

1 **Office of Inspector General of Medicaid Services Amendments**

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Luz Escamilla

House Sponsor: Norman K Thurston

2
3 **LONG TITLE**

4 **Committee Note:**

5 The Rules Review and General Oversight Committee recommended this bill.

6 Legislative Vote: 7 voting for 0 voting against 3 absent

7 **General Description:**

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

9 **Highlighted Provisions:**

10 This bill:

11 ▶ establishes the Office of Inspector General of Medicaid Services (office) as an office
12 within the Department of Government Operations (department);

13 ▶ removes the office as an independent entity subject to Title 63H, Independent State
14 Entities;

15 ▶ requires the office to submit a budget for the office to the department;

16 ▶ requires the executive director of the department (executive director) to:

17 • establish performance metrics for the office;

18 • establish a process for employees and members of the public to report concerns to the
19 executive director;

20 • report the concerns to the advisory board; and

21 • report to an advisory board on the office's performance based on performance metrics;

22 ▶ requires the inspector general of Medicaid services (inspector general) to:

23 • submit an annual report to the Social Services Appropriations Subcommittee; and

24 • present certain information at meetings of the Social Services Appropriations

25 Subcommittee and the Health and Human Services Interim Committee;

26 ▶ requires the executive director to create an advisory board to:

27 • promote coordination of Medicaid program integrity activities;

28 • make recommendations regarding audit prioritization to the office and the department;

29 • make recommendations to the Office of the Legislative Auditor General for audits

30 based on concerns reported to the executive director; and

- 31 • make recommendations regarding improving the office's performance to the inspector
 32 general, the executive director, and the Legislature;
 33 ▸ defines terms; and
 34 ▸ makes technical and conforming changes.

35 **Money Appropriated in this Bill:**

36 None

37 **Other Special Clauses:**

38 None

39 **Utah Code Sections Affected:**

40 AMENDS:

- 41 **63A-13-102**, as last amended by Laws of Utah 2023, Chapter 329
 42 **63A-13-201**, as last amended by Laws of Utah 2021, Chapter 344
 43 **63A-13-202**, as last amended by Laws of Utah 2024, Chapter 178
 44 **63A-13-204**, as last amended by Laws of Utah 2023, Chapter 329
 45 **63A-13-205**, as renumbered and amended by Laws of Utah 2013, Chapter 12
 46 **63A-13-301**, as last amended by Laws of Utah 2024, Chapter 277
 47 **63A-13-303**, as renumbered and amended by Laws of Utah 2013, Chapter 12
 48 **63A-13-502**, as last amended by Laws of Utah 2025, Chapter 271
 49 **63H-9-101**, as last amended by Laws of Utah 2025, First Special Session, Chapters 9, 11

50 ENACTS:

- 51 **63A-13-701**, Utah Code Annotated 1953

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

54 Section 1. Section **63A-13-102** is amended to read:

55 **63A-13-102 . Definitions.**

56 As used in this chapter:

- 57 (1) "Abuse" means:
 58 (a) an action or practice that:
 59 (i) is inconsistent with sound fiscal, business, or medical practices; and
 60 (ii) results, or may result, in unnecessary Medicaid related costs; or
 61 (b) reckless or negligent upcoding.
 62 (2) "Advisory board" means the Office of the Inspector General of Medicaid Services
 63 Advisory Board created under Section 63A-13-701.
 64 [~~(2)~~] (3) "Claimant" means a person that:

