

**Chapter 13**  
**Office of Inspector General of Medicaid Services**

**Part 1**  
**General Provisions**

**63A-13-101 Title.**

This chapter is known as "Office of Inspector General of Medicaid Services."

Renumbered and Amended by Chapter 12, 2013 General Session

**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 Inspector General of Medicaid Services Advisory Board created under Section 63A-13-701.
- (3) "Claimant" means a person that:
  - (a) provides a service; and
  - (b) submits a claim for Medicaid reimbursement for the service.
- (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) "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act.
- (11) "Office" means the Office of Inspector General of Medicaid Services, created in Section 63A-13-201.
- (12) "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.
- (13) "Retaliatory action" means the same as that term is defined in Section 67-19a-101.
- (14) "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.
- (15)
  - (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.

Amended by Chapter 48, 2026 General Session

## **Part 2 Office and Powers**

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

- (1) There is created within the 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, compliance, and financial 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) shall use the legal services of the state attorney general's office;
  - (b) shall submit a budget for the office directly to the Department of Government Operations;
  - (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;
  - (d) when requested, shall provide reports to the governor, the president of the Senate, or the speaker of the House of Representatives;
  - (e) shall regularly provide the legislative auditor general updates on the office's audit activities authorized under Subsections 63A-13-202(1)(h) and (2); and
  - (f) 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) respond to an employee's concern reported in accordance with the process established under this Subsection (8) as soon as reasonably possible; and
  - (ii) submit a written report of the concerns reported according to the process established under this Subsection (8) 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 (8).

Amended by Chapter 48, 2026 General Session

**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 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 Medicaid program;
  - (d) investigate and identify potential or actual fraud, waste, or abuse in the Medicaid program;
  - (e) consult with the Centers for 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 Medicaid program;
  - (g) work closely with the fraud unit to identify and recover improperly or fraudulently expended Medicaid funds;
  - (h) audit, investigate, inspect, and evaluate the functioning of the Medicaid program to ensure that the Medicaid program is managed:
    - (i) in the most efficient, accountable, 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) identify areas where the Medicaid program can enhance participant health outcomes while maximizing the prudent use of public funds;
  - (j) identify opportunities for innovation and transformation within the Medicaid program to maximize effectiveness and efficiency;
  - (k) establish a list of high-risk Medicaid program audit areas the office may use to prioritize the office's audit work;
  - (l) regularly advise the department and the division of an action that could be taken to ensure that the Medicaid program is managed in the most efficient and cost-effective manner possible;

- (m) refer potential criminal conduct, relating to Medicaid funds or the Medicaid program, to the fraud unit;
  - (n) 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;
  - (o) determine ways to:
    - (i) identify, prevent, and reduce fraud, waste, and abuse in the Medicaid program; and
    - (ii) balance efforts to reduce costs and avoid or minimize increased costs of the Medicaid program with the need to encourage robust health care professional and provider participation in the Medicaid program;
  - (p) recover improperly paid Medicaid funds;
  - (q) track recovery of Medicaid funds by the state;
  - (r) 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;
  - (s) 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
  - (t) 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 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, compliance, 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 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 Medicaid program or change the policies and procedures of the Medicaid program.
    - (ii) The office shall identify conflicts between the state Medicaid plan, Department of Health and Human Services administrative rules, Medicaid provider manuals, and Medicaid information bulletins and recommend that the Department of Health and Human Services reconcile inconsistencies. If the Department of Health and Human Services does not reconcile the inconsistencies, the office shall report the inconsistencies to the Legislature's General Oversight Committee created in Section 36-35-102.
    - (iii) The office shall review a Medicaid provider manual and a Medicaid information bulletin in accordance with Subsection (2)(b)(ii), prior to the Department of Health and Human Services making the provider manual or Medicaid information bulletin available to the public.
  - (c) 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)(iii) prior to releasing the document to the public. The 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 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.

Amended by Chapter 48, 2026 General Session

**63A-13-203 Memorandum of understanding with fraud unit.**

The inspector general shall enter into a memorandum of understanding with the fraud unit to:

- (1) formalize communication, cooperation, coordination of efforts, and the sharing of information, on a regular basis, between the office and the fraud unit;
- (2) provide for reporting criminal activity discovered by the office to the fraud unit;
- (3) ensure that investigations and other actions by the office and the fraud unit do not conflict; and
- (4) provide for the sharing and classification of records between the office and the fraud unit under the Government Records Access and Management Act.

