

Annual Report

Fiscal Year 2025



Utah Office of Inspector General
Medicaid Services

"2025 Fraud, Abuse and Waste Elimination Efforts"



Message from the Interim Inspector General of Medicaid Services

The Utah Office of the Inspector General of Medicaid Services (UOIG) presents the SFY2025 Annual Report to Governor Cox, the State Legislature, and the citizens of Utah. The UOIG's goal is to eliminate fraud, abuse, and waste in the Medicaid system, thereby protecting taxpayer dollars. The UOIG conducts audits and investigations and provides oversight of the managed care entities. Medicaid constitutes one of Utah's largest state expenditures and UOIG staff take their fiduciary responsibility to the taxpayers of Utah seriously.

The Office recouped \$3.25 million dollars and saved the taxpayers an additional \$12.42 million in cost avoidance during SFY 2025. The Office opened 400 allegations during the year with most of them coming from complaints submitted by the public through the fraud hotline or the online submission tool. The UOIG referred five cases for criminal investigation to the Medicaid Fraud Control Unit (MFCU), 31 to the Department of Workforce Services for a recipient fraud investigation, and eight to other partners for additional investigation.

Management for the UOIG has changed significantly for SFY2026. The previous Inspector General resigned in August of 2025, and the Deputy Inspector General resigned in July of 2025. While this report reflects the final activities completed under prior management, ongoing corrective actions and improvements are being made by the new management to bring increased accountability and transparency to the office's important work.

As Interim Inspector General, my goal is to take the office in a new direction. Management is evaluating Medicaid risk, current processes, and looking for areas of improvement. Our long-term strategic planning is underway and SFY2026 activities will be based on areas of highest program and financial risk to ensure resources are used effectively and our outcomes are measurable. We will continue reviewing the August 25, 2025, audit from the Office of Legislative Auditor General and implement the recommendations as well as look for new opportunities for change as we improve our performance and strengthen public trust in our oversight role.

We look forward to a new year and how we can provide oversight of taxpayer dollars and the state's ability to provide safe and adequate care to the vulnerable population that Medicaid services.

Respectfully,

Neil Erickson

Neil Erickson
Interim Inspector General
Office of Inspector General of Medicaid Services

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Goal

Eliminate Medicaid Fraud, Abuse, and Waste

Mission

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

We are considering how to ensure that the Office’s mission fully encapsulates the scope of the work that we do to not only protect taxpayer dollars and ensure that Medicaid is operated sustainably, but also in safeguarding Medicaid Members and mitigating risks to vulnerable Utah residents, while balancing the need for a robust provider network.

Background

The Utah State Legislature created the Office of Inspector General of Medicaid Services during the 2011 General Session to provide independent oversight of the Medicaid program and all Medicaid related spending. The authority, by which the Office conducts oversight related activities, is *Utah Code 63A-13*.

The Utah Medicaid State Plan designates the Utah Department of Health and Human Services, Division of Integrated Healthcare as the Single State Agency, responsible for “implementing, organizing, and maintaining¹” the State’s Medicaid Program. The Single State Agency holds responsibility for making management decisions pertaining to the Medicaid program. Therefore, the Inspector General may only make recommendations for improvement of the program to the Department of Health and Human Services.

¹ UT Code 26B-3-102

Understanding Program Integrity

All state Medicaid programs must comply with federal program integrity requirements which include the following:

1. **Fraud Control Unit:** States must have a Medicaid Fraud Control Unit (MFCU) that is separate from the Medicaid agency to investigate and prosecute fraud.
2. **Cooperation:** States must cooperate with federal program integrity initiatives, such as the Centers for Medicare & Medicaid (CMS) Medicaid Integrity Program and the Payment Error Rate Measurement (PERM) program.
3. **Compliance oversight:** States must oversee their plan's compliance with federal and state laws, regulations, and policies.
4. **Provider Screening:** States must screen all participating providers according to their categorical risk level.

Sec. 1936 of the Social Security Act (42 U.S.C.1396u-6)

- Reviews of Medicaid Service Providers to determine if fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in the expenditure of funds in a manner which is not intended
- Audits of Medicaid Claims for payment for items, services, and administrative services rendered, including Service Provision, Cost Reports, Contracts, Risk Contracts, etc.
- Investigations of Medicaid Fraud, Waste, and Abuse and Identification of overpayments made
- Training and Education

Program integrity activities are meant to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, and abuse from taking place. Because fraud is particularly difficult to detect, its precise magnitude is unknown, though analysis has shown that the great majority of Medicaid providers do not engage in such actions.

Ultimately, parts of Medicaid program integrity are the responsibility of all stakeholders.

When designed and implemented well, program integrity initiatives help to ensure that:

- eligibility decisions are made correctly;
- prospective and enrolled providers meet federal and state participation requirements;
- services provided to enrollees are medically necessary and appropriate; and
- provider payments are made in the correct amount and for appropriate services.

Waste, which is not defined in federal Medicaid regulations, includes inappropriate utilization of services and misuse of resources. An example would be duplication of tests that can occur when providers do not share information with each other. Waste is not a criminal or intentional act but results in unnecessary expenditures to the Medicaid program that might be preventable.

Program Integrity Activities

Depending on their specific mission and scope, federal and state agencies may use a number of tools to identify and address fraud and abuse in the Medicaid program. Specific methods can include:

- data mining to identify possible fraud and abuse for further examination;

- audits to determine compliance with federal and state rules and regulations or to identify fraud and abuse;
- investigations of suspected fraud and abuse;
- enforcement actions (e.g., provider termination, provider exclusion) against those who have committed fraud;
- technical assistance and education for state staff so they are able to prevent and identify fraud and abuse; and
- outreach to and education for the provider and enrollee communities (e.g., how to report suspected fraud, explaining Medicaid rules and requirements).