- 65 (a) provides a service; and
- 66 (b) submits a claim for Medicaid reimbursement for the service.
- 67 [~~(3) "Department" means the Department of Health and Human Services created in Section~~
- 68 ~~26B-1-201.~~]
- 69 (4) "Division" means the Division of Integrated Healthcare, created in Section 26B-3-102.
- 70 (5) "Extrapolation" means a method of using a mathematical formula that takes the audit
- 71 results from a small sample of Medicaid claims and projects those results over a much
- 72 larger group of Medicaid claims.
- 73 (6) "Fraud" means an intentional or knowing:
- 74 (a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, a
- 75 claim, reimbursement, or services; or
- 76 (b) violation of a provision of Sections 26B-3-1102 through 26B-3-1106.
- 77 (7) "Fraud unit" means the Medicaid Fraud Control Unit of the attorney general's office.
- 78 (8) "Health care professional" means a person licensed under:
- 79 (a) Title 58, Chapter 5a, Podiatric Physician Licensing Act;
- 80 (b) Title 58, Chapter 16a, Utah Optometry Practice Act;
- 81 (c) Title 58, Chapter 17b, Pharmacy Practice Act;
- 82 (d) Title 58, Chapter 24b, Physical Therapy Practice Act;
- 83 (e) Title 58, Chapter 31b, Nurse Practice Act;
- 84 (f) Title 58, Chapter 40, Recreational Therapy Practice Act;
- 85 (g) Title 58, Chapter 41, Speech-Language Pathology and Audiology Licensing Act;
- 86 (h) Title 58, Chapter 42a, Occupational Therapy Practice Act;
- 87 (i) Title 58, Chapter 44a, Nurse Midwife Practice Act;
- 88 (j) Title 58, Chapter 49, Dietitian Certification Act;
- 89 (k) Title 58, Chapter 60, Mental Health Professional Practice Act;
- 90 (l) Title 58, Chapter 67, Utah Medical Practice Act;
- 91 (m) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act;
- 92 (n) Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act;
- 93 (o) Title 58, Chapter 70a, Utah Physician Assistant Act; and
- 94 (p) Title 58, Chapter 73, Chiropractic Physician Practice Act.
- 95 (9) "Inspector general" means the inspector general of the office, appointed under Section
- 96 63A-13-201.
- 97 (10) "Office" means the Office of Inspector General of Medicaid Services, created in
- 98 Section 63A-13-201.

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

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

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

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

104 ~~[(12)]~~ (13) "Upcoding" means assigning an inaccurate billing code for a service that is
105 payable or reimbursable by Medicaid funds, if the correct billing code for the service,
106 taking into account reasonable opinions derived from official published coding
107 definitions, would result in a lower Medicaid payment or reimbursement.

108 ~~[(13)]~~ (14)(a) "Waste" means the act of using or expending a resource carelessly,
109 extravagantly, or to no purpose.

110 (b) "Waste" includes an activity that:

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

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

114 Section 2. Section **63A-13-201** is amended to read:

115 **63A-13-201 . Creation of office -- Inspector general -- Appointment -- Term.**

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

119 (2) The governor shall:

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

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

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

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

129 (b) strong management skills;

130 (c) extensive knowledge of performance audit methodology;

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

132 (e) strong interpersonal skills.

- 133 (4) The inspector general of Medicaid services:
134 (a) shall serve a term of four years; and
135 (b) may be removed by the governor, for cause.
- 136 (5) If the inspector general is removed for cause, a new inspector general shall be
137 appointed, with the advice and consent of the Senate, to serve the remainder of the term
138 of the inspector general of Medicaid services who was removed for cause.
- 139 (6) The Office of Inspector General of Medicaid Services:
140 [~~(a)~~] is not under the supervision of, and does not take direction from, the executive
141 director, except for administrative purposes;]
142 [~~(b)~~] (a) shall use the legal services of the state attorney general's office;
143 [~~(c)~~] (b) shall submit a budget for the office directly to the [~~department~~] Department of
144 Government Operations;
145 [~~(d)~~] (c) except as prohibited by federal law, is subject to:
146 (i) Title 51, Chapter 5, Funds Consolidation Act;
147 (ii) Title 51, Chapter 7, State Money Management Act;
148 (iii) Title 63A, Utah Government Operations Code;
149 (iv) Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
150 (v) Title 63G, Chapter 4, Administrative Procedures Act;
151 (vi) Title 63G, Chapter 6a, Utah Procurement Code;
152 (vii) Title 63J, Chapter 1, Budgetary Procedures Act;
153 (viii) Title 63J, Chapter 2, Revenue Procedures and Control Act;
154 (ix) Chapter 17, Utah State Personnel Management Act;
155 (x) Title 67, Chapter 16, Utah Public Officers' and Employees' Ethics Act;
156 (xi) Title 52, Chapter 4, Open and Public Meetings Act;
157 (xii) Title 63G, Chapter 2, Government Records Access and Management Act; and
158 (xiii) coverage under the Risk Management Fund created under Section 63A-4-201;
- 159 [~~(e)~~] (d) when requested, shall provide reports to the governor, the president of the
160 Senate, or the speaker of the House; and
161 [~~(f)~~] (e) shall adopt administrative rules to establish policies for employees that are
162 substantially similar to the administrative rules adopted by the Division of Human
163 Resource Management.
- 164 (7)(a) The executive director shall establish operational performance metrics for the
165 office, including metrics for:
166 (i) key performance indicators to evaluate the office's overall performance;

