold imposed on a provider, partially discontinue a payment hold imposed on a provider, and convert a full payment hold imposed on a provider to a partial payment hold. The bill requires the executive commissioner, in determining what constitutes good cause for such purposes, to consider the following: a specific request by a law enforcement agency that the office not impose a payment hold on a provider or discontinue a payment hold imposed on a provider; a determination by the office that other available remedies implemented by the office or HHSC could more effectively or quickly protect Medicaid funds than imposing or continuing a payment hold; evidence submitted by a provider that convinces the office that a payment hold should be discontinued or partially imposed; a determination by the office that a Medicaid recipient's access to items or services will be jeopardized by the imposition of a payment hold; a

determination by the office that a payment hold should be discontinued because the state's Medicaid fraud control unit or a law enforcement agency declines to cooperate in certifying that the unit or agency is continuing to investigate the credible allegation of fraud that is the basis of the payment hold; a determination by the office that imposing a full or partial payment hold is not in the best interest of the Medicaid program; and a determination by the office that a partial payment hold will ensure that potentially fraudulent claims under the Medicaid program will not be continued to be paid. The bill authorizes an employee of the office to bring a whistleblower suit in accordance with applicable statutory provisions.

C.S.S.B. 1803 requires HHSC to maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available, and provides for the confidentiality and authorized disclosure of such a record. The bill requires the office of inspector general, if HHSC receives an allegation of fraud or abuse against a provider from any source, to conduct a preliminary investigation of the allegation; sets out requirements for the conduct of such an investigation; and requires the preliminary investigation report to document the allegation, the evidence reviewed, if available, the procedures used to conduct the investigation, the office's findings, and the office's determination regarding whether a full investigation is warranted.

C.S.S.B. 1803 authorizes the continuation of a payment hold based on a credible allegation of fraud, if the state's Medicaid fraud control unit or other law enforcement agency accepts a fraud referral from the office of inspector general for investigation, until that investigation and any associated enforcement proceedings are complete or until a determination is made by the appropriate authorities that there is insufficient evidence of fraud by the provider. The bill requires a payment hold based on a credible allegation of fraud to be discontinued if the state's Medicaid fraud control unit or any other law enforcement agency declines to accept a fraud referral from the office for investigation, unless HHSC has alternative federal or state authority under which it may impose a payment hold or the office makes a fraud referral to another law enforcement agency.

C.S.S.B. 1803 requires the office of inspector general, on a quarterly basis, to request a certification from the state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter accepted by the unit or agency on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of the payment hold is warranted. The bill requires the office to post on its public website a description in plain English of, and a video explaining, the processes and procedures the office uses to determine whether to impose a payment hold on a provider.

C.S.S.B. 1803 requires HHSC or the office of inspector general to provide a provider with written notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation. The bill sets out content requirements for the written notice and requires the executive commissioner to adopt rules that allow a provider who is the subject of a proposed recoupment of an overpayment or debt to seek informal resolution of the issues identified in the notice. The bill requires the rules to require a provider who seeks such an informal resolution to request an initial informal resolution meeting by a specified deadline and sets out provisions relating to such a request and to scheduling and giving notice regarding the time and place of an initial informal resolution meeting. The bill requires the rules to allow a provider to request a second informal resolution meeting by a specified deadline; sets out provisions relating to such a request and to scheduling and giving notice regarding the time and place of a second meeting; and requires the provider to have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office.

C.S.S.B. 1803 requires HHSC or the office of inspector general, not later than the 60th day after the date of the initial informal resolution meeting or, if a second informal resolution meeting is requested by the provider, after the second informal resolution meeting, or on a later date at the

request of a provider, to provide the provider with written notice of HHSC's or the office's final determination of whether HHSC or the office will seek to recoup an overpayment or debt from the provider. The bill requires HHSC or the office, if a provider does not request an informal resolution meeting and not later than the 60th day after the date the provider receives the notice of a proposed recoupment, to provide the provider with written notice of HHSC's or the office's final determination of whether HHSC or the office will seek to recoup an overpayment or debt from the provider. The bill prohibits its provisions from being construed to require a provider to request an informal resolution meeting before requesting an appeal of HHSC's or the office's final determination to recoup an overpayment or debt from the provider.