Many oversight activities focus on identifying and recovering improper payments made to providers, such as payments that should not have been made or that were made in an incorrect amount (this includes both overpayments and underpayments). When an improper payment is identified, the state must return the federal share to CMS.

Duties and Powers of the UOIG as outlined in State Statute

The duties and powers that the Utah Legislature created for the Office are found in Utah Code at 63A-13-202. The list of codified duties and powers are:

1. Inspect and monitor the following in relation to the state Medicaid program:
 - a. the use and expenditure of federal and state funds;
 - b. the provision of health benefits and other services;
 - c. implementation of, and compliance with, state and federal requirements; and
 - d. records and recordkeeping procedures.
2. Receive reports of potential fraud, waste, and abuse in the state Medicaid program.
3. Investigate and identify potential or actual fraud, waste, or abuse in the state Medicaid program.
4. Consult with the Centers for Medicaid and Medicare Services and other states to determine and implement best practices for:
 - a. educating and communicating with health care professionals and providers about program and audit policies and procedures;
 - b. discovering and eliminating fraud, waste, and abuse of Medicaid funds; and
 - c. 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.
5. Obtain, develop, and utilize computer algorithms to identify fraud, waste, or abuse in the state Medicaid program.
6. Work closely with the fraud unit to identify and recover improperly or fraudulently expended Medicaid funds.
7. Audit, inspect, and evaluate the functioning of the division for the purpose of making recommendation to the Legislature and the department to ensure that the state Medicaid program is managed:
 - a. in the most efficient and cost-effective manner possible; and
 - b. in a manner that promotes adequate provider and health care professional participation and the provision of appropriate health benefits and services.

8. Regularly advise the department and the division of an action that could be taken to ensure that the state Medicaid program is managed in the most efficient and cost-effective manner possible.
9. Refer potential criminal conduct, relating to Medicaid funds or the state Medicaid program, to the fraud unit.
10. 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.
11. Determine ways to:
 - a. Identify, prevent, and reduce fraud, waste, and abuse in the state Medicaid program; and
 - b. Balance efforts to reduce costs and avoid or minimize increased costs of the state Medicaid program with the need to encourage robust health care professional and provider participation in the state Medicaid program.
12. Recover improperly paid Medicaid funds.
13. Track recovery of Medicaid funds by the state.
14. In accordance with 63A-13-502:
 - a. Report on the actions and findings of the inspector general; and
 - b. Make recommendations to the Legislature and the governor.
15. Provide training to:
 - a. Agencies and employees on identifying potential fraud, waste, or abuse of Medicaid funds; and
 - b. Health care professionals and providers on program and audit policies and compliance.

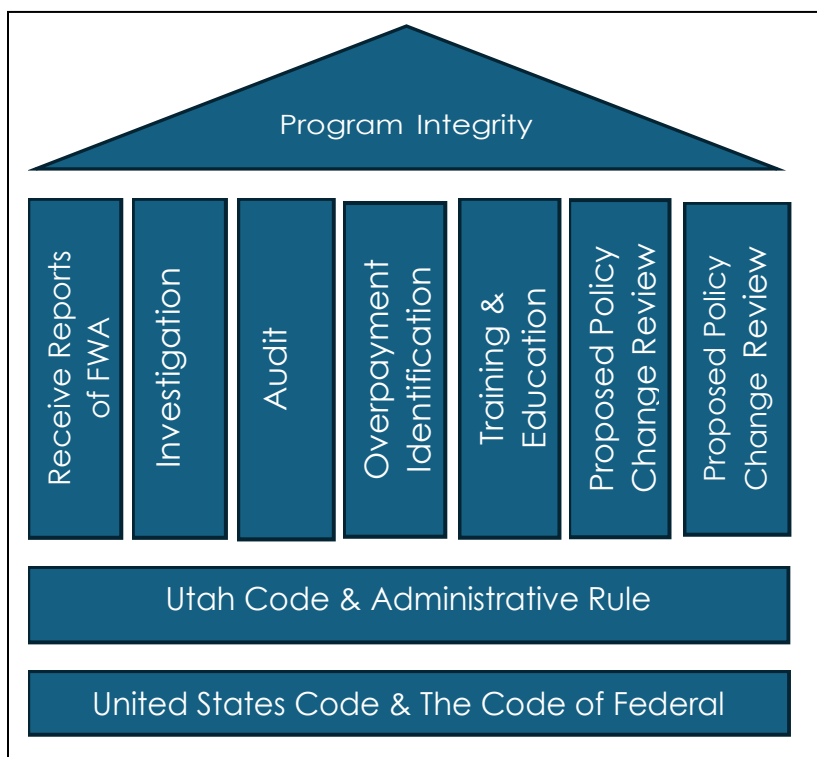
The office accomplishes each of these responsibilities in a professional manner to ensure that Medicaid Program Integrity is accomplished to ensure the program is protected against taxpayer loss through fraud, waste or abuse. This report will highlight a number of these responsibilities, including outcomes and key performance indicators.

UOIG Core Activities

Sec. 1936 (42 USC 1396u-6) of the Social Security Act requires that every state must have an entity dedicated to Medicaid Program Integrity (PI).

Statutorily mandated PI activities include Audits; Investigations of Fraud, Waste, and Abuse; Review of Medicaid Providers; Identification of Medicaid Overpayments; and Training and Education.

UT Code 63A-13-202 reiterates federal requirements and outlines additional responsibilities of the UOIG.



Receive Reports of Fraud, Waste, and Abuse 63A-13-501

Defining Fraud, Waste, and Abuse (FWA)

Fraud and abuse are both defined in Medicaid regulations (42 CFR 433.304 and 42 CFR 455.2).