- 167 (ii) financial recoveries;
 168 (iii) office return on investment;
 169 (iv) reporting practices and data presentation;
 170 (v) stakeholder communication; and
 171 (vi) employee performance.
- 172 (b) The executive director shall report on the office's performance based on the metrics
 173 established under this Subsection (7):
 174 (i) upon request, to the Health and Human Services Interim Committee and Social
 175 Services Appropriations Subcommittee; and
 176 (ii) at least annually and more frequently upon request to the advisory board.
- 177 (8)(a) The executive director shall establish a process for an employee of the office to
 178 report the employee's concerns related to:
 179 (i) the performance metrics established under Subsection (7); and
 180 (ii) other concerns related to the office's duties.
- 181 (b) The process the executive director establishes under Subsection (8)(a) shall provide
 182 for an employee or member of the public to report concerns anonymously.
- 183 (c) The executive director shall:
 184 (i) act to address an employee's concern reported in accordance with the process
 185 established under this subsection as soon as reasonably possible, if it is within the
 186 executive director's authority under this title to take an action to address the
 187 concern; and
 188 (ii) submit a written report of the concerns reported according to the process
 189 established under this subsection to the advisory board at each meeting of the
 190 advisory board, including any actions the executive director has taken to address
 191 each concern.
- 192 (d) The executive director or the inspector general may not take retaliatory action against
 193 an employee that reports in good faith a concern in accordance with the process
 194 established under this subsection.

195 Section 3. Section **63A-13-202** is amended to read:

196 **63A-13-202 . Duties and powers of inspector general and office.**

- 197 (1) The inspector general of Medicaid services shall:
 198 (a) administer, direct, and manage the office;
 199 (b) inspect and monitor the following in relation to the state Medicaid program:
 200 (i) the use and expenditure of federal and state funds;

- 201 (ii) the provision of health benefits and other services;
- 202 (iii) implementation of, and compliance with, state and federal requirements; and
- 203 (iv) records and recordkeeping procedures;
- 204 (c) receive reports of potential fraud, waste, or abuse in the state Medicaid program;
- 205 (d) investigate and identify potential or actual fraud, waste, or abuse in the state
- 206 Medicaid program;
- 207 (e) consult with the Centers for ~~[Medicaid and Medicare]~~ Medicare and Medicaid
- 208 Services and other states to determine and implement best practices for:
- 209 (i) educating and communicating with health care professionals and providers about
- 210 program and audit policies and procedures;
- 211 (ii) discovering and eliminating fraud, waste, and abuse of Medicaid funds; and
- 212 (iii) differentiating between honest mistakes and intentional errors, or fraud, waste,
- 213 and abuse, if the office enters into settlement negotiations with the provider or
- 214 health care professional;
- 215 (f) obtain, develop, and utilize computer algorithms to identify fraud, waste, or abuse in
- 216 the state Medicaid program;
- 217 (g) work closely with the fraud unit to identify and recover improperly or fraudulently
- 218 expended Medicaid funds;
- 219 (h) audit, inspect, and evaluate the functioning of the division for the purpose of making
- 220 recommendations to the Legislature and the ~~[department]~~ Department of Health and
- 221 Human Services to ensure that the state Medicaid program is managed:
- 222 (i) in the most efficient and cost-effective manner possible; and
- 223 (ii) in a manner that promotes adequate provider and health care professional
- 224 participation and the provision of appropriate health benefits and services;
- 225 (i) regularly advise the ~~[department]~~ Department of Health and Human Services and the
- 226 division of an action that could be taken to ensure that the state Medicaid program is
- 227 managed in the most efficient and cost-effective manner possible;
- 228 (j) refer potential criminal conduct, relating to Medicaid funds or the state Medicaid
- 229 program, to the fraud unit;
- 230 (k) refer potential criminal conduct, including relevant data from the controlled
- 231 substance database, relating to Medicaid fraud, to law enforcement in accordance
- 232 with Title 58, Chapter 37f, Controlled Substance Database Act;
- 233 (l) determine ways to:
- 234 (i) identify, prevent, and reduce fraud, waste, and abuse in the state Medicaid