C.S.S.B. 1803 authorizes a provider, if after a final determination HHSC or the office of inspector general seeks to recoup from the provider an overpayment or debt arising out of a fraud or abuse investigation in an amount that is less than $1 million, to appeal the determination not later than the 15th day after the date the provider receives a notice of HHSC's or the office's final determination by requesting in writing that HHSC or the office set an administrative hearing on the determination. The bill requires HHSC or the office, on receipt of a timely written request for an administrative hearing from the provider, to file a docketing request with SOAH or the appeals division of HHSC, as requested by the provider, for an administrative hearing on the final determination to recoup the overpayment or debt and any associated damages and penalties.

C.S.S.B. 1803 authorizes a provider, if after a final determination HHSC or the office of inspector general seeks to recoup from the provider an overpayment or debt arising out of a fraud or abuse investigation in an amount of $1 million or more, to appeal the determination not later than the 15th day after the date the provider receives notice of HHSC's or the office's final determination by requesting in writing that HHSC or the office file a docketing request with SOAH for an administrative hearing on the final determination to recoup an overpayment or debt and any associated damages and penalties or by filing a petition to appeal the final determination to recoup an overpayment or debt and any associated damages and penalties in a district court in Travis County.

C.S.S.B. 1803 prohibits a provider who requests that HHSC or the office of inspector general set such an administrative hearing from appealing any administrative order issued by an administrative law judge relating to HHSC's or the office's final determination to recoup an overpayment or debt and any associated damages and penalties from the provider in a district court. The bill requires the state and the provider, at any administrative hearing relating to the recoupment of an overpayment or debt before SOAH and unless otherwise determined by the administrative law judge for good cause, to each be responsible for one-half of the costs charged by SOAH, for one-half of the costs for transcribing the hearing, for the party's own costs, and for all other costs associated with the hearing that are incurred by the party. The bill requires SOAH and the executive commissioner of HHSC to jointly adopt rules that require a provider, before an administrative hearing regarding a recoupment before SOAH, to advance security for the costs for which the provider is responsible.

C.S.S.B. 1803 requires HHSC to employ a person whose salary is paid by HHSC and who is independent of the office of inspector general to attend the informal resolution meetings held regarding a payment hold or a recoupment of overpayment or debt as a neutral third-party observer. The bill requires the person to report to the executive commissioner on the proceedings and outcome of each informal resolution meeting.

C.S.S.B. 1803 amends the Human Resources Code to revise statutory provisions relating to a postpayment hold on future claims submitted by a Medicaid provider to establish that such payment holds are governed by the requirements and procedures specified for a payment hold under Government Code provisions relating to HHSC's office of the inspector general and makes related conforming changes.

C.S.S.B. 1803 repeals Section 32.0291(d), Human Resources Code.

EFFECTIVE DATE

September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.S.B. 1803 may differ from the engrossed version in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the engrossed and committee substitute versions of the bill.

SENATE ENGROSSED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Section 531.1011, Government Code, is amended to read as follows:	SECTION 1. Section 531.1011, Government Code, is amended to read as follows:
Sec. 531.1011. DEFINITIONS. For purposes of this subchapter:	Sec. 531.1011. DEFINITIONS. For purposes of this subchapter:
(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an 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, including beneficiary practices that result in unnecessary cost to the Medicaid program.	(1) "Abuse" means: (A) a practice by a provider that is inconsistent with sound fiscal, business, or medical practices and that results in: (i) an unnecessary cost to the Medicaid program; or (ii) the reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care; or (B) a practice by a recipient that results in an unnecessary cost to the Medicaid program.
(2) "Allegation of fraud" means an allegation of Medicaid fraud received by the commission from any source, that has not been verified by the state, including an allegation based upon fraud hotline complaints, claims mining data, data analysis processes or patterns identified through provider audits, civil false claims cases, and law enforcement investigations.	(2) "Allegation of fraud" means an allegation of Medicaid fraud received by the commission from any source that has not been verified by the state, including an allegation based on: (A) a fraud hotline complaint; (B) claims data mining; (C) data analysis processes; or (D) a pattern identified through provider audits, civil false claims cases, or law enforcement investigations.
(3) "Credible allegation of fraud" means an allegation of fraud that has been verified by the state. An allegation is considered to be credible when the commission has: (A) verified that the allegation has indicia of reliability; and (B) reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.	(3) "Credible allegation of fraud" means an allegation of fraud that has been verified by the state. An allegation is considered to be credible when the commission has: (A) verified that the allegation has indicia of reliability; and (B) reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.
(4) "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	(4) "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.

(5) [~~(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.

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

(7) "Physician" includes an individual licensed to practice medicine in this state, a professional association composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code, or a partnership composed solely of physicians.

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

(9) [~~(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.

(10) [~~(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.

