An Audit of the Deficit Reduction Act, Section 6032 Compliance, Federal Fiscal Year 2024

Report Number A2025-03

May 20, 2025

Utah Office of
Inspector General

Gene Cottrell
Inspector General

May 20, 2025

To: Utah Department of Health and Human Services

Please see the attached report, An Audit of the Deficit Reduction Act Section 6032 Compliance for Federal Fiscal Year 2024, Report 2025-03. An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 3 of this report.

Sincerely,

Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Sen. Heidi Balderee, Social Services Appropriations Subcommittee, Senate Chair
Rep. Raymond Ward, Social Services Appropriations Subcommittee, House Chair
Jon Pierpont, Chief of Staff, Office of Governor Spencer Cox
J. Stuart Adams, President of the Utah Senate
Mike Schultz, Speaker of the Utah House of Representatives
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EXECUTIVE SUMMARY

Medicaid is a joint state and federal government health insurance program established by Title XIX of the 1965 Social Security Act. State Law designates the Utah Department of Health and Human Services (DHHS) as the single state agency responsible for administration of the Utah Medicaid program (Utah Medicaid). At the federal level, the Centers for Medicaid, and Medicare Services (CMS) are responsible for regulation and oversight of Medicaid. Together, Utah and the federal government jointly fund Utah Medicaid at percentage rates determined by the federal Medicaid assistance percentage (FMAP). Throughout this report, "Medicaid funds" refers to the federal and state taxpayer dollars used to fund Utah Medicaid.

On February 8, 2006, President George W. Bush signed the Deficit Reduction Act of 2005 (DRA) into law. Several provisions in the DRA changed the Medicaid program. One of those changes requires an entity that receives payment of at least $5,000,000 annually of Medicaid funds to have written policies and procedures in place. Specifically, under DRA Section 6032, these entities must establish written policies to provide employees, managers, and contractors with detailed information about the following:

- False Claims Act.
- Administrative remedies for false claims and statements.
- State laws pertaining to civil or criminal penalties for false claims and statements.
- Whistleblower protections are available under state laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs; and
- Policies and procedures for detecting and preventing fraud, waste and abuse.

State Medicaid programs were required to impose requirements of DRA section 6032 by January 1, 2007, and amend their State-Plan no later than March 31, 2007. The amendments to Utah's Medicaid State Plan (State Plan) are in Section 4.42(Appendix A) and Attachment 4.42-A (Appendix B). The State Plan requires all entities subject to DRA Section 6032 requirement to verify compliance by attestation or audit. The Utah Office of Inspector General (UOIG) performs ongoing compliance verification pursuant to the Memorandum of Understanding (MOU) between DHHS and UOIG.

Audit Objectives:

- Determine if entities that received or paid at least $5,000,000 of Medicaid funds, during Federal Fiscal year (FFY) 2024 complied with DRA Section 6032.

Audit Findings:

No non-compliant issues were discovered. No findings are reported for the third year of the three-year audit cycle.

INTRODUCTION

BACKGROUND

Since January 1, 2007, entities that receive or pay at least $5,000,000 of Medicaid funds annually under the State Plan, or any waiver of the State Plan, are required to comply with the DRA, Section 6032. Entities that meet the $5,000,000 threshold are required to establish written policies for all employees, managers and contractors that provide detailed information about:

- False Claims Act.
- Administrative remedies for false claims and statements[1];
- State Laws that provide civil or criminal penalties for making false claims and statements.
- Whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs; and
- Policies and procedures for detecting and preventing fraud, waste and abuse.

Additionally, employee handbooks must include a special discussion of the items listed above.

Compliance Oversite: 3-year Cycle

As part of the implementation process, CMS required each state with a Medicaid program to amend their State Plan to define the manner and methodology of DRA Section 6032 Compliance oversight. Attachment 4.42-A (Appendix A) of the Utah State Plan defines a 3-year cycle for DRA Section 6032 compliance. During the third year of the compliance cycle, all entities that meet the $5,000,000 threshold are required to complete an attestation. In the preceding two years, new entities paying or receiving at least $5,000,000 of Medicaid funds annually are required to complete a compliance attestation. Attachment 4.42-A (Appendix B) also defines an annual audit sampling of entities that meet the $5,000,000 threshold. Entities selected for review are required to produce copies of written or electronic policies and procedures such as a handbook or compliance review.

Rolls and Responsibilities:

DHHS delegates responsibility for "performing compliance review and conducting audits to ensure entities comply with the requirements of Section 6032 of the Deficit Reduction Act of 2005 as described in the Utah Medicaid State Plan Section 4.42 and Attachment 4.42-A" to UOIG through a Memorandum of Understating (MOU).[2]

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[1] In 1986, Congress enacted the Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C §§ 3801-3812. The PFCRA provides administrative remedies for false claims and statements when the liability is $150,000 or less and the Department of Justice declines to pursue FCA remedies. Importantly, while PFCRA and FCA are complementary laws and similar in many respects, they are two different federal laws.

[2] "Utah Department of Health and Human Services Memorandum of Agreement." April 2023.

FUNDING SOURCE

Utah receives matching payment from the federal government to pay health care coverage and long-term services for Utah Medicaid recipients. The matching payment rates, the Federal Medical Assistance Percentage (FMAP), are set every federal fiscal year. Federal matching payments range from 50%-100%.

OBJECTIVES AND SCOPE

Audit Objectives:

- Determine if entities that received or paid at least $5,000,000 of Medicaid funds, during fiscal year (FFY) 2024 complied with DRA Section 6032.