- 235 program; and
- 236 (ii) balance efforts to reduce costs and avoid or minimize increased costs of the state
- 237 Medicaid program with the need to encourage robust health care professional and
- 238 provider participation in the state Medicaid program;
- 239 (m) recover improperly paid Medicaid funds;
- 240 (n) track recovery of Medicaid funds by the state;
- 241 (o) in accordance with Section 63A-13-502:
- 242 (i) report on the actions and findings of the inspector general; and
- 243 (ii) make recommendations to the Legislature and the governor;
- 244 (p) provide training to:
- 245 (i) agencies and employees on identifying potential fraud, waste, or abuse of
- 246 Medicaid funds; and
- 247 (ii) health care professionals and providers on program and audit policies and
- 248 compliance; and
- 249 (q) develop and implement principles and standards for the fulfillment of the duties of
- 250 the inspector general, based on principles and standards used by:
- 251 (i) the [Federal] federal Offices of Inspector General;
- 252 (ii) the Association of Inspectors General; and
- 253 (iii) the United States Government Accountability Office.
- 254 (2)(a) The office may, in fulfilling the duties under Subsection (1), conduct a
- 255 performance or financial audit of:
- 256 (i) a state executive branch entity or a local government entity, including an entity
- 257 described in Section 63A-13-301, that:
- 258 (A) manages or oversees a state Medicaid program; or
- 259 (B) manages or oversees the use or expenditure of state or federal Medicaid funds;
- 260 or
- 261 (ii) Medicaid funds received by a person by a grant from, or under contract with, a
- 262 state executive branch entity or a local government entity.
- 263 (b)(i) The office may not, in fulfilling the duties under Subsection (1), amend the
- 264 state Medicaid program or change the policies and procedures of the state
- 265 Medicaid program.
- 266 (ii) The office shall identify conflicts between the state Medicaid plan, [department]
- 267 Department of Health and Human Services administrative rules, Medicaid
- 268 provider manuals, and Medicaid information bulletins and recommend that the [

269 department] Department of Health and Human Services reconcile inconsistencies.
270 If the [department] Department of Health and Human Services does not reconcile
271 the inconsistencies, the office shall report the inconsistencies to the Legislature's
272 Rules Review and General Oversight Committee created in Section 36-35-102.

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

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

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

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

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

293 Section 4. Section **63A-13-204** is amended to read:

294 **63A-13-204 . Selection and review of claims.**

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

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

- 303 (2) The office may directly contact the recipient of record for a Medicaid reimbursed
304 service to determine whether the service for which reimbursement was claimed was
305 actually provided to the recipient of record.
- 306 (3) The office shall:
- 307 (a) generate statistics from the sample described in Subsection (1) to determine the type
308 of fraud, waste, or abuse that is most advantageous to focus on in future audits or
309 investigations;
- 310 (b) ensure that the office, or any entity that contracts with the office to conduct audits:
- 311 (i) has on staff or contracts with a medical or dental professional who is experienced
312 in the treatment, billing, and coding procedures used by the type of provider being
313 audited; and
- 314 (ii) uses the services of the appropriate professional described in Subsection (3)(b)(i)
315 if the provider that is the subject of the audit disputes the findings of the audit;
- 316 (c) ensure that a finding of overpayment or underpayment to a provider is not based on
317 extrapolation, unless:
- 318 (i) there is a determination that the level of payment error involving the provider
319 exceeds a 10% error rate:
- 320 (A) for a sample of claims for a particular service code; and
321 (B) over a three year period of time;
- 322 (ii) documented education intervention has failed to correct the level of payment
323 error; and
- 324 (iii) the value of the claims for the provider, in aggregate, exceeds \$200,000 in
325 reimbursement for a particular service code on an annual basis; and
- 326 (d) require that any entity with which the office contracts, for the purpose of conducting
327 an audit of a service provider, shall be paid on a flat fee basis for identifying both
328 overpayments and underpayments.
- 329 (4)(a) If the office, or a contractor on behalf of the [department] Department of Health
330 and Human Services:
- 331 (i) intends to implement the use of extrapolation as a method of auditing claims, the [
332 department] Department of Health and Human Services shall, prior to adopting the
333 extrapolation method of auditing, report its intent to use extrapolation:
- 334 (A) to the Social Services Appropriations Subcommittee; and
335 (B) as required under Section 63A-13-502; and
- 336 (ii) determines Subsections (3)(c)(i) through (iii) are applicable to a provider, the