Renumbered and Amended by Chapter 12, 2013 General Session

**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 Medicaid program to determine whether fraud, waste, or abuse occurred.
  - (b) The office shall limit 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 of Health and Human Services:
    - (i) intends to implement the use of extrapolation as a method of auditing claims, the office or the 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.

Amended by Chapter 48, 2026 General Session

**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 of Health and Human Services and the division shall fully comply with a hold ordered under this section.

Amended by Chapter 48, 2026 General Session

### **Part 3 Investigation or Audit**

#### **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 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 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)
- (a) 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.
  - (b) 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 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.

Amended by Chapter 48, 2026 General Session

**63A-13-302 Access to employees -- Cooperating with investigation or audit.**

- (1) The office shall have access to interview the following persons if the inspector general determines that the interview may assist the inspector general in fulfilling the duties described in Section 63A-13-202:
  - (a) a state executive branch official, executive director, director, or employee;
  - (b) a local government official or employee;
  - (c) a consultant or contractor of a person described in Subsection (1)(a) or (b); or
  - (d) a provider or a health care professional or an employee of a provider or a health care professional.
- (2) A person described in Subsection (1) and each supervisor of the person shall fully cooperate with the office by:
  - (a) providing the office or the inspector general's designee with access to interview the person;
  - (b) completely and truthfully answering questions asked by the office or the inspector general's designee;
  - (c) providing the records, described in Subsection 63A-13-301(1), in the manner described in Subsection 63A-13-301(4), requested by the office or the inspector general's designee; and
  - (d) providing the office or the inspector general's designee with information relating to the office's investigation or audit.
- (3) A person described in Subsection (1)(a) or (b) and each supervisor of the person shall fully cooperate with the office by:
  - (a) providing records requested by the office or the inspector general's designee in the manner described in Subsection 63A-13-301(4); and
  - (b) providing the office or the inspector general's designee with information relating to the office's investigation or audit, including information that is classified as private, controlled, or protected under Title 63G, Chapter 2, Government Records Access and Management Act.

Renumbered and Amended by Chapter 12, 2013 General Session

Amended by Chapter 359, 2013 General Session

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

The Department of Health and Human Services, the division, each consultant or contractor of the 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.

Amended by Chapter 48, 2026 General Session

**63A-13-304 Interference with an investigation or audit prohibited.**

No person may:

- (1) interfere with or impede an investigation or audit of the office or fraud unit; or
- (2) interfere with the office relative to the content of a report, the conclusions reached in a report, or the manner of disclosing the results and findings of the office.

Renumbered and Amended by Chapter 12, 2013 General Session

**63A-13-305 Audit and investigation procedures.**

- (1)
  - (a) The office shall, in accordance with Section 63A-13-602, adopt administrative rules in consultation with providers and health care professionals subject to audit and investigation under this chapter to establish procedures for audits and investigations that are fair and consistent with the duties of the office under this chapter.
  - (b) If the providers and health care professionals do not agree with the rules proposed or adopted by the office under Subsection (1)(a) or Section 63A-13-602, the providers or health care professionals may:
    - (i) request a hearing for the proposed administrative rule or seek any other remedies under the provisions of Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and
    - (ii) request a review of the rule by the Legislature's General Oversight Committee created in Section 36-35-102.
- (2) The office shall notify and educate providers and health care professionals subject to audit and investigation under this chapter of the providers' and health care professionals' responsibilities and rights under the administrative rules adopted by the office under the provisions of this section and Section 63A-13-602.

Amended by Chapter 484, 2026 General Session

**Part 4  
Subpoena Power**

**63A-13-401 Subpoena power -- Enforcement.**

- (1) The inspector general has the power to issue a subpoena to obtain a record or interview a person that the office or inspector general has the right to access under Part 3, Investigation or Audit.
- (2) A person who fails to comply with a subpoena issued by the inspector general or who refuses to testify regarding a matter upon which the person may be lawfully interrogated:
  - (a) is in contempt of the inspector general; and
  - (b) upon request by the inspector general, the attorney general shall:
    - (i) file a motion for an order to compel obedience to the subpoena with the district court;
    - (ii) file, with the district court, a motion for an order to show cause why the penalties established in Title 78B, Chapter 6, Part 3, Contempt, should not be imposed upon the person named in the subpoena for contempt of the inspector general; or
    - (iii) pursue other legal remedies against the person.
- (3) Upon receipt of a motion under Subsection (2), the court:
  - (a) shall expedite the hearing and decision on the motion; and

