SB0147S01 compared with SB0147

~~{Omitted text}~~ shows text that was in SB0147 but was omitted in SB0147S01
inserted text shows text that was not in SB0147 but was inserted into SB0147S01

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Office of Inspector General of Medicaid Services Amendments

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Luz Escamilla

House Sponsor:

LONG TITLE

General Description:

This bill addresses oversight of the Office of Inspector General of Medicaid Services.

Highlighted Provisions:

This bill:

- ▸ establishes the Office of Inspector General of Medicaid Services (office) as an office within the Department of Government Operations (department);
- ▸ removes the office as an independent entity subject to Title 63H, Independent State Entities;
- ▸ requires the office to submit a budget for the office to the department;
- ▸ requires the executive director of the department (executive director) to:
  - establish performance metrics for the office;
  - establish a process for employees and members of the public to report concerns to the executive director;
  - report the concerns to the advisory
  - report to an advisory board on the office's performance based on performance metrics;
- ▸ requires the inspector general of Medicaid services (inspector general) to:

SB0147

- submit an annual report to the Social Services Appropriations Subcommittee; and
- present certain information at meetings of the Social Services Appropriations Subcommittee and the Health and Human Services Interim Committee;

▸ requires the executive ate an advisory board to:

- promote coordination of Medicaid program integrity activities;
- make recommendations regarding audit prioritization to the office and the department;
- make recommendations to the Office of the Legislative Auditor General for audits based on concerns reported to the executive di
- make recommendations regarding improving the office's performance to the inspector general, the executive director, and the Legislature;

▸ defines terms; and

▸ makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

63A-1-109 , as last amended by Laws of Utah 2022, Chapter 169

63A-1-111 , as last amended by Laws of Utah 2016, Chapters 193, 298

63A-13-102 , as last amended by Laws of Utah 2023, Chapter 329

63A-13-201 , as last amended by Laws of Utah 2021, Chapter 344

63A-13-202 , as last amended by Laws of Utah 2024, Chapter 178

63A-13-204 , as last amended by Laws of Utah 2023, Chapter 329

63A-13-205 , as renumbered and amended by Laws of Utah 2013, Chapter 12

63A-13-301 , as last amended by Laws of Utah 2024, Chapter 277

63A-13-303 , as renumbered and amended by Laws of Utah 2013, Chapter 12

63A-13-502 , as last amended by Laws of Utah 2025, Chapter 271

63H-9-101 , as last amended by Laws of Utah 2025, First Special Session, Chapters 9, 11

ENACTS:

63A-13-701 , Utah Code Annotated 1953

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **63A-1-109** is amended to read:

63A-1-109. Divisions of department -- Administration.

(1) The department is composed of:

(a) the following divisions:

(i) the Division of Purchasing and General Services, created in Section 63A-2-101;

(ii) the Division of Finance, created in Section 63A-3-101;

(iii) the Division of Facilities Construction and Management, created in Section 63A-5b-301;

(iv) the Division of Fleet Operations, created in Section 63A-9-201;

(v) the Division of Archives and Records Service, created in Section 63A-12-101;

(vi) the Division of Technology Services, created in Section 63A-16-103;

(vii) the Division of Human Resource Management, created in Section 63A-17-105; and

(viii) the Division of Risk Management, created in Section [~~63A-16-201~~] 63A-4-101.5; [~~and~~]

(b) the Office of Administrative Rules, created in Section 63G-3-401[~~.~~] ; and

(c) the Office of Inspector General of Medicaid Services, created in Section 63A-13-201.

(2) Each division described in Subsection (1)(a) shall be administered and managed by a division director.

Section 2. Section **63A-1-111** is amended to read:

63A-1-111. Service plans established by each division -- Contents -- Distribution.

(1) Each division and each office of the department described in Subsections 63A-1-109(1)(a) and (b) shall formulate and establish service plans for each fiscal year.

(2) The service plans shall describe:

(a) the services to be rendered to state agencies;

(b) the methods of providing those services;

(c) the standards of performance; and

(d) the performance measures used to gauge compliance with those standards.