337 office or the contractor may use extrapolation only for the service code associated
 338 with the findings under Subsections (3)(c)(i) through (iii).

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

341 (A) each individual claim; or

342 (B) the extrapolation sample.

343 (ii) Nothing in this section limits a provider's right to appeal the audit under Title
 344 63G, Chapter 4, Administrative Procedures Act, the Medicaid program and its
 345 manual or rules, or other laws or rules that may provide remedies to providers.

346 Section 5. Section **63A-13-205** is amended to read:

347 **63A-13-205 . Placement of hold on claims for reimbursement -- Injunction.**

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

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

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

357 (4) A claimant may, at any time during which a hold is in place, appeal the hold under Title
 358 63G, Chapter 4, Administrative Procedures Act.

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

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

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

366 Section 6. Section **63A-13-301** is amended to read:

367 **63A-13-301 . Access to records -- Retention of designation under Government**
 368 **Records Access and Management Act.**

369 (1) In order to fulfill the duties described in Section 63A-13-202, and in the manner
 370 provided in Subsection (4), the office shall have unrestricted access to all records of

- 371 state executive branch entities, all local government entities, and all providers relating,
372 directly or indirectly, to:
- 373 (a) the state Medicaid program;
 - 374 (b) state or federal Medicaid funds;
 - 375 (c) the provision of Medicaid related services;
 - 376 (d) the regulation or management of any aspect of the state Medicaid program;
 - 377 (e) the use or expenditure of state or federal Medicaid funds;
 - 378 (f) suspected or proven fraud, waste, or abuse of state or federal Medicaid funds;
 - 379 (g) Medicaid program policies, practices, and procedures;
 - 380 (h) monitoring of Medicaid services or funds; or
 - 381 (i) a fatality review of a person who received Medicaid funded services.
- 382 (2) The office shall have access to information in any database maintained by the state or a
383 local government to verify identity, income, employment status, or other factors that
384 affect eligibility for Medicaid services.
- 385 (3) The records described in Subsections (1) and (2) include records held or maintained by
386 the department, the division, the Department of Health and Human Services, the
387 Department of Workforce Services, a local health department, a local mental health
388 authority, or a school district. The records described in Subsection (1) include records
389 held or maintained by a provider. When conducting an audit of a provider, the office
390 shall, to the extent possible, limit the records accessed to the scope of the audit.
- 391 (4) A record, described in Subsection (1) or (2), that is accessed or copied by the office:
- 392 (a) may be reviewed or copied by the office during normal business hours, unless
393 otherwise requested by the provider or health care professional under Subsection
394 (4)(b);
 - 395 (b) unless there is a credible allegation of fraud, shall be accessed, reviewed, and copied
396 in a manner, on a day, and at a time that is minimally disruptive to the health care
397 professional's or provider's care of patients, as requested by the health care
398 professional or provider;
 - 399 (c) may be submitted electronically;
 - 400 (d) may be submitted together with other records for multiple claims; and
 - 401 (e) if it is a government record, shall retain the classification made by the entity
402 responsible for the record, under Title 63G, Chapter 2, Government Records Access
403 and Management Act.
- 404 (5) Except as provided in Subsection (7), notwithstanding any provision of state law to the

405 contrary, the office shall have the same access to all records, information, and databases
 406 to which the [department] Department of Health and Human Services or the division has
 407 access.

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

- 411 (a) access, review, retention, and use of records; and
- 412 (b) use of information included in, or derived from, records.