Fraud involves an intentional deception, such as billing for services that were never provided.

Abuse includes taking advantage of loopholes or bending the rules, such as improper billing practices.

Waste is defined in UT Code 63A-13-102 as the act of using or expending a resource carelessly, extravagantly, or to no purpose.

Waste is often the result of program inefficiencies.

Utah Code 63A-13-501 requires health care providers, state or local government officials, or employees who become aware of fraud, waste, or abuse to report it. Reports can come from anyone and can be made anonymously.

During 2025 the UOIG received 400 allegations through the various reporting tools, which include the fraud hotline, the UOIG website and the MPI.utah.gov email address. Those 400 allegations are mostly comprised of reports from private citizens.

Recoveries 63A-13-502(2)(a)(iv)

The Utah Office of the Inspector General of Medicaid Services (UOIG or Office) recovers funds that are inappropriately billed by providers. The cause of most recoveries are errors in billing by providers, most commonly due to miscoding or misinterpretation of Medicaid policy. If a provider does not have a history of inappropriate billing and if the claims do not present a pattern of fraud a recovery action is undertaken to recoup the inappropriately billed Medicaid funds.

The Recovery action includes a detailed review of medical records that support the billing of Medicaid Services. The UOIG requests those records from the provider. Those records are then reviewed by the UOIG staff for accuracy, completeness, and appropriateness of coding.

During an average year the UOIG expects to recover between \$3-5 million.

The UOIG conducts recoveries using three techniques:

- **Cash Collection** is done through checks drafted by the provider to cover the amount of the recovery.
- **Directed rebilling of claims.** In many instances inappropriately billed claims can be voided and rebilled correctly. The amount of recovery is calculated using the difference between the inappropriately billed claims and the corrected claims. This recovery technique is the most desirable of the three, as it also serves as a training opportunity for the provider.
- **Offsets against future payments or credit adjustments.** Offsets are a claims system process where a debt is entered into the system and future payments are adjusted until the debt is satisfied. Frequently when the Office uses offsets it is because the provider requests it to refund inappropriately billed claims. However, the Office may impose offsets if a provider refuses to participate in the recovery process. An example of such refusal is a Provider's failure to submit requested medical records in a timely manner.

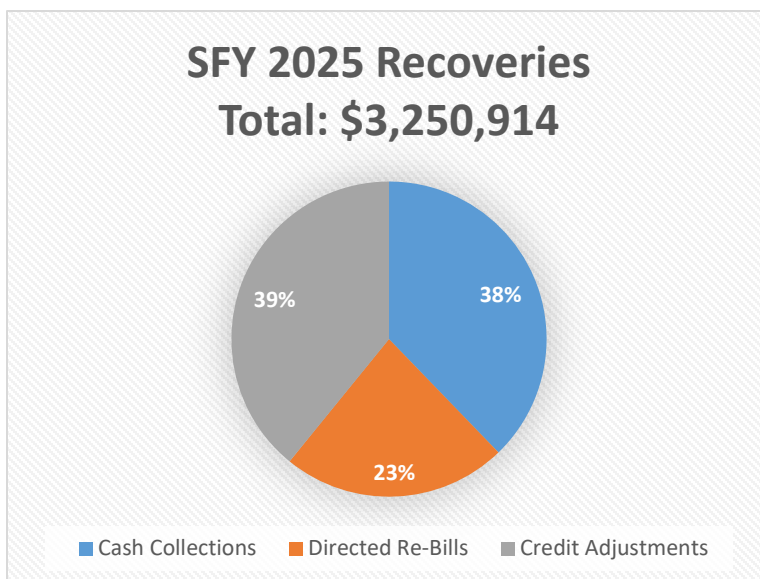


Figure 1: SFY 2024 Recoveries

During SFY 2025 the UOIG recovered \$3.2 million dollars of inappropriately billed claims. Importantly, these recovery amounts do not include the fraud related recoveries outlined in the next section of this report.

Adjudicative Procedure rights accompany every Notice of Recovery the Office issues in accordance with Utah Administrative Rule R30-2 and pursuant to Utah Code 63G-4-201.

Figure 2 shows UOIG recoveries for the past six years. In all cases, recoveries are guided by Medicaid Policy and Correct Coding Initiatives.

Over the past six fiscal years the UOIG recovered **\$33,564,289**.