SECTION 2. Section 531.102, Government Code, is amended by amending Subsections (f) and (g) and adding Subsections (l), (m), and (n) to read as follows:

(f)(1) If the commission receives a complaint of Medicaid fraud or abuse from any source, the office must conduct a preliminary investigation [~~an integrity~~

person or some other person, including any act that constitutes fraud under applicable federal or state law.

(5) [~~(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.

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

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

(8) [~~(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.

(9) [~~(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.

SECTION 2. Section 531.102, Government Code, is amended by amending Subsections (f) and (g) and adding Subsections (l), (m), (n), (o), and (p) to read as follows:

(f)(1) If the commission receives a complaint or allegation of Medicaid fraud or abuse from any source, the office must conduct a preliminary investigation as

~~review~~] to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation [~~An integrity review~~] must begin not later than the 30th day after the date the commission receives a complaint or has reason to believe that fraud or abuse has occurred. A preliminary investigation [~~An integrity review~~] shall be completed not later than the 90th day after it began.

(2) If the findings of a preliminary investigation [~~an integrity review~~] give the office reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in the Medicaid program, the office must take the following action, as appropriate, not later than the 30th day after the completion of the preliminary investigation [~~integrity review~~]:

(A) if a provider is suspected of fraud or abuse involving criminal conduct, the office must refer the case to the state's Medicaid fraud control unit, provided that the criminal referral does not preclude the office 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 office may conduct a full investigation of the suspected fraud.

(g)(1) Whenever the office learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

(2) In addition to other instances authorized under state or federal law, the office shall impose without prior notice a payment hold on [~~payment of~~] claims for reimbursement submitted by a provider to compel production of records, when requested by the state's Medicaid fraud control unit, or upon the determination that a credible

provided by Section 531.118(c) [~~an integrity review~~] to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation [~~An integrity review~~] must begin not later than the 30th day after the date the commission receives a complaint or allegation or has reason to believe that fraud or abuse has occurred. A preliminary investigation [~~An integrity review~~] shall be completed not later than the 90th day after it began.

(2) If the findings of a preliminary investigation [~~an integrity review~~] give the office reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in the Medicaid program, the office must take the following action, as appropriate, not later than the 30th day after the completion of the preliminary investigation [~~integrity review~~]:

(A) if a provider is suspected of fraud or abuse involving criminal conduct, the office must refer the case to the state's Medicaid fraud control unit, provided that the criminal referral does not preclude the office 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 office may conduct a full investigation of the suspected fraud, subject to Section 531.118(c).

(g)(1) Whenever the office learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

(2) In addition to other instances authorized under state or federal law, the office shall impose without prior notice a payment hold on [~~payment of~~] claims for reimbursement submitted by a provider to compel production of records, when requested by the state's Medicaid fraud control unit, or on the determination that a credible allegation

allegation of fraud exists [~~on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or wilful misrepresentation under the state Medicaid program in accordance with 42 C.F.R. Section 455.23, as applicable~~]. The office must notify the provider of the payment hold [~~on payment~~] in accordance with 42 C.F.R. Section 455.23(b). In addition to the requirements of 42 C.F.R. Section 455.23(b), the notice of payment hold provided under this subsection shall also include:

(A) the specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation and a representative sample of any documents that form the basis of the hold; and

(B) a description of administrative and judicial due process remedies, including an informal review, a formal administrative appeal hearing, or both.

(3) On timely written request by a provider subject to a payment hold [~~on payment~~] under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, the office shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold. The provider must request an expedited hearing under this subdivision not later than the 30th [~~10th~~] day after the date the provider receives notice from the office under Subdivision (2).

Unless otherwise determined by the administrative law judge for good cause at the administrative hearing, the state and the subject provider

shall each be responsible for
one-half of the costs charged by the State Office of Administrative Hearings,
for one-half of the costs for transcribing the hearing, and
for each party's own additional costs related to the administrative hearing, including costs associated with discovery, depositions, subpoenas, services of process and witness

of fraud exists, subject to Subsections (l) and (m), as applicable, and the criteria adopted under Subsection (n)(3) [~~on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or wilful misrepresentation under the state Medicaid program in accordance with 42 C.F.R. Section 455.23, as applicable~~]. The office must notify the provider of the payment hold [~~on payment~~] in accordance with 42 C.F.R. Section 455.23(b). In addition to the requirements of 42 C.F.R. Section 455.23(b), the notice of payment hold provided under this subdivision must also include:

(A) the specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation and a representative sample of any documents that form the basis for the hold; and

(B) a description of administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both.