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

- 415 (a) is not subject to this section; and
- 416 (b) is subject to Title 26B, Chapter 8, Part 5, Utah Health Data Authority.

417 Section 7. Section **63A-13-303** is amended to read:

418 **63A-13-303 . Cooperation and support.**

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

423 Section 8. Section **63A-13-502** is amended to read:

424 **63A-13-502 . Report and recommendations to governor and General**
 425 **Government Appropriations Subcommittee.**

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

428 (2) The report shall include:

- 429 (a) non-identifying information, including statistical information, on:
 - 430 (i) the items described in Subsection 63A-13-202(1)(b) and Section 63A-13-204;
 - 431 (ii) action taken by the office and the result of that action;
 - 432 (iii) fraud, waste, and abuse in the state Medicaid program, including emerging trends
 433 of Medicaid fraud, waste, and abuse and the office's actions to identify and
 434 address the emerging trends;
 - 435 (iv) the recovery of fraudulent or improper use of state and federal Medicaid funds,
 436 including total dollars recovered through cash recovery, credit adjustments, and
 437 rebilled claims;
 - 438 (v) measures taken by the state to discover and reduce fraud, waste, and abuse in the

- 439 state Medicaid program;
- 440 (vi) audits conducted by the office, including performance and financial audits;
- 441 (vii) investigations conducted by the office and the results of those investigations,
- 442 including preliminary investigations;
- 443 (viii) administrative and educational efforts made by the office and the division to
- 444 improve compliance with Medicaid program policies and requirements;
- 445 (ix) total cost avoidance attributed to an office policy or action;
- 446 (x) the number of complaints against Medicaid recipients received and disposition of
- 447 those complaints;
- 448 (xi) the number of educational activities that the office provided to a provider or a
- 449 state agency;
- 450 (xii) the number of credible allegations of fraud referred to the Medicaid fraud
- 451 control unit under Section 63A-13-501; and
- 452 (xiii) the number of data pulls performed and general results of those pulls;
- 453 (b) recommendations on action that should be taken by the Legislature or the governor
- 454 to:
- 455 (i) improve the discovery and reduction of fraud, waste, and abuse in the state
- 456 Medicaid program;
- 457 (ii) improve the recovery of fraudulently or improperly used Medicaid funds; and
- 458 (iii) reduce costs and avoid or minimize increased costs in the state Medicaid
- 459 program;
- 460 (c) recommendations relating to rules, policies, or procedures of a state or local
- 461 government entity; and
- 462 (d) services provided by the state Medicaid program that exceed industry standards.
- 463 (3) The report described in Subsection (1) may not include any information that would
- 464 interfere with or jeopardize an ongoing criminal investigation or other investigation.
- 465 (4) On or before November 1 of each year, the inspector general of Medicaid services shall
- 466 provide the electronic report described in Subsection (1) to the General Government
- 467 Appropriations Subcommittee and the Social Services Appropriations Subcommittee of
- 468 the Legislature and to the governor.
- 469 (5) In addition to the report described in Subsection (1), the inspector general shall present
- 470 the information described in Subsections (2)(a)(iii) and (vii):
- 471 (a) at the first interim meeting each year of the Health and Human Services Interim
- 472 Committee and the Social Services Appropriations Subcommittee; and

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

475 Section 9. Section **63A-13-701** is enacted to read:

476 **Part 7. Office of the Inspector General of Medicaid Services Advisory Board**

477 **63A-13-701 . Office of the Inspector General of Medicaid Services Advisory**

478 **Board.**

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

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

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

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

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

492 (2) The department shall make rules to establish:

493 (a) composition of the advisory board, which:

494 (i) may include :

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

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

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

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

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

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

504 (d) quorum requirements; and

505 (e) voting requirements.