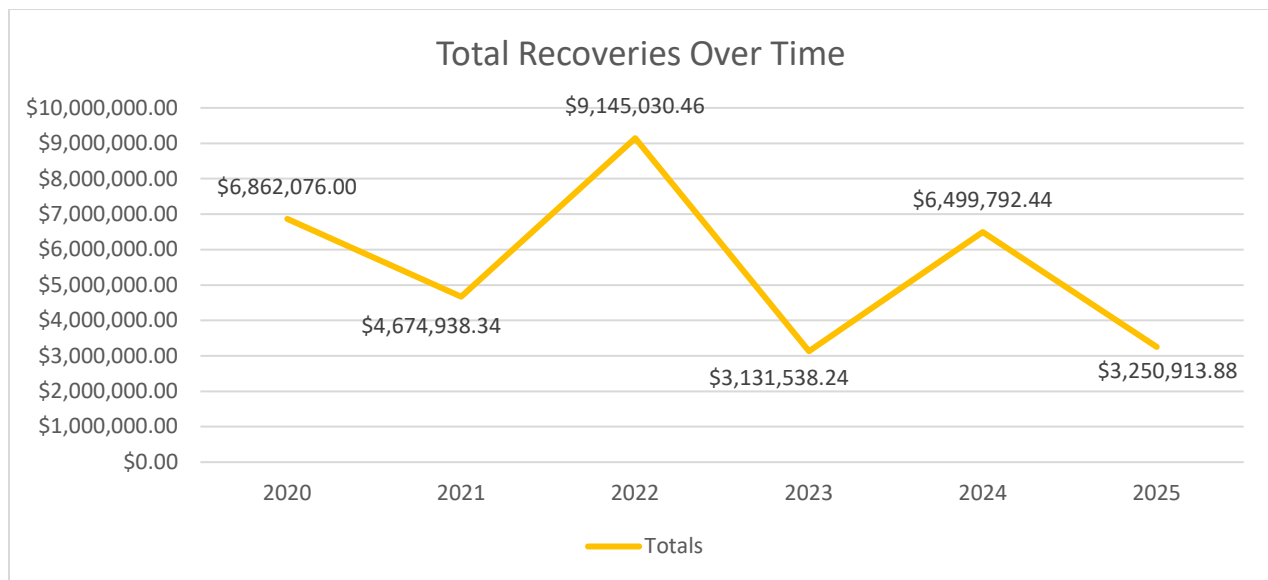


Figure 2. UOIG Recoveries over the previous six years

Investigations 63A-13-502(2)(a)(vii)

The UOIG’s role in fraud is outlined in 42 CFR § 455. Once the Office receives an allegation of fraud from any source, it conducts a preliminary investigation. The purpose of the preliminary investigation is to determine if a fraud referral is credible and warrants a full criminal investigation and merits possible prosecution. The UOIG does not have prosecutorial authority. The responsibility for conducting full criminal investigations and the prosecution of providers lies with the Medicaid Fraud Control Unit (MFCU). Similar to the federal requirements for a Medicaid Program Integrity Entity, there are also federal requirements for a MFCU.

The Office of Inspector General refers all credible allegations of fraud to MFCU for full investigation. MFCU reviews the referral and can choose from three courses of action. They can accept the referral and begin their full investigation, they can reject the referral, or they can send the referral back to the UOIG for further development. In instances where MFCU rejects the referral, they send it back to UOIG for other administrative remedies. During SFY2025, the UOIG made five referrals to MFCU for full investigation.

During SFY2025, the UOIG opened 400 allegations based on referrals from UOIG FWA reporting tools (calls, emails, and the UOIG website) or from UOIG identified areas of risk. These projects include hospital billing, prior authorization (PA) paid but not approved, mental health over billing, substance use disorder treatment centers, labs, billing for services not rendered, services in the home, and transportation. Ten of these referrals required on-site investigations. The on-site investigators reviewed 98 recipient records or 2,765 claims. Of the ten on-sites, two were referred to MFCU.

Initiatives to Identify Medicaid Abuse and Waste

The Office conducts initiatives that are designed to identify Abuse and Waste within the Utah State Medicaid program. Initiatives include performance audits, financial audits, evaluations, provider assessments, and medical record reviews.

Abuse. CMS defines this type of abuse as, “provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.”

Waste. CMS does not adequately define waste. However, Utah Code 63A-13-102(13) defines waste as, “(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.”

Abuse primarily occurs from billing errors by providers. Overtime those errors can become common practice. The UOIG uses Medicaid record reviews to ensure services provided to Medicaid recipients are performed, billed correctly using correct coding, and then paid appropriately through the Medicaid claims system. Abuse can become Fraud if a provider continues improper billing practices after the UOIG takes administrative action.

Waste can occur at any level of the Medicaid program. It is important that laws and policies are clear and give providers adequate guidance when submitting claims for rendered services. Waste may also occur if processes lack adequate controls or have adequate controls that are not adhered to. The UOIG conducts performance audits of programs to test controls to ensure taxpayer dollars are not expended wastefully.

Audits are available for review on the UOIG website at oig.utah.gov.

Outcomes

UOIG administrative actions result in several possible outcomes and may include a combination of outcomes. Audits, provider assessments, and claims reviews may result in one of the following outcomes:

- Recovery, Rebill, or Cash Recovery as outlined in the recovery section of this report.
- Training is often used as the least intrusive approach to correcting inappropriate billing. If a provider’s billing practices are deemed low to mid risk the Office issues training letters. If the billing practice is deemed mid to high risk the office conducts on-site training to correct the behavior.

In every case of recovery instance, the provider is given an opportunity to request reconsideration in a settlement conference. At any time during the reconsideration process either party may request to move the matter to administrative hearing.

Audits 63A-13-502 (2)(a)(vi)

Audits conducted by the office, including performance and financial audits.

The Utah State Legislature established the Office to provide oversight of the Utah Medicaid Program. The audit universe (see Figure 3) is complex and covers any part of the program where Medicaid funds are spent.