(3) On timely written request by a provider subject to a payment hold [~~on payment~~] under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, the office shall file a request with the State Office of Administrative Hearings or the appeals division of the commission, as requested by the provider, for an expedited administrative hearing regarding the hold. The provider must request an expedited administrative hearing under this subdivision not later than the 30th [~~10th~~] day after the date the provider receives notice from the office under Subdivision (2). Unless otherwise determined by the administrative law judge for good cause at an expedited administrative hearing before the State Office of Administrative Hearings under this subdivision, the state and the provider shall each be responsible for:

(A) one-half of the costs charged by the State Office of Administrative Hearings;

(B) one-half of the costs for transcribing the hearing;

(C) the party's own costs related to the hearing, including the costs associated with preparation for the hearing, discovery, depositions, and subpoenas, service of

expenses, preparation for the administrative hearing, investigation costs, travel expenses, investigation expenses, and all other costs, including attorney's fees, associated with the case.

The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before a hearing, to advance security for the costs for which the provider is responsible under this subdivision.

(4) Following an administrative hearing under Subdivision (3), a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.

(5) The executive commissioner [~~commission~~] shall adopt rules that allow a provider subject to a [~~hold on~~] payment hold under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, to seek an initial informal resolution of the issues identified by the office in the notice provided under that subdivision. A provider must request [~~seek~~] an initial informal resolution meeting under this subdivision not later than the deadline prescribed by Subdivision (3).

On receipt of a timely request, the office shall schedule an initial informal resolution meeting not later than the 60th day after the date the office receives the request from the provider, but the office shall schedule the meeting on a later date as determined by the office if requested by the provider. The office shall give notice to the provider of the time and place of the initial informal resolution meeting not later than the 30th day before the date the initial informal resolution meeting is to be held. A provider may request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the

process and witness expenses, travel expenses, and investigation expenses; and

(D) all other costs associated with the hearing that are incurred by the party, including attorney's fees.

(4) The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before an expedited administrative hearing before the State Office of Administrative Hearings under Subdivision (3), to advance security for the costs for which the provider is responsible under that subdivision.

(5) Following an expedited administrative hearing under Subdivision (3), a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.

(6) The executive commissioner [~~commission~~] shall adopt rules that allow a provider subject to a [~~hold on~~] payment hold under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, to seek an informal resolution of the issues identified by the office in the notice provided under that subdivision. A provider must request [~~seek~~] an initial informal resolution meeting under this subdivision not later than the deadline prescribed by Subdivision (3) for requesting an expedited administrative hearing.

On receipt of a timely request, the office shall schedule an initial informal resolution meeting not later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall give notice to the provider of the time and place of the initial informal resolution meeting not later than the 30th day before the date the meeting is to be held. A provider may request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the request, but the office shall

request from the provider, but the office shall schedule the meeting on a later date as determined by the office if requested by the provider. The office shall give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the second informal resolution meeting is to be held. A provider shall have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office. A provider's decision to seek an informal resolution under this subdivision does not extend the time by which the provider must request an expedited administrative hearing under Subdivision (3). However, a hearing initiated under Subdivision (3) shall be stayed [~~at the office's request~~] until the informal resolution process is completed.

(6) [~~(5)~~] The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which payment holds [~~on payment~~] or program exclusions:

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

(B) shall automatically be imposed on a provider.

(l) The office shall employ a medical director who is a licensed physician under Subtitle B, Title 3, Occupations Code, and the rules adopted under that subtitle by the Texas Medical Board, and who preferably has significant knowledge of the Medicaid program. The medical director shall ensure that any investigative findings based on medical necessity or quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(m) The office shall employ a dental director who is a licensed dentist under Subtitle D, Title 3, Occupations Code, and the rules adopted under that subtitle by the State Board of Dental Examiners, and who preferably has significant knowledge of the Medicaid program. The dental director shall ensure that any investigative findings based on the necessity of dental services or the

schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the meeting is to be held. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office. A provider's decision to seek an informal resolution under this subdivision does not extend the time by which the provider must request an expedited administrative hearing under Subdivision (3). However, a hearing initiated under Subdivision (3) shall be stayed [~~at the office's request~~] until the informal resolution process is completed.

(7) [~~(5)~~] The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which payment holds [~~on payment~~] or program exclusions:

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

(B) shall automatically be imposed on a provider.