(3) Before the beginning of each fiscal year, the service plans shall be distributed to each state agency that uses the services provided by that division.

Section 3. Section **63A-13-102** is amended to read:

63A-13-102. Definitions.

As used in this chapter:

(1) "Abuse" means:

(a) an action or practice that:

(i) is inconsistent with sound fiscal, business, or medical practices; and

(ii) results, or may result, in unnecessary Medicaid related costs; or

(b) reckless or negligent upcoding.

(2) "Advisory board" means the Office of the Inspector General of Medicaid Services Advisory Board created under Section 63A-13-701.

[~~(2)~~] (3) "Claimant" means a person that:

(a) provides a service; and

(b) submits a claim for Medicaid reimbursement for the service.

[~~(3) "Department" means the Department of Health and Human Services created in Section 26B-1-201.~~]

(4) "Division" means the Division of Integrated Healthcare, created in Section 26B-3-102.

(5) "Extrapolation" means a method of using a mathematical formula that takes the audit results from a small sample of Medicaid claims and projects those results over a much larger group of Medicaid claims.

(6) "Fraud" means an intentional or knowing:

(a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, a claim, reimbursement, or services; or

(b) violation of a provision of Sections 26B-3-1102 through 26B-3-1106.

(7) "Fraud unit" means the Medicaid Fraud Control Unit of the attorney general's office.

(8) "Health care professional" means a person licensed under:

(a) Title 58, Chapter 5a, Podiatric Physician Licensing Act;

(b) Title 58, Chapter 16a, Utah Optometry Practice Act;

(c) Title 58, Chapter 17b, Pharmacy Practice Act;

(d) Title 58, Chapter 24b, Physical Therapy Practice Act;

(e) Title 58, Chapter 31b, Nurse Practice Act;

(f) Title 58, Chapter 40, Recreational Therapy Practice Act;

(g) Title 58, Chapter 41, Speech-Language Pathology and Audiology Licensing Act;

(h) Title 58, Chapter 42a, Occupational Therapy Practice Act;

(i) Title 58, Chapter 44a, Nurse Midwife Practice Act;

(j) Title 58, Chapter 49, Dietitian Certification Act;

(k) Title 58, Chapter 60, Mental Health Professional Practice Act;

(l) Title 58, Chapter 67, Utah Medical Practice Act;

(m) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;

(n) Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act;

(o) Title 58, Chapter 70a, Utah Physician Assistant Act; and

(p) Title 58, Chapter 73, Chiropractic Physician Practice Act.

(9) "Inspector general" means the inspector general of the office, appointed under Section 63A-13-201.

(10) "Office" means the Office of Inspector General of Medicaid Services, created in Section 63A-13-201.

(11) "Provider" means a person that provides:

(a) medical assistance, including supplies or services, in exchange, directly or indirectly, for Medicaid funds; or

(b) billing or recordkeeping services relating to Medicaid funds.

(12) "Retaliatory action" means the same as that term is defined in Section 67-19a-101.

[~~(12)~~] (13) "Upcoding" means assigning an inaccurate billing code for a service that is payable or reimbursable by Medicaid funds, if the correct billing code for the service, taking into account reasonable opinions derived from official published coding definitions, would result in a lower Medicaid payment or reimbursement.

[~~(13)~~] (14)

(a) "Waste" means the act of using or expending a resource carelessly, extravagantly, or to no purpose.

(b) "Waste" includes an activity that:

(i) does not constitute abuse or necessarily involve a violation of law; and

(ii) relates primarily to mismanagement, an inappropriate action, or inadequate oversight.

Section 4. Section **63A-13-201** is amended to read:

63A-13-201. Creation of office -- Inspector general -- Appointment -- Term.

(1) There is created [~~an independent entity~~]within the [~~department~~] Department of Government Operations an office known as the "Office of Inspector General of Medicaid Services."

(2) The governor shall:

(a) appoint the inspector general of Medicaid services with the advice and consent of the Senate; and

(b) establish the salary for the inspector general of Medicaid services based upon a recommendation from the Division of Human Resource Management which shall be based on a market salary survey conducted by the Division of Human Resource Management.