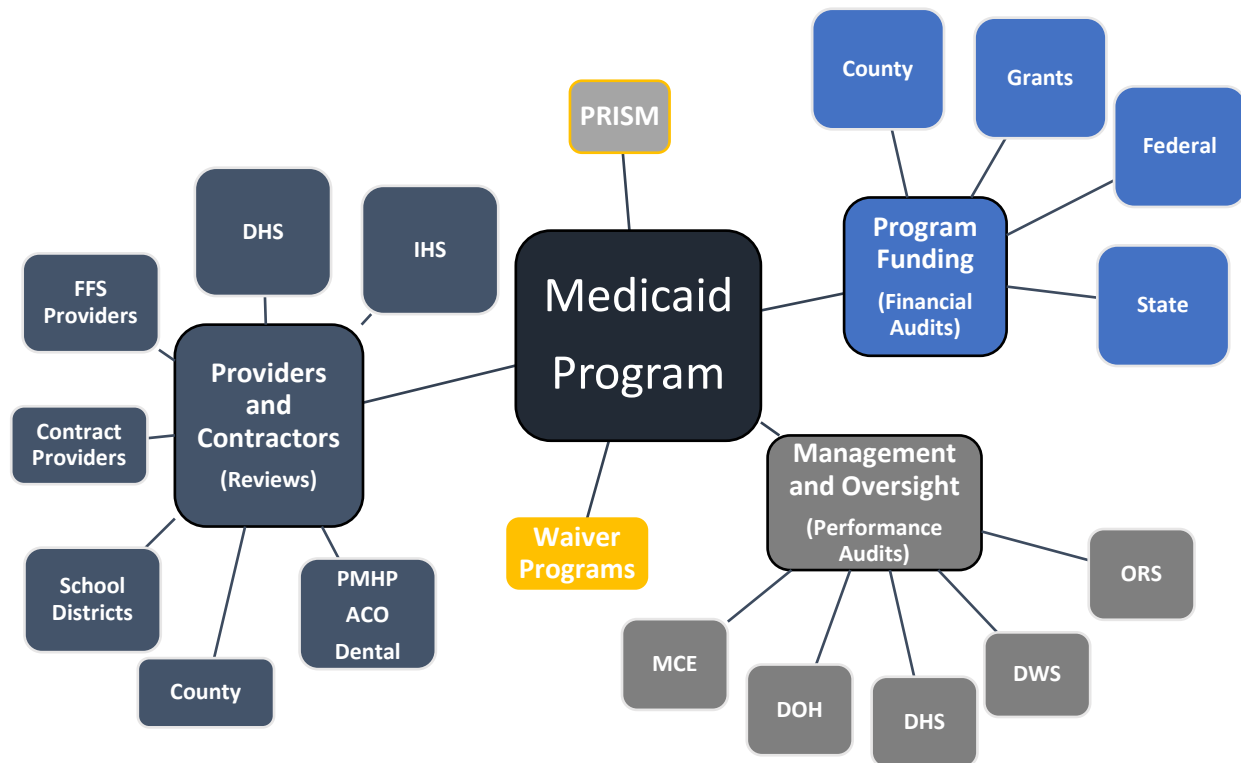


Figure 3. Audit Universe

The Office conducts performance and financial audits, evaluations, and provider assessments as part of the audit program.

Audit Reports Issued	1
Audits in Progress	5
Provider Assessments in Progress	2

Audits - The Office conducts audits on entities that have fiduciary responsibility for the proper expenditure of taxpayer dollars in the form of Medicaid funds. The Office divides this category into two types of primary audit types, financial and performance. *Financial Audits* are audits that identify sources of funding and applicable controls that safeguard those funding sources. *Performance Audits* are audits associated with sound management practices. These audits examine the efficiency and effectiveness of Medicaid. Audits reports are public, and the Office posts them on their webpage but reports are de-identified to protect personal health information (PHI) and personally identifiable information (PII).

Audit Reports Completed - UOIG conducts an annual audit of healthcare organizations receiving more than \$5 million in Medicaid payments to ensure compliance with Section 6032 of the Deficit Reduction Act of 2005. Under the act, healthcare entities must safeguard Medicaid taxpayer dollars by establishing, maintaining, and communicating policies and procedures to prevent and detect fraud, waste, and abuse. The audit found that all providers reviewed complied with Section 6032 of the DRA.

Audits In Progress - *Audit of Capitation Payments Made Concurrently with Another State.* In a joint audit with the United States Department of Health and Human Services Office of Inspector General (HHS OIG) capitation payments were reviewed for Medicaid members that were concurrently enrolled in Utah Medicaid and at least one other state. The audit team estimates Utah Medicaid made unallowable capitation payments to the MCEs of \$14.3 million for recipients concurrently enrolled in Utah September 1, 2021, and \$6.5 million for recipients concurrently enrolled February 1, 2024. The audit is currently in progress, and the final report is scheduled for release in the next fiscal year.

Provider Assessments – The office uses Provider Assessments are claim-by-claim post-payment review of billing practices across multiple providers, typically 4 to 6 providers per project. Findings are reported to each provider including details on any overpayment identified. When there are indications in billing patterns of potential systemic issues, provider assessments may be expanded to a performance audit.

For example: Hospice services are provided to terminally ill individuals with a prognosis to live no more than six months if the illness runs its ordinary course. For this provider assessment, UOIG conducted a post-payment claim review of members receiving hospice services for 15 months or more. During fieldwork, the provider assessment team identified approximately \$600,000.00 in overpayments and the detailed findings are being reported to the providers included in the assessment.

Another example: Expenditures for mental health and substance abuse services have steadily increased since 2020. UOIG started a post-payment claims review of mental health services to verify that services are rendered and documented properly to ensure Medicaid members are receiving appropriate behavioral health care. Early findings indicate billing errors and at least one credible allegation of fraud which will be referred to MFCU.

Evaluations - The Office uses evaluations to gain better understanding of a Medicaid Program and to identify potential risks that may need addressed through a performance audit. Evaluations are for internal purposes, and the Office does not release them publicly. However, evaluations could be useful to the Governor’s Office or the State Legislature if they desire an independent review of a particular Medicaid service.

Status of Projects in Progress

Audits	Preliminary Survey	Fieldwork	Report Writing	Final Report Issuance
30-day Hospital Readmission Billing Policy Audit	Complete	Complete	Complete	In Progress
Audit of Capitation Payments Made Concurrently with Another State	Complete	Complete	Complete	In Progress
Audit of Attendant Care Services	Complete	In Progress		
Audit of Improper Crossover Fee-for-Service Payments	Complete	In Progress		
Re-Audit of Capitations Paid After Death	In Progress			

Provider Assessments	Project Planning	Fieldwork & Analysis	Reporting
Hospice	Complete	Complete	In Progress
Mental Health Review	Complete	In Progress	

The UOIG provides training and education to Medicaid staff, Medicaid providers, and community stakeholders on topics such as:

- How to identify and prevent Medicaid fraud, waste, and abuse
- The Federal False Claims Act
- Utah's False Claims Act
- The Deficit Reduction Act
- State and Federal program regulations, including Payment Suspension requirements
- Whistleblower protections
- Qui Tam Incentives
- Risk Mitigation
- Utah Administrative Rules pertaining to Licensing and the Medicaid Program
- The Medicaid State Plan and Waiver Implementation Plans
- Utah Medicaid policies and resources, etc.