(l) The office shall employ a medical director who is a licensed physician under Subtitle B, Title 3, Occupations Code, and the rules adopted under that subtitle by the Texas Medical Board, and who preferably has significant knowledge of the Medicaid program. The medical director shall ensure that any investigative findings based on medical necessity or the quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence who preferably has knowledge of Medicaid program rules and requirements before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(m) The office shall employ a dental director who is a licensed dentist under Subtitle D, Title 3, Occupations Code, and the rules adopted under that subtitle by the State Board of Dental Examiners, and who preferably has significant knowledge of the Medicaid program. The dental director shall ensure that any investigative findings based on the necessity of dental services or the

quality of dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(n) To the extent permitted under federal law, the office, acting through the commission, shall adopt rules establishing

the criteria for initiating a full-scale fraud or abuse investigation, conducting the investigation, collecting evidence, accepting and approving a provider's request to post a surety bond to secure potential recoupments in lieu of a payment hold or other asset or payment guarantee, and establishing minimum training requirements for Medicaid provider fraud or abuse investigators.

quality of dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence who preferably has knowledge of Medicaid program rules and requirements before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(n) The executive commissioner shall, in conjunction with the office and in consultation with the state's Medicaid fraud control unit, adopt rules for the office that establish:

(1) criteria for initiating a full fraud or abuse investigation, conducting the investigation, and collecting evidence;

(2) training requirements for Medicaid provider fraud or abuse investigators; and

(3) criteria for determining, in accordance with state and federal law, when good cause exists to:

(A) not impose a payment hold on a provider;

(B) discontinue a payment hold imposed on a provider;

(C) partially discontinue a payment hold imposed on a provider; and

(D) convert a full payment hold imposed on a provider to a partial payment hold.

(o) In determining what constitutes good cause for purposes of Subsection (n)(3), the executive commissioner shall consider:

(1) a specific request by a law enforcement agency that the office not impose a payment hold on a provider or discontinue a payment hold imposed on a provider;

(2) a determination by the office that other available remedies implemented by the office or commission could more effectively or quickly protect Medicaid funds than imposing or continuing a payment hold;

(3) evidence submitted by a provider that convinces the office that a payment hold should be discontinued or partially imposed;

(4) a determination by the office that a Medicaid recipient's access to items or services will be jeopardized by the imposition of a payment hold;

(5) a determination by the office that a payment hold should be discontinued because the state's Medicaid fraud control

unit or a law enforcement agency declines to cooperate in certifying that the unit or agency is continuing to investigate the credible allegation of fraud that is the basis of the payment hold;

(6) a determination by the office that imposing a full or partial payment hold is not in the best interest of the Medicaid program; and

(7) a determination by the office that a partial payment hold will ensure that potentially fraudulent claims under the Medicaid program will not be continued to be paid.

(p) An employee of the office may bring a whistleblower suit in accordance with Chapter 554.

SECTION 3. Subchapter C, Chapter 531, Government Code, is amended by adding Sections 531.118, 531.119, 531.120, 531.1201, and 531.1202 to read as follows:

Sec. 531.118. PRELIMINARY INVESTIGATIONS OF ALLEGATIONS OF FRAUD OR ABUSE. (a) The commission shall maintain a record of all allegations of fraud or abuse against a Medicaid provider containing the date the allegation of fraud or abuse was received or identified and the source of the allegation, if available. This record shall remain confidential under Sections 531.1021(g) and (h).

(b) If the commission receives an allegation of fraud or abuse against a Medicaid provider from any source, the office must conduct a preliminary investigation of each allegation of fraud or abuse to determine whether there is sufficient basis to warrant a full investigation. A preliminary investigation must begin not later than the 30th day after the date the commission receives or identifies an allegation of fraud or abuse.

(c) A preliminary investigation shall consist of a review of all allegations, facts, and evidence by the commission's office of inspector general and must result in a preliminary investigation report documenting the allegations, evidence reviewed, if available, procedures utilized to

SECTION 3. Subchapter C, Chapter 531, Government Code, is amended by adding Sections 531.118, 531.119, 531.120, 531.1201, and 531.1202 to read as follows:

Sec. 531.118. PRELIMINARY INVESTIGATIONS OF ALLEGATIONS OF FRAUD OR ABUSE AND FRAUD REFERRALS. (a) The commission shall maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. The record is confidential under Section 531.1021(g) and is subject to Section 531.1021(h).

(b) If the commission receives an allegation of fraud or abuse against a provider from any source, the commission's office of inspector general shall conduct a preliminary investigation of the allegation as provided by Section 531.102(f)(1).

