

Part 5 Reporting

63A-13-501 Duty to report potential Medicaid fraud to the office or fraud unit.

- (1)
 - (a) Except as provided in Subsection (1)(b), a health care professional, a provider, or a state or local government official or employee who becomes aware of fraud, waste, or abuse shall report the fraud, waste, or abuse to the office or the fraud unit.
 - (b)
 - (i) The reporting exception in this Subsection (1)(b) does not apply to fraud and abuse. Suspected fraud and abuse shall be reported in accordance with Subsection (1).
 - (ii) If a person described in Subsection (1)(a) reasonably believes that the suspected waste is a mistake, and is not intentional or knowing, the person may first report the suspected waste to the provider, health care professional, or compliance officer for the provider or health care professional.
 - (iii) The person described in Subsection (1)(b)(ii) shall report the suspected waste to the office or the fraud unit unless, within 30 days after the day on which the person reported the suspected waste to the provider, health care professional, or compliance officer, the provider, health care professional, or compliance officer demonstrates to the person that the suspected waste has been corrected.
- (2) A person who makes a report under Subsection (1) may request that the person's name not be released in connection with the investigation.
- (3) If a request is made under Subsection (2), the person's identity may not be released to any person or entity other than the office, the fraud unit, or law enforcement, unless a court of competent jurisdiction orders that the person's identity be released.

Renumbered and Amended by Chapter 12, 2013 General Session
Amended by Chapter 359, 2013 General Session

63A-13-502 Report and recommendations to governor and Executive Appropriations Committee.

- (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;
 - (iv) the recovery of fraudulent or improper use of state and federal Medicaid funds;
 - (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;
 - (vii) investigations conducted by the office and the results of those investigations; and
 - (viii) administrative and educational efforts made by the office and the division to improve compliance with Medicaid program policies and requirements;
 - (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 Executive Appropriations Committee of the Legislature and to the governor.

Amended by Chapter 222, 2016 General Session