(3) A person appointed as the inspector general shall have the following qualifications:

(a) a general knowledge of the type of methodology and controls necessary to audit, investigate, and identify fraud, waste, and abuse;

(b) strong management skills;

(c) extensive knowledge of performance audit methodology;

(d) the ability to oversee and execute an audit; and

(e) strong interpersonal skills.

(4) The inspector general of Medicaid services:

(a) shall serve a term of four years; and

(b) may be removed by the governor, for cause.

(5) If the inspector general is removed for cause, a new inspector general shall be appointed, with the advice and consent of the Senate, to serve the remainder of the term of the inspector general of Medicaid services who was removed for cause.

(6) The Office of Inspector General of Medicaid Services:

[~~(a) is not under the supervision of, and does not take direction from, the executive director, except for administrative purposes;~~]

[~~(b)~~] (a) shall use the legal services of the state attorney general's office;

[~~(c)~~] (b) shall submit a budget for the office directly to the [~~department~~] Department of Government Operations;

[~~(d)~~] (c) except as prohibited by federal law, is subject to:

(i) Title 51, Chapter 5, Funds Consolidation Act;

(ii) Title 51, Chapter 7, State Money Management Act;

(iii) Title 63A, Utah Government Operations Code;

(iv) Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(v) Title 63G, Chapter 4, Administrative Procedures Act;

(vi) Title 63G, Chapter 6a, Utah Procurement Code;

(vii) Title 63J, Chapter 1, Budgetary Procedures Act;

(viii) Title 63J, Chapter 2, Revenue Procedures and Control Act;

(ix) Chapter 17, Utah State Personnel Management Act;

(x) Title 67, Chapter 16, Utah Public Officers' and Employees' Ethics Act;

(xi) Title 52, Chapter 4, Open and Public Meetings Act;

(xii) Title 63G, Chapter 2, Government Records Access and Management Act; and

(xiii) coverage under the Risk Management Fund created under Section 63A-4-201;

[~~(e)~~] (d) when requested, shall provide reports to the governor, the president of the Senate, or the speaker of the House; and

[~~(f)~~] (e) shall adopt administrative rules to establish policies for employees that are substantially similar to the administrative rules adopted by the Division of Human Resource Management.

(7)

(a) The executive director shall establish operational performance metrics for the office, including metrics for:

(i) key performance indicators to evaluate the office's overall performance;

(ii) financial recoveries;

(iii) office return on investment;

(iv) reporting practices and data presentation;

(v) stakeholder communication; and

(vi) employee performance.

(b) The executive director shall report on the office's performance based on the metrics established under this Subsection (7):

(i) upon request, to the Health and Human Services Interim Committee and Social Services Appropriations Subcommittee; and

(ii) at least annually and more frequently upon request to the advisory board.

(8)

(a) The executive director shall establish a process for an employee of the office to report the employee's concerns related to:

(i) the performance metrics established under Subsection (7); and

(ii) other concerns related to the office's duties.

(b) The process the executive director establishes under Subsection (8)(a) shall provide for an employee or member of the public to report concerns anonymously.

(c) The executive director shall:

(i) act to address an employee's concern reported in accordance with the process established under this subsection as soon as reasonably possible, if it is within the executive director's authority under this title to take an action to address the concern; and

(ii) submit a written report of the concerns reported according to the process established under this subsection to the advisory board at each meeting of the advisory board, including any actions the executive director has taken to address each concern.

(d) The executive director or the inspector general may not take retaliatory action against an employee that reports in good faith a concern in accordance with the process established under this subsection.

Section 5. Section **63A-13-202** is amended to read:

63A-13-202. Duties and powers of inspector general and office.