(c) In conducting a preliminary investigation, the office must review the allegations of fraud or abuse and all facts and evidence relating to the allegation and must prepare a preliminary investigation report before the allegation of fraud or abuse may proceed to a full investigation. The

conduct the preliminary investigation, findings of the preliminary investigation, and the office's determination of whether a full investigation is warranted before the allegation proceeds to a full investigation.

preliminary investigation report must document the allegation, the evidence reviewed, if available, the procedures used to conduct the preliminary investigation, the findings of the preliminary investigation, and the office's determination of whether a full investigation is warranted.

(d) If the Medicaid fraud control unit or other law enforcement agency accepts a fraud referral from the office for investigation, a payment hold based upon a credible allegation of fraud may be continued until such time as that investigation and any associated enforcement proceedings are completed, or until the Medicaid fraud control unit, other law enforcement agency, or other prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

(d) If the state's Medicaid fraud control unit or any other law enforcement agency accepts a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud may be continued until:
(1) that investigation and any associated enforcement proceedings are complete; or
(2) the state's Medicaid fraud control unit, another law enforcement agency, or other prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

(e) If the Medicaid fraud control unit or any other law enforcement agency declines to accept the fraud referral for investigation, a payment hold based upon a credible allegation of fraud must be discontinued unless the commission has alternative federal or state authority by which it may impose a payment hold or unless the office makes a fraud referral to another law enforcement agency.

(e) If the state's Medicaid fraud control unit or any other law enforcement agency declines to accept a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud must be discontinued unless the commission has alternative federal or state authority under which it may impose a payment hold or the office makes a fraud referral to another law enforcement agency.

(f) On a quarterly basis, the office must request a certification from the state's Medicaid fraud control unit or other law enforcement agency that any matter accepted on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of the payment hold is warranted.

(f) On a quarterly basis, the office must request a certification from the state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter accepted by the unit or agency on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of the payment hold is warranted.

Sec. 531.119. WEBSITE POSTING. The office shall post on its publicly available website a description in plain English of, and a video explaining, the processes and procedures that the office uses to determine whether to impose a payment hold on a provider under this subchapter.

Sec. 531.119. WEBSITE POSTING. The commission's office of inspector general shall post on its publicly available website a description in plain English of, and a video explaining, the processes and procedures the office uses to determine whether to impose a payment hold on a provider under this subchapter.

Sec. 531.120. INFORMAL RESOLUTION OF PROPOSED OVERPAYMENTS.

Sec. 531.120. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR

(a) The commission or the commission's office of inspector general must provide a provider with written notice of intent to recover any proposed overpayment or debt amount and any related damages or penalties arising out of a fraud or abuse investigation. The notice shall include

the specific basis for overpayment,

a description of facts and supporting evidence,

a representative sample of any documents that form the basis of the overpayment,

extrapolation methodology,

calculation of the overpayment amount,

damages and penalties, if applicable, and

a description of administrative and judicial due process remedies, including the provider's right to request informal resolution meetings under this section, a formal administrative appeal hearing, or both.

(b) A provider must request an initial informal resolution meeting under this section not later than the 30th day after the date the provider receives notice under Subsection (a). On receipt of a timely request, the office shall schedule an initial informal resolution meeting not later than the 60th day after the date the office receives the request from the provider, but the office shall schedule the meeting on a later date as determined by the office if requested by the provider. The office shall give notice to the provider of the time and place of the initial informal resolution meeting not later than the 30th day before the date the initial informal resolution meeting is to be held.

DEBT.

(a) The commission or the commission's office of inspector general shall provide a provider with written notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation. The notice must include:

(1) the specific basis for the overpayment or debt;

(2) a description of facts and supporting evidence;

(3) a representative sample of any documents that form the basis for the overpayment or debt;

(4) the extrapolation methodology;

(5) the calculation of the overpayment or debt amount;

(6) the amount of damages and penalties, if applicable; and

(7) a description of administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both.

(b) The executive commissioner shall adopt rules that allow a provider who is the subject of a proposed recoupment of an overpayment or debt to seek informal resolution of the issues identified in the notice provided under Subsection (a).

(c) The rules adopted under Subsection (b) must require a provider who seeks informal resolution of the issues identified in the notice provided under Subsection (a) to request an initial informal resolution meeting not later than the 30th day after the date the provider receives the notice. On receipt of a timely request, the office shall schedule the initial informal resolution meeting not later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall give notice to the provider of the time and place of the initial informal resolution meeting not later than the 30th day before the date the meeting is to be held.