Utah Medicaid Providers now actively seek out and request UOIG training.

The UOIG has conducted 126 trainings from 2020-present.

*42 USC 1396u-6; 42 USC 1396(a)(68); UT Code 63A-13-202(1)(p); etc.

Stakeholder Training 63A-13-502(2)(a)(viii) and (xi)

One of the UOIG's responsibilities under Utah Code 63A-13 is the training of stakeholders on the identification and reporting of Medicaid fraud, abuse, and waste.

Prior to 2020, the UOIG offered a handful of training sessions each year, but we found that providers were not actively participating in training in a meaningful way. Our office cannot require providers to attend training, so we took a collaborative approach and began, whenever possible, to tailor the content of our training to each audience, to help ensure its relevancy. In FY24, the UOIG has gone out to provide training to every county health department and PMHP in the state. We train each Medicaid Office and their staff every year. We've also had an increasing number of Medicaid providers each year reach out to request specific training from us, and now we deliver training to professional groups, like the local American Academy of Professional Coders (AAPC) chapters, and even the Governor's Office of Planning and Budget (GOPB).

Since 2020, we have conducted and participated in 126 different training courses on the topics listed in figure 4. We see very positive outcomes from our efforts, ranging from increased quality of Fraud,

Waste, and Abuse reporting to the office, to providers utilizing the resources presented in training to proactively align their internal practices with better documentation practices or correct coding and Medicaid billing guidance.

Cost Avoidance 63A-13-502(2)(a)(ix)

Cost avoidance is quantifiable savings to the Medicaid program attributable to actions taken by the UOIG, including recommendations to the Single State Agency that cause positive changes in the program. During State Fiscal Year 2019, the Office fully implemented the cost avoidance methodology. The Centers for

Medicare and Medicaid Services (CMS) asked the Inspector General to present this methodology to other states in a training session at the Medicaid Integrity Institute (MII) in Columbia, South Carolina, which the Office did on March 12, 2019. Many states are now implementing the same, or similar, methodologies to capture the total value of Program Integrity work they conduct. Subsequently, CMS asked the Office to present the methodology in a distance-learning module and again at the MII in September 2019. We are also now seeing private industry companies utilize cost avoidance methodology in their own outcome models. In August 2025 Deloitte's presentation at the annual National Association for Medicaid Program Integrity (NAMPI) included Cost Avoidance while discussing measurements of ROI in Medicaid Integrity Efforts.

The UOIG determines cost avoidance by observing billing trends prior to UOIG involvement and then again after UOIG intervention. To determine cost avoidance, the Office compares the average difference in billing behavior and projects the associated savings over five years. For example, if Provider A is upcoding evaluation and management (E&M) codes and billing Medicaid for \$50,000 annually, the Office may perform a recoupment and simultaneously conduct provider training. The Office then continues to monitor Provider A's billing practices to observe any changes. If Provider A's billed charges drop to \$20,000 the following year, due to appropriate billing, the cost avoidance (taxpayer savings) is \$30,000 which represents the change in billing behavior by the provider. The UOIG projects \$30,000 annually for the next year and continues to monitor the provider, at least annually, to ensure the claimed cost avoidance remains. These changes in actual billing behavior, combined with the potential for future changes in Medicaid policies governing the cost avoidance subject matter may result in variation between how long cost avoidance is calculated for each subject.

The UOIG operationalized the current cost avoidance methodology during 2018, and it became a model adopted by other states throughout the country.

Cost Avoidance Results

The UOIG saved Medicaid and Utah taxpayers an additional \$12,423,329.45 during SFY25. Figure 5 shows the cost avoidance trend since UOIG implemented the methodology.