(1) The inspector general of Medicaid services shall:

(a) administer, direct, and manage the office;

(b) inspect and monitor the following in relation to the state Medicaid program:

(i) the use and expenditure of federal and state funds;

(ii) the provision of health benefits and other services;

(iii) implementation of, and compliance with, state and federal requirements; and

(iv) records and recordkeeping procedures;

(c) receive reports of potential fraud, waste, or abuse in the state Medicaid program;

(d) investigate and identify potential or actual fraud, waste, or abuse in the state Medicaid program;

(e) consult with the Centers for [~~Medicaid and Medicare~~] Medicare and Medicaid Services and other states to determine and implement best practices for:

(i) educating and communicating with health care professionals and providers about program and audit policies and procedures;

(ii) discovering and eliminating fraud, waste, and abuse of Medicaid funds; and

(iii) differentiating between honest mistakes and intentional errors, or fraud, waste, and abuse, if the office enters into settlement negotiations with the provider or health care professional;

(f) obtain, develop, and utilize computer algorithms to identify fraud, waste, or abuse in the state Medicaid program;

(g) work closely with the fraud unit to identify and recover improperly or fraudulently expended Medicaid funds;

(h) audit, inspect, and evaluate the functioning of the division for the purpose of making recommendations to the Legislature and the [~~department~~] Department of Health and Human Services to ensure that the state Medicaid program is managed:

(i) in the most efficient and cost-effective manner possible; and

(ii) in a manner that promotes adequate provider and health care professional participation and the provision of appropriate health benefits and services;

(i) regularly advise the [~~department~~] Department of Health and Human Services and the division of an action that could be taken to ensure that the state Medicaid program is managed in the most efficient and cost-effective manner possible;

(j) refer potential criminal conduct, relating to Medicaid funds or the state Medicaid program, to the fraud unit;

(k) refer potential criminal conduct, including relevant data from the controlled substance database, relating to Medicaid fraud, to law enforcement in accordance with Title 58, Chapter 37f, Controlled Substance Database Act;

(l) determine ways to:

(i) identify, prevent, and reduce fraud, waste, and abuse in the state Medicaid program; and

(ii) balance efforts to reduce costs and avoid or minimize increased costs of the state Medicaid program with the need to encourage robust health care professional and provider participation in the state Medicaid program;

(m) recover improperly paid Medicaid funds;

(n) track recovery of Medicaid funds by the state;

(o) in accordance with Section 63A-13-502:

(i) report on the actions and findings of the inspector general; and

(ii) make recommendations to the Legislature and the governor;

(p) provide training to:

(i) agencies and employees on identifying potential fraud, waste, or abuse of Medicaid funds; and

(ii) health care professionals and providers on program and audit policies and compliance; and

(q) develop and implement principles and standards for the fulfillment of the duties of the inspector general, based on principles and standards used by:

(i) the [~~Federal~~] federal Offices of Inspector General;

(ii) the Association of Inspectors General; and

(iii) the United States Government Accountability Office.

(2)

(a) The office may, in fulfilling the duties under Subsection (1), conduct a performance or financial audit of:

(i) a state executive branch entity or a local government entity, including an entity described in Section 63A-13-301, that:

(A) manages or oversees a state Medicaid program; or

(B) manages or oversees the use or expenditure of state or federal Medicaid funds; or

(ii) Medicaid funds received by a person by a grant from, or under contract with, a state executive branch entity or a local government entity.

(b)

(i) The office may not, in fulfilling the duties under Subsection (1), amend the state Medicaid program or change the policies and procedures of the state Medicaid program.

(ii) The office shall identify conflicts between the state Medicaid plan, [~~department~~] Department of Health and Human Services administrative rules, Medicaid provider manuals, and Medicaid information bulletins and recommend that the [~~department~~] Department of Health and Human Services reconcile inconsistencies. If the [~~department~~] Department of Health and Human Services does not reconcile the inconsistencies, the office shall report the inconsistencies to the Legislature's Rules Review and General Oversight Committee created in Section 36-35-102.

(iii) Beginning July 1, 2013, the office shall review a Medicaid provider manual and a Medicaid information bulletin in accordance with Subsection (2)(b)(ii), prior to the [~~department~~] Department of Health and Human Services making the provider manual or Medicaid information bulletin available to the public.