A provider may request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the request from the provider, but the office shall schedule the meeting on a later date as determined by the office if requested by the provider. The office shall give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the second informal resolution meeting is to be held. A provider shall have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office.

(d) The rules adopted under Subsection (b) must allow a provider to request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the meeting is to be held. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office.

(e) Not later than the 60th day after the date of the initial informal resolution meeting or, if a second informal resolution meeting is requested by the provider, after the second informal resolution meeting, or on a later date at the request of a provider, the commission or the office shall provide the provider with written notice of the commission's or office's final determination of whether the commission or office will seek to recoup an overpayment or debt from the provider.

(f) If a provider does not request an informal resolution meeting under this section, not later than the 60th day after the date the provider receives the notice under Subsection (a), the commission or the office shall provide the provider with written notice of the commission's or office's final determination of whether the commission or office will seek to recoup an overpayment or debt from the provider.

(g) Nothing in this section shall be construed to require a provider to request an informal resolution meeting under this section before requesting an appeal under Section 531.1201 of the commission's or office's final determination to recoup an overpayment or debt from the provider.

Sec. 531.1201. RECOUPMENT OF OVERPAYMENTS OR RECOUPMENT

Sec. 531.1201. APPEAL OF DETERMINATION TO RECOUP

OF DEBT; APPEALS. (a) A provider must request an appeal under this section not later than the 15th day after the date the provider is notified that the commission or the commission's office of inspector general will seek to recover an overpayment or debt from the provider.

On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the Health and Human Services Commission appeals division, as requested by the provider, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office shall file the docketing request under this section not later than 60 days after the provider's request for an administrative hearing or not later than 60 days after the completion of the informal resolution process, if applicable.

(See Subsection (b) below.)

OVERPAYMENT OR DEBT. (a) If, after a final determination, the commission or the commission's office of inspector general seeks to recoup from a provider an overpayment or debt arising out of a fraud or abuse investigation in an amount that is less than $1 million, the provider may appeal the determination not later than the 15th day after the date the provider receives the notice under Section 531.120(e) or (f), as applicable, by requesting in writing that the commission or office set an administrative hearing on the determination. On receipt of a timely written request for an administrative hearing from the provider under this section, the commission or the office shall file a docketing request with the State Office of Administrative Hearings or the appeals division of the commission, as requested by the provider, for an administrative hearing on the final determination to recoup the overpayment or debt and any associated damages and penalties.

(b) If, after a final determination, the commission or the commission's office of inspector general seeks to recoup an overpayment or debt arising out of a fraud or abuse investigation in an amount of $1 million or more from a provider, the provider may appeal the determination not later than the 15th day after the date the provider receives the notice under Section 531.120(e) or (f), as applicable, by:

(1) requesting in writing that the commission or office file a docketing request with the State Office of Administrative Hearings for an administrative hearing on the final determination to recoup an overpayment or debt and any associated damages and penalties; or

(2) filing a petition to appeal the final determination to recoup an overpayment or debt and any associated damages and penalties in a district court in Travis County.

	(c) If a provider requests that the commission or office set an administrative hearing under Subsection (b)(1), the provider may not appeal any administrative order issued by an administrative law judge relating to the commission's or office's final determination to recoup an overpayment or debt and any associated damages and penalties from the provider in a district court.
Unless otherwise determined by the administrative law judge at the administrative hearing under this subsection for good cause, the state and the subject provider shall each be responsible for one-half of the costs charged by the State Office of Administrative Hearings, for one-half of the costs for transcribing the hearing, and for each party's own additional costs related to the administrative hearing, including costs associated with discovery, depositions, subpoenas, services of process and witness expenses, preparation for the administrative hearing, investigation costs, travel expenses, investigation expenses, and all other costs, including attorney's fees, associated with the case.	(d) Unless otherwise determined by the administrative law judge for good cause, at any administrative hearing under this section before the State Office of Administrative Hearings, the state and the provider shall each be responsible for: (1) one-half of the costs charged by the State Office of Administrative Hearings; (2) one-half of the costs for transcribing the hearing; (3) the party's own costs related to the hearing, including the costs associated with preparation for the hearing, discovery, depositions, and subpoenas, service of process and witness expenses, travel expenses, and investigation expenses; and (4) all other costs associated with the hearing that are incurred by the party, including attorney's fees.
The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before a hearing, to advance security for the costs for which the provider is responsible under this subsection.	(e) The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before an administrative hearing under this section before the State Office of Administrative Hearings, to advance security for the costs for which the provider is responsible under Subsection (d).
(b) Following an administrative hearing under Subsection (a), a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.	*(See Subsection (b) above.)*
Sec. 531.1202. PRESENCE OF NEUTRAL THIRD PARTY AT INFORMAL RESOLUTION MEETINGS. The	Sec. 531.1202. PRESENCE OF NEUTRAL THIRD PARTY AT INFORMAL RESOLUTION MEETINGS. The

commission shall employ a person whose salary is paid by the commission and who is independent of the commission's office of inspector general to attend the informal resolution meetings held under Sections 531.102(g)(5) and 531.120(b) as a neutral third-party observer. The person shall report to the executive commissioner on the proceedings and outcome of each informal resolution meeting.