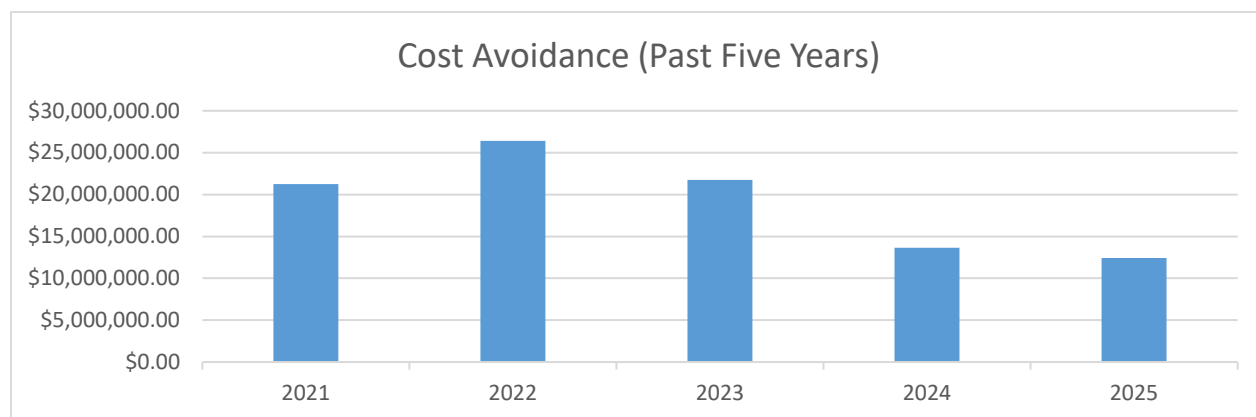


Figure 5. Cost Avoidance Over Time

Program Integrity Coordination Efforts

The Office coordinates PI efforts with various stakeholders. While the State Legislature intends that the Office remain completely independent, the reality is that the Department of Health and Human Services (DHHS) is the Single State agency responsible for administering the Medicaid Program, as designated in Utah Code 26B-3-102 and the Utah State Medicaid Plan. The UOIG works closely with the Medicaid Agency to coordinate many program integrity projects, while seeking to remain professionally independent. Medicaid does not direct the work of the Office, but coordination is key to successful Program Integrity. In addition to DMHF, other state agencies such as the Department of Workforce Service (DWS) are critical in identifying fraud, abuse, and waste within the Medicaid program. The Office also meets monthly with the Attorney General's Medicaid Fraud Control Unit (MFCU) to discuss fraud referrals and the status of ongoing investigations.

In addition to state agencies, the Office coordinates with contractors who play a key role in the State's Program Integrity efforts.

Medicaid Policy Change Reviews

63A-13-202(b)(ii) and (iii), and 63A-13-202(2)(c)

Anytime that Medicaid changes a policy, they issue a Medicaid Information Bulletin (MIB). Utah Code requires that Medicaid sends draft MIBs and draft changes to Provider Manuals to our office for review prior to publication.

We review conflicts between the proposed change and USC, CFR, UT Code, Administrative Rule, CMS Authorization, the State Plan, Waiver Programs, or other existing Medicaid policies, and then make recommendations to resolve those conflicts.

Additionally, we review the proposed change to determine whether that change may result in increased risk to the Medicaid program and taxpayer resources, to Medicaid beneficiaries, or to a healthy and robust network, and make recommendations to mitigate those risks.

The UOIG reviews* all draft Medicaid policy changes for conflict with U.S.C., C.F.R., Utah Code, Administrative Rule, CMS Authorization, the Medicaid State Plan, Waiver Programs, or other existing Medicaid policies, and makes recommendations to resolve any identified conflicts.

The UOIG further reviews all draft policy changes to determine if the change will adversely impact Medicaid Program Integrity through increased risk to the Program, to taxpayer dollars, to a robust provider network, or to Medicaid Beneficiaries, and then makes recommendations to mitigate identified risks.

The UOIG has made 953 MIB recommendations to Medicaid from 2020-present.

* UT Code 63A-13-202(2)(b)(ii), and (iii), and 63A-13-202(2)(c)

The UOIG is prohibited from changing Medicaid policies or procedures, as part of maintaining our independence, but we found, since 2020, the UOIG has reviewed 579 draft MIB policy changes, and made 953 recommendations to Medicaid regarding those draft changes. When tracked, Medicaid accepted an average of approximately 50% of UOIG MIB recommendations. Medicaid reported system limitations prevented some recommendation implementation. Medicaid also eventually implemented approximately 50% of the UOIG MIB recommendations that Medicaid did not report initial agreement with.

Managed Care Entities (MCE)

The Utah State Medicaid Agency manages about 85% of Medicaid through contracts with Managed Care Entities (MCE). Each MCE contractually maintains a program integrity unit, or special investigations unit (SIU), to address fraud, abuse and waste identification and reporting. The UOIG and MFCU meet quarterly with each of the individual SIUs to discuss concerns and to share information about evolving fraud schemes. The UOIG also hosts a quarterly combined meeting of all MCE SIUs to present training and exchange information amongst the various groups.

Western Region Unified Program Integrity Contractor (UPIC-W)

The Centers for Medicaid and Medicare Services (CMS) incorporated a new contractor program designed to assist states in their Program Integrity efforts. The Western Region contractor is Qlarant, which covers all western states including the Pacific Island territories. DOH opted not to create a data feed to Qlarant, but the Office refers some projects to Qlarant and assists in ad hoc data pulls for those projects. The advantage of utilizing the UPIC-W is that the contractor helps strengthen areas where the Office may not have sufficient resources to pursue every identified risk. The Office holds monthly meetings with Qlarant to receive updates regarding referred projects and to discuss emerging fraud trends. UPIC contractors are free to the States and are, therefore, a cost-effective tool in the State's fight against Medicaid fraud, abuse, and waste. For example, during SFY21, the UOIG completed the first project with Qlarant.

Health Fraud Prevention Partnership (HFPP)

During SFY 2021, the UOIG joined the Health Fraud Prevention Partnership. This partnership is a CMS contracted third party that seeks to identify and address fraud schemes across multiple jurisdictions. It includes Program Integrity Units, MCE SIUs, and law enforcement at all levels from multiple states. The HFPP conducts studies of emerging fraud trends using data from all partners, and releases white papers based on their findings. If the HPFF identifies Utah as a possible target of an emerging fraud trend, they notify the state's Program Integrity unit so they can take appropriate action. Participation in HFPP is free to state partners and a valuable resource for identifying emerging trends.

Professional Certifications and Continuing Education

The UOIG staff is composed of professionals holding multiple certifications that demonstrate expertise in investigating, auditing, accounting, and internal controls. These certifications represent our commitment to maintaining high standards and professional competency. All team members met or exceeded the required continuing professional education hours for the SFY 2025 reporting period.

Certifications held by team members include:

- Certified Fraud Examiner (CFE)
- Certified Government Audit Professional (CGAP)
- Certified Information Systems Auditor (CISA)
- Certified Inspector General Auditor (CIGA)
- Certified Internal Auditor (CIA)
- Certified Professional Coder (CPC)
- Certified Public Accountant (CPA)

Registered Nurse (RN)

Additionally, during SFY 2025 one team member served on the board of Utah Government Auditors Association (UGAA), and another was named Executive Chair of the American Academy of Professional Coders (AAPC) Local Chapter Association Board.