(c) Beginning July 1, 2013, the Department of Health and Human Services shall submit a Medicaid provider manual and a Medicaid information bulletin to the office for the review required by Subsection [~~(2)(b)(ii)~~] (2)(b)(iii) prior to releasing the document to the public. The [~~department~~] Department of Health and Human Services and the Office of Inspector General of Medicaid Services shall enter into a memorandum of understanding regarding the timing of the review process under Subsection (2)(b)(iii).

(3)

(a) The office shall, in fulfilling the duties under this section to investigate, discover, and recover fraud, waste, and abuse in the Medicaid program, apply the state Medicaid plan, [~~department~~] Department of Health and Human Services administrative rules, Medicaid provider manuals, and Medicaid information bulletins in effect at the time the medical services were provided.

(b) A health care provider may rely on the policy interpretation included in a current Medicaid provider manual or a current Medicaid information bulletin that is available to the public.

(4) The inspector general of Medicaid services, or a designee of the inspector general of Medicaid services within the office, may take a sworn statement or administer an oath.

Section 6. Section **63A-13-204** is amended to read:

63A-13-204. Selection and review of claims.

(1)

(a) The office shall periodically select and review a representative sample of claims submitted for reimbursement under the state Medicaid program to determine whether fraud, waste, or abuse occurred.

(b) The office shall limit [~~its~~] the office's review for waste and abuse under Subsection (1)(a) to 36 months prior to the date of the inception of the investigation or 72 months if there is a credible allegation of fraud. In the event the office or the fraud unit determines that there is fraud as defined in Section 63A-13-102, then the statute of limitations defined in Section 26B-3-1115 shall apply.

(2) The office may directly contact the recipient of record for a Medicaid reimbursed service to determine whether the service for which reimbursement was claimed was actually provided to the recipient of record.

(3) The office shall:

(a) generate statistics from the sample described in Subsection (1) to determine the type of fraud, waste, or abuse that is most advantageous to focus on in future audits or investigations;

(b) ensure that the office, or any entity that contracts with the office to conduct audits:

(i) has on staff or contracts with a medical or dental professional who is experienced in the treatment, billing, and coding procedures used by the type of provider being audited; and

(ii) uses the services of the appropriate professional described in Subsection (3)(b)(i) if the provider that is the subject of the audit disputes the findings of the audit;

(c) ensure that a finding of overpayment or underpayment to a provider is not based on extrapolation, unless:

(i) there is a determination that the level of payment error involving the provider exceeds a 10% error rate:

(A) for a sample of claims for a particular service code; and

(B) over a three year period of time;

(ii) documented education intervention has failed to correct the level of payment error; and

(iii) the value of the claims for the provider, in aggregate, exceeds $200,000 in reimbursement for a particular service code on an annual basis; and

(d) require that any entity with which the office contracts, for the purpose of conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both overpayments and underpayments.

(4)

(a) If the office, or a contractor on behalf of the [~~department~~] Department of Health and Human Services:

(i) intends to implement the use of extrapolation as a method of auditing claims, the [~~department~~] Department of Health and Human Services shall, prior to adopting the extrapolation method of auditing, report its intent to use extrapolation:

(A) to the Social Services Appropriations Subcommittee; and

(B) as required under Section 63A-13-502; and

(ii) determines Subsections (3)(c)(i) through (iii) are applicable to a provider, the office or the contractor may use extrapolation only for the service code associated with the findings under Subsections (3)(c)(i) through (iii).

(b)

(i) If extrapolation is used under this section, a provider may, at the provider's option, appeal the results of the audit based on:

(A) each individual claim; or

(B) the extrapolation sample.

(ii) Nothing in this section limits a provider's right to appeal the audit under Title 63G, Chapter 4, Administrative Procedures Act, the Medicaid program and its manual or rules, or other laws or rules that may provide remedies to providers.

Section 7. Section **63A-13-205** is amended to read:

63A-13-205. Placement of hold on claims for reimbursement -- Injunction.

(1) The inspector general or the inspector general's designee may, without prior notice, order a hold on the payment of a claim for reimbursement submitted by a claimant if there is reasonable cause to believe that the claim, or payment of the claim, constitutes fraud, waste, or abuse, or is otherwise inaccurate.