506 (3) Members of the advisory board not described in Subsection(2)(a) shall be qualified by

- 507 training, education, and experience.
- 508 (4) The advisory board chair shall call meetings of the advisory board:
- 509 (a) at least two times each year; and
- 510 (b) in addition to the meetings described in Subsection (4)(a), at the request of the
- 511 executive director.
- 512 (5) The advisory board is subject to Title 52, Chapter 4, Open and Public Meetings Act.
- 513 (6)(a) A member of the advisory board who is not a legislator may not receive
- 514 compensation or benefits for the member's service, but may receive per diem and
- 515 travel expenses in accordance with:
- 516 (i) Section 63A-3-106;
- 517 (ii) Section 63A-3-107; and
- 518 (iii) rules made by the Division of Finance in accordance with Sections 63A-3-106
- 519 and 63A-3-107.
- 520 (b) Compensation and expenses of a member of the advisory board who is a legislator
- 521 are governed by Section 36-2-2 and Legislative Joint Rules, Title 5, Legislative
- 522 Compensation and Expenses.
- 523 Section 10. Section **63H-9-101** is amended to read:
- 524 **63H-9-101 . Definitions.**
- 525 As used in this chapter:
- 526 (1) "Best practices toolbox" means the collection of resources for governmental entities
- 527 provided on the website of the Office of the Legislative Auditor General that includes a
- 528 best practice self-assessment and other resources, tools, surveys, and reports designed to
- 529 help government organizations better serve the citizens of the state.
- 530 (2) "Consensus group" means the Office of Legislative Research and General Counsel, the
- 531 Office of the Legislative Auditor General, and the Office of the Legislative Fiscal
- 532 Analyst.
- 533 (3)(a) "Independent entity" means an entity that:
- 534 (i) has a public purpose relating to the state or its citizens;
- 535 (ii) is individually created by the state;
- 536 (iii) is separate from the judicial and legislative branches of state government; and
- 537 (iv) is not under the direct supervisory control of the governor.
- 538 (b) "Independent entity" does not include an entity that is:
- 539 (i) a county;
- 540 (ii) a municipality as defined in Section 10-1-104;

- 541 (iii) an institution of higher education as defined in Section 53H-1-101;
 542 (iv) a public school as defined in Section 53G-8-701;
 543 (v) a special district as defined in Section 17B-1-102;
 544 (vi) a special service district as defined in Section 17D-1-102;
 545 (vii) created by an interlocal agreement as described in Section 11-13-203; or
 546 (viii) an elective constitutional office, including the state auditor, the state treasurer,
 547 and the attorney general.
- 548 (c) Independent entities that are subject to the provisions of this chapter include the:
- 549 (i) Career Service Review Office created in Section 67-19a-201;
 550 (ii) State Capitol Preservation Board created in Section [~~63C-9-201~~] 63O-2-201;
 551 (iii) Heber Valley Historic Railroad Authority created in Section 63H-4-102;
 552 (iv) Military Installation Development Authority created in Section 63H-1-201;
 553 [~~(v) Office of Inspector General of Medicaid Services created in Section 63A-13-201;~~]
 554 [~~(vi)~~] (v) Point of the Mountain State Land Authority created in Section 11-59-201;
 555 [~~(vii)~~] (vi) Public Service Commission created in Section 54-1-1;
 556 [~~(viii)~~] (vii) School and Institutional Trust Fund Office created in Section [~~53C-1-201~~]
 557 53D-1-201;
 558 [~~(ix)~~] (viii) School and Institutional Trust Lands Administration created in Section [~~53D-1-201~~]
 559 53C-1-201;
 560 [~~(x)~~] (ix) Utah Beef Council created in Section 4-21-103;
 561 [~~(xi)~~] (x) Utah Capital Investment Corporation created in Section 63N-6-301;
 562 [~~(xii)~~] (xi) Utah Communications Authority created in Section 63H-7a-201;
 563 [~~(xiii)~~] (xii) Utah Dairy Commission created in Section 4-22-103;
 564 [~~(xiv)~~] (xiii) Utah Education and Telehealth Network created in Section 53H-4-213.4;
 565 [~~(xv)~~] (xiv) Utah Housing Corporation created in Section 63H-8-201;
 566 [~~(xvi)~~] (xv) Utah Inland Port Authority created in Section 11-58-201;
 567 [~~(xvii)~~] (xvi) Utah Lake Authority created in Section 11-65-201;
 568 [~~(xviii)~~] (xvii) Utah Retirement Systems created in Section 49-11-201; and
 569 [~~(xix)~~] (xviii) [~~Utah~~]State Fair Park Authority created in Section 11-68-201.

570 Section 11. **Effective Date.**

571 This bill takes effect on May 6, 2026.