commission shall employ a person whose salary is paid by the commission and who is independent of the commission's office of inspector general to attend the informal resolution meetings held under Sections 531.102(g)(6) and 531.120(c) and (d) as a neutral third-party observer. The person shall report to the executive commissioner on the proceedings and outcome of each informal resolution meeting.

(See SECTION 4 below.)

SECTION 4. The heading to Section 32.0291, Human Resources Code, is amended to read as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND PAYMENT [~~POSTPAYMENT~~] HOLDS.

SECTION 4. Section 32.0291, Human Resources Code, is amended to read as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND PAYMENT [~~POSTPAYMENT~~] HOLDS. (a) Notwithstanding any other law, the department may:

(1) perform a prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse; and

(2) as necessary to perform that review, withhold payment of the claim for not more than five working days without notice to the person submitting the claim.

SECTION 5. Sections 32.0291(b) and (c), Human Resources Code, are amended to read as follows:

(b) Notwithstanding any other law and subject to Section 531.102, Government Code, the department may impose a payment [~~postpayment~~] hold on [~~payment of~~] future claims submitted by a provider [~~if the department has reliable evidence that the provider has committed fraud or wilful misrepresentation regarding a claim for reimbursement under the medical assistance program~~]. The department must notify the provider of the payment [~~postpayment~~] hold not later than the fifth working day after the date the hold is imposed.

(b) Subject to Section 531.102, Government Code, and notwithstanding [~~Notwithstanding~~] any other law, the department may impose a payment [~~postpayment~~] hold on [~~payment of~~] future claims submitted by a provider [~~if the department has reliable evidence that the provider has committed fraud or wilful misrepresentation regarding a claim for reimbursement under the medical assistance program. The department must notify the provider of the postpayment hold not later than the fifth working day after the date the hold is imposed~~].

(c) A payment hold authorized by this section is governed by the requirements and procedures specified for a payment hold under Section 531.102, Government Code, including the notice requirements under

(c) A payment hold authorized by this section is governed by the requirements and procedures specified for a payment hold under Section 531.102, Government Code, including the notice requirements under

Subsection (g) of that section [~~On timely written request by a provider subject to a postpayment hold under Subsection (b), the department shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold. The provider must request an expedited hearing under this subsection not later than the 10th day after the date the provider receives notice from the department under Subsection (b). The department shall discontinue the hold unless the department makes a prima facie showing at the hearing that the evidence relied on by the department in imposing the hold is relevant, credible, and material to the issue of fraud or wilful misrepresentation.~~	Subsection (g) of that section. [~~On timely written request by a provider subject to a postpayment hold under Subsection (b), the department shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold. The provider must request an expedited hearing under this subsection not later than the 10th day after the date the provider receives notice from the department under Subsection (b). The department shall discontinue the hold unless the department makes a prima facie showing at the hearing that the evidence relied on by the department in imposing the hold is relevant, credible, and material to the issue of fraud or wilful misrepresentation.~~]
[~~(d) The department shall adopt rules that allow a provider subject to a postpayment hold under Subsection (b) to seek an informal resolution of the issues identified by the department in the notice provided under that subsection. A provider must seek an informal resolution under this subsection not later than the deadline prescribed by Subsection (c). A provider's decision to seek an informal resolution under this subsection does not extend the time by which the provider must request an expedited administrative hearing under Subsection (c). However, a hearing initiated under Subsection (c) shall be stayed at the department's request until the informal resolution process is completed~~].	*(Repealed in SECTION 6 below.)*
SECTION 5. If before implementing any provision of this Act, a state agency determines that a waiver or authorization from a federal agency is necessary for the 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 7. Same as engrossed version.
(Removed in SECTION 4 above.)	SECTION 6. Section 32.0291(d), Human Resources Code, is repealed.
SECTION 6. This Act takes effect September 1, 2013.	SECTION 8. Same as engrossed version.