(2) The office shall, within seven days after the day on which a hold described in Subsection (1) is ordered, notify the claimant that the hold has been placed.

(3) The inspector general or the inspector general's designee may not maintain a hold longer than is necessary to determine whether the claim, or payment of the claim, constitutes fraud, waste, or abuse, or is otherwise inaccurate.

(4) A claimant may, at any time during which a hold is in place, appeal the hold under Title 63G, Chapter 4, Administrative Procedures Act.

(5) If a claim is approved or denied before a hearing is held under Title 63G, Chapter 4, Administrative Procedures Act, the appeal shall be dismissed as moot.

(6) The inspector general may request that the attorney general's office seek an injunction to prevent a person from disposing of an asset that is potentially subject to recovery by the state to recover funds due to a person's fraud or abuse.

(7) The [~~department~~] Department of Health and Human Services and the division shall fully comply with a hold ordered under this section.

Section 8. Section **63A-13-301** is amended to read:

63A-13-301. Access to records -- Retention of designation under Government Records Access and Management Act.

(1) In order to fulfill the duties described in Section 63A-13-202, and in the manner provided in Subsection (4), the office shall have unrestricted access to all records of state executive branch entities, all local government entities, and all providers relating, directly or indirectly, to:

(a) the state Medicaid program;

(b) state or federal Medicaid funds;

(c) the provision of Medicaid related services;

(d) the regulation or management of any aspect of the state Medicaid program;

(e) the use or expenditure of state or federal Medicaid funds;

(f) suspected or proven fraud, waste, or abuse of state or federal Medicaid funds;

(g) Medicaid program policies, practices, and procedures;

(h) monitoring of Medicaid services or funds; or

(i) a fatality review of a person who received Medicaid funded services.

(2) The office shall have access to information in any database maintained by the state or a local government to verify identity, income, employment status, or other factors that affect eligibility for Medicaid services.

(3) The records described in Subsections (1) and (2) include records held or maintained by the department, the division, the Department of Health and Human Services, the Department of Workforce Services, a local health department, a local mental health authority, or a school district. The records described in Subsection (1) include records held or maintained by a provider. When conducting an audit of a provider, the office shall, to the extent possible, limit the records accessed to the scope of the audit.

(4) A record, described in Subsection (1) or (2), that is accessed or copied by the office:

(a) may be reviewed or copied by the office during normal business hours, unless otherwise requested by the provider or health care professional under Subsection (4)(b);

(b) unless there is a credible allegation of fraud, shall be accessed, reviewed, and copied in a manner, on a day, and at a time that is minimally disruptive to the health care professional's or provider's care of patients, as requested by the health care professional or provider;

(c) may be submitted electronically;

(d) may be submitted together with other records for multiple claims; and

(e) if it is a government record, shall retain the classification made by the entity responsible for the record, under Title 63G, Chapter 2, Government Records Access and Management Act.

(5) Except as provided in Subsection (7), notwithstanding any provision of state law to the contrary, the office shall have the same access to all records, information, and databases to which the [~~department~~] Department of Health and Human Services or the division has access.

(6) The office shall comply with the requirements of federal law, including the Health Insurance Portability and Accountability Act of 1996 and 42 C.F.R., Part 2, relating to the office's:

(a) access, review, retention, and use of records; and

(b) use of information included in, or derived from, records.

(7) The office's access to data held by the Department of Health and Human Services under Title 26B, Chapter 8, Part 5, Utah Health Data Authority:

(a) is not subject to this section; and

(b) is subject to Title 26B, Chapter 8, Part 5, Utah Health Data Authority.

Section 9. Section **63A-13-303** is amended to read:

63A-13-303. Cooperation and support.

The [~~department~~] Department of Health and Human Services, the division, each consultant or contractor of the [~~department~~] Department of Health and Human Services or division, and each provider shall provide its full cooperation and support to the inspector general and the office in fulfilling the duties of the inspector general and the office.