In the next fiscal year UOIG will continue to foster the professional development of our UOIG staff, focusing on obtaining professional certifications and attending training which will strengthen the knowledge, skills, and experience needed to perform the 2026 and future work plans. Additionally, as of the publication of this report, UOIG is in the hiring process to add new experienced auditors to the team.

Concerns

Balance Billing

The UOIG observed a sharp increase in reports of balance billing in SFY25. When providers bill a balance, that Medicaid does not cover, to the recipient, the recipient frequently ends up in collections. The Office received 88 complaints about balance billing during SFY25, and that trend is continuing upward during the first part of SFY26. Medicaid policy is very clear on the prohibition of balance billing and the Office resolved many of these issues in favor of the recipient. The Office developed a training letter to these providers to instruct them that a provider who accepts a member as a Medicaid patient, that they must accept the Medicaid or state payment as full reimbursement in full. The Office also published a Training Bulletin on the UOIG website about this topic. The Office will continue to address these balance billing issues as they are received and will conduct pattern analysis to determine if certain providers are repeat offenders.

Common Provider FWA Examples

- Billing for services not rendered and/or supplies not provided
- Double billing
- Coding Schemes such as Unbundling and Upcoding
- Altering medical documentation or claim forms
- Misrepresentation of medical conditions or services
- Soliciting, offering or receiving a kickback, bribe or rebate
- Failure to report third party liability in billing

PRISM System

The UOIG recently identified significant risks in Medicaid's PRISM program that have gone unreported by Medicaid. Claims are not being processed or paid correctly in multiple areas, including both fee-for-service, and capitation payments. Additionally, Medicaid Member eligibility is often inaccurate. The UOIG is actively working to identify the scope of risk and impact to Utah taxpayers, Medicaid providers, and Medicaid Members.

UOIG Identified Risks to Utah Medicaid Members

- Substance Use and Mental Health providers taking Medicaid Members to 6-hour movie marathons instead of providing therapy.
- Substance Use and Mental Health provider whose Janitor was providing therapy for Medicaid Members.
- Nursing Facilities with un-licensed nurses, and other nurses who have been providing service for several years after their license expired.
- HCBS Waiver caregivers entering the homes of elderly or disabled Medicaid Members without evidence or documentation to support that any services were provided.

UOIG Mitigated Risks to Utah Taxpayer Dollars

- HCBS Waiver providers volume of claims between 2022 and 2023 increased 30%, without approved Care Plans.
- HCBS Waiver providers billing Medicaid using deliberately inaccurate service information.
- HCBS Waiver providers billing for up to \$590,000,000 without sufficient documentation to support service provision.
- Utah Medicaid capitation payments paid after the Member enrolled in other state Medicaid programs, or after the Member was determined to be a resident of another state, for an average of 14 Months after the end of the PHE.

Looking Towards the Future!

UOIG Improvements for Reporting and Visibility

Utah Code 63A-13-502(2) requires the UOIG to report annually to General Government Appropriations Subcommittee and the Utah Governor's Office. Additionally, Utah Code 63A-13-201(6)(e) requires the UOIG to report, "when requested" to the governor, the president of the Senate, or the Speaker of the House. The UOIG has consistently met and exceeded these requirements, by proactively sending copies of audit reports, and publishing them on the UOIG website. However, the UOIG recognizes and agrees with OLAG findings that current reporting processes appear to be insufficient; it appears that many Utah Legislators were unaware of the UOIG or the scope of work the Office is responsible for.

- The UOIG has already begun meeting with Utah Legislators and is working to build robust communication lines with both individual legislators and legislative committees.
- The UOIG has requested the opportunity to begin reporting regularly to the Social Services Appropriations Subcommittee regarding UOIG audit outcomes, identified risks or trends in Medicaid, and to provide committee members with context and information, to assist with any necessary decision-making processes.
- The UOIG is available to assist in the development of increased parameters for reporting. The UOIG would welcome any feedback or information from Legislators regarding additional elements that they would find beneficial, for inclusion future UOIG reports.

UOIG Improvements for Audits & Risk Assessments

- The UOIG is working to narrow the gap in how the UOIG historically defined audits and risk assessments and in how OLAG defines each. The UOIG is working to incorporate OLAG definitions into UOIG practices.

- The UOIG has begun connecting with other states (Texas, New York, Louisiana, and Nebraska) to identify how each conducts their ACO audits and identify the elements included in their respective Medicaid risk assessment processes.
- The UOIG will ensure future audit and risk assessment processes align with not only industry standards and federal regulation but also incorporate Utah Legislative direction.
- Upon completion of updates, the UOIG will publish and report upon the formal Risk Assessment process.
- The UOIG will utilize improved Risk Assessments to drive ACO audits, and audits of other high risk Medicaid program areas.

Improvements to the UOIG Website and Resources

The UOIG has already begun to update its website and is working to develop additional reporting elements that will assist users and increase traffic. Some of the many changes include:

- UOIG Training Request form. Providers may now request training online.
- Updated UOIG webpages with current and historic reports and resources.
- Published Advisory Opinions/compliance-based training bulletins.
- Planned metrics with UOIG audit plans, and current audit stage progress.

Planned publication of UOIG's development of Cost Avoidance methodology and its adoption by other States and private industry

Conclusion

UOIG Employees take great pride in their responsibility to safeguard taxpayer dollars through oversight of Utah State's Medicaid program. Through vigilance, cooperation with stakeholders, and tireless effort, the Office will continue seeking to work toward its goal of eliminating fraud, abuse and waste.

During SFY 2026, the Office will continue refining processes and continue improving the skills necessary to achieve that goal. It is our pleasure and honor to serve the great State of Utah.