- (b) may:
  - (i) order the person named in the subpoena to comply with the subpoena; and
  - (ii) impose any penalties authorized by Title 78B, Chapter 6, Part 3, Contempt, upon the person named in the subpoena for contempt of the inspector general.
- (4)
  - (a) If a subpoena described in this section requires the production of accounts, books, papers, documents, or other tangible items, the person or entity to whom it is directed may petition a district court to quash or modify the subpoena at or before the time specified in the subpoena for compliance.
  - (b) The inspector general may respond to a motion to quash or modify the subpoena by pursuing any remedy authorized by Subsection (3).
  - (c) If the court finds that a subpoena requiring the production of accounts, books, papers, documents, or other tangible items is unreasonable or oppressive, the court may quash or modify the subpoena.
- (5) Nothing in this section prevents the inspector general from seeking an extraordinary writ to remedy contempt of the inspector general.
- (6) Any party aggrieved by a decision of a court under this section may appeal that decision directly to the Utah Supreme Court.

Renumbered and Amended by Chapter 12, 2013 General Session

## **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 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 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 Medicaid program;
    - (vi) audits conducted by the office, including performance, compliance, 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 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 Medicaid program;
  - (c) recommendations relating to rules, policies, or procedures of a state or local government entity; and
  - (d) services provided by the 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.

Amended by Chapter 48, 2026 General Session

## **Part 6 Miscellaneous Provisions**

### **63A-13-601 Provision of contract services to Office of Inspector General of Medicaid Services.**

- (1) The division and the assistant attorneys general assigned to the division shall provide, without charge, contract review, contract enforcement, and other contract management services to the office.
- (2) The division shall ensure that the services described in Subsection (1) are provided in an expeditious manner.
- (3) The attorney general shall designate one of the assistant attorneys general assigned to the division to give first priority to providing the services described in Subsection (1) to the office.
- (4) The office and the division shall enter into a memorandum of understanding in order to execute the requirements of this section in an effective and efficient manner.

Renumbered and Amended by Chapter 12, 2013 General Session

### **63A-13-602 Rulemaking authority.**

The office may make rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and Section 63A-13-305, that establish policies, procedures, and practices, in accordance with the provisions of this chapter, relating to:

- (1) inspecting and monitoring the Medicaid program;
- (2) discovering and investigating potential fraud, waste, or abuse in the Medicaid program;
- (3) developing and implementing the principles and standards described in Subsection 63A-13-202(1)(t);
- (4) auditing, investigating, inspecting, and evaluating the functioning of the Medicaid program under Subsection 63A-13-202(1)(h);
- (5) conducting a performance, compliance, or financial audit under Subsection 63A-13-202(1)(h) or (2); or
- (6) ordering a hold on the payment of a claim for reimbursement under Section 63A-13-205.

Amended by Chapter 48, 2026 General Session

## **Part 7 Office Of Inspector General Of Medicaid Services Advisory Board**

### **63A-13-701 Office of 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 Inspector General of Medicaid Services Advisory Board," to:

- (a) promote coordination of Medicaid program 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 of Government Operations regarding prioritization of the office's financial audit activities;
  - (c) review employee concerns reported in accordance with the process the executive director establishes under Subsection 63A-13-201(8);
  - (d) make recommendations to the inspector general, the executive director, and the Legislature for improving the office's operations;
  - (e) review the office's annual risk assessment and the office's annual audit plan;
  - (f) review limitations that impede the office's ability to appropriately conduct audits; and
  - (g) review agencies' implementation of the office's audit recommendations.
- (2) The Department of Government Operations shall make rules to establish:
- (a) composition of the advisory board, which shall include:
    - (i) the executive director of the Department of Health and Human Services or the executive director's designee; and
    - (ii) the state Medicaid director appointed under Section 26B-3-103;
  - (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 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) In carrying out the advisory board's duties, the advisory board shall coordinate with the legislative auditor general.
- (6) The advisory board is subject to Title 52, Chapter 4, Open and Public Meetings Act.
- (7) A member of the advisory board may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:
- (a) Section 63A-3-106;
  - (b) Section 63A-3-107; and
  - (c) rules made by the Division of Finance in accordance with Sections 63A-3-106 and 63A-3-107.

Enacted by Chapter 48, 2026 General Session