Section 10. Section **63A-13-502** is amended to read:

63A-13-502. Report and recommendations to governor and General Government Appropriations Subcommittee.

(1) The inspector general of Medicaid services shall, on an annual basis, prepare an electronic report on the activities of the office for the preceding fiscal year.

(2) The report shall include:

(a) non-identifying information, including statistical information, on:

(i) the items described in Subsection 63A-13-202(1)(b) and Section 63A-13-204;

(ii) action taken by the office and the result of that action;

(iii) fraud, waste, and abuse in the state Medicaid program, including emerging trends of Medicaid fraud, waste, and abuse and the office's actions to identify and address the emerging trends;

(iv) the recovery of fraudulent or improper use of state and federal Medicaid funds, including total dollars recovered through cash recovery, credit adjustments, and rebilled claims;

(v) measures taken by the state to discover and reduce fraud, waste, and abuse in the state Medicaid program;

(vi) audits conducted by the office, including performance and financial audits;

(vii) investigations conducted by the office and the results of those investigations, including preliminary investigations;

(viii) administrative and educational efforts made by the office and the division to improve compliance with Medicaid program policies and requirements;

(ix) total cost avoidance attributed to an office policy or action;

(x) the number of complaints against Medicaid recipients received and disposition of those complaints;

(xi) the number of educational activities that the office provided to a provider or a state agency;

(xii) the number of credible allegations of fraud referred to the Medicaid fraud control unit under Section 63A-13-501; and

(xiii) the number of data pulls performed and general results of those pulls;

(b) recommendations on action that should be taken by the Legislature or the governor to:

(i) improve the discovery and reduction of fraud, waste, and abuse in the state Medicaid program;

(ii) improve the recovery of fraudulently or improperly used Medicaid funds; and

(iii) reduce costs and avoid or minimize increased costs in the state Medicaid program;

(c) recommendations relating to rules, policies, or procedures of a state or local government entity; and

(d) services provided by the state Medicaid program that exceed industry standards.

(3) The report described in Subsection (1) may not include any information that would interfere with or jeopardize an ongoing criminal investigation or other investigation.

(4) On or before November 1 of each year, the inspector general of Medicaid services shall provide the electronic report described in Subsection (1) to the General Government Appropriations Subcommittee and the Social Services Appropriations Subcommittee of the Legislature and to the governor.

(5) In addition to the report described in Subsection (1), the inspector general shall present the information described in Subsections (2)(a)(iii) and (vii):

(a) at the first interim meeting each year of the Health and Human Services Interim Committee and the Social Services Appropriations Subcommittee; and

(b) at subsequent meetings at the request of the chairs of the Health and Human Services Interim Committee or the Social Services Appropriations Subcommittee.

Section 11. Section **11** is enacted to read:

63A-13-701. Office of the Inspector General of Medicaid Services Advisory Board.

7. Office of the Inspector General of Medicaid Services Advisory Board

(1) In consultation with the inspector general, the executive director or the executive director's designee shall create an advisory board known as the "Office of the Inspector General of Medicaid Services Advisory Board," to:

(a) promote coordination of Medicaid integrity activities between the office, the Department of Health and Human Services, the division, the Legislature, and other federal, state, and local entities;

(b) make recommendations to the office and the department regarding prioritization of the office's audit activities;

(c) make recommendations to the Office of the Legislative Auditor General regarding audits related to employee concerns reported in accordance with the process the executive director establishes under Subsection 63A-13-201(8); and

(d) make recommendations to the inspector general, the executive director, and the Legislature for improving the office's operations.

(2) The department shall make rules to establish:

(a) composition of the advisory board, which:

(i) may include :

(A) members of the House of Representatives appointed by the speaker of the House of Representatives;

(B) members of the Senate appointed by the president of the Senate; and

(C) other members as determined by the department; and

(ii) shall include the legislative auditor general or the legislative auditor general's designee;

(b) the method of selection or appointment of advisory board members, including for the selection of an advisory board chair;

(c) terms of service for members of the advisory board;

(d) quorum requirements; and

(e) voting requirements.