Audit Scope:

The scope of the audit covered FFY 2024 for entities that received or paid at least $5,000, 000 of Medicaid funds under the State Plan, or any waiver of the State Plan. FFY 2024 is the year three of the three-year cycle described in Attachment 4.42-A of the Utah State Plan for DRA Section 6032 compliance. See Appendix B.

METHODOLOGY

UOIG performed two methods of compliance verification defined in Attachment 4.42-A of the State Plan: Compliance attestation and audit.

The UOIG conducted fieldwork between January and May of 2025. Initial fieldwork included review of federal and state laws; Section 4.42 and Attachment 4.42-A of the State Plan, and federal policy guidance; Section 5.2 of the Memorandum of Understanding between the DHHS and the UOIG.

Using the Medicaid Data Warehouse containing data extracted from the Provider Reimbursement information System (PRISM) for Medicaid, UOIG obtained a list of entities that received at least $5,000,000 of Utah Medicaid funds during the audit scope period. UOIG reviewed all entities by tax identification number (TIN), that received at least $5,000,000. For the annual compliance audit, the UOIG reviewed a 10% sampling from the listing of entities that matched the $5,000,000 threshold. Every entity that reached the $5,000,000 threshold in the third year of the three-year cycle, but was not part of the 10% audit sample, participated in the required compliance attestation for the third year of the current 3-year compliance cycle.

UOIG mailed notice letters to the entities selected for the compliance audit and attestation letters to those entities that required attestations. All entities were required to supply documentation within 45 days or sign and return the attestation as required by the state plan.

Any entity that did not respond withing the 45 days received a courtesy follow-up phone call or a follow-up email. UOIG reviewed the documentation for compliance to verify that the documents included required information. Finally, UOIG reviewed all attestations returned for signature and date as required for compliance. For this audit cycle eight entities were selected for the audit, with sixty-seven entities receiving attestation.

CONCLUSION

UOIG determined that 75 entities reached the threshold of $5,000,000 in payments made or received from Utah Medicaid funds during FFY 2024. Data was pulled in January 2025 from the Utah Medicaid Data warehouse for use in the annual audit. From the 75 entities reaching the threshold, sixty-seven attestations with issued and eight audits were requested.

All sixty-seven attestation letters were signed and returned by providers within the audit time frame and are considered compliant.

All eight audits were received from providers with supporting documentation of compliance with the Deficit Reduction Act requirements and the state Medicaid plan requirements.

No non-compliant issues were discovered. No findings are reported for the third year of the three-year audit cycle.

Appendix A: Utah Medicaid State Plan, Section 4.42

Revision: HCFA-PM-92-2 (HSQB) Page 79v(1)
March 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 4 - GENERAL PROGRAM ADMINISTRATION (Continued)

Citation
1902{a){68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act {the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for profit or not for profit, which receives or makes payments under a State Plan approved under Title XIX or under any waiver of such plan totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: _____

SECTION 4 - GENERAL PROGRAM ADMINISTRATION (Continued)

Citation
1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries (Continued)

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) "A contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies, which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: _____U=c....T-'--'A-'"H--'----------

SECTION 4 - GENERAL PROGRAM ADMINISTRATION (Continued)

Citation
1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries (Continued)

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each state's provider enrollment agreements.

(5) The State will implement this State Plan Amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

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Approval Date ___ [illegible]
Effective Date _____1-1-07_____

Appendix B: Utah Medicid Stat Plan, Attachment 4.42-A

ATTACHMENT 4.42-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 4 - GENERAL PROGRAM ADMINISTRATION (Continued)

Citation
1902(a)(68) of the Act, P.L 109-171

(1) All entities covered under 4.42(A) must be in compliance with section 6032 of the Deficit Reduction Act of 2005.

(2) Initial Compliance: Upon approval of the State Plan Amendment, notice shall be sent to all entities as described in 4.42(A) requiring compliance with section 6032 of the DRA. The notice shall include a compliance attestation that must be returned to the Department within 45 days of the date of the notice.

(3) Ongoing compliance: At the end of the first calendar quarter of every third year after 2007, notice and compliance attestation will be sent to each entity as described in 4.42(A). Compliance verification must be received by each entity noted above no later than June 30 of that year.

(4) In between each third year, at the end of each first calendar quarter, a list of all entities will be checked and reviewed for all new entities meeting the requirements as noted in 4.42(A). Notice and compliance attestation will be sent as directed in #2 above.

(5) Annually, the Department will conduct a random audit of all entities to determine compliance with section 6032 of the DRA. The Department will use sampling methodology to make this determination and the audits will be completed by the end of the State Fiscal Year.

(6) If compliance is not met or there is a failure to return attestations within the stated time frame, appropriate action will be taken against the entity according to the current State and Department Program Integrity Rules in effect at the time notice was given to the entity.

T.N. # 07-002 Approval Date 6-29-07

Supersedes T.N. # New Effective Date 1-1-07

GLOSSARY OF TERMS

Term	Description
CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
DHHS	Utah Department of Health and Human Services
FFY	Federal Fiscal Year (October 1 to September 30)
FMAP	Federal Medical Assistance Percentage
MOU	Memorandum of Understanding
PRISM	Provider Reimbursement Information System for Medicaid
MMIS	Medicaid Management Information System
TIN	Tax Identification number
UOIG	Utah Office of Inspector General

MANAGEMENT RESPONSE

None

EVALUATION OF MANAGEMENT RESPONSE

None

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

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UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services will protect taxpayer dollars by identifying fraud, abuse and waste risks and vulnerabilities in the State Medicaid Program and by taking action to mitigate or eliminate those risks.

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