(3) Members of the advisory board not described in Subsection(2)(a) shall be qualified by training, education, and experience.

(4) The advisory board chair shall call meetings of the advisory board:

(a) at least two times each year; and

(b) in addition to the meetings described in Subsection (4)(a), at the request of the executive director.

(5) The advisory board is subject to Title 52, Chapter 4, Open and Public Meetings Act.

(6)

(a) A member of the advisory board who is not a legislator may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(i) Section 63A-3-106;

(ii) Section 63A-3-107; and

(iii) rules made by the Division of Finance in accordance with Sections 63A-3-106 and 63A-3-107.

(b) Compensation and expenses of a member of the advisory board who is a legislator are governed by Section 36-2-2 and Legislative Joint Rules, Title 5, Legislative Compensation and Expenses.

Section 12. Section **63H-9-101** is amended to read:

63H-9-101. Definitions.

As used in this chapter:

(1) "Best practices toolbox" means the collection of resources for governmental entities provided on the website of the Office of the Legislative Auditor General that includes a best practice self-assessment and other resources, tools, surveys, and reports designed to help government organizations better serve the citizens of the state.

(2) "Consensus group" means the Office of Legislative Research and General Counsel, the Office of the Legislative Auditor General, and the Office of the Legislative Fiscal Analyst.

(3)

(a) "Independent entity" means an entity that:

(i) has a public purpose relating to the state or its citizens;

(ii) is individually created by the state;

(iii) is separate from the judicial and legislative branches of state government; and

(iv) is not under the direct supervisory control of the governor.

(b) "Independent entity" does not include an entity that is:

(i) a county;

(ii) a municipality as defined in Section 10-1-104;

(iii) an institution of higher education as defined in Section 53H-1-101;

(iv) a public school as defined in Section 53G-8-701;

(v) a special district as defined in Section 17B-1-102;

(vi) a special service district as defined in Section 17D-1-102;

(vii) created by an interlocal agreement as described in Section 11-13-203; or

(viii) an elective constitutional office, including the state auditor, the state treasurer, and the attorney general.

(c) Independent entities that are subject to the provisions of this chapter include the:

(i) Career Service Review Office created in Section 67-19a-201;

(ii) State Capitol Preservation Board created in Section [~~63C-9-201~~] 63O-2-201;

(iii) Heber Valley Historic Railroad Authority created in Section 63H-4-102;

(iv) Military Installation Development Authority created in Section 63H-1-201;

[~~(v) Office of Inspector General of Medicaid Services created in Section 63A-13-201;~~]

[~~(vi)~~] (v) Point of the Mountain State Land Authority created in Section 11-59-201;

[~~(vii)~~] (vi) Public Service Commission created in Section 54-1-1;

[~~(viii)~~] (vii) School and Institutional Trust Fund Office created in Section [~~53C-1-201~~] 53D-1-201;

[~~(ix)~~] (viii) School and Institutional Trust Lands Administration created in Section [~~53D-1-201~~] 53C-1-201;

[~~(x)~~] (ix) Utah Beef Council created in Section 4-21-103;

[~~(xi)~~] (x) Utah Capital Investment Corporation created in Section 63N-6-301;

[~~(xii)~~] (xi) Utah Communications Authority created in Section 63H-7a-201;

[~~(xiii)~~] (xii) Utah Dairy Commission created in Section 4-22-103;

[~~(xiv)~~] (xiii) Utah Education and Telehealth Network created in Section 53H-4-213.4;

[~~(xv)~~] (xiv) Utah Housing Corporation created in Section 63H-8-201;

[~~(xvi)~~] (xv) Utah Inland Port Authority created in Section 11-58-201;

[~~(xvii)~~] (xvi) Utah Lake Authority created in Section 11-65-201;

[~~(xviii)~~] (xvii) Utah Retirement Systems created in Section 49-11-201; and

[~~(xix)~~] (xviii) [~~Utah~~]State Fair Park Authority created in Section 11-68-201.

Section 13. **Effective date.**

Effective Date.

This bill takes effect on May 6, 2026.

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